Figure 2

Figure 3

Figure 4

Figure 5

A cheap, simple and sterile surgical bolster

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BACKGROUND

The use of a bolster in orthopaedic surgery is commonplace for cases such as retrograde nailing of the femur, antegrade nailing of the tibia or tibial plateau fracture fixation. An oft-used technique is to insert a non-

Figure 1 A pack of incontinence pads (the bolster) is placed on a non-sterile Mayo stand and an image intensifier cover is placed over the top half.

sterile block into a sterile Mayo stand cover. Contamination of the outer surfaces is easier than expected. Rolling back the edges of the cover before inserting the bolster means only the internal surface of the Mayo cover should be contaminated. However, to roll the edge back and secure it without contaminating the surgeon's gloves and the bolster is difficult. Our simple method eliminates this breach in sterility.

Figure 2 The sterile image intensification cover allows the bolster to be handled.

Figure 3 The bolster is placed sterile side down on a sterile, covered Mayo stand.

Figure 4 A second sterile image intensifier cover is now used to completely enclose the bolster.

Figure 5 The completely enclosed bolster is transferred into a sterile Mayo stand cover without risk of contaminating the edges. The cover is then rolled around the bolster, sealing off the interior.

Figure 6 The rolled Mayo stand cover is secured with adhesive operating tape, creating a seal.

Figure 7 The completed bolster, with an uncontaminated surface and a happy surgeon!

TECHNIQUE

A pack of sheet-type incontinence pads makes a cheap, padded block, the size of which can be altered to fit the patient by adding or removing pads (a large sharps bucket can also be used for tibial nailing). Two image intensification covers are used to cover the pack. The first is put over the pack on a non-sterile surface (Figs 1 and 2). The pack is inverted and placed sterile side down on a sterile Mayo stand (Fig 3). The opposing image intensifier cover is then applied overlapping the first (Fig 4) and the pack inserted into a sterile Mayo stand cover (Fig 5). Air is eliminated and the cover folded back on itself and sealed with adhesive tape (Figs 6 and 7).

DISCUSSION

Any risk of introducing contaminants to the operative field in the process is minimised by this simple step of using sterile image intensification covers.

Video Link

<https://www.youtube.com/watch?v=ZvVISMqQoMc&feature=youtu.be>

A simple method to find the proximal stump of the cut flexor pollicis longus tendon in the thenar zone

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BACKGROUND

When the flexor pollicis longus tendon is lacerated in zone 2, the proximal stump may retract and can be difficult to retrieve through the original incision in the flexor sheath.¹ In order to overcome this difficulty (especially in heavy labourers with bulging thenar muscles), a wire loop is introduced into the proximal sheath at the A1 pulley and is advanced to the thenar eminence. Afterwards, the surgeon has to find the tip of the wire loop, which is close to the cut tendon. We describe a simple technique to locate the wire loop.

TECHNIQUE

The wound is excised and extended to expose the A1 pulley of the thumb. A wire loop is gently passed proximally along the sheath until the point of the loop reaches the thenar eminence (Fig 1). Pressure is applied at the thenar eminence to try to feel the edge of the wire loop while it is moving back and forth. The skin is incised carefully over the thenar eminence at the point of feeling the edge of the wire loop (Fig 2). The tissue is dissected layer by layer until the tip of the loop is found. A C-arm can help in locating the wire edge. The tip of the wire loop is close to the proximal stump of the cut tendon if it is in the thenar zone. The tendon is then sutured to the wire loop and passed through the A1 pulley.

Figure 1 The wire loop is advanced through the A1 pulley to the thenar zone.

Figure 2 Skin incision over the thenar eminence at the point of feeling the edge of the wire loop