event of pain or for revisions can be technically quite challenging since various screw manufacturers use different types of screw-drivers and the screw heads can be of varying sizes.

TECHNIQUE

We have devised a simple technique for removing such screws using Steinman pin and bone cement. The senior author (NA) has used this successfully in three cases. The cross-section of the proximal (blunt) end of the Steinman pin is quadrangular or triangular. The blunt end of a pin is inserted into the screw socket to check for a reasonably snug fit and the pin is bent into an 'L'-shape to aid gripping. A small quantity of bone cement is then pressed into the screw socket, the end of the pin is tapped in, and the cement is left to set. An essential component of the technique is to allow time for the cement to set. Once the cement is set, the screw can be removed without much effort by turning on the bent end of the pin.

DISCUSSION

Cannulated screws often need to be removed if they are causing symptoms or in patients subsequently requiring hip replacement or a revision of their ACL reconstruction. This is an essential part of surgical process, which can be quite challenging and often frustrating. A set of sterile Allen keys of different diameters and lengths would be a possible solution but these are rarely available in most operating theatres. There are different techniques described in the literature for removal;¹⁻⁴ however, one often attempts to use the pliers. Removing such screws by gripping their ends with pliers is not only difficult and time-consuming, but also often necessitates a considerable amount of bone around the screw to be chiselled or nibbled out specially in the case of headless cannulated screws commonly used in ACL reconstruction.

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Technical Tips

Knee arthroscopy: 1-ml syringe as an out-flow cannula

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A 'soft' quill can be used to drain 'arthroscopy debris'. A 1-ml syringe with the nozzle cut off at an angle of 45° is a better alternative – being stiff, it is easier to manoeuvre in the joint. To direct the entry of the syringe during insertion, slide it over the arthroscopic trochar, positioning the trochar point where the syringe will end at insertion into the joint. This 'Seldinger technique' also eases its passage through the soft tissues.

The fibre-glass spica bar

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Hip spicas control hip position and are used in the management of a number of conditions, e.g. developmental dysplasia of the hip (DDH). The wooden bar between the thighs markedly

Figure 1 A fibre-glass spica bar.

improves the strength and durability of the cast, but trimming the bar results in wood-shaving contamination in theatre. Instead of this, use a roll of fibreglass casting tape (e.g. Scotchcast™ Casting Tape, 3M, St Paul, MN, USA). The tape is rolled forward and back on itself to the desired length then folded longitudinally in half repeatedly. By continuing to roll more tape around this bar the construct is strengthened and it can be applied to the spica.

Preventing mal-reduction in antegrade femoral nailing

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Subtrochanteric femoral fractures require great attention to correct reduction in order to minimise the chances of serious complications like malunion, non-union and coxa vara. Due to altered hip biomechanics, the proximal fragment often gets pulled into abduction and flexion. A unicortical Shanz pin mounted on a T-handle is inserted percutaneously into the anterolateral cortex of the proximal fragment just above the fracture site (Fig. 1). By pushing this fragment medially and posteriorly, both the deformities are corrected. As the assistant holds the T-handle, the surgeon proceeds with entering the canal using standard technique.

Figure 1 Use of unicortical pin to aid reduction in subtrochanteric fractures.

Technique for anastomosis to a short attenuated aortic neck

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An attenuated short neck of infra-renal aneurysms is a common cause of technical difficulty. The neck length is limited, tissues are friable and hold stitches poorly, and a wide neck folds into 'hills and valleys' immediately below the clamp. The problems can be minimised by passing the looped end of a doubled nylon tape (5 mm) around the neck, snugging it down to control neck diameter to about 25–30 mm and tying the free ends to the apex of the loop. The tape narrows the aneurysm neck, elevates the valleys, and buttresses the sutures.

Figure 1 Tape placement around the short attenuated aortic neck