TECHNICAL TIPS

Use of saline in surgical wounds

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Figure 1 Radiograph with (A) and without (B) normal saline.

We report a simple method to improve the quality of intra-operative fluoroscopy obtained using an image intensifier. The figures shown (Fig. 1A,B) were taken during the initial stages of open reduction and internal fixation of a distal radial fracture, through a Henry approach. In Figure 1A, the surgical wound has been filled with 10 ml of sterile saline. The patient and C-arm machine position are unchanged. The fluid has displaced the air within the wound and allowed a clearer image of the operative site by eliminating the air-fluid interface.

Removal of fibro-epithelial anal polyps

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Fibro-epithelial anal polyps can sometimes become a nuisance if they become enlarged and repeatedly prolapse. Removal under general anaesthetic is easy, but under local anaesthetic it can be difficult to obtain haemostasis after the polyp has been removed. If the polyp is first infiltrated with local anaesthetic, two rubber bands can be applied to the polyp using suction banding equipment and an Eisenhammer retractor. The polyp is then cut off with scissors just beyond the bands, and no bleeding occurs. The bands slough off in due course. The procedure can be carried out in out-patients.

Methylene blue dye aids postoperative inflation of breast tissue expanders

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The Becker Adjustable Breast Implant (Mentor; Santa Barbara, CA, USA) for breast augmentation has an inner lumen for saline allowing serial tissue expansion, and an outer lumen of silicone gel. The port is tunnelled beneath the skin, but can be difficult to orientate a needle into correctly, especially in the larger

Figure 1 Aspiration of blue dye rapidly confirms correct positioning of the needle into the port for expansion.

patient. We use 5 ml of methylene blue dye added to the volume of saline prior to peri-operative infiltration of the implant. In the clinic, this allows a visible aspiration into a butterfly needle and syringe (Fig. 1), confirming rapidly that the needle is correctly sited within the port, and that expansion or deflation can proceed.

Check radiograph following hip arthroplasty

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Although it has been suggested that an immediate postoperative radiograph after hip arthroplasty is not needed,¹ we favour one, principally to confirm reduction and exclude any intra-operative fracture. The patient is kept in the lateral position following arthroplasty. A pillow is placed between the patient's knees to abduct the hip. The back support is loosened and the X-ray plate is positioned behind the hip. A radiograph is then obtained as

Figure 1 Position of X-ray machine and plate to obtain check radiograph.

shown in Figure 1. We have found this technique to produce reliable radiographs for postoperative purposes. It avoids the need for moving the patient in recovery for a radiograph and reduces the burden on nursing and portering staff by avoiding the need for departmental radiographs.

Reference

1. Crawford JR, Syed I, Babatope M, Keene GS. Total hip replacement – are check radiographs required? [Abstract] *J Bone Joint Surg Br* 2006; **88** (Suppl II): 249.

The Tubiglove – a novel means of support in hand injuries

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Metacarpal and proximal phalangeal fractures are common injuries that are often treated non-operatively. It is important with these injuries to allow controlled mobilisation of the fingers to prevent stiffness whilst splintage from neighbouring structures is utilised. This can be achieved by using the Tubigrip (Medlock Medical; Oldham, UK) to create a supportive glove. A double Tubigrip is cut to about 25 cm in length. Three longitudinal rows of machine stitching are used to create four 'finger compartments'. A small opening is cut out for the thumb. Unwanted finger compartments are trimmed off. The 'Tubiglove' provides firm support to the hand and fingers (Fig. 1). In addition,