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.

Figure 2 Illustration of a D-shaped incision with modified Burow's triangular excision for advancement (shaded). The D shape is skewed laterally.

Figure 3 The defect is closed, from medial to lateral. A skin hook marks the lateral extent of the 'D' to allow accurate apposition of the skin at the apex. The anterolateral part of the superior skin flap is actively advanced into a more anterior position.

my have included the fish-tail plasty method, which results in a Y-shaped closure.¹⁻³ However, the disadvantages of this method are that it involves additional scarring, potentially creates two smaller dog ears and can be complicated by skin necrosis at the Y confluence. Another alternative is a teardrop shape incision but this is less predictable in its outcome depending on the point at which the lateral apex of closure is commenced.⁴

Our technique results in consistently good cosmetic and functional outcomes. The triangular component of the technique may be regraded as a modified Burow's triangle excision.⁵ Excess tissue is removed laterally while avoiding buckling of the tissues that would create a dog-ear effect.

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Figure 4 Final result

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Progressive dilatation of stenosed suprapubic tracts using Nelaton catheters in the emergency setting

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BACKGROUND

Suprapubic catheter (SPC) changes are generally managed in the community by district nurses. Failed reinsertion of SPCs is frequently encountered and usually dealt with by junior doctors in hospital in an emergency setting. An extensive literature review revealed only two related publications, both describing the use of an Otis urethrotome to dilate the old tract.^{1,2} There have been anecdotal references on the use of progressive dilatation.

TECHNIQUE

We present a technique using single use hydrophilic-coated female Nelaton catheters to progressively dilate the stenosed tract. Ultrasonography is performed to ensure a full bladder. After analgesia and local anaesthetic infiltration, starting with a well lubricated 8Fr catheter, the tract is dilated up to 18Fr. Successful insertion into the bladder each time is confirmed by efflux of urine. After dilatation, an 18Fr silicone long-term Foley catheter is inserted.

DISCUSSION

This is a simple procedure that can be carried out safely in an emer-