Figure 1 The Trousseau tracheal dilator.

Figure 2 Hole cut to simulate stenosed stoma.

Figure 3 Stenosis dilated 50%.

Figure 4 Stenosis dilated 100%.

Figure 5 Slit cut to simulate traditional tracheostomy incision.

Figure 6 Slit dilated 50%.

Figure 7 Slit dilated 100%.

tube (Fig. 1).¹ We have observed that tracheal dilators are always included in the pack when changing a tracheostomy tube in an established tracheostomy or when there is stenosis of the stoma.²⁻⁴ We believe, however, that, in these circumstances, the Trousseau dilator impedes the insertion of a tube and could be dangerous in an emergency.

TECHNIQUE

We used two sheets of rubber: one cut with a circular hole to represent a stenosed stoma and one with a vertical slit to represent a tracheostomy incision. We then measured the vertical and horizontal diameters of the holes before and after using the tracheal dilator to 50% and 100% of its capacity. In a circular stoma, the vertical height decreases from 5 mm to 4 mm (20%) when dilated (Figs 2-4). Dilating a vertical slit, however, only reduces the vertical diameter by 10% from 20 mm to 18 mm (Figs 5-7).

DISCUSSION

A slit incision, when dilated, becomes a diamond-shaped aperture through which a tube can easily be passed. In the circular hole, the instrument constricts the available aperture by 20%. Our simple experiment has confirmed our suspicions that using a tracheal dilator in cases of annular stomal stenosis can make the task of inserting a tracheostomy tube more difficult, by narrowing the aperture. Is it time for our wards and emergency departments to consign the Trousseau dilator to the historical archive?

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A technique to avoid leg-length discrepancy in total hip arthroplasty

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BACKGROUND

Leg-length discrepancy is common after hip arthroplasty.¹ Surgeons conventionally check leg-length by comparing the position of the two knees. But lateral positioning can rotate the pelvis and give a misleading impression. Calliper use is described to achieve leg-length equality.² We describe a simple technique.

TECHNIQUE

Pre-operatively, leg-length discrepancy is measured and a decision made on required length. Following exposure and before hip

Figure 1 Tip of artery forceps at the level of the mark on exposed femur.

dislocation, a suture is tied to the skin below the iliac crest in line with the greater trochanter and ends of suture secured to an artery forceps. A mark is made on the greater trochanter with diathermy corresponding to the tip of the artery forceps (Fig. 1). This distance from the iliac crest suture to the trochanteric mark acts as a guide to limb length. After trial reduction, leg-length can be assessed by comparing the tip of the artery forceps to the trochanteric mark and the desired length achieved by varying neck length while inserting the femoral prosthesis.

DISCUSSION

Leg-length discrepancy is a risk factor for nerve injury, back pain and abnormal gait. This technique is effective in avoiding this complication in patients operated on the lateral side.

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A cuff of a flatus tube – an aid to the endoscopic removal of small, sharp ingested foreign bodies

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BACKGROUND

Ingested foreign bodies present a common clinical problem. Sharp objects that could risk intestinal perforation should be removed.^{1,2} Although flexible endoscopy is the treatment option of choice for most patients, a major difficulty is how to limit trauma to the gastrointestinal and oropharyngeal walls, once the sharp object is being removed. Endoscopic overtubes have successfully been used for this purpose in reported case series.^{1,3} Olympus (Olympus Endotherapy

Figure 1 Olympus (GIF – 2T240) gastroscope with the rubber cuff placed over the end.

UK, Olympus Keymed, Southend on Sea SS2 5QH, UK) and Pentax (Pentax House, Slough SL3 8PN, UK), two of the major manufacturers of endoscopic equipment in the UK, do not produce overtubes to fit their endoscopes. As a consequence, overtubes are unavailable in our hospital. We demonstrate an alternative technique, which proved successful in the endoscopic removal of ingested bare razor blades in a psychiatric patient.

TECHNIQUE

The adhesive rubber cuff of a flatus tube (34-French, 150 cm Faucher Tube: Vygon, 5–11 Rue Adeline, Ecouen 95440, France) was removed and applied to the end of the Olympus gastroscope (GIF-2T240) to aid the removal of the small sharp objects (Fig. 1). The razor blades were grasped with Olympus 'rat-toothed alligator jaw' re-usable grasping forceps (FG-47L-1, Olympus Endotherapy, UK). The cuff provided a 4–5 cm sheath in which to house the razor blades, thus shielding the mucosa on withdrawal and preventing wall perforation.

DISCUSSION

Endoscopic extraction of sharp, ingested objects can be a technically challenging procedure. The aid of a latex hood has been previously described in the literature.^{4,5} We, however, have concern about the strength of thinner materials providing adequate protection during the enshruding and withdrawal of sharp foreign bodies. With the absence of formal overtubes, the above method has proven useful in our department.

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