cases the surgeon should have the wisdom not to attempt the impossible. The characteristics of the Herbert bone screw make it an attractive alternative to Kirschner wires, Smillie pins or small conventional screws for the fixation of osteochondral fractures.

We would like to thank the orthopaedic surgeons of Bristol, Exeter, Barnstaple, Torbay and Truro for permission to report on cases under their care.

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SUTURING ARTHROSCOPY WOUNDS: BRIEF REPORT

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The number of arthroscopic procedures has increased dramatically during recent years. One of their advantages is that complications are rare; those that do occur (a stitch abscess or a haematoma) are usually related to the small puncture wounds. Since a 5 mm wound of the knee presenting as an injury would not be sutured, it was felt to be illogical to suture an arthroscopy incision; a sutureless technique was therefore tested.

Method and results. Over a one-year period, a sutureless technique was used in all 140 patients undergoing arthroscopic procedures of the knee under the care of one surgeon (SC). The vast majority were done through standard anteromedial and anterolateral portals, although occasionally a third (posteromedial or transpatellar ligament) was used. Gravity-feed irrigation only was employed. At the end of the arthroscopic procedure but before removing the tourniquet, a gauze dressing and wool-and-crepe pressure bandage were applied. Post-operatively the patients were taught exercises and were mobilised the same day. They were not given anti-inflammatory drugs and were subsequently reviewed at two weeks and at two months.

There were no complications related to the wounds and, in particular, no haematomas or infection. In a number of cases inspection of the gauze dressing at two weeks revealed a significant blood seepage which could well have resulted in the formation of a haematoma

predisposing to subsequent wound infection had the wound been sutured. The cosmetic results were excellent; in a few patients one puncture wound was sutured and the other left open; the unsutured wound was definitely neater.

Discussion. Standard orthopaedic texts advocate the use of a single stitch to close an arthroscopy wound (Edmonson and Crenshaw 1980; Dandy 1981; Apley and Solomon 1982). Dandy (1981) states that "a stitch will close the deeper layers of the wound more effectively and reduce the risk of a haematoma developing". It is our view that a large and deep stitch would be necessary to achieve this objective. Leaving the wound open allows any potential haematoma to evacuate into the dressings so that blood cannot accumulate and cannot be the potential site of infection. This is borne out by the results of our series. The possibility of stitch-abscess formation is also obviously averted if no stitch is used.

Arthroscopy wounds rarely cause a cosmetic problem, but they can be significant in an adolescent girl's knee or in those prone to keloid formation. Often the ugliest part of the scar is the cross-hatching from the suture. With the sutureless technique the cosmetic appearance of the wounds was excellent; they closed in a linear fashion and were unobtrusive. Savings in the cost of suture materials are a bonus. Leaving arthroscopy wounds open is safe, cosmetic, effective and economical.

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COMPARTMENT SYNDROME COMPLICATING ARTHROSCOPIC SURGERY: BRIEF REPORT

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Compartment syndrome in the leg after arthroscopic surgery is rare, but has serious consequences if it is not recognised (Mattsen, Winquist and Krugmire 1980).

Case report. A 43-year-old man with a six-month history suggestive of a lesion of the medial meniscus had an arthroscopy. The arthroscope was introduced