A new technique for securing drains to the scalp

R JANDHYALA, C HEALY

Department of Plastic Surgery, St Thomas's Hospital, London, UK

CORRESPONDENCE TO

R Jandhyala, Department of Plastic Surgery, Chelsea & Westminster NHS Trust, 369 Fulham Road, London SW10 9NH, UK

E: ravi_jandhyala@yahoo.co.uk

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.

References

1. Lim PVH, Jalaludin MA. An alternative method for securing surgical drains in the neck. *Med J Malaysia* 2000; **55**: 141–2.
2. Jayaraj SM, Ghufoor K, Patel KS. Securing of surgical drains in the neck. *Ann R Coll Surg Engl* 1998; **80**: 438.
3. O'Flynn P, Akhtar S. Effective securing of a drain. *Ann R Coll Surg Engl* 1999; **81**: 418–9.
4. Voltaris NS, Chang S, Bridger MW. Securing of suction drains in head and neck surgery. *J Laryngol Otol* 1989; **103**: 869.
5. Stern Y. Securing of suction drains in head and neck surgery. *J Laryngol Otol* 1990; **104**: 282.

Accurate, single pass retrograde distal interphalangeal joint K-wiring

B WILSON, S HASSAN, A KOCHETA

Orthopaedic Department, Rotherham General Hospital, Rotherham, UK

CORRESPONDENCE TO

A Kocheta, Consultant Orthopaedic and Hand Surgeon, Rotherham General Hospital, Moorgate Road, Rotherham S60 2UD, UK

T: +44 (0)1709 304128; E: alex.kocheta@rothgen.nhs.uk

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.

Figure 1 View of a right index finger with a wire entering at the intersection of the lines drawn on the skin.

DISCUSSION

Accurate, single passage K-wiring is a technically demanding technique. This simple method eases the process substantially. Fixing the joint in flexion or extension is avoided by keeping the lines straight. Fixing the joint in a subluxated position is avoided by ensuring that there is no step in the line.

Reference

1. Scott JR, Dabernig J, Shelley O. Landmarks for K-wire placement in the distal phalanx. *Ann Plast Surg* 2005; **55**: 438–9.

A novel technique for wound irrigation

R AHMAD, SMY AHMED, M RADFORD
Department of Orthopaedics and Trauma, Weston General
Hospital, Weston-super-Mare, UK

CORRESPONDENCE TO

R Ahmad, 18 Oakwood, Coxhoe, Durham DH6 4SQ, UK
E: riazhzhi@yahoo.co.uk

BACKGROUND

Irrigation of wounds to remove bacteria and foreign material is an essential part of wound care along with debridement. High-pressure flow has been shown to remove more bacteria and debris and lower the rate of wound infection compared to low-pressure irrigation.¹ We present a simple and inexpensive method of wound irrigation that is ideal for use in both casualty and theatre situations. This versatile system allows the surgeon to change the speed of irrigant with a minimum of manipulation.

TECHNIQUE

The equipment needed is a sterile bag of saline (any volume) and a transfer device (Fig. 1). The transfer device is readily available

Figure 1 Saline bag and the transfer device.

Figure 2 Irrigation device.

in the wards and is used for the aseptic transfer of a drug from a vial to a bag. The narrow end of the transfer device is inserted into the additive port of the saline bag, puncturing the membrane. This forms an easily controlled irrigation device (Fig. 2). The flow rate and pressure can be adjusted by squeezing the bag. This device can be very useful for high-pressure irrigation of small lacerations especially small joints of the hand and fight bite injuries.

DISCUSSION

We have used this device effectively in our accident and emergency department and it can be useful in theatre. The