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TECHNICAL TIPS

The use of Tegaderm™ for finger buddy-strapping: a dressing with many advantages

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Buddy-strapping is a method of finger splinting that allows protected active movement in situations such as stable phalangeal fractures, undisplaced stable metacarpal fractures and ligamentous interphalangeal joint injuries. We have found buddy-strapping with Tegaderm™ (3M Healthcare, Germany) a transparent adhesive dressing, has a number of advantages over tape. It is simple for patients to self-apply. A full range of movement is possible with full support provided throughout. The dressing is waterproof, easy to clean and does not discolour. Finally, it allows easy inspection and is cosmetically more appealing to patients. We have not found that it stretches.

Figure 1 Buddy-strapping of the little and ring fingers with Tegaderm™. This particular patient had a stable fracture of her little finger metacarpal.

Technique for reducing incision-related post-operative pain

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We describe a technique to help reduce the pain associated with transverse abdominal wall incisions (Fig. 1). During closure of the wounds, two 6-Ch PVC end-perforated 350 mm wound drains (Van Straten Medinorm, Nieuwegein, The Netherlands) are inserted deep to the internal oblique muscle (corresponding with the neurovascular bundle). The 'drain' exits laterally, 6–7 cm away from the transverse incision and away from any bone. It is stuck to the skin with two Vygon dermafilms (Dermafilm®, Vygon, UK). Once closure is complete, 0.25% levobupivacaine is infiltrated via a pink (20-G) cannula affixed to the end of the drain as this minimises spillage. Further local anaesthesia can be instilled at the appropriate dose postoperatively using either boluses or continuous infusion via a pump (Bupivacaine Easypump, Braun, France).

Figure 1 Anaesthetic infiltrated via pump.

Use of anterior cruciate ligament guide for minimally invasive subtalar arthrodesis

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For the successful outcome of minimally invasive subtalar arthrodesis, skilful and accurate screw positioning are essential.

Figure 1 Diagrammatic illustration of ACL guide placement during subtalar joint arthrodesis.

Figure 2 Photograph taken during the operation, illustrating the placement of the ACL guide.

Repetitive fluoroscopy is often needed to achieve this, which can increase the surgical time and radiation exposure to the surgeon. Use of an anterior cruciate ligament (ACL) guide during screw placement for subtalar arthrodesis has not been described previously. The technique involves placing one end of the ACL guide on the superior aspect of talar neck while the other end is placed on the plantar aspect of calcaneum (Figs 1 and 2). Satisfactory bony union was obtained in all cases using this simple technique.

A useful and economical suture passer

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Sutures are often passed through trochanteric drill holes to effect a strong soft tissue repair after posterior approach to the hip. We use a 3/0 nylon on a straight needle. The needle is held with a needle holder, passed backwards through the drill holes and the nylon pulled through making a loop (Fig. 1). The suture to be passed is placed into the loop. The needle and nylon are pulled back, dragging the suture through the drill holes. A nylon suture is approximately one-tenth of the cost of a disposable suture passer and can easily be passed through small drill holes.

Figure 1 Illustration of the technique.