My approach to consent is individualised to the specific patient and the planned procedure. I do not believe in long lists or exhaustive documentation as at the end of the day you rely on your relationship with the patient and trust. I explain the procedure in terms the patient understands, taking their level of education and language skills into account. In private practice, I see the patient the week before the elective admission to discuss the procedure and risks again. The financial aspects are discussed and they are given a printed quote at the time of booking. In state practice, the procedure is discussed on booking and day of admission.

I explain that there is a multitude of risks starting with the car journey to the hospital and that I cannot list all. I explain that the major three complications in spine surgery seldom occur. I discuss these in particular, viz. neurological injury (1:300 mild to severe), infection (0.8%) and non-union (5%). I also explain that although they are few and far between if they occur their incidence is 100%. At the end I make the comparison to a flight where they trust the pilot to do his best and possibly have to make intra-operative decisions on their behalf.

I then ask them if they have any questions. Sometimes this is short and people want minimal explanation but others take far longer.

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Radial head fractures as a result of an indirect injury such as a fall on the outstretched hand is a serious injury to the whole of the fore-arm (i.e. interosseous ligament), as well as the wrist and distal radio-ulnar joints (i.e. Essex-Lopresti injury).

These injuries are more common than previously realised and often go unrecognised.

Late complications pose very difficult clinical management. These include proximal migration of the radius resulting in subluxation of the distal radio-ulnar joint and thus an ulnar positive position. This can have a secondary effect on the TFCC ligament and cause abutment on the ulnar carpal bones.

It is therefore imperative to exclude Essex-Lopresti injuries when dealing with radial head fractures. The radial head must be retained at all cost in these cases.

If the head can be reconstructed this needs to be done as soon as possible. However if the head is comminuted a replacement is indicated with a fixed, straight stem prosthesis.

Unfortunately one sees neglected radial head fractures or failed reconstructed heads which need to be replaced. Invariably soft tissue changes take place which influence the normal functional alignment of the radial head on the capitellum. If a fixed stem prosthesis is used in these cases, mal-alignment is often seen, and even during surgery, when testing flexion-extension and pronation-supination, instability is a real problem.

In order to address this difficult and unsatisfactory problem, a swivel radial head prosthesis has been developed which accommodates the mal-alignment during elbow movements.

The surgical procedure is similar to the fixed head prosthesis. The added advantage of using the swivel head prosthesis lies in the head “following” the capitellum and therefore it adjusts to the relative position of the capitellum, reducing the chances of radial head subluxation or dislocation.

The clinical results with this “mobile” radial head prosthesis warrant the use of the swivel head when biomechanical mal-alignment of the radial head causes instability.

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