Technical Tips

Vascular clamping of calcified vessels: the peanut technique

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We have used this technique to deal with calcified vessels to achieve a secure clamp thus making vascular anastomosis relatively easy in a bloodless field and causing minimum damage to the clamped vessel. The peanut swab is placed into the minimally calcified segment and a vascular clamp is softly applied over it (Fig. 1). This technique is useful in dealing with vessels which are calcified up to two-thirds in circumference for renal transplant patients.

Figure 1 Placement of swab

Percutaneous tibial plate removal

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Percutaneous plate fixation for peri-articular distal tibial fractures reduces the risk of complications such as non-union and infection when compared to traditional open fixation. To remove

such plates whilst minimising soft tissue disruption, carefully open the old incisional scars, locate the plate and remove the screws. Using a simple punch, sequentially tap the plate from either side so as to free it from any bony adhesions. Remove the plate through a subcutaneous tunnel recreated with minimal soft tissue dissection and close all the wounds with nylon sutures. We have experienced no complications with this procedure but would recommend a pre-operative X-ray to confirm that the fracture has healed (Fig. 1).

Figure 1 Pre-operative X-ray

Easy placement of transanastomotic nasojejunal triple lumen feeding tube during gastrectomy

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Difficulties passing nasojejunal tubes occur under drapes with patients in awkward positions. To avoid this, pass Ryle's tube into the oesophagus pre-operatively. Post-resection, pass long forceps from Roux loop enterotomy to half-closed anastomosis with the

tip of a vicryl reel held in the jaws. Advance Ryle's tube through open part of anastomosis. Tie vicryl to the tube orifices. Withdraw tube and deliver vicryl per nostril. Tie thread to tip of a nasojejun tube. Extract tube at the Roux loop enterotomy and pass tip distally. Remove guide wire and secure tube by suturing to nose. Close both anastomoses in normal way.

Optimum incision length for port insertion in laparoscopic surgery

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Surgeons estimate the length of incision required for port insertion. The incision is often too long causing a greater cosmetic blemish and possible loss of pneumoperitoneum. A small incision risks tissue necrosis and infection due to pressure effects on the tissues. Using the equation for the circumference of a circle, the correct incision size is $\pi d/2$ where d is the approximate external diameter of the port in millimetres. Each side of the wound is equivalent to half the circumference of the port. For a 10-mm port:

$$\frac{3.142 \times 10 \text{ mm}}{2} = 15.7 \text{ mm} \\ (\text{Approx. } 16 \text{ mm})$$

Table 1 Common port sizes and appropriate skin incisions

Port size (mm)	Approximate skin incision (mm)
5	8
10	16
12	19

Use of this guide should minimise patient scarring, air leak, and tissue damage.

Arthroscopically-assisted percutaneous fixation of a posterior fracture dislocation of the proximal humerus

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Posterior fracture dislocation of the proximal humerus is a rare and potentially complicated injury. Several authors have advocated treatment with open reduction and rigid internal fixation through various approaches. However, open reduction increases the risk of damaging the already tenuous blood supply to the head fragment, leading to osteonecrosis. Consequently, others have advocated a trial of closed manipulation. Unfortunately, this makes it more difficult to achieve and maintain an accurate reduction. I would advocate the use of arthroscopy during manipulation. A standard posterior portal provides easy visualisation to guide both the reduction of the fracture and the placement of percutaneous fixation with threaded wires.

Cementing technique made easy

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Third generation cementing techniques are aimed towards proper vacuum mixing of the polymer and monomer using a bowl to ensure air-bubble-free mix followed by pressurisation with a cement gun. I follow a simple technique for transferring the cement from the bowl to the gun. The suction tube used for sucking the blood is disconnected from its plastic attachment. The suction tube is connected to the tip of the plastic barrel of the cement gun. The tip of the suction tube may also be widened to accommodate the barrel. Once the cement is ready in the liquid state, the broader end of the barrel is sunk into the bowl with the suction on. This ensures a smooth suction of cement into the barrel. The suction tube is disconnected as the cement level reaches the meeting point of the tube and the barrel. This technique, which is simple and practical, ensures smooth, quick and complete collection of cement into the barrel for pressurisation.