Reverse tissue expansion

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Excision of skin tumours in the lower limbs of elderly patients often leaves defects that require skin grafts or flaps. We have employed a

Figure 1 Preoperative photograph of a lesion on the medial aspect of a 91-year-old woman's calf. Arrow indicating the abnormality to be excised.

Figure 2 Postoperative photograph with arrow indicating a neat, linear scar following excision. Patient had undergone three weeks of compression bandaging preoperatively, excisional surgery with direct closure and by two weeks of compression bandaging postoperatively for wound support.

simple method to enable direct closure of lower limb defects by performing compression bandaging 2–4 weeks prior to surgery. The skin of elderly patients often lacks elasticity. Compression bandaging results in the reduction of calf volume but the skin envelopes remain static, creating skin laxity. Preoperative and postoperative photographs are shown in Figures 1 and 2. We term this reduction in tissue volume 'reverse tissue expansion'. We have not seen this technique described previously and consider it a useful addition to our wound closure armamentarium.

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The use of alginate dressing on grafted donor sites in burns

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Kaltostat® (ConvaTec, Uxbridge, UK) calcium sodium alginate has become the dressing of choice for split-thickness skin graft (SSG) donor sites in most burn centres.¹ We used to reapply the residual small pieces of harvested SSG on the donor sites and we have used Kaltostat® to dress these donor sites. Figure 1A shows the remaining meshed SSG fixed with Histoacryl® (TissueSeal, Ann Arbor, MI, US)

Figure 1 Grafted donor site (right thigh) dressed with Kaltostat® during surgery (A), on day 7 following surgery (B) and on day 10 (C)

topical skin adhesive. Figures 1B and 1C reveal the wound check on day 7 without removing the adherent Kaltostat® and on day 10 with full graft take. This method may already be in use but it has not been published previously.

Reference

1. Geary PM, Tiernan E. Management of split skin graft donor sites – results of a national survey. *J Plast Reconstr Aesthet Surg* 2009; **62**: 1,677–1,683.

A novel method for community monitoring of flexion contracture in Dupuytren’s disease

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Measuring deformity in Dupuytren’s contracture is important when planning interventions and assessing outcome but it is prone to error. Even goniometric measurement has been shown to have poor interobserver reliability.¹ Devised by a patient with the condition (EWS), we describe a new method that can test for worsening contracture in the community without expert medical knowledge.

The hand is painted with water soluble paint and placed as flat as possible on a sheet of paper (Fig 1), creating a permanent record for future comparison. When progression of contracture is noted, the patient can request an outpatient appointment to discuss treatment options.

Reference

1. Ellis B, Bruton A. A study to compare the reliability of composite finger flexion with goniometry for measurement of range of motion in the hand. *Clin Rehabil* 2002; **16**: 562–570.

Figure 1 Handprints demonstrating the degree of contracture

The ‘do-it-yourself’ silastic ring for the silastic ring Roux-en-Y gastric bypass

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A silastic ring can limit gastric pouch distension and weight regain. We manufacture a ring using an 8Fr silastic catheter and a length of 2/0 polypropylene (Fig 1). The catheter is cut to the intended circumference. A small incision is made 1cm from one end of the catheter, allowing access to the lumen. The polypropylene is passed behind the gastric pouch and brought extracorporeally. Both ends are introduced into the lumen. The ring is positioned using a knot pusher and the polypropylene knotted. A 2/0 braided polyester suture is placed between the cut ends. The ring is cheap to make and easily removed.

Figure 1 The ‘do-it-yourself’ silastic ring