



**Figure 1** The Tuohy needle and Ethilon® suture have been passed through the labrum. The Mitek® anchor is in place.

graspers can be inserted through the 6mm cannula to aid manipulation of the labrum or the Tuohy needle. A size 0 Ethilon® suture (Ethicon, Somerville, NJ, US) is advanced through the needle and across the face of the glenoid as a shuttle suture (Fig 1), and the labral repair is undertaken in the normal way.



**Figure 2** The small anterior scar visible at two weeks

**DISCUSSION**

This technique uses readily available equipment and allows access to the inferior labrum as a Tuohy needle is sufficiently slim to pass through the superior part of the subscapularis. Furthermore, it leaves the patient with only one small anterior scar (Fig 2).

**Metacarpal Titanium Elastic Nail insertion**

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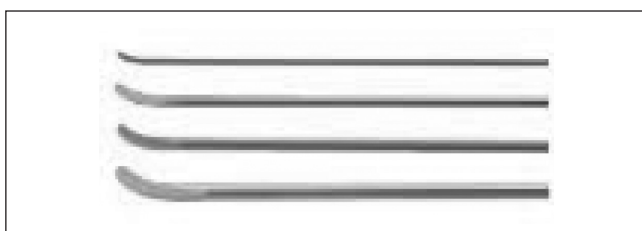
Standard Titanium Elastic Nail (TEN; Synthes, Welwyn Garden City, UK) fixation requires a 2.5mm drilled entry point at the base of the metacarpal. This can damage soft tissues including the extensor tendon and also risks breaching the volar cortex. We recommend opening the dorsal metacarpal cortex with a curved artery clip (Fig 1). Initially,



**Figure 1** Entry point gained using clip to penetrate the near cortex



**Figure 2** Clip turned 180° to continue along medullary canal



**Figure 3** Titanium Elastic Nails, showing the curved profile

point the tip downwards to penetrate the cortex, turning the clip 180° to advance it down the medullary canal (Fig 2). The curve on the clip mimics the profile of a 2.0mm TEN (Fig 3) and its natural entry to the metacarpal. The less traumatic nature of this approach may lead to improved soft tissue protection.

### The poke test in lower limb fasciotomy: a potentially limb saving technical note

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#### BACKGROUND

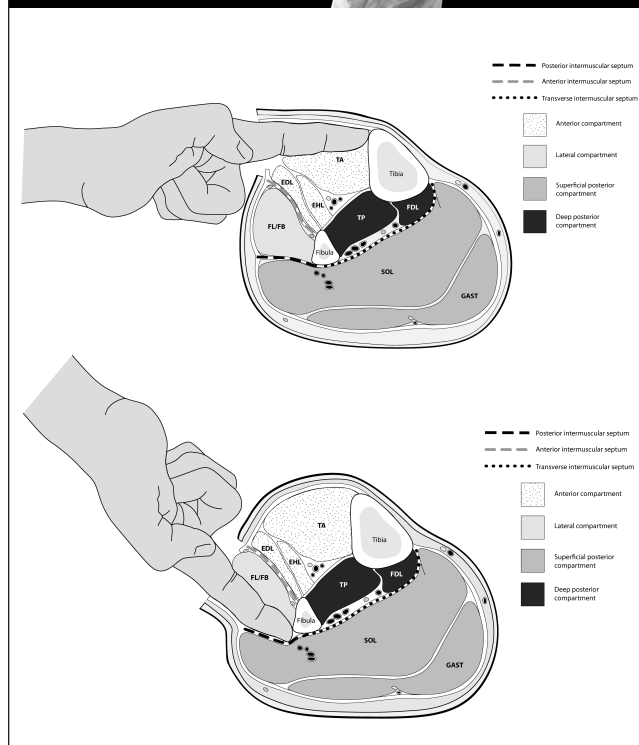
Delayed or incomplete fasciotomy may result in limb loss or even death in severe polytrauma.<sup>1</sup> The angiosomal blood supply of the anterior compartment renders it particularly vulnerable if not correctly decompressed.<sup>2</sup> Swelling and local trauma distort anatomy significantly, making it possible to 'miss' the intended compartment without some simple means of double-checking. The anterior and lateral compartments may be decompressed via separate fascial incisions through an axial skin incision (running midway between the fibula head and the tibial tuberosity proximally, and the lateral malleolus and the anterior tibia distally).<sup>2</sup> Alternatively, the anterior compartment is decompressed via an incision 2cm lateral to the tibial crest. The lateral compartment is then decompressed into the anterior by incising the intermuscular septum, extremely difficult in the presence of severe swelling.<sup>3</sup>

#### TECHNIQUE

After entering the deep fascia, a finger is inserted and advanced towards the midline, superficial to the muscle but deep to the fascia. If the finger is in the anterior compartment, it will touch the tibia easily. If, however, the finger is in the lateral compartment, this will be impossible. Furthermore, if the direction of the finger is reversed and advanced, the fibula will be felt (Fig 1). It is imperative to 'poke' the finger in and never to sweep it along the length of the wound. This would avulse perforators with potentially disastrous results.

#### DISCUSSION

By using this simple poke test, the surgeon can identify swiftly and with certainty which compartment he or she has entered and decompressed.



**Figure 1** Top diagram: The surgeon's finger has been introduced through an incision in the fascia and poked across to touch the tibia, confirming this is the anterior compartment. Bottom diagram: The finger is again introduced through a second fascial incision and palpates the fibula, confirming entry into the peroneal compartment. If the surgeon entered the peroneal compartment (believing it to be the anterior due to swelling and distortion) and attempted to poke the tibia, this would prove impossible because of the intermuscular septum. Correspondingly, the septum prevents palpation of the fibula from the anterior compartment.

#### References

1. Ritenour AE, Dorlac WC, Fang R *et al.* Complications after fasciotomy revision and delayed compartment release in combat patients. *J Trauma* 2008; **64**: S153–S161.
2. Clasper JC, Standley D, Heppell S *et al.* Limb compartment syndrome and fasciotomy. *J R Army Med Corps* 2009; **155**: 298–301.
3. Nanchahal J, Nayagam S, Khan U *et al.* *Standards for the Management of Open Fractures of the Lower Limb*. London: BAPRAS; 2009.