Figure 1 The self-adhesive irrigation pouch.

Figure 3 Pulsed lavage fluid removed with suction.

TECHNIQUE

A self-adhesive irrigation pouch (Fig. 1) is attached around the tibia distal to the wound, completely surrounding the lower leg (Fig. 2). This successfully catches the irrigation fluid that can then be removed using suction (Fig. 3).

DISCUSSION

We have found this technique to be very effective, without compromising the surgical field, and preventing the dangers of a wet theatre floor and body fluids contacting the surgical team. Due to its success, we now routinely also use this technique for total knee arthroplasty.

References

1. Murray DW, Goodfellow J, O'Connor J, Dodd C. *The Oxford Phase 3 Unicompartement Knee – Manual of the Surgical Technique*. Swindon: Biomet Europe, 2004; 1–10.
2. Maistrelli GL, Antonelli L, Fornasier V, Mahomed N. Cement penetration with pulsed lavage versus syringe irrigation in total knee arthroplasty. *Clin Orthop* 1995; **312**: 261–5.

Figure 2 The irrigation pouch applied around the lower leg.

3. Breusch SJ, Schneider U, Reitzel T, Kreutzer J, Ewerbeck V, Lukoschek M. Significance of jet lavage for *in vitro* and *in vivo* cement penetration. *Z Orthop Ihre Grenzgeb* 2001; **139**: 52–63.
4. Breusch SJ, Reitzel T, Schneider U, Volkmann M, Ewerbeck V, Lukoschek M. Cemented hip prosthesis implantation: decreasing the rate of fat embolism with pulsed pressure lavage. *Orthopade* 2000; **29**: 578–86.

A novel technique to aid urethral catheterisation in patients presenting with acute urinary retention due to urethral stricture disease

ARPUTHARAJ J CHELLADURAI, SHALOM J SRIRANGAM, ROSIE A BLADES
Department of Urology, East Lancashire Teaching Hospitals NHS Trust, Preston Royal Infirmary, Preston, UK

CORRESPONDENCE TO

SJ Srirangam, 93 Cromwell Rd, Stretford, Manchester M32 8QL, UK. E: sjsrirangam@yahoo.co.uk

BACKGROUND

The immediate management of male patients with urethral stricture disease presenting with acute urinary retention can constitute a clinical dilemma. Blind urethral catheterisation is

Figure 1 The Microvasive HydroPlus™ hydrogel-coated ureteral dilatation system containing 6-, 8-, 10-, 12-, 14-, 16-Fr dilators (length 69 cm).

usually impossible and supra-pubic catheter insertion contra-indicated in certain clinical situations (*e.g.* bladder tumour, midline laparotomy, anticoagulation or bleeding diatheses, and impalpable bladder).¹ Immediate optical urethrotomy may be impractical due to inadequate emergency theatre access or patient co-morbidity. We describe a novel technique to aid urethral catheter insertion without the requirement of general/regional anaesthesia.

TECHNIQUE

Following failed attempts at urethral catheterisation in patients with known or suspected urethral stricture disease, a flexible cystoscopy is performed after urethral instillation of lidocaine gel (11 ml, 2% lidocaine gel). Under vision, a standard 0.035-inch diameter guidewire is negotiated past the stricture and into the bladder. The cystoscope is removed leaving the guidewire in place. Over the guidewire, well-lubricated, serial ureteric dilators (Microvasive HydroPlus™ hydrogel-coated ureteral dilatation system; Boston Scientific Corporation, Watertown, MA, USA) are introduced into the bladder resulting in sequential stricture dilatation with minimal patient discomfort (Fig. 1). A catheter is inserted over the guidewire to achieve bladder drainage. The stricture can undergo delayed definitive treatment under optimal conditions.

DISCUSSION

Guidewire-assisted dilatation of urethral stricture disease under anaesthesia has been described before but not in patients with acute urinary retention.^{2,3} Ureteric, rather than urethral, dilator usage is advantageous as their narrower calibre, hydrophilic coating and longer length ensure an easier and more comfortable passage through the stricture. This technique is safe, simple yet effective, convenient, and requires no general anaesthesia; it can be an invaluable tool in the management of urethral stricture patients in retention.

References

1. Kumar P, Pati J. Suprapubic catheters: indications and complications. *Br J Hosp Med* 2005; **66**: 466–8.
2. Niesel T, Moore RG, Alfert HJ, Kavoussi LR. Alternative endoscopic management in the treatment of urethral strictures. *J Endourol* 1995; **9**: 31–9.
3. Mkony CA. Guided dilatation of urethral strictures. *East Afr Med J* 1992; **69**: 381–3.

TECHNICAL TIPS

Coraco-clavicular sling for acromio-clavicular joint disruption

CA WILLIS-OWEN

Department of Orthopaedics and Trauma, Northwick Park Hospital, Harrow, Middlesex, UK

CORRESPONDENCE TO

CA Willis-Owen, SpR Orthopaedics and Trauma, Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ, UK
E: cawillisowen@hotmail.com

The coraco-clavicular sling, using a variety of materials, is a popular method for repair of grade 3/4 acromio-clavicular joint disruptions.¹ The most demanding part of the procedure involves passing the sling around the coracoid.

By using an additional glove with the tip of the index finger cut off, the sling material can be secured at the tip on the finger. After minimal blunt dissection, the finger can be passed medially, and a suitably curved clip laterally, around the coracoid. The open tips of the clip can be palpated with the index finger and the sling material can be easily directed into the tips. The sling is then pulled through (Fig. 1).

Figure 1 Illustration of the technique.

Reference

1. Clayer M, Slavotinek J, Krishnan J. The results of coraco-clavicular slings for acromio-clavicular dislocation. *Aust NZ J Surg* 1997; **67**: 343–6.