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.

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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

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