Figure 1 The lithoclast probe (white arrow) beside the nephrostomy tube (black arrow).

Figure 2 Intraluminal insertion of lithoclast probe into nephrostomy tube.

Figure 3 The potential for the lithoclast probe to exit the nephrostomy tube side holes (white arrow).

ureteric stents, but is probably only suitable in women where the distal coil is more readily accessible. In conclusion, this minimally invasive technique appears safe and definitive.

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A closed vacuum drainage system for the management of postoperative seromas

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BACKGROUND

Seroma formation is a common complication of any surgery producing a significant dead space or causing disruption of the lymphatic

drainage. Traditionally, large seromas require multiple aspirations using a 60-ml syringe with the contents dispensed into a kidney bowl. This method can introduce infection, which is of particular significance when the seroma cavity is associated with a biomedical

Figure 1 A white (14-G) needle is connected to a 3-way tap and the extension of the latter is attached to the suction tubing of a 600-ml Redovac® drain.

Figure 2 Aspiration of a large abdominal seroma using the closed vacuum drainage system.

device such as an implant or mesh. In addition, multiple aspirations can dislodge the needle causing pain and also increasing the likelihood of exposure to bodily fluids. The use of a calibrated drainage bag to maintain a closed system has been described previously.¹ We have developed a closed drainage system which utilises the negative pressure from a Redovac® drain (B. Braun, PO Box 1120, D-34209 Melsungen, Germany).

TECHNIQUE

Under aseptic conditions, a white (14-G) needle is connected to a 3-way tap and the extension of the latter is attached to the suction tubing of a 600-ml Redovac® drain (Fig. 1). With the needle inserted into the most dependent part of the seroma, the negative pressure of the Redovac® drain is applied by releasing the clamp, resulting in rapid aspiration of the collection (Fig. 2). The Redovac® bottle can be changed whilst maintaining a closed system thereby avoiding fluid spillage.

DISCUSSION

We have described a safe, simple and efficient technique using a closed vacuum drainage system for aspiration of large seromas. This method allows rapid aspiration of large seroma volumes, whilst reducing the possibility of introducing infection and the spillage of bodily fluids.

Reference

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Impressing the scrub nurse

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BACKGROUND

Correct handling and manipulation of a needle is not only a basic surgical skill and principle but it is also an important component of theatre etiquette as well as surgical safety. Scrub nurses are vital to safe and successful surgery. The surgeon and the scrub nurse should have a mutual respect for one another. It is the scrub nurse's duty to hand the surgeon the correct needle on the correct suture on the correct needle holder. Similarly, it is the surgeon's responsibility to hand back the needle and suture in a safe manner as demonstrated below. Junior surgical trainees in particular would benefit from getting into good habits early in their surgical careers.

TECHNIQUE

Traditionally, the suture is handed back to the scrub nurse as soon as

Figure 1 The exposed sharp mounted on the needle holder as it is usually passed from surgeon to scrub nurse.

Figure 2 The needle re-mounted with the tip securely locked in the jaws of the needle holder together with the swage thereby making it impossible to suffer a sharps injury from the tip.

the final throw has been placed, the suture has been cut and the needle remounted. Often, little attention is paid to how the needle is mounted when being handed back to the scrub nurse, which can potentially cause needle-stick injuries.¹⁻³ Needle-stick injuries are an occupational hazard; however, they can be minimised by simple and safe measures as shown below. This technique involves reverse mounting the needle in the jaws of the needle holder thereby preventing exposure of the sharp needle tip which could leave the surgeon, scrub nurse or patient's skin prone to inadvertent injury.

DISCUSSION

This technique is now standard surgical practice for the first author after the senior author introduced this concept when operating together. He had picked it up 20 years before from a New Zealand cardiac surgeon. We advocate this simple and easily