

# Best of Times

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I remember one of the hardest things that I had to learn when I became an attending was how to take care of all the little details. As a resident, I could walk into the operating room after reading about a case and simply enjoy every minute of the operation. It was a great time—as I fulfilled my destiny to become a surgeon and to operate. However, the attending first must determine that the patient needs surgery; next discuss the procedure and possible complications with the patient; then decide on the positioning, approach, and implant; and finally, determine the appropriate timing for intervention. Some of these decisions are based on the objective and scientific factors taught to us in our training as residents, but others are more ambiguous, subjective, and decidedly more challenging.

For a displaced intertrochanteric hip fracture, I know I can use an intramedullary device or a sliding hip screw and the procedure can be performed on a fracture table. That's the easy part. The tough part comes in deciding when the patient is best prepared to undergo this surgery. We rely on medical consultants and our anesthesia colleagues so that we can become the consummate surgeon, but some decisions only we as the treating physician can make. I propose that determining the appropriate timing of the operative procedure is the most crucial and difficult decision that we must make.

The 3 articles in this supplement are all informative and excellent resources. They help us with the “how to,” but we still have the task of finding out the “why, who, and when.” The article by Dr. Dirschl is on tibial plateau fractures. Past lessons have taught us to delay the treatment of almost all periarticular fractures until the swelling has decreased. We swing on the pendulum from plate fixation to limited fixation to hybrid fixators and back again to plate fixation, but we now do so in a delayed fashion. In the absence of something more concrete, we depend on the semiobjective, so-called wrinkle sign to determine whether patients' soft tissues can withstand our surgical assault. Waiting for the right surgical moment is often made difficult by extraneous factors, but this must be done with diligence and not seen as simply procrastination.

The article by Dr. Koval on femoral nailing reminds us that we are more than technicians. Our learning curve for femoral fracture has shown not only that we could affect morbidity but possibly also mortality. The dogma in the early 1990s was “the patient is too sick *not* to be operated on.” This led to every fellowship-trained orthopedic trauma surgeon coming in to do surgery before the donut baker ever even got out of bed. With blood-shot eyes and lots of coffee, the next day we bragged about how we helped to save a patient's life. Thankfully, several prospec-



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tive studies helped the sleep-deprived trauma surgeon. The process of evaluation and resuscitation of each patient was initiated, and appropriate treatment at a more reasonable hour was instituted. The outcomes were better when the orthopedic surgeon stepped back and critically determined who might be “too sick” for a secondary insult. We felt better and slept better knowing that we were able to live up to our oath, “first, do no harm.”

The article on bone grafting by Dr. Desai is very informative and shows how far we have come in a short period of time, although we still don't have all the answers. Should we use allograft or autograft or both? Which preparation is the best for each situation? Again the question is raised, when is the appropriate time to bone graft? There is a sinking feeling when the open tibia fracture with bone loss is grafted only to find that in 2 weeks the site is infected or the graft has resorbed. Either the patient sustained the pain of an iliac crest bone graft with no beneficial effect or some hospital paid a lot of money for bone graft substitutes with an unfortunate negative outcome.

So, is there such an entity as “good timing?” There can be, but for now, the best we have is a subjective evaluation by an experienced surgeon. Are we always going to be right? No, even with the best of intentions and armed with all of the knowledge available to us, we will still have failures. Our goal is to continue to be critical of ourselves and others and to learn from both our successes and failures. Blaming the patient, their blisters, or the implant should not be acceptable. We need to be diligent in our assessment of the soft tissues surrounding fractures and the patient's overall medical condition. It's not just an ankle fracture or a femur fracture. Teaching our residents that the assessment of the whole patient is an important part of the surgical procedure is an integral part of their education. Timing is everything. ■

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