Table 1 Rates of extrusion and migration in sutured gold weights

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

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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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Mount Vernon Hospital,
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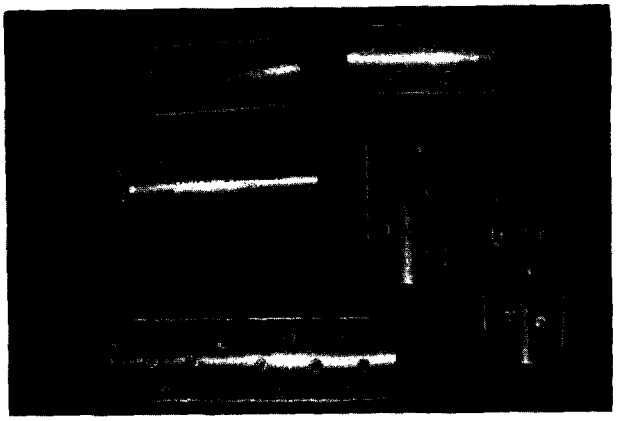
Finger injury splints

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 sogginess, 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

by duplication of articles in different journals, this may be one of the occasions when it would be useful if it were reprinted in an orthopaedic journal.

The young age of the patients (average 24 years) highlights the importance of correct management of these injuries from the outset. Is it therefore adequate that only 24 out of 46 patients were referred to the plastic surgery unit from orthopaedic surgeons within 72 hours? It would seem to us that the most appropriate time for plastic surgery input is at the onset of management and not after several days. The arrangement of having a plastic surgeon associated to a trauma team is surely one step that may help to avoid the tragic scenario of non-union or osteomyelitis occurring as a complication of these injuries. The potential benefits from simultaneous orthopaedic and plastic surgical input at the time of presentation, makes the recent decision by Riverside Health Authority to separate the two specialities onto different hospital sites a disappointing one. We feel that this is a retrograde step that can only hinder the potential for achieving early and suitable soft tissue cover.

Yours faithfully,

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London

The vestibular fold

Sir,

The vestibular fold is one of the characteristic features in patients with cleft lip nose deformity, but its anatomy is poorly understood. We have investigated the relationship between the vestibular fold and the lower lateral cartilage by insertion of a hypodermic needle under direct vision during secondary repair of cleft lip noses in 38 patients. As a result, it was learned that the vestibular fold is formed by the *lower* border of the lower lateral cartilage in every case (Figure).

Huffman and Lierle[1] must be credited with the in-depth description of the anatomy of the cleft lip nasal deformity. Berkeley[2] discussed the vestibular fold and stated that it runs from the apex of the nostril along the *upper* border of the lower lateral cartilage to the margin of the piriform sinus. The erroneous passage by Berkeley above has been quoted in 'Cleft Craft' by Millard[3]. Moreover, even in the textbook of Plastic Surgery by Tord Skoog[4], the vestibular fold is illustrated as though formed by the upper border of the lower lateral cartilage. In contrast, Uchida[5] referred to the vestibular fold as the plica vestibularis and stated that the lower border of the lower lateral cartilage curves toward the vestibule and forms the plica vestibularis. Consequently, the results of our own investigation and Uchida's paper provide convincing evidence that the statements in Berkeley's paper and the Millard and Skoog textbooks concerning the vestibular fold are erroneous. Knowing what gives shape to the vestibular fold is an extremely important point from the standpoint of performing corrective surgery.

Figure

Figure—A 5-year-old female at operation. When needles are inserted along the line of the lower border of the lower lateral cartilage, they are seen to conform to the vestibular fold.

Yours faithfully,

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Necrotising fasciitis

Sir,

I would like to comment on the recently published paper "Necrotising fasciitis in the head and neck region" by Maqbool *et al.* (*British Journal of Plastic Surgery*, **45**, 481).

In their review of the literature, Maqbool *et al.* did not find any case of necrotising fasciitis affecting the head and neck region. Nevertheless, this rare disease has been previously reported in several papers. Bahna and Canalis[1] reviewed the literature and found seven cases of this infection involving head and neck structures. Ezquerra *et al.*[2] described a clostridial gangrene of head and neck, affecting the subcutaneous fat, superficial and deep fascia, frontal muscle and cranial periosteum. Yamaoka *et al.*[3] reported a case in which the infection was secondary to self-inflicted bite wound, and extended to the infratemporal fossa, lateral pharyngeal space and carotid sheath.

Immunocompromised patients with acquired immunodeficiency syndrome can also develop necrotising infections. Leiva and Escudero[4] reported the clinical course of a woman with a history of prostitution, heroin addiction and AIDS, who sustained a progressive and extensive necrotising fasciitis of the head and neck. It was secondary to a small wound on the left parietal region of the scalp, and extended to several areas of the scalp, forehead, both left eyelids, left preauricular and retroauricular regions, and neck (Figure).