Fracture healing and NSAIDs

The article by Taylor et al provided very limited data comparing use of analgesics and rates of nonunion.[1] It is pretty drastic to conclude that "patients should not be denied NSAIDs [nonsteroidal anti-inflammatory drugs] for short-term pain relief."[1] In terms of fracture healing there is evidence in rodent studies that NSAIDs can slow healing.[2-4] A review article by Boursinos et al advised caution in using NSAIDs in patients with fractures.[5] As inflammation is the first step in the healing process, and given the range of choice of analgesics, there is no particular reason to recommend NSAIDs after a fracture.

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Competing interests
None declared

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Guidelines for mild head injuries in children

We would like to reply to Dr Zemek's letter[1] about the new Guidelines for Diagnosing and Managing Pediatric Concussion[2] and his reference to our clinical review of the office management of mild head injury in children and adolescents.[3]

We are very pleased that the theme of concussion in the pediatric population has been the focus of much attention recently at different levels and in different institutions and associations. Clear and readily available information about concussion is an obvious need that family physicians, emergency physicians, and pediatricians are currently facing.

Our recommendations and those of the guidelines follow each other very closely. The guideline recommendations are organized into 5 topics in tables at the beginning of the document. Clicking on the number automatically jumps to the details of each recommendation in this very extensive guideline.[2] Their topics include the following: "In advance (before the first activity)"; "On presentation (what are the 'red flags'?)"; "On discharge (what do we tell parents and/or caregivers?)"; "On interim assessment (when can the child/adolescent return to learn/play?)"; and "On re-assessment after one month (what do we do next if the child/adolescent still has symptoms?)."[2]

The intention of our review was to provide practical, current approaches and specific tools for family physicians to help diagnose, manage, and provide information to families, teachers, and coaches. We appreciate that the guidelines advocated by Dr Zemek have a similar purpose, which is to equip physicians with updated information to facilitate their work to identify patients suffering from concussion and its complications, and to guide adequate focused management.

Our review advocates for a full clinical initial evaluation that requires not only a complete history and a comprehensive focused physical examination, but also identification of the mechanism of injury, the evolution and timeline of the symptoms, and determination of any factors that could affect its presentation or management. We stated that family physicians should be well aware of the available standardized tools and where to quickly find them to assess the general symptoms and cognitive status of pediatric patients. Adequate observation of patients with concussion is paramount, and family physicians should guide parents in this process by providing the correct information and providing education; the available resources we presented can be used to accomplish this task. When complications need to be ruled out, the physician can make evidence-based decisions whether to request imaging studies by using information from the CATCH (Canadian Assessment of Tomography for Childhood Head Injury) study.[4]

The management of concussion is based on the status and progress of the individual patient, and the treating doctor should coordinate adequate follow-up assessments, allow return to study or to play in a safe manner, and use neuropsychologic testing when needed.

We gladly welcome the presented guidelines, which contribute to cooperative work directed to facilitate the efforts of treating physicians and to improve the attention offered to children and adolescents.

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