Figure 1 Activation of the Atlas LigaSure device.

Figure 2 Ligation of major vessel.

Surgical Corp. Norwalk, CT, USA) is a bipolar diathermy with an incorporated blade. We present a new technique for liver resection with minimal morbidity especially in cirrhotic livers.

TECHNIQUE

Eight cirrhotic patients underwent 12 liver segmentectomies. No vascular control was applied. The activation of the Atlas LigaSure device started with the clamp open on the liver parenchyma (Fig. 1). Then, gradually, the clamp was closed and the parenchyma was crushed between the limbs and divided using the incorporated blade at the same time. Anytime that a major vessel was identified, the liver parenchyma surrounding the vessel was crushed so that the vessel could easily be incorporated between the instrument's limbs, and safely ligated and divided at the same time (Fig. 2). No patient required any blood transfusion intra-operatively and none of them had biliary leak.

DISCUSSION

The Atlas LigaSure device is a bipolar electrocautery; therefore, the charring effect and the collateral thermal damage is minimised up to 2–3 mm.⁴ The incorporated blade allows the simultaneous division of the tissue saving operative time. There is ambiguous information in the literature regarding the safety of major bile ducts and vessels ligation using the LigaSure energy.⁵ However, all our cases were minor resections and we cannot comment on that further. One of the tips of this technique is the slow, gradual closure and the frequent cleaning of the clamp.

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Use of a cortical screw to aid single piece excision of the trapezium: a simple technique

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BACKGROUND

Simple excision of the trapezium or in combination with soft tissue or silicone interposition, fusion, ligament reconstruction or total joint replacement, remains an effective surgical treatment for trapezio-metacarpal osteoarthritis. Excision of the trapezium

Figure 1 Cortical screw inserted into the trapezium.

is often challenging due to its small dimensions and intimate ligamentous attachments. When removed piece-meal, remnants of trapezium left *in situ* may cause persistent symptoms. We describe a simple surgical technique to aid single piece trapezial excision.

TECHNIQUE

The trapezium is approached via a volar incision centred over the trapezio-metacarpal joint. The midpoint of the volar aspect of the trapezium is identified and perforated in the antero-posterior plane using a 2.5-mm drill. A standard 3.5-mm partially threaded cortical screw of 18-mm length is inserted into the drill hole utilising the full threaded length (Fig. 1). The screw is held using a pair of Kocker's forceps and sharp dissection is carried out aided by 'joysticking' and tractioning manoeuvres via the forceps. The trapezium is thereby delivered as a single piece.

DISCUSSION

Due to inaccessibility of all trapezial ligaments using conventional techniques, often piece-meal trapeziectomy is unavoidable. This may result in risk of injury to surrounding structures, increased operation time and incomplete excision of trapezial fragments. The senior author (SA) has employed this method of trapeziectomy for over 10 years without major complications. We believe this to be a safe and reproducible technique for excising the trapezium as one piece.

The Nottingham lead foot

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BACKGROUND

Flexor tenotomy of the toes to correct clawing is a common operation in foot surgery and is frequently performed by a surgeon operating alone. The technique involves manual dorsiflexion of each toe, exposure of the plantar surface, dissection to the underlying tendon and tenotomy followed by wound closure. The majority of the operation is commonly performed using one hand as the other is required to maintain the toe in dorsiflexion. It is, therefore, difficult to retract the wound edges, cut the tendon under direct vision and suture the wound.

TECHNIQUE

We have designed a 'lead foot' which is able to hold toes firmly in dorsiflexion, thus freeing the surgeon to operate with both hands allowing safer and quicker surgery (Fig. 1). Lead feet are simple and cheap to produce, are autoclaveable, re-usable and durable. We recommend the use of 2-mm thick roofing lead which is available from builders' merchants. The adult version is depicted (Fig. 2) but we also use a two-thirds' scale version for paediatric cases. The Nottingham lead foot is also potentially suitable for other operations on the plantar aspect of the foot and toes.

Figure 1 Cut lead sheet showing support structures.