Fingerless gloves for hand trauma cases

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doi 10.1308/003588412X13171221500222

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COMMENT ON
doi 10.1308/003588411X12851639107313k

I read the original technique by Tang and Bebbington and the resulting correspondence by Lim and Cole\(^1\) with interest. The report of the National Patient Safety Agency referred to two problems leading to serious incident.\(^2\) As correctly stipulated, the first is as a consequence of tourniquets left in situ. The second is that finger tourniquets generate a very high tourniquet pressure. This is due to using a complete ring of tourniquet, which is often extremely tight, taking no account of variation in finger size, and frequently difficult to use. The report recommended the use of specific finger tourniquet devices that were made for the purpose. An alternative method that I have found useful includes:

1. Cut the finger off an appropriate sized glove.
2. Remove the tip of this glove finger.
3. Roll up to the base of the finger (metacarpophalangeal joint).
4. Apply a clip to the tourniquet.
5. Cut the tourniquet transversely above this.
6. Apply another clip below the first.
7. Leave the second clip in situ and remove the first.

This has the same advantages as Tang and Bebbington’s method but is using an incomplete ring held on to the finger with a vascular clip. The clip will need to be removed for your final count, which will of course be included in all documentation. The tourniquet cannot be left in situ. This method has the same advantage of cost effectiveness but the extra safety of the surgical count and lower mmHg pressures at the finger tourniquet.

References

Authors’ Response

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The report by the National Patient Safety Agency\(^1\) was aimed primarily at ways to prevent tourniquets being left on. Our technique would require you to accidentally leave an entire glove on the patient’s hand, which would be extremely difficult to do. The purpose of our technique was to highlight that it simultaneously acts as a tourniquet for whichever digit you want while helping to prevent contamination from other dirty fingers.

Reference

Closure of skin lacerations under tension

Comment 1

O Gilleard, C Tsang, B Dheansa
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doi 10.1308/003588411X12851639107313k

We read with interest the article advocating the use of adhesive strips as a means of reinforcing fragile wound edges in the closure of wounds under tension. However, one wonders if there may be an element of false economy. Although direct closure is achieved at the time of surgery, there are no reported outcomes following suture removal. It would be particularly interesting to know the rates of wound dehiscence and hypertrophic scar formation, complications that often require further treatment.

In order to achieve the optimal functional and cosmetic result, laboratory and clinical studies suggest that alternative options on the reconstructive ladder should be considered when the dermis cannot be opposed directly without undue tension.\(^1,2\) In the absence of any substantial new data to the contrary, it is important that this principle is adhered to when managing the vast majority of wounds in the accident and emergency department and operating theatre.
LETTERS AND COMMENTS

Readers may also be interested to read the following correspondence on the Annals Readers’ Pages:

Urinary catheters in carotid endarterectomy – a stimulus for aggression?
Mohan A, Goodman R, Walsh AKM

Reference

Editor’s note

Please refer to the editorial in this month’s technical section for the Editor’s response to these three letters.

Comment 2
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doi 10.1308/003588412X13171221500628

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We read the technical tip by Nawaz et al with interest. The approximation of skin in thin-skinned individuals is often difficult due to the natural contracture of thin skin coupled with local soft tissue swelling and the potential for suture ‘cut-out’. We have used a technique of applying wide Steri-Strip™ (3M, St Paul, MN, US) skin closures perpendicular to the wound edges to approximate the skin edge and subsequently suturing through the Steri-Strip™. This technique has been particularly helpful for tibial lacerations with skin flaps and for the dorsum of the hand in patients with thin or poor quality skin. The use of Steri-Strip™ skin closures across and perpendicular to the wound reduces shear forces on the epidermis. The wounds can then be monitored in a ‘soft tissue/dressings’ clinic, with sutures removed after a period of time as outlined by the operating surgeon.

Reference

Comment 3
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doi 10.1308/003588412X13171221500664

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It was interesting to see a short report of ours¹ effectively republished in the November 2011 issue of the Annals. Redundant publications are a continuing problem in the medical literature. It is principally the responsibility of authors to have researched the published literature thoroughly to prevent this from happening. It is, however, also up to the reviewers to act as a safety net where the authors have not performed their due diligence competently.

Reference

Reference

References