A new technique for securing drains to the scalp

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BACKGROUND

Drains are usually placed if there is a risk of bleeding and subsequent haematoma or seroma formation. The vascular nature of the scalp leads most surgeons to place a drain postoperatively. Traditionally, drains are secured to the skin with a length of non-absorbable suture. Drains secured in this way can become both dislodged and accidentally pulled out. In this event, wound complications such as infection and fistula formation have been seen to occur.¹ As a result, several different techniques to improve anchoring of drains have been described.²⁻⁵

TECHNIQUE

In this method, the drain is passed out of the skin flap in the usual way, leaving the perforated end in the wound completely intact. No wastage of the drain occurs in this technique. After the trocar has been cut, a loop is formed from the drain and two staples are used to anchor the loop to the scalp. There is no appreciable reduction to the lumen of the drain and the staples can safely be identified and removed on the ward despite the presence of large amounts of hair (Fig. 1).

Figure 1 Tubing leading to a suction drain secured to the scalp using two staples.

DISCUSSION

This method, using staples, is a quick and reliable technique to secure drains to the scalp. The staples are easily located and removed with blunt instruments eliminating the risk of sharps injuries in their removal. We would recommend this technique to others securing drains in the scalp.

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Accurate, single pass retrograde distal interphalangeal joint K-wiring

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BACKGROUND

There are a number of occasions in both fingers and toes where retrograde K-wiring of the digit is required. The medullary cavity of the phalanges lies dorsal to the midline of the digit in the sagittal plane and placing the wire too volar will miss the medullary cavity and the distal interphalangeal joint. The slope of the distal phalangeal tuft tends to make the wire tip skive off the bone and into the flexor tendon. These technical difficulties make multiple attempts at passing a K-wire across the DIPJ all too common even when the nail plate is used as a guide.¹

TECHNIQUE

With a sterile skin-marking pen, draw perpendicular lines along the digit. One should be along the mid-axial line of the digit in the coronal plane, where the glabrous (volar) skin meets the sebaceous (dorsal) skin. The second is in the mid-line of the digit in the sagittal plane. These lines cross at the centre of the distal phalangeal tuft, which is the insertion point of the wire (Fig. 1). Keeping the wire aligned with the marked lines allows accurate passage of the wire along the medullary cavity and across the joint.