COMMENT ON

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B Levy, A Charkin. A revised guide-wire technique for urethral catheter insertion. *Ann R Coll Surg Engl* 2006; **88**: 228–9

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A better way to insert urethral catheter with guide-wireVINCENT CY TANG¹, SIMON RJ BOTT²

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Levy and Charkin described the longitudinal cut at the tip of the catheter to allow the guide-wire to pass through for rail-roading into the bladder. This method maintains the manufactured conical shape of the catheter tip, hence the ease of advancement. However, the longitudinal cut to the tip of the catheter can potentially cause the catheter to bivalve and split, which can lead to urethral trauma.

An alternative technique, using a 14-gauge (Brown) intra-venous cannula needle threads through the side drainage hole of the urethral catheter and then punctures the centre of the tip of the catheter to form a track; the guide-wire is subsequently passed retrograde through the intravenous cannula needle. The needle is removed which allows the guide-wire to pass into the central catheter drainage lumen. After lubricating the guide-wire and the urethral catheter with lignocaine gel, the catheter is passed into the bladder over the guide-wire. From our experience, this method is easy to use, and also maintains the integrity of the shape of the catheter with no risk of the above complication.

AUTHORS' RESPONSE

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We have never experienced the theoretical problem of the

catheter splitting. We believe this is because the slit made in the catheter is small as it only needs to allow a guide-wire to pass through. We do agree though that a long slit could potentially cause the catheter to bivalve and, hence, cause further trauma. Therefore, the slit should be kept as short as possible to allow the guide-wire to pass through.

The technique described involving the guide-wire being passed through the side drainage hole and then through the tip of the catheter using a 14-G intravenous cannula is an alternative technique. The problem we have had with this approach is the difficulty in advancing the catheter over the guide-wire. As the authors state, the guide-wire and catheter must be well lubricated: if not, the catheter catches on the guide-wire due to the oblique angle that it runs through the distal catheter. Advancement is then very difficult and one is uncertain whether the resistance is due to the guide-wire or due to urethral narrowing.

COMMENT ON

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J. Gosling, ES McKain, S Dumont, BM Stephenson. Lost 'swab' at inguinal hernioplasty under local anaesthesia. *Ann R Coll Surg Engl* 2006; **88**: 161–2

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Another advantage of the laparoscopic approach

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Originally, the National Institute for Clinical Excellence (NICE) recommended laparoscopic inguinal hernia repair for bilateral and recurrent hernias. However, on 23 September 2004, the NICE Technology Appraisal Guidance No. 18 stated that the laparoscopic approach was suitable for all inguinal hernias. In 1998, Wellwood *et al.*¹ published a randomised control trial comparing open tension-free mesh hernioplasty under local anaesthetic with transabdominal preperitoneal laparoscopic hernia repair under general anaesthesia. Patients' perception of health one month post-surgery and patient satisfaction were superior in the laparoscopic group and the convalescent period shorter. There will, of course, always be a place for open repair under local anaesthetic in patients who are unfit for general anaesthesia, or indeed patients who request this technique. However, the laparoscopic approach