This technique makes use of equipment that is easily available in most units undertaking hip arthroplasty without expensive loan kit or extraction devices.

Cellacast® Splint as an adjunct to postoperative neck dressings for burns patients

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BACKGROUND

Dressings to the neck can be particularly challenging following burns surgery. Excision of deep burns or burn scars to the neck are often reconstructed using split skin graft (SSG) with or without an acellular dermal matrix (ADM).¹ Prevention of shearing force is paramount to graft survival; thus, surgeons are meticulous with their choice and method of dressings. Cellacast® Splint (Lohmann & Rauscher, Neuwied, Germany) is a cost-effective, lightweight and versatile splint that can be used as an adjunct to neck dressings.

TECHNIQUE

After excision of the burn or scar from the neck and application of SSG or ADM, standard dressings can be applied. In our practice, we apply UrgoTul Ag® (UrgoMedical, Chenôve, France) over the SSG or ADM, then chlorhexidine soaked gauze, dry gauze, and wool bandage. Next, a piece of Cellacast® Splint is cut long enough to cover the anterior and lateral aspects of the neck (Fig 1). The splint is contoured to fit around the neck and slits are cut in the superior and inferior borders to

Figure 1 Rectangular piece of Cellacast® Splint cut to correct length

Figure 2 Cellacast® Splint moulded to neck and slits applied to superior and inferior borders and activated

ensure a comfortable fit (Figs 2 and 3). It is then activated in sterile water and left to harden. Finally, the cast is put on to the dressings and secured in place with crepe bandage.

DISCUSSION

Cellacast® Splint is a synthetic splint composed of seven layers of fibreglass impregnated with polyurethane resin with padding on both sides.² In our experience, patients do not experience any airway, swallowing or chewing difficulties. This splint is an excellent way to secure neck dressings, prevent interference and prevent shearing forces that may compromise SSG or ADM take.

Figure 3 Cellacast® Splint fitted around the neck over dressings, prior to securing with crepe bandage

References

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A method for performing intraoperative enteroscopy

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On-table intraoperative enteroscopy is occasionally required. We present a technique to reduce contamination of the surgical field. To do this we use a 15-mm bladeless laparoscopic port introduced into

the small bowel via an enterotomy. This port is covered with an easi-drape® (Leonhard Lang, Innsbruck, Austria) camera sleeve taped to the port. The colonoscope is passed through the sleeve and laparoscopic port into the bowel. This set-up allows one surgeon to remain sterile while still being able to adjust the position of the scope in the bowel and the other to be unscrubbed and to operate the colonoscope.

L-shaped nipple reconstruction

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We developed a modified nipple reconstruction over a 36-month period (2011–2014). The L flap produced an optimal nipple position in patients with a transverse mastectomy scar, where the possibilities

Figure 1 Skin markings for nipple reconstruction L flap (optimum) and C-V flap (with arrows, not ideal)

Figure 2 Raising an L flap