We report a simple method of splinting the interphalangeal joints that we have employed as our standard technique without complication.

Journal of Hand Surgery (British and European Volume, 1999) 24B: 5: 610–611

There are many occasions in hand surgery when a lightweight or temporary splint is required for immobilization of an interphalangeal joint. We describe a cheap, low profile, light weight method of splintage using the Adaptic dressing (Johnson and Johnson Medical Ltd, Gargrave, Skipton, UK) and plaster of Paris or fibre-glass splinting material.

**TECHNIQUE (FIG 1)**

At the end of the procedure the wound is closed and the first non-adherent layer of the Adaptic dressing is turned down. The second layer of the Adaptic dressing is then rolled down over the finger. A suitable length of plaster of Paris or fibre-glass splint is then cut, depending upon...
the site of splintage. We have found that five layers of plaster or three layers of fibre-glass are adequate in most patients. The splint is then moistened and applied so that it forms a U-shaped gutter around not more than two-thirds of the finger circumference to allow for swelling. The third layer of the Adaptic dressing is then rolled down to form a “sandwich” of dressing and splint. This is then held in position until the splint material has set and the proximal end of the dressing taped in the usual way. The whole “sandwich” becomes a single unit as the plaster or resin bonds with the cotton dressing. Splints can be applied on the dorsal, palmar or lateral aspects of the finger with equal ease, and the length can be altered to include one, or both, of the interphalangeal joints. Clinical experience has shown that the splints are comfortable, stable and durable, and because of the design, exercising the non-splinted joints is easy. The exothermic reaction during hardening of the splint material is not sufficient to cause pain or tissue damage and the dressing does not adhere to the underlying finger. Removal is simple: the non-splinted portion of the dressing is simply cut longitudinally and the dressing and splint come away from the finger.

Received: 3 February 1999
Accepted after revision: 5 May 1999
Mr J. A. Pereira, Queen Victoria Hospital, Holtye Road, East Grinstead, West Sussex RH19 3DZ, UK.
E-mail: johnpereira@compuserve.com
© 1999 The British Society for Surgery of the Hand
Article no. jhs.1999.0244

Fig 1 (e) The completed dressing is taped in place at the base. (f) Because of the light weight low profile design, finger exercises are easily done.