Technical Section

TECHNICAL NOTES AND TIPS

A simple technique to ensure adequate moulding of a cast into the Edinburgh position

A Iqbal, AE Cattell, S Dhillon
New Cross Hospital, Wolverhampton, UK

CORRESPONDENCE TO

Abid Iqbal, E: abid.iqbal@nhs.net

BACKGROUND

First described by Professor James from the University of Edinburgh,¹ the Edinburgh position has been used to immobilise the injured hand for many years. The main aim of placing the hand in the Edinburgh position is to ensure the metacarpophalangeal (MCP) joint collateral ligaments are fully stretched in flexion and the interphalangeal (IP) joint collateral ligaments are maximally stretched in extension, thus preventing contraction from scar tissue. The ideal position is with the wrist in up to 30° degrees of extension, MCP joints in 90° of flexion and IP joints in full extension.² Incorrect immobilisation of the injured

hand can lead to shortening of the collaterals, resulting in major loss of hand function.³

TECHNIQUE

The patient has a cast or back slab applied in the usual manner. To achieve a satisfactory Edinburgh position, the clinician/plaster technician places his or her opposite hand held in a reciprocal Edinburgh position onto the volar aspect of the forearm with the second hand on the dorsum of the patient's hand to further mould the cast into a satisfactory position.

DISCUSSION

Hand injuries are common and the Edinburgh position is employed to ensure optimal protection and preservation of hand function. Initial assessment and treatment is often initiated by junior medical staff and, more commonly, nursing staff, who may have little experience of managing hand injuries. This technique allows moulding of the cast into a satisfactory Edinburgh position and can be taught easily to junior medical staff.

References

1. James JI. Fractures of the proximal and middle phalanges of the fingers. *Acta Orthop Scand* 1962; **32**: 401–412.
2. James JI. The assessment and management of the injured hand. *Hand* 1970; **2**: 97–105.
3. Sprague BL. Proximal interphalangeal joint injuries and their initial treatment. *J Trauma* 1975; **15**: 380–385.

Figure 1 Moulding into the Edinburgh position

A technique to elevate the seminal vesicles during robotic prostatectomy

BW Turney, A Jones
Royal Berkshire NHS Foundation Trust, UK

CORRESPONDENCE TO

Adam Jones, E: adam.jones@royalberkshire.nhs.uk

BACKGROUND

During robot assisted laparoscopic prostatectomy (RALP), the seminal vesicles (SVs) are usually elevated with the fourth arm prior to dissection posterior to the prostate and subsequent division of the pedicles. In order to retract the SVs, the fourth arm must release the bladder, which can permit bowel to fall into the operative field. We describe a simple method to retract the SVs that does not require repositioning the robotic arm.

TECHNIQUE

During RALP using a da Vinci® robot (Intuitive Surgical, Sunnyvale, CA, US), we retract the prostate towards the anterior abdominal wall by passing a suture through the hole in the end of the catheter using a