



CODEN [USA]: IAJ PBB

ISSN: 2349-7750

**INDO AMERICAN JOURNAL OF  
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.1246931>Available online at: <http://www.iajps.com>

Research Article

**TO DETERMINE DRY OR WET CRAPE BANDAGES  
ADVANTAGES IN ORTHOPEDIC WARD FOR APPLYING  
BACKSLABS**<sup>1</sup>Dr. Iqra Akhter, <sup>2</sup>Dr. Naeem Iqbal, <sup>3</sup>Dr. Hafiz Muhammad Hanzlah Shahid<sup>1</sup>WMO Anaesthesia Dept, Govt General Hospital Ghulam Muhammad Abad Faisalabad<sup>2</sup>Basic Health Unit, Chuchak, Pindi Bhattian, Hafizabad<sup>3</sup>Sheikh Zayed Hospital Rahim Yar Khan**Abstract:**

**Purpose:** To determine if there is any change in the length of the crepe bandage and when the wet cotton bandage is wet and left to dry again. This will simulate the application of a wet bandage to the Paris plasterboard (POP) and then to the crockery.

**Place of Work:** Orthopedic Surgery Unit I Sheikh Zayed Hospital Rahim Yar Khan.

**Study plan:** Experimental study

**Materials and methods:** 50 cm crepe strips and simple cotton bandages were taken. We made them moist and we measured them, then dried them up and measured them again.

**Findings:** Both the bandage and the simple cotton bandage were wetted and then dried at a total of about 6%. For this reason, this phenomenon has the potential to cause compression effects on the limbs and to raise the intra-compartmental pressure in the case of POP plaque application.

**Conclusion:** As a result of the need to apply POP support plates to bandages such as crepe or cotton in dry back.

**Key words:** Crepe bandage, POP back plate, simple cotton bandage.

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Please cite this article in press Iqra Akhter et al., *To Determine Dry or Wet Crape Bandages Advantages in Orthopedic Ward for Applying Backslabs*, Indo Am. J. P. Sci, 2018; 05(05).

**INTRODUCTION:**

Crape bandages and simple cotton bandages are routinely used in the practice of plasters in the orthopedic practice of Paris (POP) supplements. It is believed that the fractures are undergoing extensions without causing compression effects on the limb structures, which they allow for swelling after an injury. In addition, back slabs are used on the supine and soft tissues after surgical treatment of upper and lower extremity injuries. Applying a wet bandage prevents the POP from adjusting too quickly and allows time to reach the position and shape of the limb. This technique is taught in many orthopedic textbooks. However, we assume that you think that a wet bandage is dry and may cause a constriction. This can lead to higher pressures in the splint and can lead to compartment syndrome.

**MATERIALS AND METHODS:**

In this study, two types of bandages were used: a 6-inch-wide crepe bandage and a 6-inch-wide bandage.

Each bandage was cut into strips of 50 cm and marked with a permanent marker. The bandage strips were immersed in a container filled with tap water. They were slowly bored and lying on a bench. Bandages are measured in length. The strips were left to dry. After drying, the length was measured again.

**RESULTS:**

Both crepe and cotton bandages were shrunk in wet condition, according to the original dry condition. The crepe bandage stretched 48 cm from the original length of 50 cm. This contraction was 4% of the original length. The cotton bandage stretched from 50 cm to 47.5 cm in original length, and the contraction constituted 5% of the original length. Both bandages shrank after drying. Bandage bandage was 48 cm to 47 cm (2.08% additional contraction) and cotton bandage was 47.5 cm to 47 cm (1.05% additional contraction). The results of the individual strips are described in Table 1.

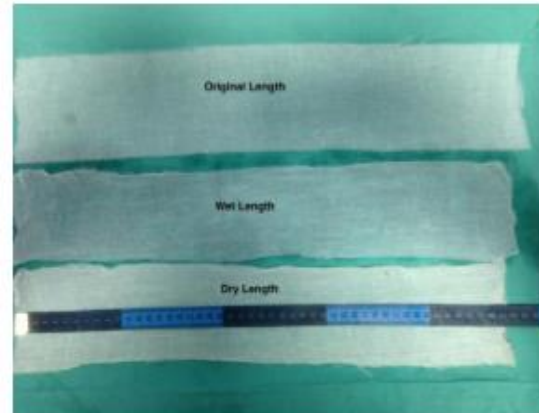
**Table 1:** Changes in length of crepe and cotton bandages when wet and re-dried.

