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**Re: Ozcelik B, Egemen O, Sacak B. How to prevent the avulsed soft tissues from wrapping around the K-wire. *J Hand Surg Eur.* 2011, 36: 518 –519**

Sandeep J Sebastin, Bulent Ozcelik, Raja Sabapathy and Onur Egemen  
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**Conflict of interests**

None declared.

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**Re: Ozelik B, Egemen O, Sacak B. How to prevent the avulsed soft tissues from wrapping around the K-wire. *J Hand Surg Eur*. 2011, 36: 518–519**

Dear Sir,

We read with interest this short report letter about the use of a plastic aspiration tube to prevent soft tissue entrapment during K-wire fixation. We have been using a similar technique in our practice for some time (Sabapathy et al., 2003). Instead of a plastic aspiration tube, we use the plastic protective sleeve of a hypodermic needle (after cutting one end off). This is easily available and is more rigid. We find this technique especially valuable in replantation of ring avulsion amputations. In fixation of these amputations, the sleeve must be maintained till the K-wire is withdrawn from outside the finger and clears the proximal end of the bone being fixed.

**Reference**

- Sabapathy R, Venkatramani H, Bharathi R, Sebastin SJ. Replantation of ring avulsion amputations. *Indian J Plast Surg*. 2003, 36: 76–83.

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**Reply**

Dear Sir,

**Re: Ozelik B, Egemen O, Sacak B. How to prevent the avulsed soft tissues from wrapping around the K-wire. *J Hand Surg Eur*. 2011, 36: 518–519**

We would first like to thank Dr Sebastin for his comment on our article. We have read their article (Sabapathy et al., 2003) which describes the use of the protective sleeve of a hypodermic needle to prevent soft tissue entrapment during K-wire fixation. We prefer a more flexible material, the plastic aspiration tube. We feel that the stainless steel K-wire possesses enough rigidity and does not need another rigid material to guide it. While we introduce the K-wire, sometimes we bend it and change its direction to obtain proper alignment of the bones. The flexible aspiration tube does not interfere with this maneuver. However a more rigid material may eliminate this flexibility.

**Reference**

- Sabapathy R, Venkatramani H, Bharathi R, Sebastin SJ. Replantation of ring avulsion amputations. *Indian J Plast Surg*. 2003, 36: 76–83.

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**Re: Toros T, Özaksar K, Sığun TS, Kayalar M, Bal E, Ademoğlu Y. Unipedicled laterodigital transposition flap for covering dorsal longitudinal skin defects in multi-digit injuries. J Hand Surg Eur. 2011, 36: 179–84**

Dear Sir,

We read with interest this article describing a new technique to manage longitudinal soft tissue defects on multiple digits with a non-graftable bed. It is very useful to use homodigital tissues. However, we suggest a staged approach to the management of such defects using the techniques described by Yii and Elliot (1999) and that by Toros et al. (2011).

Initially we start by attempting to close the defect with adjacent (skinless) subcutaneous tissue. If this is not possible, we proceed with a lateral incision (if necessary encroaching beyond the midlateral line), and again assess the advancement. As described by Yii and Elliot (1999), incising Cleland's ligaments will allow advancement of the dorsal subcutaneous tissues (adjacent to the full-thickness defect), and if performed bilaterally may be all that is required to cover the defect completely. If necessary, to permit further advancement, the commissural vessels can be divided. If there is still a defect, having performed the release bilaterally, the distal skin can be incised, hence creating a unipedicled flap. In our experience too, as long as there is adequate soft tissue to cover the defect, the wound will heal by secondary intention along with the donor sites – skin-to-skin closure is not essential.

Although the unipedicled flap is of use in longitudinal dorsal digital defects, we advocate a staged approach to its use. This may end in the use of a unipedicled laterodigital transposition flap, but may stop short of that, and avoid the need to skin graft the donor site, or to raise a flap with poorer vascularity.

## References

- Toros T, Ozaksar K, Sugun TS, Kayalar M, Bal E, Ademoğlu Y. Unipedicled laterodigital transposition flap for covering dorsal longitudinal skin defects in multi-digit injuries. *J Hand Surg Eur.* 2011, 36: 179–84.
- Yii NW, Elliot D. Bipedicle strap flaps in reconstruction of longitudinal dorsal skin defects of the digits. *Plast Reconstr Surg.* 1999, 103: 1205–11.

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## Reply

Dear Sir,

**Re: Toros T, Özaksar K, Sığun TS, Kayalar M, Bal E, Ademoğlu Y. Unipedicled laterodigital transposition flap for covering dorsal longitudinal skin defects in multi-digit injuries. J Hand Surg Eur. 2011, 36: 179–84**

We agree with these authors that a staged approach should be used when dealing with such difficult injuries. The transposition flap described in this article should be used when there is no suitable adjacent soft tissue to cover the defect, especially at the distal edge. Usually there is a narrow strip of soft tissue devoid of skin on both sides of the defect due to the convexity of the dorsal side of the finger. Thus, the defect is deepest at the centre, gradually becoming superficial near the edges. Those adjacent soft tissues are extremely useful, and should be spared whenever possible. This tissue should be mobilized first to close the deeper parts of the defect, taking care to preserve vascularity. This is the easiest and simplest way of covering such defects, since a skin graft can be applied on to healthy subcutaneous tissue, or if the defect is narrow, even healing with granulation could be anticipated although if severe scarring occurs on the dorsum of the finger, flexion may be limited.

Creating a bipedicled flap as described by Yii and Elliot (1999) is very useful for coverage, but, as stated in our article, this flap is mobile at the centre, gradually becoming less mobile towards the distal end as it approaches the pedicle. We think that unipedicled flaps are more useful in such situations. As the surgeon frees the distal end of a bipedicled flap, the mobility of the distal end increases greatly, enabling the surgeon to cover the defect easily.