carried out, especially during longer procedures, as it is acknowledged that infuser bags can leak. At the end of the procedure, the bag can be completely deflated to aid wound closure.

DISCUSSION

Using a pressure infuser bag to provide neck extension has been described previously in the context of intubating patients with difficult airways.¹ We have applied this technique to operative procedures of the neck, particularly thyroid and parathyroid surgery, and found that this innovative application is excellent at providing and adjusting neck extension with minimal patient manual handling and operative disruption.

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Utility of ultrasound in locating the linea semilunaris in the endoscopic component separation technique in ventral hernia repair

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BACKGROUND

Component separation techniques are being increasingly employed when repairing complex ventral hernias. They may be performed using open or endoscopic techniques. In the latter, determination of the location of the linea semilunaris is critical in placement of the initial trocar. Lateral displacement of the linea semilunaris due to the hernia makes the use of traditional landmarks challenging. This is especially pronounced in patients who are morbidly obese or have large hernias. Ultrasonography has the potential to overcome this challenge.

TECHNIQUE

A 7.5MHz transducer is used for the purpose. Scanning is started just lateral to the hernia defect in a plane at the level of the 11th rib. Scanning from a medial to lateral approach allows the edge of the rectus mus-

cle to be clearly made out. Scanning is then repeated at several points along the abdominal wall to trace the outline of the linea semilunaris (Fig 1). The initial trocar for an endoscopic component separation can then be made 2cm lateral to the linea semilunaris at the level of the 11th rib.

DISCUSSION

Distortion of the abdominal wall anatomy by the hernia may result in lateral displacement of the rectus, increasing the likelihood of placement of the initial trocar into the rectus and inadvertent dissection of the retrorectus space. This may result in significant bleeding, especially if the epigastric vessels are injured during balloon dissection of the space. Ultrasonography clearly identifies the location of the linea semilunaris and aids in the performance of the endoscopic component separation.

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The Oxford procedure for the treatment of lesser toe deformities

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BACKGROUND

This procedure has been developed to treat fixed flexion deformities at the proximal interphalangeal joint (PIPJ) without the complications associated with K-wire use.

TECHNIQUE

A dorsal elliptical incision is made over the PIPJ and deepened to expose the extensor tendon (Fig 1A). The tendon is divided transversely, leaving enough proximally to suture down onto the flexor tendon. Soft tissues including the collaterals are dissected free of the joint. The distal part of the proximal phalanx is exposed and resected with bone nibblers. Enough bone is removed to allow the flexion deformity to correct. The proximal end of the extensor is sutured onto the volar capsule, which is exposed following resection of the head (Fig 1B). The distal end of the extensor can be sutured back onto the dorsal part of the tendon proximally, restoring extensor function (Fig 1C). The skin is closed and adhesive tape applied. The toe is taped into position using half-inch tape. The patient continues to tape the toe daily for 2–3 months.

Figure 1 Transverse sonogram of the muscles and fascias at the linea semilunaris (arrow)

DISCUSSION

The surgical treatment for a fixed PIPJ deformity by joint fusion is established practice. Other procedures include diaphysectomy, partial proximal phalangectomy and amputation.¹ The technique, first described by Taylor in 1940,² is still used today. One of the key disadvantages of this procedure is that it requires the use of a K-wire, which brings with it risks of infection, wire breakage (up to 18%) and vascular insufficiency.^{1,3} There is also patient dissatisfaction with the presence of percutaneous wires and their removal. The 'Oxford' procedure was developed to remove the need for K-wire fixation and to maintain some mobility at the interphalangeal joint.

This operation has been used by the senior author (PHC) for over 15 years with good results. In a study of patients ten years following the Oxford procedure, all were satisfied in terms of pain relief and cosmesis.⁴ Other surgeons in the UK have also adopted this technique. In a survey of 75 surgeons attending the British Orthopaedic Foot and Ankle Society annual meeting in 2010, 15% reported that they would perform an 'Oxford'.

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A triangular advancement technique to avoid the dog-ear deformity following mastectomy in large breasted women

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BACKGROUND

Mastectomy in large breasted patients frequently results in an excess of tissue laterally (the 'dog-ear' deformity). This may interfere with the fitting of a brassiere (and/or prosthesis).

TECHNIQUE

Our mastectomy technique involves a D-shaped incision, skewed laterally, together with the excision of an additional triangular area at the base of the lateral end (Figs 1 and 2). The defect is closed beginning laterally and the superior flap is intentionally disproportionately advanced across the lateral half of the inferior flap, such that lateral and superior skin is distracted medially (Fig 3). Multiple interrupted subcutaneous sutures are placed, followed by a continuous subcuticular suture closure of skin. The final result is a scar that gently slopes inferiorly at its lateral extent but with elimination of the dog-ear deformity (Fig 4).

DISCUSSION

Previous techniques to avoid the dog-ear deformity following a mastecto-

Figure 1 The incision is modified to excise an additional triangle of skin that lies inferior to the area of redundant tissue.