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 This is continuously flushed by the assistant during the whole period when the introducer is being withdrawn from the other end of the tunnel.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.

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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

Figure 1 The nipple aspiration device.

fluid. It is made up of a modified syringe barrel and a standard plunger. The modified syringe barrel is essentially a 20-cc syringe barrel from which the tip and the distal end of the barrel have been cut off resulting in a cylinder with an intact finger flange end (Fig. 1). The plunger is introduced into the barrel through the cut end. On applying the finger flange end onto the nipple areolar complex and withdrawing the plunger, the negative pressure causes breast ductal fluid to be sucked into the syringe barrel. The fluid thus obtained can be sent for cytological analysis.

DISCUSSION

The squeeze technique is not used here; rather, it is by suction that nipple discharge is elicited. Aspiration serves as a highly effective way of uniform application of negative pressure onto all breast ducts resulting in a good yield of ductal fluid. Trauma to the nipple by inadvertent pinching is avoided which limits iatrogenic, blood-stained, nipple discharge.

En Garde! A novel splash guard for use in wound irrigation

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BACKGROUND

Transmission of infections from splash injuries is a continuous risk to healthcare professionals.¹ Exposure to body fluids is greatest in the operating theatre² and conjunctival transmission has been documented for hepatitis B, hepatitis C and HIV.^{3,4} Face-guards provide insufficient protection from conjunctival transmission of viruses.⁵ Fluid splashes are associated with wound irrigation.

Figure 1 View of the irrigation guard created from a modified operating room light handle cover.

Figure 2 Top view of the irrigation guard.

Figure 3 The guard with irrigation tube.

TECHNIQUE

The irrigation guard is created from a modified operating room light handle cover, resembling the bell guard of a fencing sword. It is made from sterile, translucent, latex-free plastic (Cory Bros.