Reduction *en masse* may occur in the initial stages of the operation and visualisation of the viability of the bowel is essential before the hernia repair. This usually involves an extension of the original incision and/or a laparotomy resulting in a longer hospital stay, morbidity, mortality² and, in a significant number of cases, bowel resection is not required. We, therefore, describe a laparoscopic technique that allows an adequate assessment of bowel viability without increasing the size or nature of the initial incision.

TECHNIQUE

Should a reduction *en masse* occur in the early stages of the operation, a 10-mm laparoscopic port is inserted through the hernia sac into the peritoneal cavity. A purse string is then secured around the port, a pneumoperitoneum is established and a 30° laparoscope is passed to assess the intraperitoneal cavity. A further 5-mm port is inserted superiorly, allowing insertion of a non-traumatic instrument. This will allow an adequate assessment of bowel viability, thereby allowing the surgeon to decide whether a bowel resection is required.

DISCUSSION

This unique application of laparoscopy allows the surgeon to assess bowel viability after reduction *en masse* during the early stages of strangulated hernia repair and, in some cases, will prevent a larger abdominal incision. We have only recently started using this technique; of the three cases managed in this way, one had ischaemic-looking bowel which, after laparoscopic assessment over 20 min, was deemed viable. In the other two cases, there was no evidence of bowel ischaemia. All three patients had uneventful recoveries. A possible false negative rate is a concern and larger study to assess this is warranted.

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Reduction of abdominal pressure for prophylaxis of the mesenteric artery syndrome (cast syndrome) in a hip spica – a simple technique

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BACKGROUND

The application of hip spica cast is a routine procedure in paediatric patients, used mainly for the treatment of femoral fractures and developmental hip dysplasia.¹ However, attention to detail is important to

reduce the risk of complications such as mesenteric artery syndrome (cast syndrome) due to increased abdominal pressure.² We present a simple technique that facilitates the creation of an abdominal space, thereby avoiding increased abdominal pressure, in either a synthetic or plaster of Paris hip spica cast.

TECHNIQUE

A single, hemispherical spacer made of rubber, which is manufactured in-house is used. The spacer which is 2.5 inches in height and available in two different diameters (3 and 5 inches), is first positioned over the abdomen, then padding is rolled from the nipple line down to the ankles. Next, 4-inch or 6-inch plaster is wrapped around the padding, starting at the proximal end of the padding. At the end of the cast application and after the cast hardens, the spacer is removed.

DISCUSSION

Using this method, we have been able to create a well-contoured hip spica cast easily. A folded towel is commonly used as a spacer.³ However, the height of a folded towel is variable and has the potential to deform under the load of the plaster. Spacers made of rubber, on the other hand, are unlikely to deform. We have not observed any complications related to the cast or instability of the construct in the last 12 months that this technique has been used.

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Obtaining an optimal bone–cement interface in total knee arthroplasty

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BACKGROUND

Survival of a total knee arthroplasty is dependent on numerous factors including soft tissue balancing, limb alignment, implant choice, insertion technique and patient activity levels. Poor cementing technique results in reduced shear strengths¹ and early failure. Thorough lavage, complete coverage with cement,