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 PHILOS plating set.

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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).

DISCUSSION

This technique facilitates surveillance studies and conserves small bowel to avoid malabsorption in FAP patients. This technique does not cause biliary reflux postoperatively.

Reference

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Rapid splintage of acute long-bone fractures

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BACKGROUND

Acute long-bone fractures are painful until stabilised. The most common method of splintage requires an initial layer of wool to be wrapped around the limb before a plaster-of-Paris slab is applied; finally, the limb is wrapped in a layer of crepe bandage. To apply the initial layer of wool, the unsplinted limb needs to be supported which can be painful and distressing for the patient, especially for children.

TECHNIQUE

A method to avoid the initial step of supporting an unsplinted limb is to place the length of plaster-of-Paris inside a double layer of Tubigrip® or equivalent, wet, and apply this directly to the skin of the affected limb. This backslab can then be left to dry before elevating the splinted limb for the final wrapping of crepe bandage.

Figure 1 A young boy with a forearm fracture waiting for the slab to dry before the splinted limb is elevated for bandaging.

DISCUSSION

Whilst this method can be used in all long-bone fractures, it has proved especially useful in paediatric upper limb fractures where the child can rest the arm comfortably across their lap throughout the splinting process (Fig. 1).

Enterocutaneous fistula stent

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BACKGROUND

Abdominal sepsis and fistulae are common complications of colorectal surgery. The accepted initial management of an enterocutaneous fistula is drainage of sepsis,^{1–3} and the use of stents placed down through fistula tracts radiologically has been described.⁴ Without stent placement, sepsis may become a recurring problem if premature skin healing occludes the fistula track. A controlled fistula, however, often allows deferring repeat surgery in a hostile abdomen.² We describe a novel use of a silastic stent to allow persistence of drainage of abdominal collections (Fig. 1).

TECHNIQUE

The stent used was a 12-mm silastic stoma stud (Kapitex Healthcare Ltd, 1 Sandbeck Way, Wetherby, West Yorkshire LS22 7GH, UK). This was placed into the fistulae of two patients and sutured in place with 2/0 silk. The stud acted to stent the cutaneous component of their fistulae, thereby preventing skin closure and recurrent sepsis, a prior feature in both patients (Fig. 1).

DISCUSSION

Both patients described had benign colorectal resections which

Figure 1 Silastic fistula plugs