be stuck to both mask and visor bringing the mask away from the face. Rather than significant savings being made as claimed in the article, the use of an unnecessary second mask may actually cost more. We also note that this technique has previously been described in the literature.¹

Reference

1. Thienpont E, De Vloo R. Alternative use of a splash screen. *Acta Orthop Belg* 2007; **73**: 250–1.

RESPONSE

doi 10.1308/003588408X318057

Originality

BRUCE CAMPBELL (Technical Section Editor)

I sometimes receive letters pointing out that techniques published in the Technical Section are not original. The balance between originality and usefulness is blurred. Reviewers quite often tell me that they have seen or used a technique but they go on to point out that it may not be widely known and is, therefore, probably worth publicising. Under those circumstances I will accept Technical Tips and Notes, with the aim of promulgating useful techniques. Letters which simply point out that a technique is not original are not published – only letters which have some other useful or controversial point to make.

COMMENT ON (Technical section)

doi 10.1308/003588408X242196

A Fattah, N Niranjan. A makeshift mallet splint. *Ann R Coll Surg Engl* 2008; **90**: 72–80

doi 10.1308/003588408X318066

Makeshift mallet splint – neither safe, nor effective

NIRAV PATEL, RUPERT ECKERSLEY

Hand Management Unit, Chelsea & Westminster Hospital, London, UK

CORRESPONDENCE TO

Nirav Patel, Hand Management Unit, Chelsea & Westminster Hospital, 369 Fulham Road, London SW10 9NH, UK
E: niravpatel@doctors.org.uk

We read this article with some concern. It describes a novel technique of treating mallet finger injuries using disposable razor guards. It may be simple and inexpensive, but we believe it is neither safe, nor effective.

First, use of the single-size guard places pressure on the digit. In a field test, it caused discomfort, skin blanching and pinching

Figure 1 Disposable razor guard showing tip congestion, skin blanching and pinching.

of a petite young lady's finger (Fig. 1). This places the skin at high risk of lacerations and pressure necrosis,¹ converting a closed zone 1 extensor injury into an open zone 2 injury. Second, the part of the guard supporting the distal phalanx is angulated by approximately 5° causing corresponding flexion at the distal interphalangeal joint. This is contrary to the management aim of splinting this joint in extension for 6–8 weeks² and may lead to a poor outcome.

We encourage the use of 'eco-friendly' and inexpensive treatment options, but issues of safety and efficacy cannot be overlooked. Zimmer splints are inexpensive and are usually readily available, but the gold standard is a custom-made thermoplastic splint. We therefore advise against the use of these guards in treating mallet fingers.

References

1. Rayan GM, Mullins PT. Skin necrosis complicating mallet finger splinting and vascularity of the distal interphalangeal joint overlying skin. *J Hand Surg Am* 1987; **12**: 548–52.
2. Kalainov DM, Hoepfner PE, Hartigan BJ, Carroll IV C, Genuario J. Nonsurgical treatment of closed mallet finger fractures. *J Hand Surg Am* 2005; **30**: 580–6.

COMMENT ON

doi 10.1308/003588407X232125

A Bajwa, TR Magee, RB Galland. Reduction in varicose vein services: impact on operative training. *Ann R Coll Surg Engl* 2007; **89**: 789–91

doi 10.1308/003588408X318020

The ISCP: trainees should now be able to gain better access to appropriate clinical material

DENNIS WILKINS

Department of Surgery, Derriford Hospital, Plymouth, UK

CORRESPONDENCE TO

Denis Wilkins, Consultant General Surgeon, Level 7, Derriford Hospital, Plymouth PL6 8DH, UK

[Editor and Chair of Syllabus and Assessment Group, ISCP 2005–2007] E: denis.wilkins@btopenworld.com

Whether or not the concept of competence training is yet fully accepted, there is certainly general agreement that