Figure 4 Completion of evacuation without gel spillage

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A simple alternative to Chinese finger traps for wrist fracture reduction

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Figure 1 Thomas splint skin traction kit used for gravity-assisted reduction of a closed wrist fracture.

BACKGROUND

Chinese finger traps can be used to aid closed reduction of wrist fractures by gravity-aided countertraction, ligamentotaxis and disimpaction.¹ However, they are expensive and are often not available. We describe a simple and cheap alternative to Chinese finger traps using modified skin traction tape from a Thomas splint application kit.

TECHNIQUE

Skin traction adhesive tape is cut to the appropriate size and applied vertically across the palm of the affected arm to include the thumb, index and middle fingers. The attached cord is then tied to a drip stand, ensuring that the forearm is kept at a right angle, and the index/middle fingers are in line with the forearm to provide ulnar deviation (Fig 1). Strips of adhesive bandage tape can be placed circumferentially around the palm and a pillow or padded arm board placed below the arm as a 'failsafe'; although this has never been necessary in our practice.

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Laparoscopic retraction in Nissen fundoplication for the patient who is latex allergic

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Figure 1 A standard latex-free glove is cut along the dotted line.

Figure 2 The index and middle-finger of the glove are used as an oesophageal sling for retraction.

Laparoscopic Nissen fundoplication involves retraction of the gastro-oesophageal junction using a Penrose drain to create a retro-oesophageal window.¹ We describe a latex-free alternative to the Penrose drain for patients with latex allergy.

A size 8 or larger latex-free glove is fashioned into a sling, by cutting away all but the index and middle-finger portions (Fig 1). The bridge between these fingers, which normally covers the surgeon's interdigital space, forms the sling apex. This is passed around the distal oesophagus exactly as a Penrose drain and offers a safe, quick, and cost-effective latex-free alternative (Fig 2).

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A technique to localise occult breast lesions detected mammographically: the hybrid of wire localisation and sonography guided patent blue marking

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BACKGROUND

Mammography screening has resulted in an increase in patients with non-palpable lesions that need a histopathological study.¹ Wire localisation excisional biopsy is commonly used to take tissue for examination. Several disadvantages of this procedure exist. It is difficult to localise the wire tip precisely before the biopsy. The wire can be displaced during patient transport. The incision is made on the puncture site, making the procedure invasive and traumatic.² It can create unacceptable scarring on the breast. Lastly, the wound interferes with possible subsequent oncoplastic surgery. Our technique efficiently deals with these challenges.

TECHNIQUE

Patients undergo wire localisation under mammography and are sent for surgery. Patients are injected with 0.5 ml of patent blue dye (2.5%) around the wire tip under sonography guidance before the procedure (Fig 1). The breast tissue with blue marking is excised via a periareolar incision (Fig 2). If the lesions are far from the nipple–areola complex, a Hopkin's telescope is used (Fig 3). Specimen mammography is taken to confirm the presence of microcalcification (Fig 4).

Figure 1 0.5 ml patent blue dye is injected around the tip of the wire hook (red arrow) under sonography guidance.

Figure 2 Periareolar incision is made to access the blue-stained breast tissue.