

Technical Section [TECHNICAL NOTES AND TIPS

A bow-tie for hand trauma

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We present a video of the 'bow-tie' stitch use in hand trauma.

The bow-tie stitch is easy for staff to identify and remove by pulling one side without the need for a stitch cutter. The knot on the suture is adequate to keep the skin edges opposed, everted and approximated. It is compatible with synthetic non-absorbable suture material, which reduces the risk of bacterial contamination in repair of traumatic wounds. We have observed a reduced incidence of stitch retention and stitch abscesses. The simple and quick suture removal is preferred by patients and improves satisfaction without compromising wound repair.



Data protection: in our patients' hands

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BACKGROUND

In our technologically advancing age, data generation has vastly increased. With this increase, concerns around confidentiality and data protection have also grown. However, images of an injury can convey large amounts of information in a single photograph. Hospital-sanctioned methods of generating photographs of injuries can be

time consuming, leaving many clinicians to resort to photography from their personal phones – generating an ethical minefield.¹

TECHNIQUE

Most hospital patients in 2016 have access to a camera phone. Using the patient's phone (with their verbal consent), allows the clinician to obtain images without having to organise clinical photography or taking the data protection risks of using their personal phone. Most smartphones are equipped for photography without unlocking the phone, thus preventing the patient having to disclose their passcode. However, written information detailing the reason for photography must be provided as part of informed consent.

DISCUSSION

Using a patient's own phone means that all healthcare professionals have access to a complete record of an injury. Also, arguably more importantly, the patient has control of their data, as the pictures can be only shared with their input. Vitality, photographic record of an injury allows for long-term wound follow-up and early identification of subtle changes, such as healing ulcers,² giving patients and healthcare professionals the reassurance that even with multiple individuals reviewing the injury each person has the same point of reference to assess healing progression and identify potential problems early.

References

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A simple way to remove air bubbles in the bladder dome during transurethral resection of tumours

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BACKGROUND

During transurethral resection of a tumour in the bladder dome, gas bubbles can accumulate in the bladder dome and obscure the surgical field.

TECHNIQUE

Intermittent switching of the irrigation fluid onto the outflow channel of the continuous-flow irrigating resectoscope provides a simple and

effective way of draining gas bubbles via the inflow channel. Once clear vision returns, re-connecting the irrigation fluid to the inflow channel enables safe resection to continue.

Estimating screw lengths for cephalomedullary nails without using a depth gauge

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The cephalomedullary nail is a widely used intramedullary device for femoral neck fractures consisting of several component parts (Fig 1). Measurement of the locking screw length can be challenging, with formulae being suggested to estimate this.¹

We have found that a mathematical relationship exists between nail and component screw lengths:

$$\begin{aligned} \text{Cephalad screw length} &= \text{nail length} \div 4 \\ \text{Locking screw length} &= \text{nail length} \div 8 \end{aligned}$$

We believe this method is of use to surgeons in estimating the lengths required. Our ability to correctly predict cephalad and locking

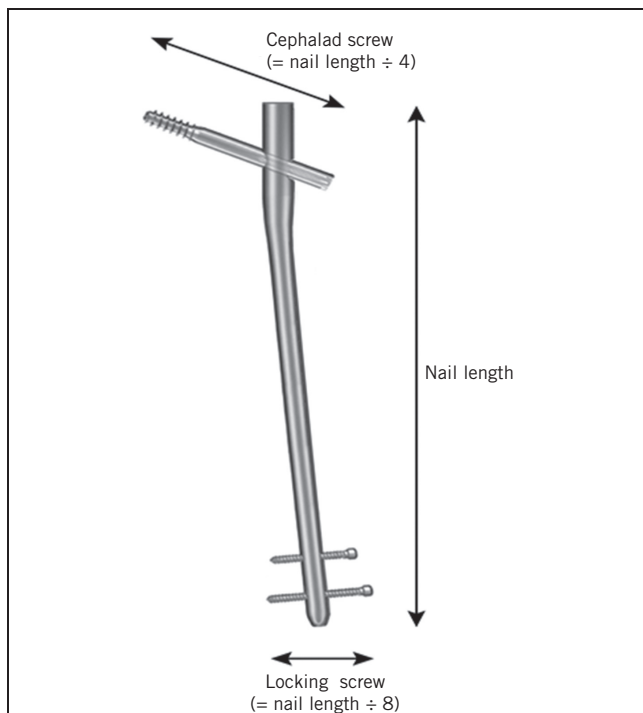


Figure 1 Component parts of a cephalomedullary nail

screw lengths to within 10mm was 88.6% and 93.7%, respectively, in a series of 104 patients.

References

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Smart phone camera: a useful adjunct in plastic surgery clinics

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Patients can present to outpatient clinics with challenging skin lesions that require some form of magnification to aid diagnosis and management. Traditional magnifiers are not always available in clinics. The use of the digital camera is well established in the surgical field.¹ We used the smartphone's digital camera zoom function to aid magnification of difficult skin lesions (Fig 1a,b). The flashlight source provided in most smartphones has an additional advantage in aiding magnification. This method can be extended to preoperative markings by the surgeon/dermatologist.² This is a simple and readily available adjunct, although it is not a substitute for dermatoscopy.

References

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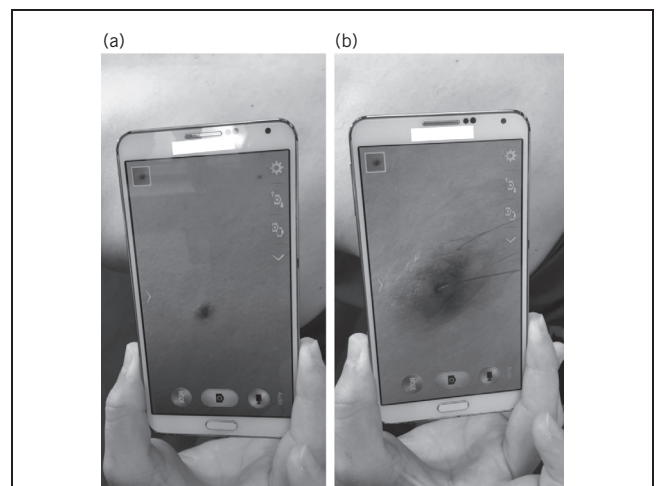


Figure 1 a) Pigmented lesion on the back without magnification b) The same lesion magnified 4 using the zoom function in the smartphone camera