Technical Section

TECHNICAL NOTES & TIPS

TECHNICAL NOTES

A simple method to overcome difficult male urethral catheterisation

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BACKGROUND

Urethral catheterisation can sometimes be difficult especially in men with large obstructive prostates or following transurethral resection of the prostate. The use of angled tip catheters or introducers can be tried in these cases, but are sometimes difficult to find in the acute setting or are not available. In addition, urethral trauma can be easily caused by the inappropriate use of these methods.¹ An alternative, cheaper and safer method is described.

TECHNIQUE

A size 12-F silicone catheter is used with the tip of the catheter folded backwards about 2 cm proximal to the tip (about mid-way along the length of the balloon). After lubricating the urethra with gel, the catheter can then be introduced into the urethra with the tip being held in position by a finger, pointing upwards (Fig. 1). The catheter is then slid down the urethra maintaining catheter orientation until the tip flips back in the bladder and urine starts draining through.

DISCUSSION

This technique gives the catheter a rounded and firmer distal end that can easily glide through the bulbous urethral curve and the prostate without jamming the tip against the posterior surface of the above mentioned anatomical sites that might be caused by the tip of straight or angled tip catheters. This method has been successfully used in more than 10 patients after failing normal catheterisation. No patient has complained of any pain during this procedure.

Figure 1 Method of bending the catheter tip and holding it in position during introduction.

Reference

1. Buddha S. Complication of urethral catheterisation. *Lancet* 2005; **365**: 909.

Biplanar intra-operative upper limb screening: a novel technique using standard and mini-image intensifiers

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BACKGROUND

Closed reduction and internal fixation of upper limb fractures is usually performed under image intensifier guidance. Accurate reduction can only be confirmed by obtaining images in two perpendicular planes. The surgeon may change the position of either the C-arm or the limb in order to acquire images in both 'AP' and 'lateral' planes. Moving the limb risks fracture displacement if the injury is unstable. Conversely, repositioning the C-arm is time

Figure 1 A conventional C-arm and a mini C-arm arranged together to provide simultaneous bi-planar images of the upper limb.

consuming, particularly if the radiographer is unfamiliar with the procedure. With both techniques, minor position adjustments and repeated screening is usually necessary to obtain accurate 'AP' and 'lateral' images rather than oblique views.

TECHNIQUE

We use two image intensifiers to obtain simultaneous 'AP' and 'lateral' images of the upper limb. The patient is positioned supine with the arm abducted. A standard C-arm is positioned at the head-end of the patient, and used to obtain AP images (Fig. 1). A mini C-arm is then brought in over the arm table to provide lateral radiographs.

DISCUSSION

A conventional C-arm and a mini C-arm may be arranged together to obtain biplanar images of the upper limb simultaneously, whilst providing the surgeon with sufficient room to work. This technique allows the surgeon to obtain the simultaneous true 'AP' and 'lateral' images reliably without repeated position adjustments. Such an arrangement is particularly useful for closed reduction and k-wire fixation of supracondylar fractures of the humerus in children. The procedure is quicker, and both the patient and the surgical team are exposed to less radiation.

Minimising implant contact intra-operatively in total knee replacement

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BACKGROUND

Total knee replacement is a very successful procedure and may last for many years. Motion between the articulating surfaces leads to wear of the ultra high molecular weight polyethylene (UHMWP) liner. This is accelerated if the femoral component was scratched on insertion and may lead to early implant failure.

TECHNIQUE

Having inserted the tibial component, we take a piece of the tough foam from the prosthesis packaging and cover the surface of the tibial component during insertion of the femoral component. The interposed foam is then removed and the UHMWP liner inserted.

DISCUSSION

By using this piece of foam, the metal implants are kept apart throughout insertion, thereby preventing scratches and resultant implant wear. For this technique, the foam dimensions must be adequate to ensure there is no contact between the implants and it must be tough enough not to fragment during use. We have not encountered difficulties with foam fragmentation and have found this intra-operative step simple, inexpensive and safe to use.

Laparoscopic re-operation for splenunculus facilitation by hookwire localisation

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BACKGROUND

Laparoscopic splenectomy has become the treatment of choice for a variety of splenic pathology.¹ It is commonly performed for idiopathic thrombocytopenic purpura (ITP), but poor surgical outcome is associated with retained splenunculi or splenosis.^{1,2}

TECHNIQUE

In patients in whom computed tomography (CT) can identify accessory or residual splenic tissue, hookwire localisation may be used to