



Letter to the Editor

Thoracolumbar fractures

I am surprised that you published this article. There is no control group to judge the results of surgical intervention. Neurological improvement in thoracolumbar fractures occurs without surgery. George Bedbrook¹ failed to find a reason to operate on these fractures to improve neurology decades ago. Nothing has changed. In 1995 Limb *et al.*² wrote:

'If surgical treatment is indicated for other reasons, it should be addressed to these and not to clearing the canal.'

In 1998 at the American Academy, Rehtine³ laid bare the myths about surgery for thoracolumbar fractures. These myths are: (1) Neurologic deficits require surgery; (2) 50% compression requires surgery; (3) 40% canal compromise requires surgery; (4) Multiple fractures require surgery; (5) Lower incidence of DVT with surgery; (6) Lower incidence of PE with surgery; (7) Lower complications with surgery; (8) Less long term pain with surgery; (9) Better neurologic recovery with surgery acutely; (10) Canal compromise correlates with neurologic deficit; (11) Neurologic recovery correlates with decompression.

There are few indications for surgery on thoraco-lumbar fractures. Patients should be protected from the complications of such surgery, in this paper 11.4%. The fact that surgery on rats had such good results as justification for such surgery on humans is ludicrous.

David C Jaffray
Consultant Orthopaedic Spinal Surgeon
The Robert Jones and Agnes Hunt
Orthopaedic and District Hospital
Oswestry, Shropshire, SY10 7AG

References

- 1 BA Kakulus. The applied neuropathology of human spinal cord injury. *Spinal Cord*, 1999; 79-88.
- 2 D Limb *et al.* Neurological injury i thoracolumbar burst fractures. *J BJS (BR)*, 1995; 774-777.
- 3 G Rehtine. American Academy Lecture. 1998.

In Reply to Mr Jaffray

We have read Mr. Jaffray's comments with interest and note that he seems to have missed the point of the paper. We accept that there is debate about the indication for operative intervention in patients with spinal fractures and neurologic deficits and Mr Jaffrays views are quite clear. However, many other surgeons favour early operative intervention and there is considerable support for this view in the literature.

The remit of our paper was not to compare operative with non-operative management, but to detail the results of operative treatment and to emphasise the need for early surgery if operative management is undertaken.

Christian Gaebler, MD
Clinic for Trauma Surgery
University of Vienna
Wahringer 18-20
A-1090 Vienna, Austria