Figure 4 The umbilical stalk fixed to the abdominal fascia and neighbouring abdominal skin at the neo-umbilical site with remaining skin closed, both with half-buried mattress sutures

of the abdominal skin and back through the umbilicus skin edge and tie the knot (Fig 3).

- > Perform the remaining umbilical wound closure using the half-buried horizontal mattress stitch with nylon 5/0 (Fig 4).
- > Remove all nylon sutures at 10 days.

DISCUSSION

The main aesthetic components of a tailored umbilicus include the position, depth, shape and location of the scar.¹ The described technique is a simple method that reduces depth, centralises the umbilicus and adjusts the shape to create a youthful and more vertically oriented umbilicus without compromise to the blood supply, supporting immaculate wound healing.

Reference

1. Lee M, Mustoe T. Simplified technique for creating a youthful umbilicus in abdominoplasty. *Plast Reconstr Surg* 2002; **109**(6): 2,136–2,140.

Judging anterior cervical plate length

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BACKGROUND

Anterior cervical discectomy and fusion or corpectomy of the cervical spine is a commonly performed procedure for pathology of the cervical spine. In trauma situations and following corpectomy, an anterior bridging plate is often employed to add stability to the construct. Judging the length of the required plate can often be a challenge due to the depth of the approach and access. We present a reliable technique for judging the correct length of plate and its positioning.

Figure 1

Figure 2

Figure 3

TECHNIQUE

Once the Caspar pins are placed in a satisfactory position and the image intensifier shows an acceptable position within the vertebral body (Fig 1), the Caspar distractor can be used in the normal manner and, once detensioned, it can be removed and used to either directly measure the length of the plate or act as an estimation of the required plate length (Fig 2). The final position of the anterior plate is shown in Figure 3. Following plate selection, the plate can then be used to compress any bone wax which has been used to fill the bony defect following removal of the Caspar pin to aid haemostasis.

DISCUSSION

We have found this to be a reliable and efficient method of judging the required length of plate for anterior cervical procedures, especially as more implant manufacturers move towards individually sterile packaged plates.

The use of a femoral distractor in the presence of an intramedullary nail proximal to an osteoporotic fracture

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Periprosthetic fractures are difficult to manage. Achieving an adequate reduction in the presence of severely osteoporotic bone and fragile soft tissues can be challenging. Often, these cases are delayed and subsequent retraction of the soft tissues compounds the problem. In the case of a femoral fracture distal to a long

intramedullary nail, the application of a femoral distractor is obstructed by the presence of the nail. Removing the distal locking screw allows a reversed Steinman pin to be inserted through the nail itself, enabling safe distraction (Fig 1).

Cutting and shutting – a novel method for wound closure following excision biopsy in areas of high skin tension

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Excision biopsy results in a defect length two to three times the diameter of the original lesion. Closure of this defect is challenging in areas of high skin tension. We describe a technique where part of the leading edge of the lesion is incised radially until the deep margin can be dissected (Fig 1). At this point, the resultant defect is simultaneously closed. Next, the radial margin is extended and the lesion reflected. The process is repeated until the lesion is excised and defect closed. This technique uses 'auto-traction' from the proximal skin, eliminating the requirement for an assistant and the complication of 'cheese wiring'.

Figure 1 Use of an AO femoral distractor in the presence of an intramedullary nail proximal to an osteoporotic fracture

Figure 1 Stepwise demonstration of excision biopsy and simultaneous wound closure