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Improving exposure in posterior cervical surgery: the elastoplasty

RJ MacFarlane, A Russo

Royal Liverpool and Broadgreen University Hospitals NHS Trust, UK

CORRESPONDENCE TO

Robert J MacFarlane, E: robert.macfarlane@doctors.org.uk

The approach to the posterior cervical spine is challenging in patients where adipose tissue creates skin creases in the mid or lower cervical region. This technique eliminates creasing, aiding the approach and closure, facilitating optimal healing and reducing the risk of irregular scarring.

In the prone position, two lengths of elastoplast are adhered from the scapular region longitudinally to the buttock and posterior thigh region. Tension is applied in a caudal direction as the tape is affixed. A third length of elastoplast is applied transversely across the first two (Fig 1), to prevent slipping and alteration of the surgical field.

Figure 1 The elastoplasty technique

Preventing cement fragments in revision arthroplasty from escaping the sterile field

Surya Gandham, Arthur Galea

Royal Free London NHS Foundation Trust, UK

CORRESPONDENCE TO

Surya Gandham, E: suryagandham@hotmail.com

Using a standard orthopaedic osteotome to remove cement in revision arthroplasty can result in fragments flying out of the wound in an uncontrollable fashion. These fragments have been known to strike non-sterile theatre equipment (eg overhead lights, theatre masks, surgeons' faces) and can land back into the sterile field, increasing the risk of surgical site infections. We have developed a simple and cost effective technique to prevent these cement fragments from leaving the sterile field. It involves placing the osteotome through an upturned, clear, sterile plastic gallipot (Fig 1) that is then placed over the cement to be removed (Figs 2 and 3). Any cement fragments flying away will strike the inside of the gallipot and will be well contained.

Figure 1 Standard osteotome placed through an upturned, sterile, clear gallipot ready to be placed over the desired area

Figure 2 Positioning of the osteotome/gallipot construct over a cement spacer in revision knee surgery