device such as an implant or mesh. In addition, multiple aspirations can dislodge the needle causing pain and also increasing the likelihood of exposure to bodily fluids. The use of a calibrated drainage bag to maintain a closed system has been described previously.¹ We have developed a closed drainage system which utilises the negative pressure from a Redovac® drain (B. Braun, PO Box 1120, D-34209 Melsungen, Germany).

TECHNIQUE

Under aseptic conditions, a white (14-G) needle is connected to a 3-way tap and the extension of the latter is attached to the suction tubing of a 600-ml Redovac® drain (Fig. 1). With the needle inserted into the most dependent part of the seroma, the negative pressure of the Redovac® drain is applied by releasing the clamp, resulting in rapid aspiration of the collection (Fig. 2). The Redovac® bottle can be changed whilst maintaining a closed system thereby avoiding fluid spillage.

DISCUSSION

We have described a safe, simple and efficient technique using a closed vacuum drainage system for aspiration of large seromas. This method allows rapid aspiration of large seroma volumes, whilst reducing the possibility of introducing infection and the spillage of bodily fluids.

Reference

1. Ashraf O, Donnelly PK. A safe closed seroma aspiration system. *Ann R Coll Surg Engl* 2007; **88**: 412.

Impressing the scrub nurse

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BACKGROUND

Correct handling and manipulation of a needle is not only a basic surgical skill and principle but it is also an important component of theatre etiquette as well as surgical safety. Scrub nurses are vital to safe and successful surgery. The surgeon and the scrub nurse should have a mutual respect for one another. It is the scrub nurse's duty to hand the surgeon the correct needle on the correct suture on the correct needle holder. Similarly, it is the surgeon's responsibility to hand back the needle and suture in a safe manner as demonstrated below. Junior surgical trainees in particular would benefit from getting into good habits early in their surgical careers.

TECHNIQUE

Traditionally, the suture is handed back to the scrub nurse as soon as

Figure 1 The exposed sharp mounted on the needle holder as it is usually passed from surgeon to scrub nurse.

Figure 2 The needle re-mounted with the tip securely locked in the jaws of the needle holder together with the swage thereby making it impossible to suffer a sharps injury from the tip.

the final throw has been placed, the suture has been cut and the needle remounted. Often, little attention is paid to how the needle is mounted when being handed back to the scrub nurse, which can potentially cause needle-stick injuries.¹⁻³ Needle-stick injuries are an occupational hazard; however, they can be minimised by simple and safe measures as shown below. This technique involves reverse mounting the needle in the jaws of the needle holder thereby preventing exposure of the sharp needle tip which could leave the surgeon, scrub nurse or patient's skin prone to inadvertent injury.

DISCUSSION

This technique is now standard surgical practice for the first author after the senior author introduced this concept when operating together. He had picked it up 20 years before from a New Zealand cardiac surgeon. We advocate this simple and easily

replicable technique as a key step in handling needles. It has been reported recently in the dermatological literature,⁴ but we feel that it illustrates a simple, yet important, message and it is likely to have escaped the attention of most surgeons. This is not only safe surgical practice but leads to better working relations with theatre staff who are crucial to the practice of surgery and can help to reduce adverse incidents.^{1–4}

References

1. Cole RP, Gault DT. Glove perforation during plastic surgery. *Br J Plast Surg* 1989; **42**: 481–3.
2. Matthews MS. Plastic Surgery Educational Foundation DATA Committee. Safer sharps. *Plast Reconstr Surg* 2004; **113**: 747–9.
3. Dagi TF, Berguer R, Moore S, Reines HD. Preventable errors in the operating room – part 2: retained foreign objects, sharps injuries, and wrong site surgery. *Curr Probl Surg* 2007; **44**: 352–81.
4. Kunishige J, Wanitphakdeedecha R, Nguyen TH, Chen TM. Surgical pearl: a simple means of disarming the 'locked and loaded' needle. *Int J Dermatol* 2008; **47**: 848–9.

TECHNICAL TIPS

Explantation of the recipient internal iliac artery for bench-surgery during live donor renal transplants with multiple renal arteries

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Transplantation of renal allografts with multiple arteries is challenging. We describe a simple technique to facilitate multiple anastomoses.

Figure 1 Explanted internal iliac artery graft in position prior to anastomosis to the renal allograft.

The internal iliac artery and suitable branches are dissected and then explanted from the recipient by dividing the main trunk of the vessel. Multiple renal arteries can then be anastomosed end-to-end to suitable branches of the internal iliac graft over silastic catheters, on the back table, under cold storage conditions (Fig. 1). The kidney is then implanted by re-anastomosis of the internal iliac trunk to its parent main stem. This quicker and simpler arterial anastomosis optimises perfusion, reduces anastomosis time and warm ischaemic injury.

Letter in response to Technical Tip by: Matthews E, Brent A, Williams S. An alternative use of Foley catheters in Ilizarov external fixation.

Ann R Coll Surg Engl 2009; **91**: 522–3.

From: JE Tomlinson and SL Royston

A 20-ml syringe bung as an economical and practical Ilizarov pin site dressing

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We write in response to the recent article by Matthews *et al.* As they have commented, pin site care is vital to keep infection rates to a minimum, and the recommended Ilizarov sponges and clips are relatively expensive. Our preferred technique is to use the rubber bung from a 20-ml syringe plunger which can be pierced and placed over a gauze dressing, with both bung and gauze soaked in chlorhexidine preparation (Fig. 1). The unit cost of a 20-ml syringe is £0.16 each (£0.19 including gauze dressing) – cheaper still than the suggested use of a Foley catheter providing bungs at £0.37 each. Syringes are also available individually, giving the advantage of only opening the exact number needed. The cross-sectional area to maintain the dressing is large and provides pressure across its area. Syringes are also widely available in theatres, wards and in out-patient clinics.

Figure 1 Rubber bung from a 20-ml syringe plunger pierced and placed over a gauze dressing, with both soaked in chlorhexidine.