

## SELECTED ABSTRACT

### **Anatomic approximation approach to correction of transverse facial clefts**

Raymond W.Tse, Robert J.Knight, David M Fisher. *J Plast Reconstr Aesthet Surg.* 2018; 71(11):1600-1608.

<https://doi.org/10.1016/j.bjps.2018.05.020>

Transverse clefts of the oral cavity have significant impacts on both appearance and function. Many methods of repair have been described, but there is no consensus on optimal approach. In addition, dissatisfaction with scars, distortion of appearance, and recurrent deformity have led to complex surgical designs that are difficult to understand and reproduce. We describe a simple approach to repair that is based upon anatomic approximation of lip components and accurate repair of the muscle.

Twenty patients underwent repair by the senior author, who devised the approach, and the corresponding author, who adopted it. Eight (62%) patients had right-sided clefts, three (23%) patients had left-sided clefts, and two (15%) patients had bilateral clefts. One patient had an associated branchial cleft remnant, two patients had multiple branchial cleft remnants and tragusdeformities, one patient had craniofacial microsomia with microtia, and one patient had a contralateral Tessier 1 cleft. Mean age of the patients at repair was 23 months. All patients achieved normal oral competence, have favorable scars and commissure appearance, and have had no recurrent deformity. None of the patients have required revision.

The described surgical approach is reproducible, easy to understand, and can produce favorable outcomes.

#### **Commentary**

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This article is an article based on a surgical technique. The senior author has performed the surgery in twenty cases. Although there are many techniques to repair a transverse facial cleft, correcting all the elements of the cleft are not there in every technique.

This technique has addressed nearly all the anatomical factors including muscle arrangements at the corner of the mouth. Most important feature in the article is the long term followup of the result. The scar behavior, we feel is the most important factor for the patient satisfaction. Looking at the article the scars have settled very nicely.

Critical evaluation of the same outcome is very important in every skin type. Particularly the Sri Lankan skin behaves differently. Scar therapy is the crucial factor which can be added and tested in a future study that can be reformed in Sri Lanka.

### **Fracture prevention with Zoledronate in older women with osteopenia**

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*N Engl J Med* 2018; 379:2407-2416,

DOI: 10.1056/NEJMoa1808082; December 20, 2018

#### **Methods**

Six years double blind study on 2000 women with osteopenia (T Score -1.0 to -2.5) was conducted. Participants randomly assigned to two groups.

zoledronate group receiving four infusions zoledronate at a dose of 5 mg at 18-month and Placebo group receiving four infusions of normal saline at 18 months interval. All participants were women 65 years or older had a total hip or a femoral neck fracture. All participants advised 1g calcium and Vitamin D before the trial and during the trial. The primary end point was the time to first occurrence of a non-vertebral or vertebral fragility fracture.

#### **Results**

As compared with the placebo group, women who received zoledronate had a lower risk of non-vertebral fragility fractures (hazard ratio, 0.66; P=0.001), symptomatic fractures (hazard ratio, 0.73; P=0.003), vertebral fractures (odds ratio, 0.45; P=0.002), and height loss (P<0.001).

#### **Conclusions**

The risk of non-vertebral or vertebral fragility fractures was significantly lower in women with osteopenia who received zoledronate than in women who received placebo.

#### **Commentary**

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There is clear evidence to say the Bisphosphonates prevent fragility fractures in patients with osteoporosis. Hence the

recommendation to treat osteoporosis and secondary prevention of fragility fractures with bisphosphonates in women with osteoporosis. How ever does bisphosphonates have a role in preventing early osteopenia thus preventing fragility fracture rates in women? A question that needs a clear answer in modern day osteoporosis management but not has been addressed well in the past. Ian R. Reid et al with a randomized control trial tries to answer the question. They have managed to clearly formulate the question select the groups randomized and obtain the results with a statistically significant difference between the two groups. This article suggests that we should start using bisphosphonates as early as when osteopenia sets in and current guidelines of using bisphosphonates may have to be revised. However it is also worth noting that this study is on treatment of IV bisphosphonate Zoledronate and whether these results can be transferred to the oral counterparts such as Alendronates is another concern that needs to be addressed.

1. Reid IR, Horne AM, Mihov B, et al. Fracture Prevention with Zoledronate in Older Women with Osteopenia. *N Engl J Med* 2018;379:2407-16.
2. Clinical guideline for the prevention and treatment of osteoporosis. In: Group NOG, ed. 2 ed. Uk2017.

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### **A most odd ratio: interpreting and describing odds ratios**

Alexander Persoskie, PhD and Rebecca A. Ferrer, PhD

*American Journal of Preventive Medicine*  
2017;52(2):224–228

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### **Introduction**

The OR is one of the most commonly used measures of association in preventive medicine, and yet it is unintuitive and easily misinterpreted by journal authors and readers.

### **Methods**

This article describes correct interpretations of ORs, explains how ORs are different from risk ratios (RRs), and notes potential supplements and alternatives to the presentation of ORs that may help readers avoid confusion about the strength of associations.

### **Results**

ORs are often interpreted as though they have the same meaning as RRs (i.e., ratios of probabilities rather than ratios of odds), an interpretation that is incorrect in cross-sectional and longitudinal analyses. Without knowing the base rate of the outcome event in such analyses, it is impossible to evaluate the size of the absolute or relative change in risk associated with an OR, and misinterpreting the OR as an RR leads to the overestimation of the effect size when the outcome event is common rather than rare in the study sample. In case-control analyses, whether an OR can be

interpreted as an RR depends on how the controls were selected.

### **Conclusions**

Education, peer reviewer vigilance, and journal reporting standards concerning ORs may improve the clarity and accuracy with which this common measure of association is described and understood in preventive medicine and public health research.

