Figure 1 Child with 'whoopie cushion' applied to foot

DISCUSSION

Controlled weight bearing after limb deformity is essential in improving bone healing, joint ranges of motion and, ultimately, function.¹ A combination of anxiety and pain may discourage the child from doing this, and distraction has been proven to reduce pain and distress in children.² This simple and fun technique works well to distract the child and encourage weight bearing. Not only does this reduce physical morbidity for the child, it may also act to reduce psychological morbidity sometimes associated with this type of surgery.³

References

1. Paley D. Problems, obstacles, and complications of limb lengthening by the Ilizarov technique. *Clin Orthop Relat Res* 1990; **250**: 81–104.
2. Chambers CT, Taddio A, Uman LS, McMurty CM. Psychological interventions for reducing pain and distress during routine childhood immunizations: a systematic review. *Clin Ther* 2009; **31**: S77–S103.
3. Ramaker RR, Lagro SW, van Roermund PM, Sinnema G. The psychological and social functioning of 14 children and 12 adolescents after Ilizarov leg lengthening. *Acta Orthop Scand* 2000; **71**: 55–59.

A novel technique for removal of bone staples

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Bone staples are commonly used in knee epiphysiodesis. Removal of staples years later can be challenging, particularly where bony overgrowth has occurred. Dissection and stripping of bone during removal risks damage to the surrounding structures. Our simple technique using common orthopaedic instruments allows safe and effective retrieval of bone staples. A bone hook is applied under the bone staple and an osteotome is introduced horizontally through the handle of the bone hook. Gentle backward blows are applied on to the osteotome handle with a mallet (analogous to using a slap hammer), lifting staples off the bone in a controlled manner (Fig 1).

Figure 1 Bone hook inserted under staple, with osteotome passed horizontally through the handle of the bone hook. Mallet used to apply gentle blows backwards on to the osteotome handle.

An innovative method for controlling presacral bleeding

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BACKGROUND

Bleeding from presacral veins is a well recognised, potentially fatal risk of rectal mobilisation.¹ Initial management involves direct pressure over the vessels or precise packing, then, if bleeding continues, underrunning the vessels. Various methods have been described to achieve control of persistent bleeding,^{2,3} including using sterile drawing pins with Surgicel® (Ethicon, Somerville, NJ, US).⁴ However, sterile drawing pins may not always be available. We describe a modification of this technique where we have successfully used Surgicel® with a ProTack™ device (Covidien, Dublin, Ireland).

TECHNIQUE

When bleeding from the presacral veins occurs and other techniques fail to achieve control, this method offers a simple alternative. A piece of Surgicel® is folded until approximately 2.5cm x 2.5cm in size and placed directly over the bleeding point. It is then secured in place with several ProTack™ fasteners inserted through the Surgicel®, around the bleeding vessel, anchored into the sacrum. This applies direct targeted pressure to achieve haemostasis.

DISCUSSION

While sterile drawing pins are effective, they are not always standard theatre stock. ProTack™ fasteners are finding wider applications in a range of laparoscopic procedures, from hernia repairs to rectopexy, and are readily available in most theatres. Furthermore, multiple drawing pins may be required if there are several bleeding points or if haemostasis proves difficult. However, a ProTack™ applicator

contains 30 titanium tacks, meaning that should the first attempt fail, additional attempts can be made. Finally, as the ProTack™ is a laparoscopic instrument, it may offer potential for controlling bleeding during laparoscopic surgery or in awkward places.

DECLARATION

The authors declare no commercial conflict of interest.

References

1. Hammond KL, Margolin DA. Surgical hemorrhage, damage control, and the abdominal compartment syndrome. *Clin Colon Rectal Surg* 2006; **19**: 188–194.
2. Hill AD, Menzies-Gow N, Darzi A. Methods of controlling presacral bleeding. *J Am Coll Surg* 1994; **178**: 183–184.
3. van der Vurst TJ, Bodegom ME, Rakic S. Tamponade of presacral hemorrhage with hemostatic sponges fixed to the sacrum with endoscopic helical tackers: report of two cases. *Dis Colon Rectum* 2004; **47**: 1,550–1,553.
4. Lucarotti ME, Armstrong CP, Bartolo DC. Control of presacral bleeding in rectal surgery. *Ann R Coll Surg Engl* 1991; **73**: 289–290.

Patient-led day-case wound care following limb surgery

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Wound management can be costly and time consuming. We present a method of supplying patients dressings to allow self-care. A bulky bandage is often applied over an adhesive dressing and usually removed 48 hours postoperatively to allow mobilisation. The dressing often needs replacement, requiring a clinic appointment or replacement by the patient. In our experience, dressings given to patients are often lost or forgotten. We suggest placing a dressing between the layers of bandage during surgery, which the patient finds when removing the bandage. Excellent feedback shows patients feel empowered and less anxious. The price of a dressing may reduce clinic visits and the financial burden.

Figure 1 Positioning of the dressing

Use of a sterile lightweight, cut-resistant Kevlar® glove to safely extract foreign bodies

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Exploration of the body cavity and retrieval of foreign bodies is hazardous after penetrating trauma. Foreign bodies entering the body cavity are often sharp and fragmented. We describe a technique in which a lightweight, cut-resistant glove made from Kevlar® (DuPont, Wilmington, DE, US) (Fig 1) is placed over a standard surgical glove to provide adequate protection from injury while allowing the flexibility essential for surgery. The Kevlar® glove needs to be sterilised and packaged prior to use. After removal of all foreign bodies, the surgeon can simply remove the cut-resistant glove and continue operating with standard surgical gloves.

Figure 1 Lightweight, cut-resistant Kevlar® glove