A quick and simple knot-free subcuticular suture

ATCHUTHAN VARATHARAJ, CLAIR ASHFORD, COLIN STEIN-LECHNER

Department of Orthopaedics and Trauma, North Devon District Hospital, Barnstaple, Devon, UK

CORRESPONDENCE TO

Atchuthan Varatharaj, Flat 5, Kingsley House, North Devon District Hospital, Barnstaple, Devon EX31 4JB, UK
E: araj@doctors.org.uk

BACKGROUND

Subcuticular sutures are commonly used for surgical wound closure. We have found that knots and free ends can protrude through the skin, leading to minor wound infections. We have devised a simple, reliable technique to avoid these problems.

TECHNIQUE

Using a braided absorbable suture, the suture is passed percutaneously, entering the wound, via the dermis, a few millimetres from its apex. The first stitch takes a very small bite

Figure 1 Starting the suture.

Figure 2 Completion of the suture.

of dermis and is then locked (Fig. 1). If the suture slips, a second short locking stitch is inserted. The usual subcuticular technique is used to close the wound and a single, short, locking stitch is sufficient to secure the repair distally (Fig. 2). The suture is passed through the wound, exiting the skin distal to the apex and the ends are cut flush with the skin.

DISCUSSION

This technique is quick and simple. It has the advantage of being entirely subcuticular and of avoiding bulky knots and free suture ends, which may protrude through the skin or lead to stitch abscesses. It also avoids piercing the suture material, thereby retaining suture strength. We have used this technique successfully for several years.

A simple addition to the swivel and Arndt multiport adapters to facilitate fibre-optic bronchoscopy in small children

AM-H HO, MK KARMAKAR

Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, NT, Hong Kong SAR, People's Republic of China

CORRESPONDENCE TO

Anthony Ho, Professor, Department of Anaesthesia and Intensive Care, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, NT, Hong Kong SAR, People's Republic of China
E: hoamh@cuhk.edu.hk

BACKGROUND

Fibre-optic bronchoscopy via an endotracheal tube *in situ* without interruption of assisted ventilation is essential in patients with low pulmonary reserve. This can be achieved with the use of a swivel adapter or, if a bronchial blocker or another catheter is also present in the tracheal tube lumen, an Arndt multiport adapter (Cook Critical Care, Bloomington, IN, USA). Unfortunately, in very small children, in whom a small fibrescope must be used, the openings for the standard swivel or Arndt adapters are too large and leak around the fibrescope make assisted ventilation ineffective.

TECHNIQUE

We use a reducer for minimal invasive surgery with a 0.67-mm pinhole (Mini Step; InnerDyne, Salt Lake City, UT, USA) to fit into a Sims Portex (Hythe, Kent, UK) 15-mm swivel bronchoscope adapter (Fig. 1) or into the Arndt fibrescope port (Fig. 2). The pin hole is suitable for a very small bronchoscope (e.g. the Olympus

Figure 1 The reducer in the fibroscope port of a swivel connector.

Figure 2 The reducer in the fibroscope port of an Arndt multiport adapter.

LF-P [Tokyo, Japan] with an external diameter of 1.8 mm), thus making it suitable for fibroscopic bronchoscopy through the lumen of endotracheal tubes for infants. After bronchoscopy is finished and the fibroscope is withdrawn, the swivel or Arndt port is capped with the original attached top.

DISCUSSION

Whether it is for diagnostic flexible bronchoscopy or for bronchial blocker placement, uninterrupted ventilation is a big advantage

without which the duration of bronchoscopy is limited by the need to ventilate intermittently. We have used this adaptation in four small children and have found that leak-free ventilation was possible despite high airway pressure.

A novel method for the salvage of bone dust generated by high-speed burrs in spinal surgery

NIMA HEIDARI¹, CLINTON JOHN², KOFI AGYARE³, STEWART TUCKER³

¹Orthopaedics and Trauma, North East Thames (Royal London) Rotation, London, UK

²Wellington Hospital, London, UK

³Spinal Deformity Unit, Royal National Orthopaedic Hospital Trust, Stanmore, Middlesex, UK

CORRESPONDENCE TO

Nima Heidari, Specialist Registrar Orthopaedics and Trauma, Spinal Deformity Unit, Royal National Orthopaedic Hospital Trust, Brockley Hill, Stanmore, Middlesex HA7 4LP, UK
E: n.heidari@gmail.com

BACKGROUND

All spinal fusion operations, for degenerative and deformity correction, require preparation of a fusion bed and subsequent grafting to achieve a solid fusion. Autogenic cancellous graft remains the gold standard for bone grafting and is usually

Figure 1 Bone dust trap.