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We were most interested to hear the opinions of the Harvard team regarding the diagnosis of the patient we presented. Whilst their suggested diagnosis of linear epidermal naevus with a related syndrome is an interesting postulation, it is unlikely. We treat a significant number of linear epidermal naevi in our unit with success using the carbon dioxide laser. In our experience, the very extensive epidermal naevi extend from head to toe in streak pattern, and do not appear in this dermatomal/semi-dermatomal pattern with a midline cut-off and as a solid block. Pathognomically, linear naevi extend along the lines of Blaschko, which almost precludes this diagnosis in our patient. Systematised linear naevi can be in a solid block (but typically are still patchy), and only in cases of very large or sub-total body surface area. The lesion in our patient was almost certainly a capillary malformation. Linear naevi in darker skin types tend to remain dark without a purple hue such as seen here. Capillary malformations also classically affect the face and nape of the neck, as in this case. Whilst we may never be certain, speculating is part of the fun, and we extend our thanks for contributing to this interesting case.

Safe splinting in hand surgery

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COMMENT ON

Maclean SBM, Dhillon S, Dias R. Safe and re-usable splinting for hand surgery. *Ann R Coll Surg Engl* 2010; **92**: 169–70

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We read this technical point with interest in the March 2010 edition of the *Annals*. The authors describe a useful method for placing a stockinet bandage around plaster-of-Paris when preparing a hand splint. A similar technique, using a Tubigrip

Figure 1 The POSI position for safe hand splinting.

Figure 2 Schematic representation of the POSI position. Reproduced with kind permission from AO Publishing.⁴

bandage, has been used by the senior author for many years.

We were, however, concerned to see the position of the splint demonstrated in Figure 2 of the article. This demonstrates the wrist, metacarpophalangeal (MCP) and interphalangeal (IP) joints in full extension. The correct position in which to immobilise the hand safely following injury or surgery is the position of safe immobilisation (POSI), also called the intrinsic-plus or Edinburgh position, originally described by JIP James.^{1,2} The POSI position places the wrist in 0–30° of extension, MCP joints in 70–90° of flexion and IP joints in full extension.³ This ensures pretension on the collateral ligaments of the wrist, and the MCP and IP joints of the hand, thereby avoiding stiffness and contracture (Figs 1 and 2).

Increasingly, non-specialist healthcare workers are involved in the delivery of first-line care to patients with hand injury and infection. We wish to stress the importance of optimum splintage of such patients. The simple technique described above is a useful method to assist in this.

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