

**Table 1** Rates of extrusion and migration in sutured gold weights

Study	No. of eyes	Extrusion	Migration
Chapman & Lamberty <sup>1</sup>	19	0	1
Soll <sup>2</sup>	14	0	0
Neuman <i>et al.</i> <sup>3</sup>	68	3	3
Sobol & Alward <sup>4</sup>	18	0	0
Seiff <i>et al.</i> <sup>5</sup>	17	0	0
Kartush & Linstrom <sup>6</sup>	37	0	0
Gilbard & Daspit <sup>7</sup>	61	4	0
O'Connell <i>et al.</i> <sup>8</sup>	20	0	2
Townsend <sup>9</sup>	23	1	0
Total (%)	277	8 (2.9%)	6 (2.2%)

- Sobol S.M., Alward P.D. Early gold weight lid implant for rehabilitation of faulty eyelid closure with facial paralysis: an alternative to tarsorrhaphy. *Head and Neck* 1990; **12**: 149-153.
- Seiff S.R., Sullivan J.H., Freeman L.N. and Ahn J. Pretarsal fixation of gold weights in facial nerve palsy. *Ophthalm Plast Reconstr Surg.* 1989; **5**: 104-109.
- Kartush J.M., Linstrom C.J., McCann P.M. and Graham M.D. Early gold weight eyelid implantation for facial paralysis. *Arch Otolaryngol Head Neck Surg.* 1990; **103**: 1016-1023.
- Gilbard S.M., Daspit C.P. Reanimation of the parietic eyelid using gold weight implantation. *Ophthalmic Plast Reconstr Surg* 1991; **7**: 93-103.
- O'Connell J.E., Robin P.E. Eyelid gold weights in the management of facial palsy. *J Laryngol and Otolg.* 1991; **105**: 471-474.
- Townsend D.J. Eyelid reanimation for the treatment of paralytic lagophthalmos: Historical perspectives and current applications of the gold weight implant. *Ophthalmic Plastic and Reconstructive Surgery*, 1992; **8**: 196-201.

### Morbidity after gold weight insertion—reply

Sir,

In response to Dr Richard Jobe and Dr Patel *et al.*'s letters regarding fixation of the gold weights, I would concur. To some extent we had been trying to make the gold weights less apparent by making them thinner and over a broader area of the tarsal plate. Most extrusions have related to previous surgery with surrounding fibrosis, but there is no doubt that the gold weights can be persuaded to shift and it may well relate to rubbing the eye, with the irritation of epiphora. For the last year we have inserted two holes in the gold weight and have sutured it to the upper edge of the tarsal plate with 6/0 nylon. It is a little early to say whether or not this has been entirely successful but judging by the two foregoing letters, it would appear to be a distinct improvement.

Regarding the final comment about astigmatism, this is certainly a complication if the gold weight is inserted insufficiently bent to the curvature of the cornea. With a rather thick flat weight it will press on the surface of the cornea, distorting it, and in consequence produce astigmatism. The thin weights that we employ are very easy to bend to the correct shape and ensure that this complication does not arise.

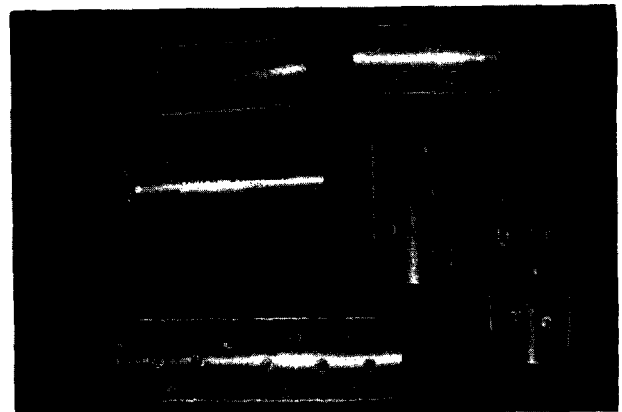
Yours faithfully,

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### Finger injury splints

Sir,

Finger injuries are the commonest of hand injuries and most of them require some kind of splintage for a period of time. We have found 'used' disposable syringes helpful for splinting fingers with various lesions. These are easily-made, convenient, non-traumatic, light in weight and practically free of cost. The size of the syringe required depends on the size of the finger. Usually 20 cc for adults and 10 cc for children are suitable. They are best used as gutter splints, which are easily prepared by longitudinally splitting the syringe with a pair of stout scissors. The ends and corners are rounded off to prevent irritation and pressure. A number of small holes are made with a hot large-bore needle to allow for evaporation of sweat and prevent soggy, which is necessary in our tropical climate (Figure). The splints are easily secured with simple adhesive plaster tape.



Figure

We have used these successfully over a period of one year in patients with finger-tip lacerations, phalangeal fractures (particularly middle and distal phalanges) and dislocations, mallet and boutonniere deformities and for splinting the fingers after small grafts and flaps for finger-tip defects.

Yours faithfully,

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### Open tibial fractures

Sir,

The paper of Small and Mollan (*British Journal of Plastic Surgery*, **45**, 571-7) was directed to the readers of the BJPS and thus may not be brought to the attention of orthopaedic surgeons, for whom the message is just as pertinent. The message of encouraging early cover of compound fractures with appropriate soft tissue should be stressed to orthopaedic surgeons, who are usually the first involved at the onset of management of such injuries. Despite the problems caused