arthroscopy port to ensure that no irrigation fluid is lost as back-flow out of the port. This allows the surgeon to concentrate on adequate wash-out of the entire joint. It also enables accurate assessment of the volume of fluid used and minimises saline spillage onto the floor of the operating theatre. This is a useful technique which helps to simplify the procedure and also improves theatre safety.

An alternative technique for mesh repair of an incisional hernia

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BACKGROUND

Incisional hernias are reported in up to 13% of patients who undergo primary abdominal incisions¹ and high recurrence rates of 25–90% three years following primary repair.^{1,2} Due to high recurrence rates many methods are described, commonly using a mesh that is placed in an on-lay, preperitoneal, or intraperitoneal position. Many patients find incisional hernias uncomfortable and aesthetically displeasing and, like any hernia, may lead to bowel obstruction. Meshes placed intraperitoneally despite being dual layered have a significant incidence of adhesion formation and fistulation into the bowel.³

TECHNIQUE

We suggest an on-lay mesh repair technique in an incisional hernia where it is possible to close the defect. The defect is closed primarily with a continuous 1 loop PDS suture incorporating a lightweight mesh (Ultrapro®; Ethicon, PO Box 1988, Livingston EH54 0AB, UK) within the suture line. This should reduce the

possibility of the suture cutting through tissues and, therefore, add strength to the repair at an early stage. Tacks (Versatek® Covidien, 154 Fareham Road, Gosport PO13 0AS, UK) are placed around the perimeter of the mesh to hold it flat (Fig. 1).

DISCUSSION

This method is similar to the on-lay mesh method; however, it incorporates the mesh into the repair of the defect. Twenty-five cases have been performed and followed up for 2 years with only one recurrence reported so far. We continue to follow-up these patients to gain long-term results. This method could be extended to close any laparotomy where an incisional hernia is deemed likely to occur such as in obese patients.

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A safe technique for olecranon osteotomy

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BACKGROUND

Olecranon osteotomy is a well-established technique, providing access to the distal humerus for reduction and fixation of intra-articular fractures.¹ The sigmoid notch of the proximal ulna articulates with the trochlea of the distal humerus and has two articular facets separated by the bare area. Ideally, the osteotomy should enter the joint at the bare area while ensuring the saw itself does not enter the joint, where it can damage the distal humerus.

TECHNIQUE

The fascia and muscle are elevated from the proximal ulna and the capsule of the elbow joint is opened both laterally and medially. The ulna nerve is identified and protected. A swab is pushed through, which is very easy when the distal humerus is fractured (Fig. 1). The swab then indicates the narrowest part of the ulna and, therefore, locates the bare area, allowing for a safe osteotomy with protection of the articular surface (Fig. 2). The osteotomy is completed with the use of an osteotome.

DISCUSSION

As the bare area lies at a relatively constant location,² at the narrowest part of the ulna, we advocate the use of a swab placed through the

Figure 1 Diagrammatic of on-lay mesh showing tacks and sutures.

Figure 1 Entry point for swab.

Figure 2 Swab in position for osteotomy.

elbow joint before executing the osteotomy, which both helps to locate the ideal site for osteotomy and protects the distal humerus from inadvertent injury.

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Seton sutures for leg ulcers associated with fistulous tracts

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BACKGROUND

Lower limb lymphoedema is characterised by chronic and often refractory swelling. This results in secondary skin changes including

fissuring, which predisposes to infection. When coupled with poor tissues drainage and often impaired sensation, an ideal environment for microbial growth is created. Infection can lead to scarring of the lymphatic channels and a cycle of deterioration is initiated. Lymphoedema, therefore, is associated with significant morbidity. Its management is often conservative, comprising long-term compression bandaging or hosiery to improve lymphatic flow, which is frequently poorly tolerated. Surgical intervention is often of limited benefit. In the context of infection, deep cavities can form which may connect to the skin's surface through sinuses or fistulous tracts (Fig. 1A). This technical note describes the use of a seton suture to avoid the need for formal incision and drainage where tissue quality and healing are impaired.

Figure 1 (A) The appearances of the lymphoedematous lower limb with ulceration and fistulous tract; (B) initial placement of the seton suture; and (C) subsequent healing in progress.

TECHNIQUE

A seton is placed by passing number 1 nylon suture through the fistula tract (Fig. 1B). This facilitates drainage of the cavity and tract, and promotes healing (Fig. 1C).

DISCUSSION

Seton sutures are established in the treatment of fistula *in ano*, and can prove beneficial in providing a simple and non-operative out-patient management of deep cavities. This interrupts the cycle of infection allowing healing to occur.