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

Figure 1 CT scan demonstrating splenunculus with localising hookwire.

Figure 2 Laparoscopic view of splenunculus with hookwire in place.

facilitate definitive laparoscopic surgery. Prior to surgery, a CT-guided hookwire is passed percutaneously to lie alongside the splenunculus. For excision of residual splenic tissue in the region of the native spleen, we employ the following configuration: right lateral decubitus position, a 10-mm port placed lateral to the umbilicus and 2 x 5-mm ports (below mid-line xiphisternum and left costal margin at the mid-axillary line). With this arrangement, the splenic flexure can be easily mobilised. The splenunculus is identified at the end of the wire and excised.

Figures 1 and 2 illustrate the application of this technique.

DISCUSSION

After previous surgery, the technical difficulty of finding a splenunculus is increased, especially for laparoscopy.³ Several techniques of intra-operative localisation and laparoscopy have been described, including the use of gamma probes, after injection of technetium.^{3–5} This is the first report of CT-directed guidewire localisation of accessory splenic tissue.

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The Campbell de Morgan spot as a method for monitoring flaps

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BACKGROUND

Although many systems are available, there is no consensus as to which is the most effective method to monitor cutaneous flaps.¹ Most clinicians rely on clinical examination: colour, capillary refill time, temperature and bleeding in response to scratch are among the most common indicators. In many cases, it can be difficult to assess colour and refill. Interobserver variation, degree of digital pressure and lighting are variables that may contribute to the difficulty in determining these signs. A Campbell de Morgan spot is a sharply circumscribed vascular proliferation that usually appears spontaneously after the age of 40 years. Histologically, they consist of numerous arterioles, venules and dilated capillaries in a thickened papillary dermis. Clinically, they present as 1–3 mm circular lesions of a uniform deep-red colouration and are not known to be associated with any other disease.²

TECHNIQUE

We have realised that Campbell de Morgan spots can act as useful indicators of flap perfusion. These lesions blanch or completely empty when pressure is applied. When the pressure is released, an obvious visible blush caused by the refill of the capillaries unequivocally demonstrates the status of the dermal microcirculation.

DISCUSSION

Although specifically designing flaps to incorporate Campbell de Morgan spots is impractical, we suggest that opportunistically