threads are fed through the U at the tip (Fig. 1). The wire is then withdrawn (Fig. 2) pulling both the core suture and tendon with it (Fig. 3).

DISCUSSION

Dental wire is cheap and readily available. It is strong, flexible and thin, thereby providing the ideal mechanical properties to allow it to pass through the pulley system and bring the tendon with it on withdrawal.

ACKNOWLEDGEMENT

This technique is not attributable to the authors but is worth recording for those who are not aware of it. We would like to acknowledge Mr Harry Belcher for demonstrating this technique to the senior author.

A novel technique for biliary T-tube fixation

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BACKGROUND

T-tube placement following bile duct exploration remains commonplace.¹ Displacement of the tube prior to planned removal can result in significant morbidity and even mortality.² Since T-tubes are often left *in situ* for an extended period of time,³ appropriate fixation is paramount. The physical properties of latex mean that adequate fixation is difficult to achieve. Overly tight retaining sutures can result in luminal obliteration impeding bile drainage, with too lax a ligature precipitating T-tube displacement. We describe a novel method of T-tube fixation that provides security whilst maintaining luminal integrity of the T-tube.

TECHNIQUE

Once the draining limb of the T-tube is brought out through the skin, a 1-cm segment length is removed from its free end. This short segment is placed over an artery clip and stretched to increase the luminal diameter. This dilated segment is then fed over the remainder of the draining limb until it is flush with the skin. This provides a cuff which presents an anchoring point for suture fixation without narrowing the tube lumen. Two sutures are then placed around the cuff and tied onto the skin. Further T-tube security is provided by coiling the tube under a clear dressing, which may prevent displacement following inadvertent traction.

Figure 1 Segment of tubing dilated with an artery clip being fed over the T-tube. The image was taken using a surgical simulation latex skin.

Figure 2 Sutured cuff *in situ* – the retaining sutures are visible beneath the cuff. The image was taken using a surgical simulation latex skin.

DISCUSSION

The fixation of a biliary T-tube would seem a simple task; however, many methods fail to provide safe anchoring while still allowing the tube to function correctly. This method of tube fixation helps to minimise the risk of T-tube displacement or blockage.

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Safe and re-usable splinting for hand surgery

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BACKGROUND

The incidence of complications, particularly wound infections,

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).