### **Commentary**

Dr. Rasika Jayatillake

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Odds ratio is a common statistic used to measure the association between a disease and an exposure factor. It is also the statistic provided in logistic regression which is fitted to binary outcome i.e. a case or control. However, it is often misinterpreted or confused with relative risk as interpretation of risk is much more intuitive than odds. And at the same time many researchers fail to understand the difference of risk and odds and the consequences of such misinterpretations. Authors of this article explains important differences and aspects of odds ratio and relative risk using 3 hypothetical scenarios. Readers are given a comprehensive explanation of how odds and risks are interpreted correctly and circumstances when they mean the same and how changing the way cases and controls are selected could influence the interpretations. As odds ratios are the common statistics in logistic regression authors also suggests with possible alternatives to logistic model which would provide with risk instead of odds.

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### **Long-term outcomes of coil embolization of unruptured intracranial aneurysms**

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*Journal of Neurosurgery*. 2018; 129 (6):1377-1662

### **Objective**

Long-term follow-up results of the treatment of unruptured intracranial aneurysms (UIAs) by means of coil embolization remain unclear. The aim of this study was to analyze the frequency of rupture, retreatment, stroke, and death in patients with coiled UIAs who were followed for up to 20 years at multiple stroke centers.

### **Method**

The authors retrospectively analyzed data from cases in which patients underwent coil embolization between 1995

and 2004 at 4 stroke centers. In collecting the late ( $\geq 1$  year) follow-up data, postal questionnaires were used to assess whether patients had experienced rupture or retreatment of a coiled aneurysm or any stroke or had died.

### Results

Overall, 184 patients with 188 UIAs were included. The median follow-up period was 12 years (interquartile range 11–13 years, maximum 20 years). A total of 152 UIAs (81%) were followed for more than 10 years. The incidence of rupture was 2 in 2122 aneurysm-years (annual rupture rate 0.09%). Nine of the 188 patients with coiled UIAs (4.8%) underwent additional treatment. In 5 of these 9 cases, the first retreatment was performed more than 5 years after the initial treatment. Large aneurysms were significantly more likely to require retreatment. Nine strokes occurred over the 2122 aneurysm-years. Seventeen patients died in this cohort.

### Conclusion

This study demonstrates a low risk of rupture of coiled UIAs with long-term follow-up periods of up to 20 years. This suggests that coiling of UIAs could prevent rupture for a long period of time. However, large aneurysms might need to be followed for a longer time.

### Commentary

Dr. Ruvini Abeygunaratne  
Consultant Neurosurgeon

The use of coil embolization (coiling) of aneurysms has now established itself firmly in the management of aneurysms in neurosurgical practice. But there is still discussion with regards to the long term outcome of coiling. Since the ISAT trial we can firmly say that coiling is here to stay. This is also an ongoing discussion amongst the neurosurgeons who are keen to surgically treat the aneurysms and the interventional neuroradiologists who wish to coil. Both parties fighting their corner vigorously. This is yet another study which reports the safety of coiling in unruptured aneurysms. In my opinion as a neurosurgeon I firmly believe there is a role to play by both modes of treatment. Not all aneurysms can be coiled but all aneurysms can be clipped. I would prefer in acute aneurysm rupture that coiling is considered if possible to avoid a craniotomy at a time when the brain is less forgiving. The patient should have the best option for them determined after discussion between the specialities to give the patient the best outcome possible. In this study the retrospective data demonstrates the low risk factors associated with coiling of unruptured aneurysms but of note the aneurysms were small in size.

When considering coiling in Sri Lanka unfortunately the cost has a huge impact as it is still significantly higher compared to clipping. Therefore it is essential that surgical trainees

continue with the training in clipping for the foreseeable future. This is a major problem in Western countries due to subspecialisation within specialities. The skill of clipping is being lost due to a combination of subspecialisation and coiling being freely available. This will be a problem in the future as there may not be the available surgical skills to clip the complex, large and uncoilable aneurysms as well as dealing with the problems arising from failure of coiling.

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### Correspondence

Re: "A case of Midgut malrotation presenting as sub-acute intestinal obstruction in an adult"

Original article: Mathangasinghe, Y. and Samaranayake, U.M.J.E., 2018. A case of midgut malrotation presenting as subacute intestinal obstruction in an adult. *Sri Lanka Journal of Surgery*, 36(1), pp.47–48.

DOI: <http://doi.org/10.4038/sljs.v36i1.8485>

Published on 30 Apr 2018.

### To the editor:

I read with interest the article "A case of Midgut malrotation presenting as sub-acute intestinal obstruction in an adult" in the April issue of *The Sri Lanka Journal of Surgery*.

As a paediatric surgeon I would like to point out certain shortcomings in the article which are as follows.

- (1) The authors have mentioned that the 3rd part of the duodenum was atretic. In medical terms atresia means a congenital absence or a complete closure of a tubular structure. This is almost impossible in this patient as he was 68 years of age and had presented only with intermittent symptoms suggestive of partial intestinal obstruction and the upper GI contrast study also clearly shows the contrast in the distal small bowel. What generally happens in malrotation is an extrinsic compression of the 2nd part of the duodenum by the so called Ladd's bands leading to a partial obstruction.
- (2) The authors also mention that they did divide the bands which they called the Ladd's procedure which is again incorrect as the Ladd's procedure involves in addition,
  - (A) The straightening of the duodenum and
  - (B) The mobilization of the caecum to the left hypochondrium so that the base of the mesentery is widened which is the most important step thus minimizing the chance of a future twisting of the base of the mesentery.

The latter (The twist of the midgut) is the most dreaded complication of uncorrected malrotation with resultant midgut ischaemia/necrosis. According to the article this most