References

1. Vidulich RA, Blanda MP, Gerson LW. Posterior epistaxis: clinical features and acute complications. *Ann Emerg Med* 1995; **25**: 592–6.
2. Tan LK, Calhoun KH. Epistaxis. *Med Clin North Am* 1999; **83**: 43–56.
3. Wurtele P. How I do it: emergency nasal packing using an umbilical cord clamp to secure a Foley catheter for posterior epistaxis. *J Otolaryngol* 1996; **25**: 46–7.
4. Ho EC, Mansell NJ. How we do it: a practical approach to Foley catheter posterior nasal packing. *Clin Otolaryngol Allied Sci* 2004; **29**: 754–7.
5. Ismail H, Buckland JR, Harries PG. The prevention of alar necrosis in Foley catheter fixation in posterior epistaxis. *Ann R Coll Surg Engl* 2004; **86**: 307.

TECHNICAL TIPS

A technique for knotting looped polydioxane during abdominal wound closure

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Abdominal wound closure with a single polydioxane loop can result in an unsightly and bulky knot which is palpable in the subcutaneous tissue, especially in thin patients. We present a simple technique to prevent this when tying a finishing knot. First, pass the needle holder through the loop and hold one strand of the suture. Cut that thread close to the needle and bring back through the loop again. The knot is tied over the loop thus securing the closure. This results in a small knot which is less likely to cause patient discomfort.

Figure 1 Passing the needle holder through the loop and holding one strand of the suture.

Fracture localisation for cast wedging

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Wedging of plaster casts is a method of manipulating malaligned long-bone fractures that are being treated non-operatively. The difficulty with this technique lies in localising the fracture accurately so the cast can be sectioned and wedged at the correct level. Traditionally, the level has been estimated by measurements of the radiograph and cast with a ruler, although differing scales can cause problems. Our technique involves placing three drawing pins into the cast near the fracture and taking a radiograph. This allows localisation of the required level with great accuracy. The cast padding prevents the pins touching the skin.

Figure 1 Cast with three drawing pins.

A simple and cost-effective method of protecting unburied K-wire ends

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We propose a simple, effective and inexpensive method of protecting unburied Kirschner-wire ends for hand surgery. This technique involves bending the protruding wire 180° to form a loop, removing the rubber gasket from a 1-ml syringe and sliding this gasket over the wire loop in order to provide the required bulk and padding (Fig. 1). The gasket is then secured onto the loop with a

Figure 1 The proposed technique of securing protruding K-wire ends

3/0 nylon suture. A less bulky dressing can then also be used on top of the protector. This technique prevents accidental injuries from sharp wire ends, and limits wire migration.

Needle locking tip that reduces needle stick injuries

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After having finished suturing, and while the needle is still mounted on the needle holder (Fig. 1), use your forceps and just rotate the needle so that the needle's axis is in line with the axis of the needle holder (Fig. 2). The needle's sharp tip is now locked (Fig. 3). The risk of a stick injury to yourself or to your assistants

Figure 1 In the position shown, the needle's sharp tip is exposed. It may also penetrate the sterile dressing causing it to lose its sterility.

Figure 2 Rotate the needle with the forceps to lock its sharp tip.

Figure 3 Illustrating how the needle tip is locked.

is minimised. If the needle is placed on a sterile table with its sharp end down there is a risk for penetrating the sterile dressing. This technical tip reduces such a risk as well. It may also contribute to reducing the risk of postoperative infection.

A simple way to aid accurate guide-wire placement in dynamic screw fixation of femoral neck fractures

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The use of the dynamic hip screw is common practice for fixation of intertrochanteric fractures of the femoral neck. Success of this procedure requires accurate guide-wire placement. This can prove difficult at times and can result in repeated attempts leading to longer operating time, multiple tracks and, more importantly, greater radiation exposure to both patient and operating staff.

Figure 1 Rotation of the intensifier image so that the guide wire is vertical.