were complicated some weeks postoperatively by multiple fistulae demonstrated by contrast-enhanced abdominal computed tomography scans. The abdominal collections were, in both cases, difficult to drain radiologically but the stoma stud allowed the drainage of sepsis without obstruction (skin wound healing) avoiding the need for surgery. We recommend their use in selected cases as they are cheap, effective and simple to place.

References

1. Boulos PB. Complicated diverticulosis. *Best Prac Res Clin Gastroenterol* 2002; **16**: 649–62.
2. Lloyd DA, Gabe SM, Windsor AC. Nutrition and management of enterocutaneous fistula. *Br J Surg* 2006; **93**: 1045–55.
3. Rolandelli R, Roslyn JJ. Surgical management and treatment of sepsis associated with gastrointestinal fistulas. *Surg Clin North Am* 1996; **76**: 1111–22.
4. Kim YJ, Han JK, Lee JM, Kim SH, Lee KH, Park SH *et al*. Percutaneous drainage of postoperative abdominal abscess with limited accessibility: pre-existing surgical drains as alternative access route. *Radiology* 2006; **239**: 591–8.

A handy hint in using an image intensifier during wrist and hand surgery

D REDFERN, A SLOAN, S WILKINS

Department of Orthopaedics, Royal Preston Hospital, Preston, UK

CORRESPONDENCE TO

S Wilkins, Department of Orthopaedics, Royal Preston Hospital, Sharoe Green Lane North, Fulwood, Preston PR2 9HT, UK. E: simonwilkins@hotmail.com

BACKGROUND

When carrying out procedures on the distal radius and hand using the image intensifier, several attempts may be needed to centre the picture. Here is a cheap and simple tip to help with this problem.

Figure 1 (A) Draping and positioning; (B) drawing around the hand and arm; (C) movement of forearm bones towards the very edge of the X-ray field; and (D) move hand back to the radial border of the marked hand.

TECHNIQUE

After preparation, draping and positioning as standard (Fig. 1A), and a satisfactory anteroposterior view has been obtained, using a sterile marker you can quickly draw around the hand and arm. This marks the position to which the arm would need to return in order to repeat this image (Fig. 1B). A common mistake is to then pronate the arm by 90° and take a lateral view. As the radius moves around the ulna, forearm bones move towards the very edge of the X-ray field. This effect is shown in Figure 1C. The surgeon then has to move the wrist back into the X-ray field and repeat the image, thereby wasting time. To obtain an adequate

lateral view, the hand should be moved back to the radial border of the marked hand and elevated to approximately 30°. This position is shown by the additional outline (Fig. 1D).

DISCUSSION

Spending 10 s drawing around the hand will, over the course of an operation, save time and the frustration of having to repeat several images. It also reduces the radiation dose to the patient, theatre staff and surgeons. A similar technique can be used for finger imaging and is particularly useful with magnified images.

The cut-down 1-ml syringe – an excellent improvised drill sleeve

MIKE RODGER, JAMES DAVIS

Department of Trauma and Orthopaedics, Torbay Hospital, Torquay, UK

CORRESPONDENCE TO

Mike Rodger, Department of Trauma and Orthopaedics, Torbay Hospital, Newton Road, Torquay TQ2 7AA, UK
E: mike.rodger@doctors.org.uk

BACKGROUND

Protecting the soft tissues while drilling bone is essential. Conventional best practice suggests use of a drill sleeve to cover the drill bit or K-wire. On occasion, the sleeve is either unavailable or too long.

Figure 1 Cut off finger rest end for drill bits less than 2 mm diameter.

Figure 2 Cut off nozzle for drill bits 2–5 mm in diameter.

TECHNIQUE

A 1-ml syringe does an excellent job as an improvised drill sleeve. For K-wires and small drill bits (< 2 mm), cut off the finger-rest end (Fig. 1); for larger drills bits and half-pins (2–5 mm), cut off the nozzle (Fig. 2).

DISCUSSION

Previous improvised devices have included a Yankauer sucker.¹ However, we found the Yankauer difficult to cut with the suture scissors or a blade. The 1-ml syringe is usually readily available. It is very cheap, at approximately 7.5 pence each (<www.medicaltek.co.uk>), it is easily cut with standard suture scissors and it is radiolucent. The syringe nozzle will centralise the drill bit in the plate hole. The interference fit between nozzle and drill bit captures and retains the bony swarf whilst on forward rotation. The syringe can be cut to leave only a short length of drill bit visible and thereby act as a drill stop. This may be of re-assurance while fixing plates to bones with vulnerable relations such as the clavicle.

Reference

1. Pratt DA, Tennent TD. Use of a Yankauer sucker as a temporary soft tissue protector and drill stop in surgical procedures. *Ann R Coll Surg Engl* 2007; **89**: 436–7.

The use of non-adhesive skin traction to prevent distal migration of a cylinder cast

SHELAIN PATEL, HENRY COLACO, MARCUS H LEE

Department of Trauma and Orthopaedics, University College London Hospital, London, UK

CORRESPONDENCE TO

Shelain Patel, Department of Trauma and Orthopaedics, University College London Hospital, 235 Euston Road, London NW1 2BU, UK
E: shelain.patel@doctors.org.uk

BACKGROUND

A cylinder cast is indicated for conservative management of injuries to the extensor apparatus and other soft tissue structures around the knee. A long-leg cast can be used for similar indications though ankle stiffness may ensue since it does not permit