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.