Figure 2 Superficial parotidectomy: wound 3 months following closure with Dermabond™.

sutures to platysma routinely and deep dermal sutures only if the wound edges require approximating. The surgical field is cleaned and dried. Dermabond™ is applied along the wound, and forceps used to maintain skin edge eversion if necessary. Two further applications are made. No further dressing is required; after 3 min the glue is dry and fully waterproof.

DISCUSSION

Skin closure with sutures can be time-consuming, and removal can be distressing for the patient. Cosmetic outcome is variable, depending on the accuracy and tension of the closure. Dermabond™ is quick to apply and no foreign material is left within the skin. It is waterproof, allowing patients to shower from day one, and requires minimal input from nursing staff. A randomised, controlled trial of 111 patients showed Dermabond™ to have a superior cosmetic outcome at 1 year compared with sutures, with no increase in complications.¹ A recent study looking at wounds greater than 4 cm found Dermabond™ provides equivalent wound closure to sutures, with a decreased incidence of wound infection.² In our experience, both patients and nurses find this method of closure preferable to sutures, with good cosmetic results (Figs 1 and 2).

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Use of a skin stapler to repair penetrating cardiac injury

BETSY J EVANS, PHILIP HORNICK

Department of Cardiothoracic Surgery, Hammersmith Hospital, London, UK

CORRESPONDENCE TO

P Hornick, Senior Lecturer and Honorary Consultant, Cardiothoracic Surgery, NHLI, Imperial College, Hammersmith Campus, 2nd Floor, B Block, DuCane Road, London W12 0NN, UK

BACKGROUND

Performance of emergency thoracotomy of penetrating cardiac injuries is a daunting experience especially for junior surgeons. The environment of accident and emergency is often sub-optimal especially with reference to operative equipment and provision of an adequate light source. We advocate the use of an automated skin stapling device rather than direct suturing for repair. This achieves rapid haemorrhage control and obviates the risk of needle-stick injury to the surgeon from such high-risk patient groups.¹

TECHNIQUE

Following anterolateral thoracotomy, opening and evacuation of the pericardial cavity,^{2,3} the wound is controlled by digital compression or with the use of clamps if the laceration is atrial. The laceration may then be closed with a standard skin stapler using wide (6 mm) staples. The staples are placed at a 3–5 mm intervals with additional ones placed only if required to achieve haemostasis. Following stapling, the laceration may be safely oversewn using a 4/1 polypropylene suture in the operating theatre.

DISCUSSION

Skin stapling may be used with success when combined with emergency thoracotomy to achieve effective and rapid control of bleeding following single or multiple cardiac stab wounds. Traditionally, the method of repair employed is by the placement of multiple non-absorbable sutures beneath the surgeon's finger. Automated skin stapling devices are readily available and easy to use with most surgeons having prior knowledge on their deployment, thus enabling this life-saving procedure to be performed without specialist expertise which may be unavailable. We additionally have found that this method reduces the exposure of the operator to needle-stick injury.

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k-Wiring of supracondylar humeral fractures

FR MIDDLETON, DR BOARDMAN, CJ COATES
Orthopaedic Department, Royal Surrey County Hospital,
Guildford, Surrey

CORRESPONDENCE TO

FR Middleton, SpR Orthopaedics, Royal Surrey County
Hospital, Egerton Road, Guildford, Surrey GU2 7XX, UK
E: fionamiddleton@doctors.org.uk

BACKGROUND

Closed manipulation and percutaneous pinning of displaced supracondylar humeral fractures (Gartland type IIB or above)¹ is commonly performed in the UK using two crossed pins or two lateral pins.² Accurate reduction and stable fixation is key to the successful surgical treatment of these fractures, but this is often hampered by soft tissue swelling and gross fracture instability. We describe a simple technique to aid successful closed reduction and percutaneous fixation.

TECHNIQUE

After closed fracture reduction, the elbow is held in a fully flexed position. Under fluoroscopic guidance, a 1.6-mm k-wire is passed through the capitellum alongside the lateral border of the olecranon and directed proximally along the longitudinal axis of the humerus (Fig. 1); this wire provides temporary stabilisation of the fracture in all planes. After adequate reduction is confirmed by fluoroscopy with the temporary k-wire in place, definitive stabilisation is achieved with two further k-wires (Fig. 2). Finally, the elbow is screened fluoroscopically to ensure satisfactory fracture reduction prior to the removal of the temporary wire.

DISCUSSION

Maintaining fracture reduction whilst percutaneous k-wires are passed can be challenging. We describe the use of a temporary stabilisation wire to ensure optimal fixation. The temporary wire resists fracture displacement whilst the limb is repositioned during definitive fixation and acts as a guide to aid the judgement of angulation in the sagittal and coronal planes. Optimal placement of the definitive k-wires is thus aided. The possibility of the loss of reduction during definitive k-wire placement is also reduced.

Figure 1 Lateral view of elbow showing position of temporary k-wire.

Figure 2 Anterior-posterior view of elbow showing position of all k-wires.

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