	Dry length (cm)	Wet length (cm)	Percentage change from original in wet state	Re-dry length (cm)	Percentage change from wet
Crepe	50	48	4%	47	2.08%
Cotton	50	47.5	5%	47	1.05%

The change in the length of the cotton and crepe dressings can easily be seen in Figures 1 and 2.



**Figure 1:** Change of length in crepe bandage



**Figure 2:** Change of length in cotton bandage

A shrink is caused by packaging a reduction of around 4%. the volume can be reduced by 28%. The reason for this is that the volume of a cylinder or a point is proportional to the radius of the circle. Previous studies have shown that the volume of an extremity is linear with a pressure of up to about 40 mm Hg. for this reason, a 28% reduction in volume can translate into a proportional increase in pressure. In a similar study by Santosh Baliga, wet and sticky bandages shrunk in wet state (16% of the original size is median). Both bandages shrugged off to a median of 7% of the original size. For this reason, it can be said that for any bandage, it is more likely to cause the problem of shrinkage of the wet and dry wet floor. Those who think that the wet bandage increases the strength when applying a wet bandage should keep this in mind. The limit of this study is the direct measurement of the pressure under the posterior slab and the compressed air pressure.

### CONCLUSION:

This experimental study shows that cotton and crepe bandages will shrink when wet. They are even smaller when allowed to dry. This phenomenon has a potentially significant increase in potency applied to the limb with a posterior slab population applied with wet bandages. We believe that the application of wet bandages may be one of the reasons why some slabs may need to be released. For this reason, it is advisable to apply bandages only in dry state. Despite partial wetting due to the wet POP plate, it will still be a better option than completely wet bandages.

### REFERENCES:

1. ANWAR, LT COL SYED FARAZ, COL M. SUHAIL AMIN, and MAJ AISHA AKHTAR. "Use of Wet or Dry Bandages for Plaster Back-Slabs." *Journal of Pakistan Orthopaedic Association* 25, no. 1 (2018): 7-7.
2. Silva M, Sadlik G, Avoian T, Ebramzadeh E. A Removable Long-arm Soft Cast to Treat Nondisplaced Pediatric Elbow Fractures: A Randomized, Controlled Trial. *Journal of Pediatric Orthopaedics*. 2018 Apr 1;38(4):223-9.
3. Ballal MS, Garg NK, Bass A, Bruce CE. Comparison between collar and cuffs and above elbow back slabs in the initial treatment of Gartland type I supracondylar humerus fractures. *Journal of Pediatric Orthopaedics B*. 2008 Mar 1;17(2):57-60.
4. Hollingsworth, R. and Morris, J., 1975. The importance of the ulnar side of the wrist in fractures of the distal end of the radius. *Injury*, 7(4), pp.263-266.
5. Kay L, Stainsby D, Buzzard B, Fearn M, Hamilton PJ, Owen P, Jones P. The role of synovectomy in the management of recurrent haemarthroses in haemophilia. *British journal of haematology*. 1981 Sep 1;49(1):53-60.
6. O'Driscoll SW. Regarding "diagnostic accuracy of five orthopedic clinical tests for diagnosis of superior labrum anterior posterior (SLAP) lesions". *Journal of shoulder and elbow surgery*. 2012 Dec 1;21(12):e23-4.
7. Snyder, S.J., Karzel, R.P., Del Pizzo, W., Ferkel, R.D. and Friedman, M.J., 1990. SLAP lesions of the shoulder. *Arthroscopy: the journal of arthroscopic & related surgery*, 6(4), pp.274-279.
8. Giugale JM, Jones-Quaidoo SM, Diduch DR, Carson EW. Glenohumeral Internal Rotation Deficit in Overhead Athletes Part 1: The Peel-Back Mechanism. *Athletic Training and Sports Health Care*. 2009 Nov 1;1(6):249-50.
9. Keener JD, Brophy RH. Superior labral tears of the shoulder: pathogenesis, evaluation, and treatment. *JAAOS-Journal of the American Academy of Orthopaedic Surgeons*. 2009 Oct 1;17(10):627-37.
10. Burkhart SS, Morgan CD. The peel-back mechanism: its role in producing and extending posterior type II SLAP lesions and its effect on SLAP repair rehabilitation. *Arthroscopy: the journal of arthroscopic & related surgery*. 1998 Sep 1;14(6):637-40.
11. Morgan, C.D., Burkhart, S.S., Palmeri, M. and Gillespie, M., 1998. Type II SLAP lesions: three subtypes and their relationships to superior instability and rotator cuff tears. *Arthroscopy*, 14(6), pp.553-565. Morgan RJ, Kuremsky MA, Peindl RD, Fleischli JE. A biomechanical comparison of two suture anchor configurations for the repair of type II SLAP lesions subjected to a peel-back mechanism of failure. *Arthroscopy*. 2008 Apr 1;24(4):383-8.
12. Kim, S.H., Ha, K.I., Ahn, J.H., Kim, S.H. and Choi, H.J., 2001. Biceps load test II: a clinical test for SLAP lesions of the shoulder. *Arthroscopy*, 17(2), pp.160-164. Wilk, K.E., Reinold, M.M., Dugas, J.R., Arrigo, C.A., Moser, M.W. and Andrews, J.R., 2005. Current concepts in the recognition and treatment of superior labral (SLAP) lesions. *Journal of Orthopaedic & Sports Physical Therapy*, 35(5), pp.273-291. Nam, E.K. and Snyder, S.J., 2003. The diagnosis and treatment of superior labrum, anterior and posterior (SLAP) lesions. *The American journal of sports medicine*, 31(5), pp.798-810.
13. Wu, J., Perron, A.D., Miller, M.D., Powell, S.M. and Brady, W.J., 2002. Orthopedic pitfalls in the ED: pediatric supracondylar humerus

