Figure 1 Stockinette used: 7.5 cm × 1 m. (Ref RML 230-011 [RML 230-A2] from Rocialle Medical Limited, Cambridge CB2 4TJ, UK).

Figure 2 The final rigid splint.

following common surgery such as that for Dupuytren's disease has been widely reported in the literature. Wound infection following splinting methods using plaster of Paris has also been reported.^{1–3} We present an alternative method for immediate post-operative splinting which addresses this problem.

TECHNIQUE

Routine volar slab splinting of the fingers and palm in extension or the 'Edinburgh' position following hand surgery is a well-accepted practice. Usually, a wound dressing is applied followed by wool, wet plaster, and lastly crepe bandage. We propose the addition of a 7.5-cm sterile stockinette over the plaster before soaking at an additional cost of approximately 44 pence per stockinette (Fig. 1). This allows formation of a rigid splint and minimises soak-through to the wool and wound (Fig. 2).

DISCUSSION

Our current splinting method minimises the risk of wound infection. As the plaster does not stick to the wool, it is easily remov-

able and re-usable. This aids regular wound checks in the early postoperative period and allows for replacement of the splint before referral to hand therapy for a definitive thermoplastic device. It may also be a more amenable way of splinting in departments without hand therapy services. This method and its benefits have implications for orthopaedic splinting in general – in both trauma and elective settings.

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A new method to pass an intramedullary cable through bones using a guide suture

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BACKGROUND

Intramedullary cable bone transport with the Ilizarov ring fixator is being increasingly used to treat lower extremity bone defects.^{1,2} The intramedullary stainless steel cable used for bone transport consists of a band of stranded interwoven fine wires. The cable is flexible and it is, therefore, problematic to pass it through the skin, subcutaneous tissue, bone cortex and finally through the intramedullary canal of a long bone.³

EXPERIMENTAL

The stainless steel cable is unthreaded by twisting using two simple pliers to unravel the interwoven threads proximal to the cable end (Fig. 1). A strong curved needle is passed through the unthreaded cable attached to a braided nylon suture (Fig. 1). The cable is then twisted back into its original form. The needle and suture are passed through the eye of a stiff Meier wire and the ends of the suture are knotted to anchor the stainless steel cable to the Meier wire (Fig. 2). The Meier wire acts as a guide for intramedullary passage of the stainless steel cable (Fig. 3).

Figure 1 Unravelling the interwoven threads proximal to the cable end.

Figure 2 Anchoring the stainless steel cable to the Meier wire.

Figure 3 The Meier wire acts as a guide for intramedullary passage of the stainless steel cable.

DISCUSSION

We have been able to guide intramedullary wires repeatedly through both the tibia and femur successfully and easily with this technique. We believe that this new method can facilitate ‘catheterisation’ into and through the intramedullary canal of long bones with these flexible wires. This system is easy to assemble using ubiquitous and inexpensive items and provides secure wire passage in reconstructive orthopaedic surgery.

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TECHNICAL TIPS

Easy insertion of the gamma nail’s end cap

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Instrumentation for the Gamma 3 Trochanteric Nail 180 (Stryker, UK) facilitates a minimally invasive approach. However, insertion of the end cap can be difficult through a small incision. The end cap can fall off the screwdriver and is sometimes lost in the soft tissues for some minutes. We have found that by re-inserting the ball-tipped wire into the top of the nail, the end cap can be easily threaded over the wire and pushed down to engage the nail. It is then screwed home. This simple technique, which is not previously reported,¹ avoids multiple insertion attempts and saves operative time.

Figure 1 Secure insertion of the end cap over the guide wire.

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