flexion (forearm still pronated). Reduction stability is confirmed by x-rays in extension/flexion and neutral/supination/pronation (Figs 1B and 1C).

DISCUSSION

By stabilising the proximal fragment, our method obviates the need for cumbersome laterally applied radial head pressure (required by both the Israeli and Neher–Torch techniques). We have used our method successfully (Fig 2) in five consecutive children: after failure of the other closed procedures in three and as the primary manoeuvre in two.

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A technique for division of the sympathetic trunk during endoscopic thoracic sympathectomy

R Sproat, A Navi, A Gordon

Frimley Health NHS Foundation Trust, UK

CORRESPONDENCE TO

Rhona Sproat, E: rhonasproat@gmail.com

During two-port thoroscopic sympathectomy, there are technical difficulties with advancing the tips of a 5mm non-U-shaped clip applicator over the sympathetic trunk owing to close apposition of nerve on to underlying rib.¹ We propose inserting one end of a length of polyglactin through the thoracic trocar and threading this through a carefully dissected space posterior to the sympathetic trunk. The potential risk of bleeding from this dissection has not been experienced in our practice. Gentle manual tension applied via both ends of this sling tents the nerve, allowing ease of clipping (Fig 1) and division. The sling is removed.

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Figure 1 Two clips applied to the sympathetic trunk, facilitated via use of a polyglactin sling

Splintage following supracondylar fracture in paediatrics

LE Thomson, J Pagkalos, H Prem

Birmingham Children's Hospital NHS Foundation Trust, UK

CORRESPONDENCE TO

Lauren Elizabeth Thomson, E: lauren.elizabeth.thomson@gmail.com

BACKGROUND

The proximity of the neurovascular bundle to paediatric elbow fractures puts these structures at risk both at the time of injury and in the following hours. During plaster or backslab application, wool padding is applied routinely in a circumferential fashion with each layer overlapping the previous by 50%.¹ With the elbow flexed at 90°, in order to apply adequate padding posteriorly (olecranon), the anterior aspect is overstuffing with either excessive layering or creasing of the wool padding. Both can increase the pressure on the antecubital fossa (ACF) neurovascular structures. A proposed alternative is using cotton wool balls in the ACF to accommodate for swelling.² However, these are rarely available on plaster trolleys.

TECHNIQUE

We present a two-stage application of wool padding to the flexed elbow that allows for space in the ACF. The first layer is applied in a figure-of-eight fashion from the proximal forearm to the distal upper arm, bridging an empty ACF and acting as a protective scaffold (Fig 1). A second layer is applied on top of this scaffold, in a conventional circumferential fashion, to allow for adequate padding posteriorly while maintaining a dead space for swelling in front of the ACF (Fig 2).

Figure 1 Lateral and front views of figure-of-eight layer

Figure 2 Overlapping second layer

DISCUSSION

This provides adequate space for swelling following injury or manipulation using the readily available consumables. Splitting a cast or removing a backslab is also easier as scissors or a plaster saw can be used over the ACF with a lower risk of skin damage.

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Preparation of the internal mammary vessels as recipients for free flap breast reconstruction

JK Dickson¹, AHR Varey², S Wilson¹

¹North Bristol NHS Trust, UK

²Melanoma Institute Australia, Sydney, Australia

CORRESPONDENCE TO

John Dickson, E: john.k.dickson@gmail.com

A video demonstrating this technique is available at:
<http://youtu.be/hq33kK-icFc>

BACKGROUND

When performing breast reconstruction with free flaps, the internal mammary artery and vein are commonly used as the recipient vessels.¹ They are consistent and reliable with a good calibre for anastomosis and they have bidirectional flow, so they can be used either superiorly or inferiorly. Alternative recipients include the thoracodorsal vessels of the subscapular trunk, and the perforating branches of the internal mammary artery and vein.^{2–4}

TECHNIQUE

Dissection and preparation necessitates removal of the third or fourth rib. Multilock retractors are used to retract the mastectomy skin flaps and improve exposure. The muscle overlying the rib is divided using cutting diathermy and retracted using a West self-retaining retractor. The periosteum is elevated using a Howarth periosteal elevator as well as both a left and right-handed Doyen rib elevator. Having removed the rib, the underlying periosteum can be removed carefully to reveal the internal mammary artery and vein(s) beneath. The vessels are then dissected further under the operating microscope.

DISCUSSION

The various techniques demonstrated in our accompanying video will enable quick and efficient preparation of the internal mammary artery and vein(s) as recipient vessels for free flap breast reconstruction. It is important to note that the use of these vessels can have implications for future coronary artery bypass. During dissection, care must be taken not to injure the pleura, as pneumothorax is a recognised complication. In the event that the internal mammary vessels are inadequate, the thoracodorsal vessels remain a useful 'lifeboat'.

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