Figure 4 Rotating the sample

Figure 5 Orientated images

- > The technique uses cheap and readily available materials.
- > The technique, coined the 'Pakzad sandwich', has been successfully used in a leading breast unit. The authors recommend its use for its simplicity and economy.

Reference

1. Dixon JM, Ravi Sekar O, Walsh J *et al*. Specimen orientated radiography helps define excision margins of malignant lesions detected by breast screening. *Br J Surg* 1993; **80**(8): 1,001–1,002.

Laparoscopic use of a 90-degree cross-stapling device for low rectal division

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Current laparoscopic technologies do not permit a truly perpendicular rectal staple line. An incision is often made to divide the lower rectum with standard open surgical staplers. Our method places the cross-stapler under laparoscopic guidance.

Figure 1 90-degree cross-stapling device in place laparoscopically for low rectal division

Place the cross-stapler through the finger of a surgical glove and secure. Stretching the cuff around the wound protector (Fig 1) permits reinsufflation and stapler deployment across the low rectum under direct laparoscopic vision.

We find this technique to be helpful in performing ultra-low division of the rectum for a laparoscopic ileo-anal pouch in the presence of massive uterine fibroids without conversion to an open procedure.

A novel technique for the explantation of a cemented femoral hip prosthesis

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Explantation of cemented femoral components can be technically challenging if an extraction device or specific introducers are not available.

After exposing the shoulder of the prosthesis and removing any excess cement blocking removal, an inverted Exeter™ V40™ Rasp Handle (Stryker, Mahwah, NJ, USA) was placed with its impacting plate hooked on the inferior surface of the prosthesis neck (Fig 1) before disimpacting the prosthesis with a mallet.

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.