Figure 2 Photograph illustrating the removal of loose bodies using this new technique.

The commonest direction of flow is in through the scope and out through a drainage cannula. This tends to push away the loose body from the field of vision, sometimes into one of the recesses of the knee. To overcome this problem, we reverse the direction of flow so that irrigation is in through the drainage cannula which is sited using a separate supero-lateral portal, and out through the scope (sited using standard antero-lateral portal) as shown in Figure 1. The effect is to suck the loose body towards the scope. The loose body either stabilises around the tip of the telescope or obscures the view because it is sucked onto the tip of the telescope.

A grabber is then introduced through the antero-medial portal and the loose body removed using one of two methods. First, using a grabber in the normal way under direct vision. Or second, when the loose body is sucked onto the tip of the scope obscuring the view, the jaws of the grabber are placed around the scope which is then gently withdrawn, dragging the loose body into the jaws of the grabber (Fig. 2).

DISCUSSION

Loose bodies within the knee can be difficult to find and remove. They are often slippery, adding difficulty to their removal.¹ This new technique helps in locating the loose bodies and stabilising them for removal with a standard grabbing instrument and standard arthroscopic portals. Common locations of loose bodies include the lateral gutter, the suprapatellar pouch, the intercondylar notch and the medial gutter.² Siting the inflow cannula helps by flushing the loose bodies away from these potential sites to the tip of the telescope.

Use of suction tip for the removal of loose bodies is a well described technique.³ Our technique is superior for three reasons: (i) it allows visualisation of the loose body before removal; (ii) suction may remove irrigant from the knee before the loose

body; and (iii) no additional equipment (i.e. suction) is required. The proposed new technique might be useful when the suction tip technique has failed. This technique adds to the various options for the surgeon upon locating an intra-articular loose body.

This technique has been useful in removing the following loose bodies: osteochondritis dessicans, osteochondral fractures, osteophytes, synovial chondromatosis and large meniscal fragments. Partial meniscectomy may result in large, loose meniscal fragments, which may become hidden in one of the recesses of the knee.⁴ Simple reversal of the fluid flow as described in this technique would aid in the retrieval of such loose bodies.

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K-wiring distal radial fractures, an alternative technique

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BACKGROUND

K-wiring of distal radial fractures is traditionally performed with the patient supine and the affected arm laid laterally on either the image intensifier or an arm table.¹ Manipulation is performed, the fracture reduced and position checked with the image intensifier. The K-wires are then inserted. During this process, constant traction is not maintained and, therefore, the reduction may be lost. We utilise a technique allowing constant traction thus facilitating insertion of the K-wires and, therefore, maintaining reduction throughout the procedure.

TECHNIQUE

The patient is placed supine on the operating table with a tourniquet placed on the arm (Fig. 1). The shoulder is abducted 90° and the elbow flexed to approximately 70°. A vertical bolster is fixed to the table so as to hold the arm in this position when longitudinal traction is applied across the wrist. An arm table is then attached to the table caudal to the bolster. The tourniquet is inflated and the arm painted and draped in standard fashion. A large, upturned kidney dish is placed under the forearm and longitudinal traction applied to the thumb and fingers by the assistant. The

kidney dish aids reduction by placing the wrist in palmar flexion. The c-arm can now be brought in from the patient's lateral side. The assistant can rotate the arm, whilst maintaining traction, to get 90° views of the wrist. Once adequate reduction is achieved, K-wires can be inserted in the standard fashion.

DISCUSSION

We have used this technique for the above procedure and also application of external fixators.

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A revised guide-wire technique for urethral catheter insertion

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BACKGROUND

A common call to an SHO/registrar covering urology is the inability to pass a urethral catheter, either to relieve urinary

Figure 1 Photograph showing the urinary catheter being cut longitudinally which is correct.

Figure 2 Photograph demonstrating the smooth shape of the catheter tip with a guide-wire after a longitudinal incision.

obstruction, or occasionally for intensive care monitoring of urine output. Often, several attempts have been made and additional techniques may be required. Flexible cystoscopy with insertion of a guide wire and rail-roading of a catheter over the guide wire is an easy and effective technique that is often employed to overcome this problem.^{1,2}

TECHNIQUE

In order for the urethral catheter to be rail-roaded, the end of the catheter has to be cut to allow the guide wire to pass through. This needs to be done in such a way as to prevent any disruption to the balloon mechanism. It has been our experience that operators cut the end of the catheter transversely. This results in a sharp edge, which produces difficulty when trying to advance the catheter and causes additional trauma. If the tip of the catheter is cut longitudinally (Fig. 1), the guide wire can be passed through the catheter and the natural manufactured shape of the catheter with a smooth edge is maintained (Fig. 2), thereby allowing easy atraumatic advancement.

DISCUSSION

It is important to document in the notes that the end of the catheter is cut so that when the catheter needs replacement, a