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Reply from the authors:

Sir,

We thank Doctors Kerr and Resnick for their interest in our paper and note that they consider that condensing osteitis of the clavicle is a well-defined non-infective disorder. However, we believe, for the reasons stated in our paper that evidence for this is currently lacking.

To give an example, one reference that they use to support their argument (Cone et al 1983) appears to add the seventh and eighth cases of condensing osteitis to the literature. This is, in fact, representative of the rather unscientific attempts to introduce this new condition. In one case the history is described in reasonable detail and radiographs, an isotope bone scan and a biopsy were performed, but there was no attempt whatsoever to exclude sepsis. The second patient was reported with very scanty clinical data, plain radiography and an isotope bone scan. Sepsis does not appear to have been considered in the differential diagnosis and there was no histological examination of the lesion.

We agree with Doctors Kerr and Resnick that condensing osteitis does not exist in children. However, we refute their diagnosis of chronic multifocal osteomyelitis in our cases when there was a single non-recurrent focal lesion. Until there is more scientific proof, condensing osteitis in adults remains a very dubious diagnosis indeed.

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USE OF TOURNIQUETS

Sir,

I read with interest the paper by Salam et al (1991; 73-B:86-7) and the resulting correspondence (1991; 73-B:869) concerning the complications arising from the use of tourniquets during tibial plating. The wound complications and leg swelling after tourniquet removal are almost certainly due to an ischaemic-reperfusion injury and are analogous

to the situation after a successful femoropopliteal arterial by-pass.

The basis of this injury is the release of free radicals and other toxic oxygen species by activated neutrophils (Paterson et al 1989). Postoperative leg swelling after arterial surgery can be prevented by administering mannitol intra-operatively or by pretreatment with the free-radical scavenger allopurinol (Paterson et al 1991). This approach may well be of use to orthopaedic surgeons who use tourniquets for prolonged periods.

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RANDOM BLOOD SALVAGE

Sir,

In your July issue (73-B:591-4) you published an article by Slagis et al, entitled 'Postoperative blood salvage in total hip and knee arthroplasty', with the subtitle 'A randomised controlled trial'.

The method of sampling the patients is not clear. Of the 109 patients entering the study, seven were excluded for different reasons, leaving 102 patients having arthroplasties. In the Results section the study and control groups are stated to be evenly matched for age and sex. It is a little confusing that the word 'randomised' is used in the subheading, when the total material is evenly matched for age and sex. This seems impossible without additional exclusions.

Some questions remain: was the material at any point allocated at random? If so, how was this procedure carried out? And why were the groups then evenly matched for age and sex? It seems to be of general interest that the prospective design of the study is clearly presented.

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Slagis SV, Benjamin JB, Volz RG, Giordano GF. Postoperative blood salvage in total hip and knee arthroplasty: a randomised controlled trial. *J Bone Joint Surg [Br]* 1991; 73-B:591-4.

Reply from the authors:

Sir,

We write in response to the questions raised by Doctor Fredin regarding the design of our study. Our patients were randomised as follows:

- 1) All patients presenting for joint replacement surgery were offered participation in the study; those who agreed were then assigned a date for operation.
- 2) The blood salvage process was carried out only on alternate weeks. The person assigning the surgery date was