- fractures. *The American journal of emergency medicine*, 20(6), pp.544-550.
14. White L, Mehlman CT, Crawford AH. Perfused, pulseless, and puzzling: a systematic review of vascular injuries in pediatric supracondylar humerus fractures and results of a POSNA questionnaire. *Journal of Pediatric Orthopaedics*. 2010 Jun 1;30(4):328-35.
  15. Carter, S.J., Germann, C.A., Dacus, A.A., Sweeney, T.W. and Perron, A.D., 2010. Orthopedic pitfalls in the ED: neurovascular injury associated with posterior elbow dislocations. *The American journal of emergency medicine*, 28(8), pp.960-965.
  16. Carter, S.J., Germann, C.A., Dacus, A.A., Sweeney, T.W. and Perron, A.D., 2010. Orthopedic pitfalls in the ED: neurovascular injury associated with posterior elbow dislocations. *The American journal of emergency medicine*, 28(8), pp.960-965.
  17. Perron, A.D., Hersh, R.E., Brady, W.J. and Keats, T.E., 2001. Orthopedic pitfalls in the ED: Galeazzi and Monteggia fracture-dislocation. *The American journal of emergency medicine*, 19(3), pp.225-228.
  18. Davis, R.T., Gorczyca, J.T. and Pugh, K., 2000. Supracondylar humerus fractures in children: comparison of operative treatment methods. *Clinical Orthopaedics and Related Research*, 376, pp.49-55.
  19. Skaggs, D.L., Hale, J.M., Bassett, J., Kaminsky, C., Kay, R.M. and Tolo, V.T., 2001. Operative treatment of supracondylar fractures of the humerus in children: the consequences of pin placement. *JBJS*, 83(5), pp.735-740.
  20. Leitch, K.K., Kay, R.M., Femino, J.D., Tolo, V.T., Storer, S.K. and Skaggs, D.L., 2006. Treatment of multidirectionally unstable supracondylar humeral fractures in children: a modified Gartland type-IV fracture. *JBJS*, 88(5), pp.980-985.