Figure 1 The nipple aspiration device.

fluid. It is made up of a modified syringe barrel and a standard plunger. The modified syringe barrel is essentially a 20-cc syringe barrel from which the tip and the distal end of the barrel have been cut off resulting in a cylinder with an intact finger flange end (Fig. 1). The plunger is introduced into the barrel through the cut end. On applying the finger flange end onto the nipple areolar complex and withdrawing the plunger, the negative pressure causes breast ductal fluid to be sucked into the syringe barrel. The fluid thus obtained can be sent for cytological analysis.

DISCUSSION

The squeeze technique is not used here; rather, it is by suction that nipple discharge is elicited. Aspiration serves as a highly effective way of uniform application of negative pressure onto all breast ducts resulting in a good yield of ductal fluid. Trauma to the nipple by inadvertent pinching is avoided which limits iatrogenic, blood-stained, nipple discharge.

En Garde! A novel splash guard for use in wound irrigation

SAMMY AL-BENNA, YAZAN AL-AJAM, NEIL PATANI
Department of Plastic and Reconstructive Surgery, The Royal London Hospital, London, UK

CORRESPONDENCE TO

Sammy Al-Benna, Department of Plastic and Reconstructive Surgery, The Royal London Hospital, Whitechapel, London E1 1BB, UK
E: sammyalbenna@doctors.org.uk

BACKGROUND

Transmission of infections from splash injuries is a continuous risk to healthcare professionals.¹ Exposure to body fluids is greatest in the operating theatre² and conjunctival transmission has been documented for hepatitis B, hepatitis C and HIV.^{3,4} Face-guards provide insufficient protection from conjunctival transmission of viruses.⁵ Fluid splashes are associated with wound irrigation.

Figure 1 View of the irrigation guard created from a modified operating room light handle cover.

Figure 2 Top view of the irrigation guard.

Figure 3 The guard with irrigation tube.

TECHNIQUE

The irrigation guard is created from a modified operating room light handle cover, resembling the bell guard of a fencing sword. It is made from sterile, translucent, latex-free plastic (Cory Bros.

CB3611, Shenley, UK). An administration set for blood components (Baxter Healthcare RMC 2071B, Newbury, UK) is passed through an opening made in the distal end of the guard (Figs 1 and 2). The rubber at the distal end of the administration set creates a seal between the guard and the administration set (Fig. 1). The wide end of the guard is applied to the area to be irrigated and can be contoured according to the shape of the wounds. The non-dominant hand holding the wide end ensures that it stays relatively closely applied to the wound allowing the dominant hand to direct the flow of irrigation fluid through the translucent plastic (Fig. 3).

DISCUSSION

The risk of splash injuries during irrigation of contaminated wounds is a potentially life threatening occupational hazard. The *En Garde* shield is easy to assemble using ubiquitous and inexpensive items and provides increased protection from splashes when used in conjunction with universal precautionary measures including protective eyewear and face shields.

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TECHNICAL TIPS

Two-knife scar excision

J LEWIS, R SAVAGE
Royal Gwent Hospital, Newport, UK

CORRESPONDENCE TO

James Lewis, Department of Trauma and Orthopaedics,
Princess of Wales Hospital, Coity Road, Bridgend CF31 3RQ, UK
E: jameslewis@fastmail.fm

Scar excision following previous surgery is often difficult leaving ragged skin edges that ultimately lead to untidy wound closure and further scarring. We describe a simple technique that obviates

Figure 1 The two-knife scar excision technique.

this problem. Prepare and drape the surgical field as per protocol. With the skin under gentle tension, hold two identical scalpel handles side by side and make a longitudinal incision along the scar (Fig. 1), creating two neat parallel incisions. The distance between the blades can be adjusted by spacers, such as suture packets, or use of bigger or smaller handles. Marking the scar with a pen will assist accurate excision. A single scalpel tapers the two incisions' ends. At completion of surgery, the freshly cut skin edges are repaired.

SECTION EDITOR'S COMMENT

I have used this technique for over 30 years and would recommend it. I point this out to draw attention to the fact that both specialist reviewers and I sometimes note that techniques are not novel or original, but they are accepted to publicise variations in technique which may not be well known.

Non-ligation of the distal cephalic vein maintains patency of median cubital vein arteriovenous fistulae

PJ YATES, A BAGUL, T DOUGHMAN, ML NICHOLSON
Department of Transplant Surgery, Leicester General Hospital,
Leicester, UK

CORRESPONDENCE TO

PJ Yates, Department of Transplant Surgery, Leicester General
Hospital, Gwendolen Road, Leicester LE4 5PW, UK
E-mail: pjy4@le.ac.uk

The utilisation of the median cubital vein is a recognised technique for upper arm arteriovenous fistula formation. In our experience, when the median cubital vein is suitable for arteriovenous fistula formation, the distal cephalic vein should not be ligated and divided. By preserving the continuity of the cephalic vein,