regard to logistic issues. I am well aware that with the newest generation of multislice scanners, combined with high resolution screens and sophisticated software packages for image reconstruction, images can be generated that provide anatomical information about the renal collecting system just as well as a standard IVU. Unfortunately, few urological centres dealing with emergency admissions enjoy the luxury of such facilities, let alone the availability of a urologist as skilled as Dr Cowan, 24 hours a day throughout the year. Until that Utopia arrives, lesser urological surgeons must look to provide the highest quality of clinical care using existing facilities; from the perspective of a clinician I believe that this can be done safely, accurately, quickly and economically with an IVU and that we need not be condemned for this clinical practice. For that reason, we wrote in respect of renal colic that 'the diagnosis can be confirmed using either CT or IVU ... there is no absolute right and wrong'. Those who read the article with an open mind may identify other clinical situations where the same statement applies.

Finally, I would like to draw attention to the first editorial that my co-editor and I wrote as editors of the *British Journal of Urology* in 1994, where we promised 'unfailing politeness'.² I would commend this philosophy to Dr Cowan.

Acknowledgements

When the first author wrote the article he was on the SHO rotation at the Hammersmith and Charing Cross Hospitals and has since moved to Oxford where he is a research fellow in the Weathrall Institute of Molecular Medicine at the John Radcliffe Hospital, with an attachment to the Churchill Hospital, Oxford. He acknowledges with regret and wishes to apologise unreservedly that he did not seek permission to use the name of the Churchill Hospital, nor did he ask any urologist or radiologist there to sanction publication of the article, which had been accepted for publication before he took up his current post. It is because of the 'important non-clinical issues' to which Dr Cowan refers that the first author felt that it would be imprudent to enter into this correspondence.

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COMMENT ON

doi 10.1308/003588405X51173

Sunderamoorthy D, Ghandour A. Intramedullary nailing of femur – syringe to avoid soft tissue interposition while reaming. *Ann R Coll Surg Engl* 2005; **87**: 388

doi 10.1308/003588406X116990

Unsuccessful use of syringe as a drill sleeve

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We read with interest the documented Technical Tip with regards the use of a modified syringe as a drill sleeve for the femoral intramedullary reamer. We agree that the cobra plate is often cumbersome and requires an assistant to keep it in the correct place. However, when we followed the authors' advice, we came across a major problem that led us to discard the syringe. The reamer shaft needs to be longer than the sum of the length of the femur and the length of the syringe. Considering that the reamer is often pushed up to the hilt at the greater trochanter, that leaves no space for a circumferential drill sleeve. The cobra plate design is effective because it is not circumferential and so the reamer can slide past utilising its full length. We tried to reduce the length of the syringe but that just reduced its effectiveness in protecting the soft tissues. Therefore, we had to remove the syringe to ream to the correct depth.

AUTHOR'S REPLY

doi 10.1308/003588406X117007

A longer reamer?

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The technique is useful most of the time for protecting the soft tissues while reaming the femur. However, there can be situations where the femur is long and the syringe can interfere with complete reaming of the femur. The current intramedullary reaming sets do have reamers of different lengths or extensions to the reamers for reaming long femurs. Therefore we advise the use of a longer reamer or the extensions to avoid the problem of reaming long femurs.