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

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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

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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

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

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

experience as well as high-quality instruction is the bedrock of satisfactory training. This article by Bajwa *et al.* regarding the removal of varicose veins surgery from a long-established training unit confirms predictions that an increasingly destabilised and fragmented health service is likely to result in sudden and major shifts of clinical material across units, both within and out with the NHS. The specialties and colleges anticipated this and consequently incorporated two important principles into the ISCP. The first was the construction of tighter, highly prescriptive syllabuses for each stage of training, which should make clear to all concerned the training to be delivered and the standards of performance to be acquired by the trainee. Indeed, recognising the need to provide maximum counter pressure to the reductions in experience that were apparent and unchecked likely to get worse, the original specialty syllabuses also specified minimum volumes of experience to be delivered in key areas. This was rejected out of hand by PMETB and I personally believe that we should have been more robust in our defence of this feature, but perhaps it may be reconsidered as time goes by.

The second principle that was adopted concerned the delivery of training. It seemed wise that if more prescriptive demands were to be made of training programmes and their trainers, then maximum flexibility as to how such training is delivered would be helpful. As promulgated in the ISCP, therefore, the Assigned Educational Supervisor (AES), in consultation with his or her programme director, has considerable devolved powers to move a trainee within or even outside of the NHS trust in order to fulfil the syllabus requirements for each placement. Commensurate with these new powers, the responsibility for monitoring and assuring the quality of training delivered remains firmly with the AES. It remains to be seen how well this mechanism can be made to work but the pivotal position occupied by the AES can be readily appreciated and must be reflected in the support that is provided for him or her to be truly effective. Certainly, it seemed clear that the existing model whereby trainees were confined to an inflexible timetable, a circumscribed number of trainers and an 'approved' training unit during each placement would be likely to deny training programmes the flexibility sometimes necessary in this changing and unpredictable environment.

e-Letters – new additions

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Since the last issue of the Annals, the following letters have been published on our website
<<http://www.rcseng.ac.uk/publications/eletters/>>:

'Sounding' the bolt: confirming the position of the locking bolts in an intramedullary nail – 1 response

Technique of urethral catheterisation in very elderly women – 2 responses

New on-line only case reports

You can access the case reports by using your College-issued Athens username and password to enter the members' area of the College website (<www.rcseng.ac.uk/members/annals/>) and following the link to the Annals.

Alternatively, if you type the following URL into the address bar of your web browser <<http://dx.doi.org/>> and then enter the DOI in the dialogue box presented on this web page, you will be taken directly to the abstract of the article.

Case report:	Cauda equina syndrome versus saddle embolism
ASJ SHAW, H ANWAR, J TARGETT, K LAFFERTY	doi 10.1308/147870808X303083
Case report:	White-out from a Wii: traumatic haemothorax sustained playing Nintendo™ Wii
AC PEEK, T IBRAHIM, H ABUNASRA, D WALLER, R NATARAJAN	doi 10.1308/147870808X303100
Case report:	Combined endoscopic trans-anal rectal mucosal ablation and laparoscopic partial proctectomy for ulcerative colitis – a new procedure
T COLEGATE-STONE, T RAYMOND, U KHOT, MC PARKER, M STEWART	doi 10.1308/147870808X303092
Case report:	Disparity in the risk stratification of major surgery
D BIRCHLEY, J CARLISLE, J THOMPSON	doi 10.1308/147870808X303074