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}

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

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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

Figure 1 An olive tipped wire is passed through distal fragment of nail.

Figure 2 A second wire is passed through distal fragment of nail.

Figure 3 The olive tipped wire is withdrawn and is shown to impinge against the second wire and the outer tip of nail.

devices have been described.¹⁻³ No additional exposure or equipment is required with this technique. It is important that the proximal part of the nail is removed first rather than attempting to extract both parts at the same time. This may cause undue stress on the olive which may break. This is a simple solution to a potentially very difficult problem.

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TECHNICAL TIP

The use of an axillary crutch as a knee flexion contracture correction device

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We describe a simple, patient-controlled technique for the treatment of early flexion contracture following total knee replacement. An axillary crutch may be used to aid passive extension in the postoperative period. The leg is placed through the inverted crutch and a foam pad is positioned between the patient's heel and the axillary pad (Fig. 1). The hand grip is then adjusted to the level of the knee joint and is wrapped with a wool dressing. The patient exerts a downward pressure on the foot of the crutch to gain knee extension.

Figure 1 The axillary crutch.

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Please note that the co-author R Telford was unfortunately omitted from the original list of authors. The correct author list is given above.