DISCUSSION

Initial fixation of vas makes the rest of the procedure more comfortable for the patient especially as the majority of vasectomies are now done under local anaesthesia. We have performed 60 vasectomies using this technique with no instance of vas slippage and improved patient comfort.

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A novel technique in applying skeletal traction for long bone fractures

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BACKGROUND

Prior to the 1900s, femoral-shaft fractures were treated with various types of splinting. In 1907 and 1909, Steinmann and Kirschner, respectively, developed the first traction treatment modalities with the use of pins or wires under tension. A single pin is usually placed either at the distal femur or proximal tibia when applying skeletal traction for treating femoral fractures. Complications associated with skeletal traction include pin track infection and loosening,¹ which may require repositioning of the pin and inefficient traction forces applied across the fracture. Pin fixation problems are particularly severe in patients with osteoporosis, which can be a relative contra-indication to external fixation and presents a challenge for any fixation technique.²

Figure 1 Denham pins *in situ* with Hoffmann connectors attached.

Figure 2 In-line traction applied across both pins.

Figure 3 Plain radiograph depicting pin positions in the proximal tibia.

TECHNIQUE

We propose a novel technique in applying skeletal traction. Two Denham pins are placed into the proximal tibia 2.5 cm posterior to and 2.5 cm distal to tibial tubercle (Fig. 1). The pins are then connected with a Hoffmann external flexator connector producing a stable construct. Traction is then applied to both pins through free weights attached to a pulley at the end of the bed (Fig. 2). This technique was used effectively in elderly osteoporotic patients who had sustained femoral supracondylar fragility fractures and were not fit for operative fixation of the fractures (Fig. 3). There was no incidence of pin loosening or pin-site infection noted.

DISCUSSION

This technique can be safely applied for the treatment of long bone fractures, particularly in osteoporotic patients where pin loosening and poor pin fixation are more likely to occur.

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An investigative technique to distinguish between the gastrojejunostomy and the hepaticojejunostomy as the cause of cholangitis following pancreaticoduodenectomy

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BACKGROUND

Pancreaticoduodenectomy is associated with a substantial post-operative morbidity and mortality of which sepsis accounts for one-third of complications.¹ A common cause of post-pancreaticoduodenectomy cholangitis is hepaticojejunostomy stricture.² However, if the gastrojejunostomy is formed too proximally on the Roux loop, for example following a Child reconstruction,³ then gastric contraction can cause reflux into the hepaticojejunostomy resulting in cholangitis. We describe a simple technique to detect reflux of gastric contents into the hepaticojejunostomy as the cause of post-pancreaticoduodenectomy cholangitis.

TECHNIQUE

Standard oral contrast mixture for a small bowel study (500 ml of a 50:50 mixture of Baritop 100 (100% barium w/v) with water and 10 ml Gastrograffin) is administered orally. Images are obtained with fluoroscopic screening with the patient supine. Intravenous erythromycin (1 g) is administered to stimulate gastric contraction. Contrast seen to reflux into the hepaticojejunostomy is suggestive that the gastrojejunostomy has been formed too proximally along the Roux-loop. Having excluded hepaticojejunostomy stricture with magnetic resonance cholangiopancreatography (MRCP), consideration should be given to revising the position of the gastrojejunostomy.

DISCUSSION

Investigations such as MRCP and percutaneous transhepatic cholangiogram can identify strictures at the hepaticojejunostomy but cannot demonstrate reflux of gastric contents into the biliary tree, which may occur if the positioning of the gastrojejunostomy is

too proximal. Our use of erythromycin to augment gastric emptying has demonstrated reflux into the biliary tree adding confidence to the diagnosis. This, in turn, gives greater confidence that reconstruction of the gastrojejunostomy will prevent recurrent episodes of cholangitis.

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A simple aid to improve patient positioning during percutaneous nephrolithotomy

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BACKGROUND

Percutaneous nephroscopic procedures are carried out with the patient in prone position. The optimal method of prone positioning for any surgical procedure is determined by the necessity of providing good operating field with minimal thoraco-abdominal compression and with patient's head in neutral position.¹ We describe our experience of using a mattress routinely used in spinal surgery, the 'Montreal' mattress (Teasdale Hospital Equipment, Manchester, UK) in performing percutaneous nephrolithotomy (PCNL).

TECHNIQUE

The 'Montreal' mattress (Fig. 1), which can be easily mounted on any operating table, is a rectangular mattress with a central hollow which helps to prevent compression of the abdomen during respiration and avoids interference with the venous return. It has a gutter at the head end to ensure mild flexion of the neck, assisting airway maintenance (Fig. 2). In our institution, we have used this mattress for positioning in 36 patients for PCNL without any complications and maintaining the pulmonary airway pressure below 30 cmH₂O.

DISCUSSION

During PCNL, the commonly used techniques of pillows or folded blankets placed under the iliac crests and chest leaving the