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

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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

Figure 3a Preoperative marking donor area: skin from right breast reduction; left breast: L flap nipple

Figure 4 L flap nipple and neo-areola reconstruction completed

Figure 3b Postoperative results: right breast – donor area closed; left breast – inset L flap nipple and neo-areola (recipient)

for the use of the C–V flap were limited and the nipple position not optimum (Fig 1).

The L-shaped nipple flap is a technical variation of raising and constructing a nipple, consisting of two local opposing skin flaps with two limbs: long and short (hence L). The flap donor areas are contained within the new areolar margins. The long arm (centred on the lateral-based random flap) is rotated through 180 degrees and sutured. The second short arm is then sutured to the upper border of the long arm to create the summit of the neo-nipple (Fig 2).

The marked areola is de-epithelialised and a full-thickness skin graft (donor area: abdomen or contralateral breast) is harvested, fenestrated and placed on de-epithelialised area to create the new areola (Fig 3 and Fig 4).

This modified technique for complex nipple–areola reconstruction can be used in either primary or secondary nipple reconstruction.¹ The advantages of the L flap are that all scars are contained within neo-

areola and nipple projection is consistently maintained and is similar to that of traditional C–V flap performed during the period of the study.²

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Removal of spinning locking screws using a scalpel blade

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BACKGROUND

The removal of locking screws from a plate can often be difficult. There are situations where the screw–plate and screw–bone interfaces have been damaged and the screw head/shaft threads no longer have purchase. This results in the screw spinning without backing out. The conventional method is to remove the screw using forceps, haemostats or a screwdriver coupling device to grip the screw head while rotating the screwdriver. However, there is often only a small amount of screw head exposed, which is not enough for the instruments to grip. Where a firm grip of the screw head is achieved, rotation is hindered, risking damage