Figure 1 'Montreal' mattress positioned on the operating table. The central hollow and the gutter at the head end are obvious. Flexion at the hips is facilitated by slight slope towards the lower end.

Figure 2 Patient positioned using all the features of the mattress allowing optimal positioning of the neck for the airway.

abdomen unhindered are cumbersome and can cause alteration of the patient position during the operation leading to complications. The 'Montreal' mattress suggested to us by an anaesthetist with experience in spinal surgery is a simple and easy alternative with all the essential features. Usage of this mattress provides an example of sharing of knowledge between specialities and we strongly recommend the mattress for patient positioning during PCNL.

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Air cystoscopy – a 19th century technique in the 21st century

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BACKGROUND

Air cystoscopy is an historical technique dating from the late 19th century.¹ The first endoscopes did not incorporate irrigation tubes; therefore, urologists frequently used air as a medium to distend and

Figure 1 Comparison of cystoscopic images using (A) air and (B) fluid.

visualise the bladder. As endoscopic technology evolved, the use of fluid became more common-place and air cystoscopy became outdated. One of the commonest uses of a cystoscope is for diagnosis and management of haematuria. Visualisation during cystoscopy may be impaired as the irrigation fluid becomes blood-stained and cloudy with the transmission of light diminished with increasing distention of the bladder. We have found that the use of air cystoscopy in these circumstances helps immensely in adequately visualising the whole of the bladder wall.

TECHNIQUE

The cystoscope is introduced urethrally in the conventional method. The bladder is initially inspected using irrigation fluid. The fluid is then drained from the bladder. Plastic tubing is then attached to the outflow of the cystoscope which, in turn, is connected to a 50-ml bladder syringe pre-filled with air. The bladder is then distended with up to 200 ml of air to allow adequate visualisation of the whole bladder. After thorough inspection of the bladder with air, irrigating fluid can be used to refill the bladder in order to proceed with further intervention if necessary.

DISCUSSION

In our experience, air cystoscopy produces a clear picture comparable to that seen using fluid cystoscopy (Fig. 1A,B). Air cystoscopy has the added advantage that the image is less likely to be distorted by bleeding. Although there is a theoretical risk of air embolus with this procedure,¹ there has been no documented evidence of this ever having occurred.^{2,3} Under the right circumstances, air cystoscopy can still play an important role in modern cystoscopic investigations.

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Aesthetics: the groin crease incision for inguinal hernia repair in girls

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BACKGROUND

Inguinal hernia is one of the most frequent operations performed. More common in boys, patency of the processus vaginalis also

affects girls in whom it is bilateral in some 56% of cases. The advantages of the scrotal approach^{1,2} stimulated us to adapt the procedure for girls.

TECHNIQUE

A 1-cm incision is made in the natural skin crease between the medial thigh and the body, parallel to the vulva. Blunt dissection and upward medial retraction at the fascia plane and beneath the subcutaneous tissue, exposes the sac, the external inguinal ring, giving access to the inguinal canal. The hernia's contents are easily inspected and reduced. Outward tension on the sac allows the necessary high ligation and division of the patent processus. A wide external inguinal ring can be closed under direct vision.

DISCUSSION

Conventional inguinal herniotomy leaves a permanent inguinal scar. We consider 'groin crease herniotomy' to be an improvement on the conventional inguinal approach. It provides excellent unimpaired visual access to the sac and its contents, to the external inguinal ring and to the inguinal canal. Dissection is minimal and is undertaken in a relatively bloodless plane between the subcutaneous tissues and the muscle fascia. The approach is easy to teach and is rapidly learnt. The scar blends well into the natural creases between the medial thigh and the vulva, and does not suffer scar hypertrophy.

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Dislodging medial-sided soft tissue interposition in ankle fractures

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BACKGROUND

Weber B ankle fractures¹ associated with deltoid ligament rupture are unstable fractures. Signs of this injury are fibula fractures at the level of the syndesmosis with medial ankle tenderness and/or talar shift.² Failure to achieve anatomical reduction in these injuries significantly increases the risk of osteoarthritis.³ Occasionally, the restoration of the ankle mortise is impeded by