DISCUSSION

We have used this technique in five sequential patients to remove cemented acetabular components, four of which were well fixed. The average time taken was 8 min (range, 3–13 min). In each case, the component came out with most of the cement mantle attached. There was little bone loss. In all cases, an uncemented revision socket was implanted, with additional bone graft in one patient. Postoperative radiographs were all satisfactory. This is now the senior author's favoured method for extracting a well-fixed cemented acetabular component.

References

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TECHNICAL TIPS

Knee arthroscopy: viewing the posterior horn of the medial meniscus

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We describe a simple technique to aid visualisation of the medial meniscus during arthroscopy. The patient's leg is flexed over the side of the operating table, with the surgeon exerting a slight valgus strain. To ensure no occult pathology is missed, we recommend that the assistant performs the simple manoeuvre of pressing the fingertips, exerting only moderate pressure into the medial aspect of the popliteal fossa. This pushes the posterior horn of the meniscus anteriorly and aids the surgeon's view, thereby easing the procedure should resection be required. This manoeuvre can be complimented by

Figure 1 The medial compartment, with no assistant.

Figure 2 The medial compartment with pressure from the assistant to the medial aspect of the popliteal fossa. Note that pathology is easily seen, thus facilitating resection.

the assistant using their contralateral hand to push down in an anteroposterior direction on the patient's distal thigh to stabilise the knee. This is illustrated in Figures 1 and 2.

An alternative use of Foley catheters in Ilizarov external fixation

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The recommended technique for preventing pin-site infection includes specially manufactured Ilizarov sponges and clips, retailing at £2.24 combined (Iliz sponge and disc; Smith and Nephew Healthcare, Hull, UK). An alternative for the more scrupulous surgeon can take the form of a cut-up urinary

Figure 1 Illustrating the use of a Foley catheter.

catheter. The catheter is pierced as shown, providing ample pressure to keep the alcohol-soaked gauze against the skin (Fig. 1). A £6.63 catheter (Foley catheter; Bard Limited, West Sussex, UK) provides approximately 18 bungs at £0.37 each which, when combined with a piece of gauze at £0.03 each (NHS Logistics), equates to a saving of £1.84 per unit.

Pre-contouring plates using synthetic bone models as a template to aid minimal access fracture fixation

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We report a technical tip for pre-contouring plates using synthetic bone models to aid reduced access surgery. By ensuring the soft tissues within the fracture envelope are less disturbed, the healing environment is improved. Using a synthetic bone model as a template,

Figure 1 Pre-contoured plate using synthetic bone femur as a template.

plates may be pre-contoured (Fig. 1). Synthetic bone models are sterilisable, so pre-contouring can be done intra-operatively. Many pre-contoured plates are available, but are more expensive. In healthcare circumstances where additional costs are unfavourable, this tip is useful. We commend this novel method of pre-contouring plates in order to make fixation less invasive.

A simple technique for *in situ* renal artery perfusion during abdominal aortic aneurysm repair

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Abdominal aortic aneurysm complicated by aberrant renal anatomy such as pelvic kidney (Fig. 1) present a technical challenge to try and prevent ischaemic damage during cross clamping. We describe the use of the Pruitt-Inahara® Carotid Shunt with T-Port (LeMaitre Vascular Inc., Boston, MA, USA) in such a situation to allow cold perfusion of the kidney. After opening the aneurysm sac, the origins of the renal arteries are identified and cannulated with the shunt. The T-port is connected to a pressurised cold saline bag and this is used to perfuse the kidney during cross clamping. This simple technique is also suitable for perfusion of normal renal arteries during more complex procedures such as suprarenal aneurysm and thoraco-abdominal aneurysm repair and avoids the morbidity associated with a further vascular procedure such as an axillo-renal bypass.

Figure 1 The complex aneurysm of the one patient in whom we have used this technique.