sterile drapes is difficult, disrupts surgery and can prolong the duration of anaesthesia. A simple and cheap solution is to use an inflated latex glove and position the patient's hand with interlocking fingers around it as shown in Figure 1, thus maintaining dorsiflexion of the patient's wrist and so preventing arterial line kinking.

Reference

1. Sferir R, Khoury S, Khoury G, Rustum J, Ghabash M. Ischaemia of the hand after radial artery monitoring. *Cardiovasc Surg* 1996; 4: 456–8.

Using sterile co-polymer overgloves as undergloves prevents hands from 'smelling' after contaminated abdominal surgery

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When performing contaminated abdominal surgery, one of the problems that all surgeons will have experienced is the nasty 'smell' left on their hands after the procedure, even when double-gloving. Surgeons at our institution have found that by using a pair of sterile co-polymer overgloves as undergloves (e.g. Bodyguards®; Medisavers, E: sales@medisavers.co.uk) instead of a pair of latex gloves results in no 'smell' being transmitted to the hands. One of the major problems reported by surgeons when using two pairs of gloves is loss of tactile sensitivity.¹ We have found that these gloves do not significantly affect tactile sensitivity.

Reference

1. Twomey CL. Double gloving: a risk reduction strategy. *Jt Comm J Qual Saf* 2003; 29: 369–78.

A radiolucent retractor for locking screws

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During proximal locking of a retrograde femoral intramedullary nail, retraction can be difficult when using traditional radio-opaque retractors. A 50-ml syringe, such as BD Plastipak™ (BD, The Danby Building, Edmund Halley Road, Oxford Science Park, Oxford, UK),

Figure 1 Syringe placed onto saw bone demonstrating retraction technique.

with the catheter tip cut off, either with scissors or a saw, can be placed directly onto bone via the skin incision. This easily retracts the tissues allowing access to the proximal femur with the added benefit of being radiolucent. This allows the surgeon to interpret the fluoroscopy findings accurately and position the proximal locking screw precisely. Furthermore, the surgical assistant is protected from erroneous exposure to radiation whilst screening.

A cost-effective transverse colostomy

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A loop transverse colostomy can be performed as an effective method of relieving acute colonic obstruction. In the setting of disseminated intra-abdominal malignancy and resultant abnormal anatomy, the procedure is frequently underestimated. By securing a coin in the right upper quadrant and obtaining a plain film of the abdomen, the location of the proposed colostomy relative to the transverse colon can be estimated pre-operatively. This facilitates less dissection of the peritoneal attachments in order to mobilise the colon to the desired site.

Figure 1 (A) Coin secured in right upper quadrant; (B) pre-operative plain film of the abdomen; (C) loop transverse colostomy in desired site.