The use of a surgical glove in the prevention of tourniquet-associated chemical burns

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BACKGROUND

Chemical burns associated with the use of pneumatic tourniquets is well documented in the surgical literature.^{1,2} The most common cause is through the use of alcohol or spirit based skin preparations.¹ If the wool beneath the tourniquet is not protected by an occlusive barrier, it can soak up the fluid and lead to focal areas of partial or full-thickness skin loss.^{3,4} This risk is significantly increased in children and the elderly.⁵

EXPERIMENTAL

We propose the use of a surgical glove as a tourniquet barrier. If the glove is cut so that the fingers are removed (Fig. 1), the remaining body of the glove can be stretched to allow the leg to be inserted up to the level of the tourniquet (Fig. 2). When positioned around the tourniquet, it provides a waterproof seal, preventing the pooling of skin preparation fluids or soaking of the wool underneath pneumatic tourniquets.

DISCUSSION

In addition to a number of commercial covers, a variety of simple, non-commercial alternatives have been proposed. Sarkhel and Stride⁴ suggested using the disposable reservoir bag from a single-use anaesthetic circuit. However, in our practice, we have found that these are not always disposed of after each case as suggested by the authors and are, therefore, not always readily available. Although this technique cannot be used in patients with large thigh diameters, it does offer a useful and readily

Figure 1 Removal of the fingers from a surgical glove.

Figure 2 The surgical glove stretched over the tourniquet.

available means of preventing chemical burns when using a limb tourniquet.

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Arthroscopic repair of tibial spine fractures

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BACKGROUND

There is debate within current literature as to the best treatment of displaced tibial spine fractures.^{1,2} We suggest a simple and effective arthroscopic approach to this injury. The Twinfix Ti Quick-T soft tissue anchor (Smith and Nephew; Warwick Technology Park, Gallows Hill, Warwick CV34 6WG, UK) has a 3.5-mm screw on a pre-tied suture attaching a high strength 'T'-bar. The system allows a secure, adjustable fixation of uncomminuted tibial spine fractures.

TECHNIQUE

The patient is positioned for a standard arthroscopic anterior cruciate ligament (ACL) reconstruction using anterolateral and