Figure 1 CT scan demonstrating splenunculus with localising hookwire.

Figure 2 Laparoscopic view of splenunculus with hookwire in place.

facilitate definitive laparoscopic surgery. Prior to surgery, a CT-guided hookwire is passed percutaneously to lie alongside the splenunculus. For excision of residual splenic tissue in the region of the native spleen, we employ the following configuration: right lateral decubitus position, a 10-mm port placed lateral to the umbilicus and 2 x 5-mm ports (below mid-line xiphisternum and left costal margin at the mid-axillary line). With this arrangement, the splenic flexure can be easily mobilised. The splenunculus is identified at the end of the wire and excised.

Figures 1 and 2 illustrate the application of this technique.

DISCUSSION

After previous surgery, the technical difficulty of finding a splenunculus is increased, especially for laparoscopy.³ Several techniques of intra-operative localisation and laparoscopy have been described, including the use of gamma probes, after injection of technetium.^{3–5} This is the first report of CT-directed guidewire localisation of accessory splenic tissue.

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The Campbell de Morgan spot as a method for monitoring flaps

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BACKGROUND

Although many systems are available, there is no consensus as to which is the most effective method to monitor cutaneous flaps.¹ Most clinicians rely on clinical examination: colour, capillary refill time, temperature and bleeding in response to scratch are among the most common indicators. In many cases, it can be difficult to assess colour and refill. Interobserver variation, degree of digital pressure and lighting are variables that may contribute to the difficulty in determining these signs. A Campbell de Morgan spot is a sharply circumscribed vascular proliferation that usually appears spontaneously after the age of 40 years. Histologically, they consist of numerous arterioles, venules and dilated capillaries in a thickened papillary dermis. Clinically, they present as 1–3 mm circular lesions of a uniform deep-red colouration and are not known to be associated with any other disease.²

TECHNIQUE

We have realised that Campbell de Morgan spots can act as useful indicators of flap perfusion. These lesions blanch or completely empty when pressure is applied. When the pressure is released, an obvious visible blush caused by the refill of the capillaries unequivocally demonstrates the status of the dermal microcirculation.

DISCUSSION

Although specifically designing flaps to incorporate Campbell de Morgan spots is impractical, we suggest that opportunistically

including such a lesion may make monitoring flaps in the postoperative period much easier.

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TECHNICAL TIPS

'Sounding' the bolt: confirming the position of the locking bolts in an intramedullary nail

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We present a technique for stabilising the unstable calcaneocuboid joint. The joint is approached laterally, elevating the extensor digitorum brevis muscle. Once the joint is exposed, two parallel

tunnels are drilled into the calcaneal neck and cuboid. The harvested gracilis tendon is prepared with whip stitches, and passed through the tunnels in a plantar-dorsal manner. The dorsal limbs of the graft are then pulled across the joint in parallel. The ends are fixed in the calcaneum and cuboid, respectively, using biotenodesis screws (Arthrex; Florida, USA). This technique recreates the dorsal support of the cuboid part of the bifurcated ligament and the dorsal calcaneocuboid ligament, while also augmenting the plantar calcaneocuboid ligament. So far, we have used this technique in one patient with a good result.

An anatomical tenodesis method for calcaneocuboid joint stabilisation

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Insertion of the locking bolts into intramedullary nails is difficult. Confirming bolt position fluoroscopically is time consuming, awkward and accounts for a significant proportion of the intraoperative radiation delivery.¹ We find the following technique swiftly confirms the bolt is within the nail. Insert the guide-wire down the nail and mark the remaining length with a clip (Fig. 1A). Retract the guide-wire and insert the distal bolt in the preferred manner. Now, re-advance the guide-wire. If the bolt is correctly through the nail, the guide-wire will be obstructed at the bolt with a characteristic metallic 'clink' (Fig. 1B). The guide-wire is retracted and process is repeated for each bolt.

Figure 1 (A) The guide-wire passes to the distal end of the canal. (B) When the locking bolt is correctly through the nail, the guide-wire is halted with a metallic 'clink'.

Figure 1 Anatomical calcaneocuboid joint stabilisation.