Technical Tips

An innovation for conventional haemorrhoidectomy

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Haemorrhoids which fail to respond to rubber band ligation are best managed surgically. Conventional haemorrhoidectomy employs dissection of haemorrhoids off the anal sphincter and requires grasping each haemorrhoid with a tissue-holding forceps. We propose the use of a single Doyen paediatric intestinal occlusion forceps (Fig. 1); it is small, lightweight, atraumatic, and has sufficient length to grasp the whole haemorrhoid. Under Eisenhammer anal visualisation, the Doyen forceps picks up the haemorrhoid securely (Fig. 2); movement of the Doyen forceps ensures that the anal sphincter has not been caught. The curve of the forceps allows easy dissection in all positions.

Figure 1 Doyen paediatric intestinal clamp, atraumatic 2 x 3 serrations, fine 2.5 mm blades, 171 mm length.

Figure 2 Doyen forceps can be used to pick up the whole haemorrhoid securely.

Internal jugular tunnelled dialysis catheters: a method permitting repeated surgical insertions

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Tunnelled dialysis catheters (TDCs) are key as an interim for haemodialysis until an atrio-venous fistulae matures. Repeated ultrasound-guided insertion of medical TDCs causes stenosis of the vein warranting a surgical cut-down. In these narrow veins, a single cut-down renders them no longer suitable for further use. We devised a method permitting repeated insertions using the omohyoid muscle as a marker. The TDC can be initially inserted above the muscle (I), followed by dividing the muscle (II) and finally below this muscle (III) as shown in Figure 1. In our experience, this permits repeated successful insertions, as the next re-insertion is centrally more proximal to the previous insertion away from the stenosis.

Figure 1 Diagram illustrating proposed technique.

Minimising scalpel handling

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During complex head and neck surgery, such as parotidectomy and neck dissection, the scalpel may be passed to and from scrub

Figure 1 Demonstration of the technique.

staff numerous times. This is time consuming and lays staff and the patient open to an increased risk of injury. We present a simple, effective method of circumventing these problems. A sterile specimen pot is inserted into a light handle cover (product reference: Liteglove, 31140257, Tycoe Healthcare Group) and clipped at a location close to the dissection thus providing both convenient and safe access to the scalpel (Fig. 1).

An effective and easy method of splitting damp Plaster of Paris casts

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Spintage using a cast is often required after fracture reduction. Splitting the cast is required to allow subsequent accommodation of postoperative swelling.¹ Splitting damp Plaster of Paris using plaster cutters or a saw is messy, awkward and often incomplete.

Figure 1 Safe splitting of damp plaster – cutting down with a scalpel onto disposable tubing.

If a length of anaesthetic tubing is placed on top of the wool and the plaster applied as normal over it, the cast can be split neatly and easily by cutting down through the damp plaster onto the tubing using a disposable scalpel (Fig. 1). This provides a split of adequate width to accommodate plaster spreaders if subsequently required.

Reference

1. Younger AS, Curran P, McQueen MM. Backslabs and plaster casts: which will best accommodate increasing intracompartmental pressures? *Injury* 1990; **21**: 179–81.

A new way of using a collar and cuff sling

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The use of a collar and cuff sling is common in children for a variety of upper limb problems. Unfortunately, the single loop around the neck can cause problems as the upper limb can swing around often requiring the sling to be worn beneath clothes. The child can remove the sling and there are concerns about safety and the risk of asphyxiation. By including the good arm in the neck loop (Fig. 1) the sling does not allow so much movement, prevents removal and guards against asphyxiation. This is useful in the young when compliance may be poor.

Figure 1 Child with collar and cuff sling.