subjective performance by different surgeons. We feel that if a surgeon considers a pair of scissors to be defective then different scissors should be used even if they have been tested with this method and 'passed'. Also, this method only assesses the efficacy when cutting suture material and not any other material or tissue requiring cutting during surgical procedures. The time taken to perform this assessment on a pair of scissors suspected to be defective may well be as time consuming as sharpening or tightening them. Whilst this is a novel and objective method, we feel that it may have limited value in the average theatre department.

COMMENT 2

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Cutting with scissors

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We welcome this article promoting an objective assessment of the function of theatre scissors; however, we are concerned about the test described. Scissors should usually be used to cut at the tips and not 'where the blades intersect'. To promote the technique described runs the risk of injury to structures beyond the tip of the instrument.

COMMENT 3

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Scissor efficacy

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Defective scissors frustrate surgeons and could potentially have life- or limb-threatening consequences. An objective method of assessing scissors would, therefore, be a useful advance. However, Beesley and colleagues' model is limited in a number of respects. First, the model only replicates force application in

the vertical plane. Hands are asymmetric and during closing, the thumb and fingers do not close vertically, but have a lateral component to the motion. This lateral motion is transmitted via the fulcrum, forcing the cutting blades together and shearing the material that comes between the blades. It is for this reason that right-handed scissors do not function well when held in the left hand, as the left hand naturally forces the cutting blades apart. Second, the model as described assesses scissor function close to the fulcrum. In practice, it is the tips of the scissors which are first to blunt, and any assessment of scissor efficacy should be directed towards the tips.

COMMENT ON

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Limitation of sling distraction in ankle arthroscopy

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The method described is useful for providing traction to the ankle in certain situations particularly where access to the distal aspect of the tibia is the desired objective and would be better than the assistant pulling on the foot manually. It is advantageous in not being invasive with its attendant possible complications. It may, however, have limitations in ankle arthroscopy.

The barrel sling described is not dissimilar to the Kerlex loop described some years ago by Yates and Grana¹ for ankle arthroscopy and, therefore, shares the disadvantages in that procedure. It does not allow as much distraction as can be obtained mechanically and the distraction obtained is not maintained in a controlled manner.² The 6-inch bandage described here (wider than the traditional Kerlex loop) will increase the difficulty with access to posterior approaches portals.

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