at passive movement increases the weeping. A confrontational situation is developing. Further X-rays are again normal (although there may be minimal osteoporosis of disuse).

A plaster reinforces the child's conviction that there is an organic explanation, as does aggressive physiotherapy. Steroid injection is irrational. I suggest to the child that there is no serious organic problem, and to use the limb normally, and do not advise any sort of bandaging. I do not arrange to see her again. To the best of my knowledge the symptoms disappear in a few weeks but some girls are certainly referred elsewhere.

For weeks the lives of the child and family revolve around the wrist. Yet the mother usually recognizes the illogicality of the situation. Despite some resemblance to Sudeck's atrophy, this syndrome is an entity in its own right. It is unrelated to attempted litigation.

Chalmers (1974) described a similar condition, noting the discrepancy between the initial trauma and subsequent disability. However his patients were usually teenage girls or young adult women, an older age group than my own. Leaman (1986) noted that girls in early adolescence often complain of more discomfort than their injuries would suggest.

This syndrome represents a definite entity, and treatment can cause significant problems.

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Cyanoacrylate tissue adhesive

Sir,
I would like to report a new application for the tissue adhesive cyanoacrylate, which has already been used successfully in the closure of simple lacerations, particularly in children (Watson, 1989), and to fix full thickness grafts (Bromley *et al.*, 1964). I have now used it for the fixation of pre-tibial flap lacerations as an alternative to Steristrips in 3 cases, all of whom have had excellent results.

CASE 1

Female, aged 83 years. Relevant medical condition: Pernicious anaemia. Medication:

Prednisolone 5 mg daily. Injury: 11 cm curvilinear pre-tibial flap, full thickness at base; very thin at edge.

CASE 2

Male, aged 69 years. Relevant medical condition: Asthma. Medication: Triamcinolone acetonide 40 mg daily. Injury: 7.5 cm inverted J pre-tibial flap, thin throughout with no fat.

CASE 3

Female, aged 85 years. Relevant medical condition: Chronic diarrhoea. Medication: Questran A 12 gms daily. Injury: 17 cm C-shaped pre-tibial flap, thin throughout with no fat.

After thorough cleansing with saline, the wound was patted dry. The edges were accurately apposed and the cyanoacrylate applied in a thin line over the skin edges, taking care not to allow any to get into the wound. Within 15 s the glue dried and held the edges together. The area was then covered with Jelonet and gauze, and a toe to knee crepe bandage applied. The patients were advised to elevate the limb, and rest. They were reviewed after 5 days, and again at 2 and 4 weeks. All had early and good healing, and there were no problems with fluid collections under the flaps.

Healing in pre-tibial lacerations is often poor and delayed because of the decreased vascularity of the skin, its papery thinness and the poor general health of the patient. Our practice in this department has been to apply Steristrips to these flaps; however, accurate apposition of the edges is extremely difficult as the thin bevelled edge of the flap tends to curl under. This is overcome by the use of cyanoacrylate, and I recommend this simple solution to a difficult problem.

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