bringing together different experiences and methods, complete with success rates and complications, will improve practice and training for the future.

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Splinting/stabilising technique for implant removal

Reading the letters from Drs Shefras[1] and Menon[2] in recent issues of this Journal has prompted me to write further about the technique I use for implant removal.

My splinting/stabilising technique has been developed after many years of experience. Using a 25G blue needle to splint the implant hardly injures any deeper tissues or structures in the arm, whether the arm in question is thin or large. The method is hardly different from introducing a needle for venesection. Blind introduction is a common practice in surgical techniques such as epidural, spinal, and so on, and the needles are much larger than what I used.

If not stabilised even the superficial implant has a tendency to slip sideways or deeper. Superficial implants can be stabilised after local anaesthesia if required. The longer needles such as amniocentesis/spinal needles tried by Dr Shefras are not easy to hold and splint the implant. I have not seen the Steritex® V-Air vent needle and so I am unable to comment on that particular needle.

If one is looking for an inexpensive and easy method then this is one to practise. I agree with Dr Shefras' suggestion that