Figure 1 Sling in situ

TECHNIQUE

A slit is cut up one side of the stockinette (Eesiban bandage stockinette; Sallis Healthcare, Nottingham, UK) approximately three-quarters of the required length, typically 110–150cm for an adult patient. The limb is inserted into the stockinette with the hand positioned on the contralateral shoulder (Fig 1). Sufficient stockinette length passes over the unaffected shoulder for posterior knot tying. The shoulder is held in a relaxed position with the elbow adducted. The proximal end of the stockinette cradles the enveloped elbow.

DISCUSSION

Benefits of the Tooting Tube sling include high elevation, uniform weight distribution and patient comfort. Patients may release the limb for clinical examination or washing (Fig 2). The safety pin of the traditional calico – which is not required in the Tooting Tube – may result in iatrogenic injury and inconsistent elevation. Material costs are comparable between the Tooting Tube and traditional triangular calico sling (40p per unit).⁴ Calculations are based on a 120cm piece of Eesiban bandage stockinette (EGJ166, NHS Supply Chain) compared with a single piece of triangular calico (EED022, NHS Supply Chain) and a safety pin (VWL004, NHS Supply Chain).

Each sling is designed, fitted and tailored for the individual patient. The Tooting tube sling has been used in over 1,000 patients as the sling of choice at the Department of Hand Surgery at St George's Hospital, London.

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Figure 2 Independent sling release

Tip to stitch the superior corner of the quadriceps tendon incision in knee arthrotomy

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A video demonstration showing how to perform this stitching technique is available at:

<http://youtu.be/Sb3nWai6OqI>

Minimally invasive knee surgery necessitates use of smaller skin incisions. Knee arthrotomy is typically performed using a medial parapatellar approach. The exposure is then facilitated by enlarging the quadriceps tendon incision. After the index procedure, it is sometimes difficult to close the superior corner of the quadriceps tendon incision as it is covered by skin. The technique involves placing a quadriceps stay stitch near the superior corner of the skin incision and delivering the superior corner of the quadriceps tendon incision into view to stitch it (Fig 1). This precludes the need for an assistant to stretch the skin with retractors and prevents quadriceps tendon defect.

Figure 1 Schematic illustration of the technique

The novel use of an external fixator connecting rod and synthetic bone substitute to achieve anatomic reduction of depressed tibial plateau fracture fragments

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Elevation of depressed articular fragments is crucial for anatomic reduction of tibial plateau fractures. We describe a technique of

Figure 1 External fixator rod

elevating the depressed fragment using a cortical window, an external fixator connecting rod (Fig 1) and injectable bone substitute.

A cortical window is made under image guidance using a 2.5mm drill to make four holes in a square configuration. A narrow osteotome is used to connect three sides. The connecting rod is inserted into the cortical window and used as a punch to elevate the articular fragment under image guidance (Fig 2). Injectable bone substitute is then used to fill the defect created (Fig 3).

Figure 2 Elevation of articular fragment with the connecting rod

Figure 3 Injectable bone substitute used to fill defect