Technical Section

TECHNICAL NOTES & TIPS

Authorship and writing for the Technical Section

Authorship

There has been a trend towards increasing numbers of authors on Technical Notes and Tips: this sometimes seems excessive and unreasonable. A simple technical idea usually has one originator (or perhaps two, as a product of discussion) and it is then common to supervise a trainee in writing it up. That means that a Tip or Note might reasonably have two or three authors. Submissions are becoming more frequent with four or five names above them. This needs to be fully justified. I have started to write to any lead author who has more than two co-authors asking for a full explanation of the contribution of each and will do so increasingly. I advise that any submissions with more than three authors should be accompanied by a letter giving those details.

Writing

Submissions of 100 or 250 words should be perfect. Especially if they are being used to increase the experience (and CV) of trainees, senior authors should be sure that they are faultless. The shoddy presentation of some of the submissions we receive is difficult to excuse – the more so when there are a number of authors, each of whom should have read the final manuscript. Each author bears personal responsibility for its content and quality. I write some fairly blunt letters to the authors of short submissions with imperfect text and (commonly) references that are not cited in proper Vancouver style. I would like to remind all authors (not least senior ones) of their responsibilities to check that manuscripts are perfect. That ought to be easy with such short submissions.

Bruce Campbell

Editor, Technical Section

TECHNICAL NOTES

A technique to stabilise the Herbert–Huene jig during scaphoid fracture fixation

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BACKGROUND

Technical factors such as inaccurate jig placement can lead to mal-alignment of the screw which, in turn, can lead to higher rate of non-union after scaphoid fracture fixation using the Herbert–Huene jig.¹ Central screw placement in the proximal fragment confers biomechanical advantage and increased strength of fixation.² We have found that the jig can slip after placement and checking the position using an image intensifier, which can lead to inappropriate screw placement.

Figure 1 Herbert–Huene jig with the inserted wire sleeve.

TECHNIQUE

The fracture is reduced and the jig is applied across the scaphoid in the usual way. A 1.6-mm K-wire sleeve from the AO proximal humeral locking plate system (PHILOS, Synthes, Welwyn Garden City, UK) can be inserted into the jig entry collar (Fig. 1). This K-wire sleeve is appropriately undersized to match the internal diameter of the jig collar and accommodates a 1.6-mm K-wire (Fig. 2). This allows the K-wire to be inserted centrally within the jig providing

Figure 2 K-wire, wire sleeve and jig construct being used in a scaphoid fixation.

stability while checking its position. The wire and sleeve are removed, the bone is predrilled and tapped, and the correct length Herbert screw is inserted in the standard manner.

DISCUSSION

The Herbert–Huene jig, wire sleeve and K-wire construct provides stability and accuracy prior to screw placement and prevents slipping of the jig during guide wire insertion. This technique is simple, reliable and utilises a common wire sleeve found in the PHILLOS plating set.

References

1. Adams BD, Blair WF, Reagan DS, Grundberg AB. Technical factors related to Herbert screw fixation. *J Hand Surg Am* 1988; **13**: 893–9.
2. McCallister WV, Knight J, Kaliappan R, Trumble TE. Central placement of the screw in simulated fractures of the scaphoid waist: a biomechanical study. *J Bone Joint Surg Am* 2003; **85**: 72–7.

A useful reconstruction arrangement following Whipple's resection for patients with familial adenomatous polyposis

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BACKGROUND

Peri-ampullary carcinoma is the third leading cause of mortality in patients with familial adenomatous polyposis (FAP),¹ who may, therefore, require a Whipple's pancreaticoduodenectomy (WPD)

Figure 1 Schematic diagrams showing the reconstructive method used to establish biliary, pancreatic and gastrointestinal continuity after Whipple's resection. (A) Before Whipple's resection with numbers indicating levels of transection; (B) after Whipple's resection with numbers indicating sites of anastomosis, and (C) the advantage of the reconstructive method in allowing endoscopic surveillance of the small bowel postoperatively.

as prophylactic or curative measure. However, patients are at risk of further small bowel polyp formation, requiring life-long surveillance with enteroscopy or contrast follow-through. Traditional reconstruction following WPD, with or without a Roux-en-Y loop, makes the subsequent surveillance study difficult due to a part of the small bowel loop being inaccessible. Similarly, the useful small bowel absorptive length is reduced. Here, we describe a reconstruction technique following WPD which facilitates surveillance studies, and conserves absorptive bowel length.

TECHNIQUE

Classical WPD is performed with extended Kocherisation of duodenum and *en-bloc* resection of pancreatic head, gastric antrum and duodenum. Subsequent reconstructions are performed as illustrated in Figure 1. The cut end of the pancreas is dunked into the stomach through a posterior gastrotomy and sutured in place using two layers of #5.0 polypropylene stitches (an inner layer between the gastric mucosa and the pancreas, and an outer layer between the gastric seromuscular layer and the pancreas). A gastroenterostomy is then performed between the end of the stomach and the side of the jejunum (two layers of continuous #3.0 PDS sutures). Finally, a hepaticojejunostomy is performed 15 cm distal to the gastroenterostomy (a single layer of interrupted #4.0 PDS sutures).