Figure 3 Contour defect after escharotomy

decompression and standard escharotomy incisions were performed in theatre (Fig 2).

DISCUSSION

Compartment pressure greater than 30mmHg for eight hours or more can cause cell death by interference with the microcirculation.¹ Immediate surgical decompression is required to prevent complications, including death. Seven patients had burns that would have warranted escharotomy based on signs and symptoms alone.

Escharotomies can cause severe bleeding and often leave a significant contour defect (Fig 3) that adversely affects the physical and psychological state of the patient long term. Two of the seven patients in our series were found to have normal compartment pressures on repeat measurements and so escharotomy was avoided.

To our knowledge, this was the first use of the Stryker® pressure monitor in a mass burn disaster. We advocate the use of this device in the assessment of all circumferential limb burns.

References

1. Tiwari A, Haq AI, Myint F, Hamilton G. Acute compartment syndromes. *Br J Surg* 2002; **89**: 397–412.

Greater palatine block in the treatment of acute epistaxis

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BACKGROUND

Epistaxis is a common acute presentation to otolaryngology units. In a significant proportion of cases, effective cauterity with silver nitrate can be carried out, reducing the necessity for nasal packing. In some cases, bleeding is too brisk to allow localisation of a bleeding point

Figure 1 Location of the greater palatine foramen

or effective silver nitrate cauterity. We describe a method of reducing nasal blood flow to facilitate more effective nasal cauterity.

TECHNIQUE

The technique involves infiltration of local anaesthetic and adrenaline into the region of the greater palatine foramen to induce vasospasm in

Figure 2 Infiltration point

the greater palatine artery. A 2ml volume of 2% lignocaine/1:80,000 adrenaline is drawn up into a 2ml syringe and a 25G needle attached. The needle shaft is then bent to 45° at midpoint, bringing the bevel towards the syringe.

The greater palatine foramen is located at the posterior aspect of the hard palate, approximately 1cm medial to the third upper molar on the side of the epistaxis (Fig 1). A finger or cotton wool pledget can be used to palpate it. The needle is gently inserted and aspiration attempted to prevent intra-arterial injection and its potential complications. If no blood is aspirated, 1–2ml of solution can be infiltrated (Fig 2). Onset of vasospasm is fairly rapid, allowing bleeding point localisation and cautery.

DISCUSSION

This is a simple, safe technique using inexpensive materials and drugs. It rapidly reduces blood flow to the nose, especially in its inferior region. This assists in localisation of bleeding points and facilitates easier cautery.

The ABC guide for the safe use of mini C-arms

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The modern mini C-arm has evolved to become an invaluable imaging tool that simplifies diagnosis and treatments in many hand surgery departments worldwide. However, radiation exposure arising from either the primary beam or its scatter remains an occupational health risk.

The *Ionising Radiations Regulations 1999* and *Ionising Radiation (Medical Exposure) Regulations 2000* (IRMER) govern the use of medical radiation in the UK. Breaching these regulations is a criminal offence. Although all operators are compelled to undertake the IRMER course, the knowledge is often not reinforced. In order to encourage a consistent adherence to the established dose reducing

measures, we have produced an easy-to-follow 'ABC' guide on the safe use of the mini C-arm, which is easily memorable and would appeal to all users (Fig 1). Since introducing this simple guide, we have raised the awareness and brought about a safer practice.

Challenging nasogastric tube insertion made easy

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Nasogastric tube placement in head and neck cancer patients can be challenging, especially following surgery. We recommend loosely tying a fiberoptic nasendoscope (FNE) to the nasogastric tube using three surgical ties. The ties are wrapped tightly around the nasogastric tube and very loosely around the FNE in a figure of eight (Fig 1). The rigidity of the FNE will guide the movement of the nasogastric tube past obstructions. A forceps must be used to hold the nasogastric tube in position while the FNE is retracted. The ties are left attached to the nasogastric tube and are removed when the tube is removed.

Figure 1 The ABC guide to safe radiation practice using the mini C-arm: seven simple steps

Figure 1 Depiction of how the nasogastric tube should be tied to the fiberoptic nasendoscope, represented by a black straw