Figure 1 Materials required for preparing device.

Figure 2 The improvised device.

Figure 3 Line diagram of technique.

TECHNIQUE

The equipment (Fig. 1) consists of a 10-mm suction-irrigation pipe, Maelecot catheter (no. 30/32), and a small plastic container with air-tight cap. The stone picker (Fig. 2) is prepared as follows. With the help of the hot metal perforator, a small hole of ~3 mm (air vent) diameter is made in the cap of the plastic container. A second hole of ~10 mm diameter is made in the side wall. A small length of Maelecot catheter is used to connect the box to the 10-mm suction-irrigation pipe. The air vent is closed

with the right index finger and the system is inserted through the 10-mm (internal diameter) cannula (Fig. 3). Its tip should be placed near the stone to be extracted. The air vent is opened. As the intra-abdominal pressure (10–12 mmHg) is high, there is a gush of air through the cannula which takes the stone out. With this technique, stones less than 10 mm in diameter can be vented out. Larger stones are crushed and then they can be dealt with similarly. This whole set-up can be sterilised 2% glutaraldehyde or in a formalin chamber.

DISCUSSION

The instrument has been used in 50 cases from July 2002. Eleven cases had larger stones which had to be crushed before retrieval. Thus, the instrument and its application has proved to be simple, easy, economic and technically faster in recovery of intra-abdominal scattered gall stones.

'Mercedes' incision – another oncoplastic technique for the excision of breast tumours

GREG McMAHON, NEIL BHARDWAJ, SALENA BAINS, ANNE STOTTER

Department of Breast Surgery, Glenfield Hospital, University Hospitals of Leicester NHS Trust, Leicester, UK

CORRESPONDENCE TO

Greg McMahon, Department of Surgery, Northampton General Hospital, Cliftonville, Northampton NN1 5BD, UK
E: gregmcmahon@hotmail.com

BACKGROUND

Oncologically safe treatment of selected neoplasms of the breast can be achieved with conservative surgery and radiotherapy. Peri-areolar tumours can be particularly cosmetically challenging, with the risk of nipple deviation and breast shape change.¹ The 'Mercedes' incision minimises these deformities.

TECHNIQUE

The incision is centred on the tumour as a concaved isosceles triangle, the base of which is formed along the circumferential border of the areola (Fig. 1), facilitating areolar elevation for dissection deep to the nipple. The tumour, with a margin of normal tissue, is excised in continuity with a triangular island of skin superficially. The skin is closed by apposing each side of the triangle and using a standard 'corner stitch' fixing all three sides of the defect centrally. The needle is passed through the skin edge from superficial to deep on one of the radial components of the wound. The areolar flap is then inverted, and a bite of sub-cuticular tissue incorporated from the underside of this flap. A third bite is made from deep to superficial through the remaining radial edge, and then a large bite is taken from side to side of the radial section,

Figure 1 The 'Mercedes' incision: an isosceles triangle centred over the tumour deep to the areola margin.

Figure 2 Incision closure, illustrating formation of the central 'corner stitch'.

Figure 3 The 'Mercedes' incision at 6 weeks – the breast shape and nipple orientation have been maintained and the scar will fade into the circum-areolar interface.

securing the suture on one side (Fig. 2). The radial component of the incision is the only visible scar; the circum-areolar portion being camouflaged in the areola–skin interface. The breast shape and nipple orientation are preserved (Fig. 3).

DISCUSSION

The 'Mercedes' incision is a useful addition to the repertoire of techniques which integrate both oncologically safe tumour excision and optimum cosmesis.^{2,3}

References

1. Morrow M, Strom E, Bassett L, Dershaw D, Fowble B, Giuliano A *et al.* Standard for breast conservation therapy in the management of invasive breast carcinoma. *CA Cancer J Clin* 2002; **52**: 277–300.
2. Tan M. The boomerang incision for periareolar breast malignancies. *Am J Surg* 2007; **194**: 690–3.
3. Shrotria S. The peri-areolar incision – gateway to the breast! *Eur J Surg Oncol* 2001; **27**: 601–8.

A technique for the removal of the distal part of a broken intramedullary nail

SM BLAKE

Department of Trauma and Orthopaedic Surgery, South Devon NHS Foundation Trust, Torquay, UK

CORRESPONDENCE TO

SM Blake, Consultant Orthopaedic Surgeon, South Devon NHS Foundation Trust, Lawes Bridge, Torquay, Devon TQ2 7AA, UK
E: stephenblake_uk@yahoo.co.uk

BACKGROUND

Removal of a broken intramedullary nail can be difficult. The proximal part is usually easily removed but the distal part often poses the greatest challenge. A simple technique for the removal of these distal parts is described.

TECHNIQUE

First, remove the proximal and distal locking screws. Next, assess whether there is any displacement of the broken ends of the nail. If displacement is minimal, an olive tipped guide wire can be passed completely through the nail (Fig. 1). The proximal part is then removed using the standard extraction equipment. If there is displacement then it may be necessary to remove the proximal part of the nail first prior to inserting the olive tipped wire. Next, pass a second, non-olive tipped, wire through the distal fragment adjacent to the previously placed wire (Fig. 2). Now withdraw the olive tipped wire causing it to impinge against the non-tipped wire and the outer tip of the nail (Fig. 3). A T-handled chuck is applied to the proximal end of the olive tipped wire and this is gently tapped back thus removing the distal fragment.

DISCUSSION

Numerous techniques to aid the removal of intramedullary