2. To obtain an air-tight seal in hair-bearing or sweaty regions such as the perineum, we have found it useful to lay the occlusive VAC film onto hydrocolloid dressings, which seem to adhere more strongly to these areas.
3. Placing Mepitel™ (Molnlycke Health Care AB [Publ], Box 13080, SE-402 52 Goteborg, Sweden) dressings (in place of paraffin gauze/nothing) under the sponge makes it easier to remove the dressing with the patient awake.
4. Putting some lignocaine into tube before removing dressing causes less pain.
5. Removing 'Part 2' of the adhesive film first allows for easier application of the dressing, as it is able to conform to irregular shaped beds.
6. Applying Compound Benzoin Tincture™ (3M Health Care, D-41453 Neuss, Germany) to the skin surrounding the wound, letting it dry and then applying the adhesive dressing gives it a better adhesion.

DISCUSSION

These techniques can be helpful in the use of VAC dressing.

Closure of the crural defect during a two-stage oesophagogastrrectomy

JM WELLS, CM PRING, SPL DEXTER

Department of Upper Gastrointestinal Surgery, Leeds General Infirmary, Leeds, UK

CORRESPONDENCE TO

SPL Dexter, Department of Upper Gastrointestinal Surgery, Leeds General Infirmary, Leeds, UK
E: simon.dexter@leedsth.nhs.uk

Figure 1 Two crural sutures are placed during the abdominal stage of an oesophagogastrrectomy and delivered to the posterior mediastinum.

Figure 2 The crural sutures are retrieved during the thoracic stage and checked for tension around the gastric tube.

BACKGROUND

Widening of the oesophageal hiatal defect during radical oesophagogastrrectomy increases the risk of herniation of colon, small bowel or spleen into the chest.^{1,2} The hiatal defect is most readily repaired during the abdominal stage, as the crural bases are not easily accessible via a 5th intercostal space thoracotomy. However, closure of the crural defect is inadvisable prior to delivery of the gastric tube into the chest, as it may compromise its ease of passage and blood supply.

TECHNIQUE

Crural sutures (O Ethibond; Johnson & Johnson, New Brunswick, NJ, USA) are placed during the abdominal phase, after dissection

Figure 3 The crural sutures in place.

of the hiatus and lower mediastinum is complete, to allow adequate closure of the hiatus. The sutures are placed via the thoracic aspect of the crura allowing the suture to be tied within the thorax. Surgical clips (Premium Surgiclip II (M); Tyco, Norwalk, CT, USA) join the ends of the sutures, which are left untied and passed into the posterior mediastinum (Fig. 1). The posteriorly placed sutures are easily retrieved at the end of the thoracic stage of the procedure (Fig. 2) and can be tied to the appropriate tension (Fig. 3), with the gastric tube *in situ*.

DISCUSSION

Herniation through the hiatal defect following oesophagogastrrectomy can occur in up to 4% of cases.¹ Considerable morbidity is associated with hiatal herniation including the need for further surgery.^{1,2} Repair of the hiatal defect at the time of oesophagogastrrectomy reduces the risk of herniation. The technique described allows easy placement of crural sutures during the abdominal stage while allowing appropriate approximation of the crura during the thoracic stage of the procedure.

References

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Use of a cork-screw femoral head extractor for removal of a stuck intramedullary nail

DE DEAKIN, JP COOPER

South Birmingham Trauma Unit, Birmingham, UK

CORRESPONDENCE TO

D Deakin, South Birmingham Trauma Unit, Birmingham, UK
E: dandeakin@doctors.org.uk

BACKGROUND

Removal of an intramedullary nail after fracture fixation has occurred can be a technically challenging procedure. A threaded bolt attached to a jig is usually screwed into the end of the nail allowing the nail to be removed. Specialist nail removal sets exist with a variety of different bolts designed to fit the more common types of intramedullary nail. If the internal thread of the nail is damaged or if the available bolts do not fit the exact type of nail, it can be almost impossible to remove a seemingly stuck nail. We have found that a standard cork-screw instrument, normally used for removal of a fractured femoral head, can be used successfully for removal of an intramedullary nail that appears stuck despite conventional techniques.

TECHNIQUE

A standard cork-screw, found in most hip hemi-arthroplasty instrument sets (Fig. 1), is firmly screwed into the end of the nail.

Figure 1 A cork-screw instrument.

The corkscrew is inserted as far as possible before it is tapped backwards, pulling the nail out of the medullary canal.

DISCUSSION

This technique has been used successfully in our unit as a 'last-ditch' attempt to remove a stuck nail when conventional techniques have failed. If this technique fails, any remaining thread inside the nail may have been damaged further. Additionally, the cork-screw instrument can become damaged. Therefore, this technique should be reserved for occasions when other methods of nail removal have failed. Despite this, this technique can be used successfully and should be considered when a stuck intramedullary nail is unable to be removed by other means.

Inserting peritoneal dialysis catheters without special instruments

DMA FRANCIS

Royal Melbourne Hospital, St Vincent's Hospital and the Royal Children's Hospital, Melbourne, Victoria, Australia

CORRESPONDENCE TO

DMA Francis, Suite 118, 55 Flemington Road, North Melbourne, Victoria 3051, Australia
E: dmafrancis@netspace.net.au

BACKGROUND

Accurate placement of peritoneal dialysis catheters is essential for proper catheter function and effective dialysis. The tip of the intraperitoneal section of the catheter must be positioned in the true pelvis, the most dependent part of the abdominal cavity and the site where peritoneal dialysis fluid accumulates, thus allowing dialysate drainage by siphoning. Accurate catheter tip placement can be achieved easily without visualisation or special instrumentation.

TECHNIQUE

The abdomen is opened through a 4-cm midline, paramedian or oblique subumbilical incision. The tip of the intraperitoneal