

wound was non-tender, non-erythematous, and had no discharge, we felt that it was safe to exclude this as a diagnosis. In essence the wound had acted as a one way valve during the running stage of the competition, trapping air within the soft tissues.

Yours faithfully,

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## References

1. Russell PG, Smith M. Subcutaneous emphysema following the use of a high-pressure water jet. *Br J Plast Surg* 2001;54:87–8.

doi:10.1016/S0007-1226(03)00089-4

## Tattooing ears—a simple method

Sir,

Tattooing is often used in the initial stages of prominent ear correction. Whether it is performed to mark the proposed position of the anthelix and crura or to indicate cartilage incisions or existing folds, it commonly involves the use of a Simms needle

dabbed in gentian violet, which is passed through the pinna and then dabbed again on the post-auricular surface before being withdrawn. Although this produces a reliable cartilage tattoo it does require an assistant and it may disperse ink on both skin surfaces obscuring skin markings.

A simpler method involves the use of a straight silk suture. The suture is cut short leaving only a centimetre of silk attached. The short strand of silk only is then dipped in gentian violet stain. The needle is then passed through the pinna at the proposed points as usual, but then pulled all the way through allowing the silk to tattoo the cartilage in a controlled manner leaving a discrete skin mark.

We have found this method can be performed single-handed. It produces clean and accurate tattoo marks.

Yours faithfully,

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## External wire frame fixation of eyelid graft

Sir,

Since 1986, we have used external wire frame fixation of eyelid skin graft in 24 cases. In 1991, we reported this method and described two of its advantages.<sup>1</sup> Since publication of the paper, we have found another advantage in the case of eyelid graft, especially for the lower eyelid.

The wire frame fixation technique is explained as follows (Fig. 1). The skin graft is fixed with sutures in the usual way (A). Then, a wire frame with the outline of the graft is made of 1 mm diameter Kirschner wire (B). Next, the wire frame is attached with sutures used for stitching the graft (C). Finally, tie-over fixation is performed in the usual way (D).

A 27-year-old female suffered from an extensive frame burn. After emergency skin grafting, severe contractures occurred in the bilateral lower eyelids. Therefore, full-thickness skin grafts with external wire frame fixations were performed for the lower eyelids after releasing the scar contractures. After removing the tie-over, the skin grafts were taken completely. Furthermore, her eyes opened partially because tarsorrhaphies were not necessary (Fig. 2).

In the case of skin grafting on the eyelid, a temporary tarsorrhaphy must be used for the appropriate tension of a recipient bed and proper contact between a skin graft and its recipient bed. However, the patient is inconvenienced, because it is impossible to open the eye due to the tarsorrhaphy, especially in the case of bilateral tarsorrhaphies. External wire frame fixation of eyelid graft overcomes this disadvantage of tarsorrhaphy.

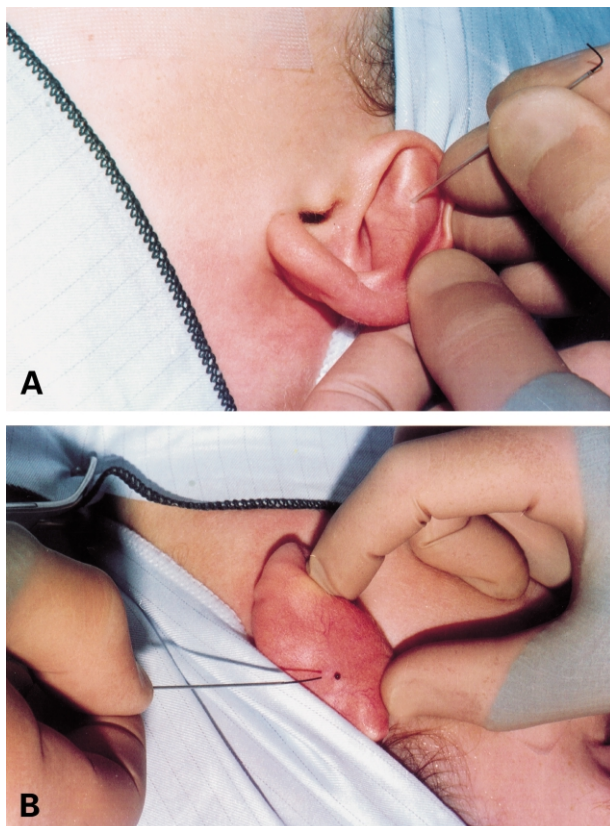
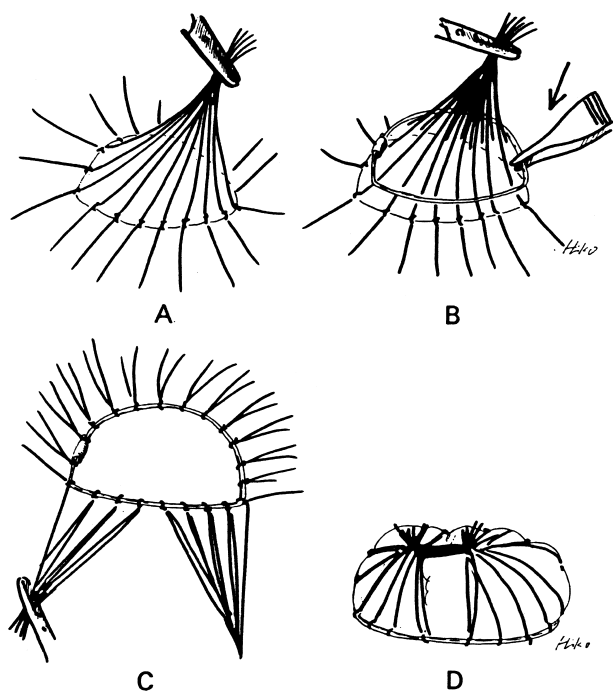


Figure 1



**Figure 1**—Method of tie-over fixation with an external wire frame (Br J Plast Surg 1991; 44: 69).



**Figure 2**—External wire frame fixation of eyelid graft.

Yours faithfully,

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#### References

1. Hirai H, Hyakusoku H, Fumiiri M. The use of a wire frame to fix grafts externally. Br J Plast Surg 1991;44:69–70.

doi:10.1016/S0007-1226(03)00082-1

## Syringe suction drain—II

Sir,

Haematoma formation can be prevented by effective suction drainage using commercially available or improvised vacuum suction drains.<sup>1,2</sup> We have devised a new technique of effective vacuum suction drainage for small operated areas. A 20 ml disposable syringe is attached to the outer end of a scalp-vein cannula or tubing (with multiple holes cut at one end) in the operated area. Vacuum is created in the syringe by pulling the piston out and keeping it in a drawn-out position by putting a K-wire through it transversely just outside the barrel (Fig. 1).



**Figure 1**—The cannula put into the operative field, and the syringe attached at its outer end. The piston is drawn out (thus creating a vacuum) and kept in its drawn-out position by passing a K-wire transversely through it.

The syringe is strapped to the dressing for the convenience of the patient. This has been found to be a very simple, effective and inexpensive method of vacuum suction drainage in emergencies where adequate alternatives are not available.

Yours faithfully,

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#### References

1. Moss ALH. The DIY mini suction drain. Br J Plast Surg 1987;40: 542–3.
2. Singh A, Thind MS, Mander KS, Singh GP. Br J Plast Surg 1992;45: 484–5.