Both active treatments were significantly better than placebo. The efficacy of the four times daily treatment appeared superior to the twice daily treatment but this finding was not statistically significant. In both ibuprofen treatment schedules the side effects profile and withdrawal rate were similar. Of the regimens evaluated, ibuprofen 600 mg four times a day is probably the most effective, but for those patients who find this schedule inconvenient, they will still derive significant benefit from ibuprofen 1200 mg twice daily. The findings of this study lead the authors to make the recommendation that in soft tissue injuries to the lateral ligament complex caused by sporting activity a short course of high dose ibuprofen should be considered.

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BOOK REVIEW

Title: **FLEXOR TENDON INJURIES**
Author: Lawrence H. Schneider, MD
Publishers: Little, Brown & Co.
Price: $42.50 177 pages Illustrations and Index

The flexor tendons of the fingers are often injured in sport — especially Rugby football — where profundus avulsions sometimes occur.

This monograph is the most comprehensive work on the flexor apparatus to date.

Dr. Lawrence Schneider has barely missed a trick in the history and management of injuries to the flexor apparatus and his bibliography is very comprehensive.

The only points one can add are as follows —

The distal profundus entrapment syndrome with the classical physical sign of loss of active flexion of the terminal phalanx when the proximal phalanx is flexed is sometimes seen after partial rupture of the profundus.

In describing the Kleinert banding technique it is surely logical after repair of a profundus tendon in any of the ulnar three digits to band all three since this part of the profundus has a mass action effect.

Finally in the matter of salvage procedures a very useful manoeuvre is to combine the Paneva-Holevitch loop anastomosis of profundus to superficialis in the palm with a silicone elastomer tendon within the digital flexor sheath. At a second procedure some ten weeks later one tendon is divided at the wrist and re-anchored to the tip of the finger by attaching the tendon to the withdrawn silicone elastomer tendon. Only one anastomosis is then necessary at the terminal phalanx. We have found this a most rewarding manoeuvre.

The bibliography is extensive so as well as the subject index an author index would prove very useful.

This book is a winner and will be particularly appreciated by all Hand Surgeons as well as those in training with an interest in this branch of surgery.

B. Helal, FRCS, MChOrth