Technical Section

TECHNICAL NOTES & TIPS

TECHNICAL NOTES

A helping hand for the lone surgeon fixing a lateral malleolus fracture

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BACKGROUND

To enable effective fixation of a lateral malleolus fracture, the position of the ankle on the operating table is important. The desirable position is with the ankle slightly raised from the table and internally rotated. Traditionally, this is achieved by placing a sand-bag under the buttock of the affected side to rotate the limb internally and placing the heel on a rolled-up operating gown or up-turned kidney dish. However, further internal rotation is often needed and this is usually achieved by the assistant holding the foot in position. This can be difficult if the surgeon is operating on their own, in which case they will need the scrub nurse to provide a helping hand.

Figure 1 A glove is placed over the foot and a finger clipped to the table.

TECHNIQUE

To overcome this, we use these traditional methods and, additionally, make use of a sterile rubber glove, which is often placed on the foot to reduce the risk of infection. We place the glove over the calcaneum and toes in the usual way and one of the 'fingers' is clipped to the operating table medial to the foot with a ball and socket clip (Fig. 1).

DISCUSSION

This additional aid enables the surgeon to keep the ankle more internally rotated than is possible with traditional techniques, allowing easier fixation without the need for an assistant. Although it is not an original idea, we think that it is worth publicising because it is so useful.

A new technique for ensuring local anaesthesia in tunnelled central venous catheters

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BACKGROUND

Insertion of tunnelled percutaneous subclavian lines into children is painful; the pain is mainly due to subcutaneous tunnelling. Local anaesthetics can be infiltrated with multiple injections along the catheter track, but this risks damage to its wall. Alternatively, local anaesthetic may be introduced proximally and distally into the tunnel, but often fails to permeate its whole length.

TECHNIQUE

The authors propose a new, simple technique whereby local anaesthesia is infiltrated along the whole track of the subcutaneous tunnel resulting in effective local pain control. The tunnelling rod is used to create the subcutaneous track. The tip of the catheter is then attached to the appropriate end of the rod.

Before the catheter is tunnelled, a small incision is made in the distal catheter at its junction with the introducer. A syringe containing the local anaesthetic is attached to the other end of the catheter. This is continuously flushed by the assistant during the whole period when the introducer is being withdrawn from the other end of the tunnel. This ensures that the whole track is effectively infiltrated with local anaesthetic. Once the catheter is in place, its distal position can be trimmed according to the size of the child and the distal position of the catheter tip. Thus, the incised segment is removed. Finally, before insertion, the catheter lumen is flushed with saline.

DISCUSSION

Inadvertent catheter damage and inadequate infiltration are thus avoided.

Hanging manoeuvre to facilitate right hepatectomy with control of the right hepatic vein

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BACKGROUND

The hanging manoeuvre facilitates right hepatectomy without prior liver mobilisation.¹ This is advantageous when tumour invades the diaphragm.² The disadvantage is that control of retro-hepatic venous structures is not prior to parenchymal division. Our modification overcomes this by controlling the right hepatic vein prior to parenchymal division.

TECHNIQUE

The anterior surface of the liver is exposed up to the level of the suprahepatic inferior vena cava and the space between the middle and right hepatic veins dissected. Attention is then turned to the infrahepatic inferior vena cava and a clamp is passed, in a cautious manner, posterior to the caudate lobe cranially towards the space created between the middle and right hepatic veins, keeping to the left of the inferior right hepatic vein. A tape is then grasped with the clamp and passed around the hepatic parenchyma.^{1,2} This process is then repeated placing a vessel loop alongside the tape. A space is dissected immediately to the right of the right hepatic vein directed towards this tunnel. The distal end of the vessel loop is then drawn alongside the lateral border of the right hepatic vein so that it is encircled. Following parenchymal transection, the right hepatic vein is divided in the usual manner (Fig. 1).

Figure 1 Illustration of the technique.

DISCUSSION

This modification of the hanging manoeuvre enables control of the right hepatic vein prior to parenchymal transection, avoiding potentially life threatening haemorrhage from inadequate control of the right hepatic vein.

References

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Nipple aspiration device

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BACKGROUND

Nipple discharge, especially if blood-stained, can be a sign of malignancy. About 5% of patients presenting to a symptomatic breast clinic have nipple discharge. It is commonly assessed by squeezing at the region of the nipple areolar complex to elicit any discharge.

TECHNIQUE

The nipple aspiration device is a device for aspirating breast ductal