We welcome letters to the Editor concerning articles which have recently been published. Such letters will be subject to the usual stages of selection and editing; where appropriate the authors of the original article will be offered the opportunity to reply.

Letters should normally be under 300 words in length, double-spaced throughout, signed by all authors and fully referenced. The edited version will be returned for approval before publication.

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Osteofibrous dysplasia of the tibia

Sir,

We read with interest the paper by Lee et al1 in the May 2006 issue entitled “Osteofibrous dysplasia of the tibia: is there a need for a radical surgical approach?”. The authors have concluded on very weak evidence that “radical extra-periosteal excision is indicated in all cases of osteofibrous dysplasia”.

This goes against all the published evidence on this rare condition and is not supported at all by the authors’ own evidence. The definitive book on diagnosis of bone tumours states “the natural history of osteofibrous dysplasia is that of gradual growth during the first decade of life followed by healing or spontaneous resolution”.2

The authors have included in their series of 16 patients, three who turned out not to have osteofibrous dysplasia on final histological review but had an adamantinoma and thus should not have been included in this paper. They have chosen to resect all of the involved bone electively in all patients that they treated without being included in this paper. They have chosen to resect all of the involved bone electively in all patients that they treated without considering conservative surgery. The authors’ own acceptance of the morbidity of the procedures they carried out is confirmed by the list of complications summarised in Table I.

We agree that diagnosing osteofibrous dysplasia and differentiating it from both adamantinoma and even fibrous dysplasia can be difficult, but careful radiological and histological analysis can almost always make a definite diagnosis. The benign nature of osteofibrous dysplasia is well established and the treatment philosophy in our unit has been to treat the symptoms, not the condition. We have had no case in the past 20 years where this treatment philosophy has failed. We believe that aggressive treatment for biopsy-proven osteofibrous dysplasia is not required and we would strongly recommend a conservative approach to this condition, but would agree that referral to a specialist musculo-skeletal oncology unit should be considered in order to confirm diagnosis.

doi:10.1302/0301-620X.89B1.19030

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Author’s reply:

Sir,

We were pleased to receive a communication from our colleagues, Messrs Grimer et al, in Birmingham. We fully acknowledge that the traditional treatment of osteofibrous dysplasia has been a conservative approach. However, not all results following a conservative approach are excellent. Often the healing of the tibia in particular can be extremely abnormal and the patient can suffer a shortened deformed bone in adolescence. Many patients and their parents are unhappy to undergo treatment with external support which may last up to ten years.

The aim of our paper was to emphasise two factors. First, that if surgery is thought to be necessary due to increasing destruction of the bone and deformity, we would recommend a radical extra periosteal approach, rather than intra-lesional curettage, which in our experience usually leads to recurrence. The second aim of our paper was to draw attention to the coincidental development of adamantinoma within osteofibrous dysplasia which occurred in three of 16 cases. Progressive osteofibrous dysplasia therefore may be hiding concomitant adamantinoma, which can of course be adequately treated at this early stage by complete en bloc excision.

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Methicillin-resistant Staphylococcus aureus in an Irish orthopaedic centre

Sir,

I read with interest the paper by Roche et al1 in the June 2006 issue entitled “Methicillin-resistant Staphylococcus aureus in an Irish orthopaedic centre: a five-year analysis”. It emphasises the growing burden of MRSA in orthopaedic practice. In the Methods section the authors state that “Routine screening is carried out on every patient previously colonised or infected with MRSA, those transferred from nursing homes and long-stay residential institutions, frequently hospitalised patients and all national and international transfers”. Does this statement mean that only the above...
category patients were screened for MRSA on admission, or does it mean that all patients admitted to the orthopaedic wards were screened for MRSA on admission? There was no mention of the policy for MRSA screening in elective patients. A total of 240 patients were colonised with MRSA, of which 173 were colonised on admission. With regard to these latter patients, what was their antibiotic prophylaxis and did any receive vancomycin for their implant-related surgery? It would be good to know the number of MRSA infections in this group, and if there was any difference in the rate of infection between those who received routine antibiotic prophylaxis and vancomycin.

doi:10.1302/0301-620X.89B1.19036

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Author’s reply:

Sir,

I found the comments and queries made by Mr Sunderamoorthy both incisive and relevant.

First, not all patients were screened on admission to the orthopaedic ward. The same criteria for screening were applied to both trauma and elective patients (as described in the Methods section). In doing so, the unit was adhering to national guidelines outlined by the Irish Department of Health in 1995. Incidentally, new national guidelines have been tabled for 2006. All elective cases are now screened at a pre-admission clinic.

We were unable to compare outcomes in those who received vancomycin and were colonised on admission, with those who did not receive vancomycin. Although we could identify those within this subgroup who received vancomycin, we were unable to state with certainty whether it was received before or after isolation of MRSA infection in the particular group who were positive on admission and subsequently developed MRSA infection.

Not all of those who were positive on admission received antibiotic prophylaxis in addition to mupirocin ointment and 4% chlorhexidine body wash. Those undergoing implant-related surgery received cephalosporins pre-operatively. Vancomycin was administered to a small minority of this group where the risk of developing MRSA infection was deemed high (i.e. immunocompromise). New guidelines are now in place at our unit in relation to the administration of vancomycin. A pre-operative intravenous dose of 1 g is given to patients who are thought to be at high risk of contracting MRSA infection. This subgroup includes those colonised on admission, patients who are deemed immunocompromised, interhospital transfers without a negative screen, and also patients who will be nursed in close proximity to other cases of MRSA colonisation or infection due to problems with availability of beds.

The patient cohorts identified by Mr Sunderamoorthy would appear to be worthy of further investigation in future prospective studies.

doi:10.1302/0301-620X.89B1.19036

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