KNEE LIGAMENT INJURIES

To the Editor: I read the article[1] on knee ligament injuries with great interest, and the author is to be congratulated on his lucid exposition.

I have been astonished at the high incidence of anterior cruciate ligament tears, often only diagnosed at operation indicated for meniscal symptoms. In these circumstances, where there is positive anterior draw-test instability, I now carry out the so-called Heidelberg operation which I believe has become quite popular. In this operation, the semitendinosus is detached at its insertion, rerouted through the posteromedial capsule and brought back through a tibial drill hole, entering the bone at the normal anterior cruciate position.

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THE 'METLIFE MEDICAL TEN'

To the Editor: May I again make use of your columns to draw attention to the second 'Metlife Medical Ten', the 10-km run, for medical men and women, that is scheduled for Saturday 8 December 1979. As before, the run will take place on the main campus of the University of Cape Town at 07h00. This year it will take place on the final day of the University of Cape Town's 150th anniversary celebration as part of that event. Last year there were 80 participants, and it is hoped that there will be at least 100 runners this year.

The event is for doctors only and the object is for men to run 10 km and the ladies 5 km.

For those who wish to have a target, there is also the time trial in which the doctor attempts to run the 10 km in a time equivalent to 1 minute per year of age, starting at 40 minutes for those aged 40 years and less.

Will those who are interested please contact me at the below address stating their age on 4 December 1979.

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RESTRAINT OF CHILDREN FOR INTRAVENOUS INFUSIONS

To the Editor: In order to keep an intravenous infusion running in a child, it is usually necessary to apply some form of restraint to prevent him dislodging the 'drip'. We have all developed our own methods of applying such restraint, usually learnt in our student days, but few people appear to have really given much thought to the techniques of restraint, and to their advantages and disadvantages. Those concerned with the problem on a daily basis, however, will know only too well the frustration of spending valuable time on a child's drip, only to see it soon dislodged due to lack of a suitable restraint. Many of the standard textbooks[1-3] make no reference at all to the technique, while others[4,5] give only a single line in the text, advising one to 'tape the limb to a splint'. Perhaps the best description was given by Hughes[6] who gives six pages of text and diagrams, involving the use of padded boards to immobilize the extremity. In practice, however, there is often no padded board available, or the sizes available are totally unsuited to the particular child, and such time-honoured expedients as using wooden spatulas, or the cardboard box of the drip-set, often prove to be inadequate.

In recent months we have found a method which is easy to use, is readily available in every ward, which works well for children of all sizes right down to the smallest premature baby, and which is very comfortable for the child, thus reducing his own attempts to wriggle out of the restraint. This consists of using a flexible pack of any intravenous solution as the splint itself (Fig. 1), simply taping the arm, hand or foot directly onto the pack, which then moulds itself to the contours of the limb, but provides adequate splinting. A pack of 1 litre in size is used for bigger children, and one of 200 ml for neonates. The weight of the pack itself holds the limb down, but if necessary it can itself be fixed to the bed for additional restraint with comfort. In this way we have kept intravenous infusions going for periods of 3 weeks and more, using different veins on the extremities. The method is readily acceptable to both staff and students, and this letter serves to pass on this 'tip' to a wider audience, who may care to try it for themselves.

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4. Barnett, H. C. (1972): *Pediatrics*, p. 1909. New York: Meredith Corporation.
5. Hill, F. S. (1955): *Practical Fluid Therapy in Pediatrics*, p. 257. Philadelphia: W. B. Saunders.
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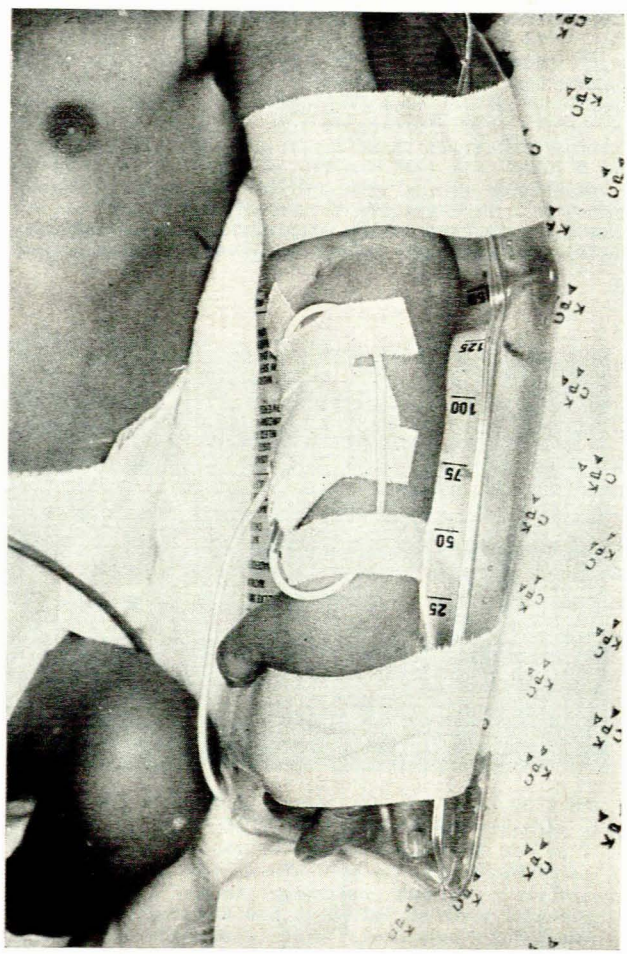

Fig. 1. The arm taped directly onto the pack.