Letters to the Editor

Re: Perioperative ulnar neuropathies; a medical legal review. John D. Stewart, Stephen H. Shantz. Can J Neurol Sci 2003;30:15-19.

For years, our neurosurgical staff at Lions Gate Hospital has been aware that the perioperative ulnar neuropathies occur in a delayed fashion following a surgical procedure under general anaesthesia. While the authors have concluded that there is no basis for a claim against medical or nursing staff or hospitals, when an ulnar neuropathy develops following anaesthesia and surgery, this writer believes that the medical and nursing staff have a duty and an obligation to remind the postoperative patient to not lie for prolonged periods of time in the supine position with their elbows resting on the mattresses.

Frequently, patients receiving generous amounts of analgesia such as morphine and Demerol will position their elbows upon the mattresses in such a way that the ulnar nerve is compressed for prolonged periods of time and thus subjected to injury. The normal protective sensations of discomfort from prolonged compression to the ulnar nerve is significantly diminished while the postoperative patient is receiving strong analgesics. It behooves the nursing staff and medical staff to frequently remind the patients to change position and to avoid lying for prolonged periods of time with their elbows resting on the mattresses while holding on to reading material. The development of post-operative ulnar neuropathies can be avoided if time is taken to educate the patient and the ward staff.

Brian Hunt
Vancouver, BC

Reply to Dr. Brian Hunt re Perioperative Ulnar Neuropathies

I agree with Dr. Hunt that postoperative patients could be counseled not to sleep or sit in positions causing pressure on their ulnar nerves. In addition, such patients could wear elbow pads and hospital chair arms could be padded. A study evaluating the efficacy of such measures would be useful.

John D. Stewart
Montreal Neurological Hospital

Re: Tests of motor function in patients suspected of having mild unilateral cerebral lesions. Teitelbaum JS, Eliasziw M, Garner M. Can J Neurol Sci 2002; 29: 337-344.

Response to Letter to the Editor

I read with interest the letter sent by Richard Bohannon. I believe the aim of our study may have been misunderstood. As mentioned in the letter, segmental exam is a poor reflection of actual strength and a grade of 5/5 may be attributed to a muscle that has only 50% of its normal strength. This helps to confirm our finding that segmental strength is actually the worst test to perform when looking for subtle central motor weakness with a sensitivity of only 38.9%. Dynamometry would make this testing only moderately more reliable. Indeed, the busy clinician will not and should not perform all the tests mentioned in the article. We proposed a combination of pronator drift, fine finger movements and reflexes as this combination is extremely sensitive, quite specific, and requires only five minutes to perform. Neither traditional nor dynamometric testing add much to the assessment of subtle central motor weakness.

Jeanne Teitelbaum,
Montreal, ON

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