Opsite applied over the entire wound. Suction is applied to the drains and the vacuum seal is thus complete.

DISCUSSION

This technique is simple, inexpensive and rapid to perform. The drape prepared as described is effective in containing the abdominal viscera and no suturing is required. The rectus sheath is thus not weakened by the application of sutures prior to definitive closure. The dressing is dry, air-tight and facilitates postoperative nursing care.

An inexpensive 3-D model for teaching local flap design on the face and head

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BACKGROUND

Due to the complex three-dimensional structure of the human face, teaching trainees the design of local flaps in the head and neck region can be difficult by using the traditional 'pen-and-paper' approach. A number of alternative teaching methods have been described in the literature.¹⁻³

TECHNIQUE

Drawing pins of different sizes are inserted onto a styrene mannequin head (male or female) to simulate raised lesions (e.g. basal cell carcinomas, BCCs). Cling film is then used to cover the whole head and carefully folded to match the contours of the face (a thin layer of paper stick glue can help secure the cling film onto the styrene, especially around the facial contours). Trainees are now taught how to design a local flap, such as a rhomboid or bilobed flap, by drawing around the simulated lesion with a marker pen (Fig. 1). The importance of vascular and aesthetic considerations is stressed during the exercise and the model can further be used to illustrate the correction of simulated scars with z-plasty. At the end of the exercise, the plastic wrap is easily removed and replaced. In addition to teaching, this model can also act as an assessment tool.

DISCUSSION

Our experience has shown that this three-dimensional model is an excellent teaching and assessment tool for the design of local

Figure 1 The mannequin model used to teach the design of a rhomboid and a bilobed flap. Note the drawing pins simulating BCCs.

facial flaps on the face and head because it is realistic, re-usable and inexpensive.

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A technique to remove cannulated screws

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BACKGROUND

Cannulated screws are used in procedures such as fixation of hip fractures, slipped upper femoral epiphysis and anterior cruciate ligament (ACL) reconstruction. Removing these screws in the

event of pain or for revisions can be technically quite challenging since various screw manufacturers use different types of screw-drivers and the screw heads can be of varying sizes.

TECHNIQUE

We have devised a simple technique for removing such screws using Steinman pin and bone cement. The senior author (NA) has used this successfully in three cases. The cross-section of the proximal (blunt) end of the Steinman pin is quadrangular or triangular. The blunt end of a pin is inserted into the screw socket to check for a reasonably snug fit and the pin is bent into an 'L'-shape to aid gripping. A small quantity of bone cement is then pressed into the screw socket, the end of the pin is tapped in, and the cement is left to set. An essential component of the technique is to allow time for the cement to set. Once the cement is set, the screw can be removed without much effort by turning on the bent end of the pin.

DISCUSSION

Cannulated screws often need to be removed if they are causing symptoms or in patients subsequently requiring hip replacement or a revision of their ACL reconstruction. This is an essential part of surgical process, which can be quite challenging and often frustrating. A set of sterile Allen keys of different diameters and lengths would be a possible solution but these are rarely available in most operating theatres. There are different techniques described in the literature for removal;¹⁻⁴ however, one often attempts to use the pliers. Removing such screws by gripping their ends with pliers is not only difficult and time-consuming, but also often necessitates a considerable amount of bone around the screw to be chiselled or nibbled out specially in the case of headless cannulated screws commonly used in ACL reconstruction.

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Technical Tips

Knee arthroscopy: 1-ml syringe as an out-flow cannula

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A 'soft' quill can be used to drain 'arthroscopy debris'. A 1-ml syringe with the nozzle cut off at an angle of 45° is a better alternative – being stiff, it is easier to manoeuvre in the joint. To direct the entry of the syringe during insertion, slide it over the arthroscopic trochar, positioning the trochar point where the syringe will end at insertion into the joint. This 'Seldinger technique' also eases its passage through the soft tissues.

The fibre-glass spica bar

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Hip spicas control hip position and are used in the management of a number of conditions, e.g. developmental dysplasia of the hip (DDH). The wooden bar between the thighs markedly

Figure 1 A fibre-glass spica bar.