

The boxer's fracture: a prospective study of functional recovery

Sir

We read with interest the article by Porter *et al.* in the December 1988 edition of *Archives of Emergency Medicine*, 'The boxer's fracture: a prospective study of functional recovery'. We would agree completely that early mobilization of the hand in order to regain normal function is of paramount importance and as such we feel that a volar plaster slab for 3 weeks is excessive.

In the Accident and Emergency Department at Guy's Hospital, uncomplicated 'boxer's fractures' are treated by neighbour strapping the involved finger to its companion and the hand is elevated in a high sling for 24 h. The patient is reviewed in our Hand Clinic a week later when the neighbour strapping is removed. Exercises are given to the patient by the attending physiotherapist.

As a result of this regime, the majority of our patients have an excellent range of movement 2 weeks after removal of the neighbour strapping and recovery is usually complete at 6 weeks. This compares very favourably with Mr Porter's recovery period of 11 weeks. This regime is also well tolerated by patients, many manual labourers returning to work after the first week.

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Sir

I read with interest the paper by Porter *et al.* 'The boxer's fracture: a prospective study of functional recovery' in *Archives of Emergency Medicine*, December 1988 and found it interesting but somewhat controversial. The authors had concluded 'surgical intervention or complex method of splintage are unnecessary', in all types of 5th metacarpal neck fractures without rotation deformity which is somewhat simplistic. Most people agree with the general conclusion of the paper that fractures with angulation of less than 30° especially in the adolescent do quite well with conservative treatment requiring simple elevation, crepe bandage support and mobilization with Bedford splint to the little and ring fingers. However, adult patients, where the fracture is angulated 30° or more, usually have extension lag of the little finger and take longer to regain normal grip using all digits. In fact this study described two adult patients with more than 30° angulation of fractures doing less well. The fact that this was not statistically significant, I suggest, is due to the small number of patients involved. The problem of treating these angulated fractures had always been that once reduced and the reduction, held by external splintage and/or cast and sometimes internal fixation, tends to re-angulate during the period of healing. We are completing two studies, one retrospective and one prospective to describe a system of external splintage and cast which will by and large