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Authors have no conflict of interest.

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WHAT BECOMES OF THE BROKEN NOSE?

Editor,

Nasal fractures are the most common facial injury, frequently associated with aesthetic, functional and psychological complications¹. Closed reduction of fractured nasal bones is first line treatment commonly employed by Otolaryngologists and Plastic Surgeons, however some patients require open septorhinoplasty¹.

In our practice the incidence of fractured nasal bones appears to be rising from approximately 100 cases in 2008 to 170 cases in 2012. For 95 percent of cases closed reduction of fractured nasal bones led to satisfactory results. However an increasing numbers of patients are being seen, following closed reduction of fractured nasal bones, who are unsatisfied with the result and are requesting further surgical intervention. Our review of 700 patients from 2008 to 2012 has shown a rise in those undergoing either rhinoplasty or septorhinoplasty from 1.9 percent to 8.4 percent.

Seventy percent of patients with fractured nasal bones were male with an average age of 31 years, of which approximately 50 percent sustained nasal injury secondary to alleged assault. SIMON (Single, Immature, Male, Overly expectant and Narcissistic) is an acronym commonly used to identify patients who are likely to be unsatisfied with the outcome of nasal surgery². We appear to be seeing an increasing number of patients fitting the SIMON criteria who are 'unsatisfied' with the outcomes of a procedure that in general provides satisfactory results. Alternatively there maybe a legal motivation for those pursuing open surgery considering that almost half of our patients reported injury secondary to alleged assault³.

Complex nasal injuries are frequently associated with high failure rates, following closed reduction of fractured nasal bones. These include grade III fractures involving the nasal septum and patients with previous nasal fractures^{1,4,5}. Septal involvement is frequently underestimated by physicians when assessing and managing nasal fractures^{1,4,5}. Our study showed many discrepancies between findings documented at the time of clinic compared to at the time of theatre, particularly in relation to the nasal septum. If closed reduction of fractured nasal bones is conducted without addressing a septal fracture, the septum will in time move the nasal bones back towards their deviated position^{1,4,5}. Moreover, our results showed that approximately 25 percent of patients who had an unsatisfactory outcome reported previous nasal fractures.

Fractured nasal bones are successfully treated by closed reduction in the vast majority of cases, however a rising number of patients are now undergoing open surgery. We believe the reason for this increasing trend is multifactorial. Our results suggest that there is an increasing number of SIMONS within our society who are frequently unsatisfied with the result of cosmetic surgery or surgery following assault or injury. Furthermore factors such as status of the nasal septum and previous nasal injuries have to be considered if initial treatment is to be successful. Finally it is the authors experience that increasing numbers of patients with nasal fractures are being booked for septorhinoplasty at the outset rather than nasal bone manipulation if this is felt acceptable at the time of consultation and we predict that this trend will continue.

The authors have no conflict of interest.

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GENERAL PAEDIATRIC SURGERY: A SURVEY OF NORTHERN IRELAND GENERAL SURGERY SPECIALIST REGISTRARS

Editor

INTRODUCTION:

From 1994 to 2005, paediatric surgical activity in district general hospitals (DGH) in England declined by 30% across all surgical specialities¹. We surveyed current NI general surgery specialist registrars to establish their intentions as regards general paediatric surgery (GPS) for eventual consultant practice if appointed to a DGH.

METHOD:

Thirty-five speciality specialist registrars were sent an on-line questionnaire. Enquires concerned previous experience of paediatric surgery, conditions and age profiles of children the respondent would be prepared to treat in eventual consultant practice if appointed to a DGH.

TABLE 1.

Service trainees would intend to provide in Consultant practice.

Operation	% Registrars (n=25)
Appendicectomy	88
Scrotal exploration	80
Suturing of minor facial laceration	76
Incision and drainage of abscess	84
Admit a child with a head injury	68
Trauma laparotomy	28
Elective circumcision	44
Toenail surgery	60
Orchidopexy	16
Herniotomy	20
No paediatric service	12

RESULTS:

The response rate was 71% (n=25). Thirty-six percent (n=9) of specialist registrars had previous experience of specialist paediatric surgery. Operations trainees would offer if appointed to a DGH are reported in table 1. The age profiles of children with a minor head injury, appendicitis and an acute scrotum that trainees would be prepared to admit under their care or operate on are reported in figures 1, 2 and 3. Sixty percent (n=15) felt a period of paediatric training

during registrar training would make them more attractive to an employing trust, yet only 52% (n=13) felt this should be mandatory.

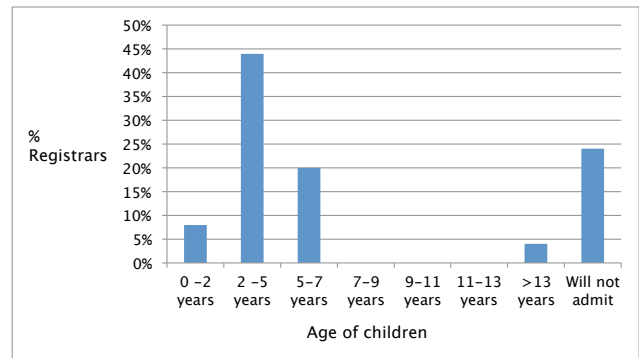


Fig 1. Minimum age profiles of patients trainees would admit with minor head injury

DISCUSSION:

The provision of GPS in the DGH has reached a crossroads. The fundamental problem has been a failure to train and appoint sufficient numbers of general surgeons with appropriate paediatric skills and experience. The major finding of this survey is that the majority of trainees are interested in emergency GPS and have indicated a desire to provide a service in the future. This is at odds with the findings of Craigie *et al* who conducted a survey of adult general surgeons and their paediatric practice in Scotland in 2005. At that time, 70% of DGH and 100% of remote and rural consultant general surgeons reported that they operated on children regularly, yet only 29% of these surgeons thought their successor would follow on in a similar role².

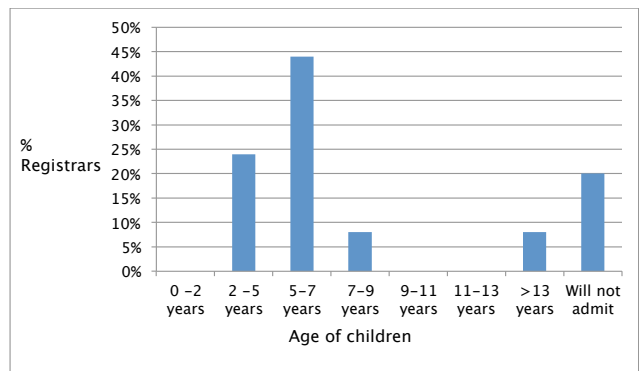


Fig 2. Minimum age profiles of boys trainees would operate on with an acute scrotum.

“Delivering a First Class Service” published in 2007 by the Children’s Surgical Forum recognised that not all DGHs would continue to provide GPS but that larger DGHs should have sufficient workload, staffing and facilities to continue to provide children’s services. The forum proposed that “children and their families must be able to access minor/routine surgery and outpatient facilities for more specialised conditions locally” and that “children’s services should be seen as an essential service”³.