Conventional diathermy in arthroscopic anterior cruciate ligament reconstruction – a safe and cost-effective alternative to commercial thermal devices

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During arthroscopic anterior cruciate ligament (ACL) reconstruction, removal of soft tissue is essential in clearing the remnant of the ruptured ACL and defining the posterolateral wall of the femoral notch. Removing soft tissue using diathermy devices as compared to a motorised shaver minimises bleeding. There are several commercially available, single-use, monopolar diathermy systems, the price of which varies from tens to hundreds of pounds.

Figure 1 The 5-mm ball-end monopolar diathermy probe

We use a 5-mm ball-end monopolar diathermy probe (Trewais Surgical Instruments Pty Ltd, Victoria, Australia) for soft tissue removal (Fig. 1). This is run on a conventional diathermy source, using the coagulation mode set at maximum. This probe is reusable, costing about £40. Due to its curvature and low profile, this probe allows precise soft tissue removal. When using this device, sterile water rather than normal saline is used for irrigation. We have used the above probe in hundreds of ACL reconstructions without any adverse effects.

A simple technique for exchanging the liner in ankle replacements

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Exchange of the liner in Mobility Ankle replacements (Depuy Orthopedics Inc., Warsaw, IN 46582, USA) for infection, wear, or

to change the size can be troublesome. Getting purchase on the liner is difficult, it is under soft tissue tension, and semi-constrained due to the contouring of the liner. The use of metal instruments to lever it out can damage the articular surfaces of the implant. We insert a 3.5 mm small fragment screw into the anterior aspect of the liner (Fig. 1). The screw head is gripped with an artery clip or pliers to facilitate removal of the liner without trauma to the joint surfaces.

Figure 1 Representation of the technique.

Safely dealing with the right hepatic vein during a right hepectomy

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Figure 1 'T'-tube placed around the vein and fixing the stapler

Figure 2 Advancing the vascular stapler.

During a right hepectomy, ligating the right hepatic vein can be tricky due to the difficult anatomical position and close proximity to the inferior vena cava. A simple technique we have devised is using a 'T'-tube (Kerrs tube; 20-F) placed around the vein, followed by threading the tip of the vascular stapler (TSW35; Ethicon Inc., Redditch B98 7ST, UK) into it. This is fixed in position using a polyglactin 3.0 (Vicryl; Ethicon Inc.) tie as shown (Fig. 1). The stapling device is then advanced safely into position across the right hepatic vein (Fig. 2), the 'T'-tube is then cut off and the vascular stapling device can thus be applied.

A simple way of threading a needle through bone

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Threading a needle through a bone can present difficulties. An easy way is after drilling a hole, the blunt end of the needle with the mounted thread, is inserted backwards, thereby preventing the pointed end catching the bony canal in transit. This can save time and frustration, and prevents blunting, bending or breakage of the sharp point of the needle, which can be used again if necessary.

Figure 1 Threaded needle.

Figure 2 Backwards insertion of needle.

Reduction with a temporary intrafocal K-wire during internal fixation of distal radius fractures

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Distal radius fractures with dorsal fragmentation are challenging. Conventional internal fixation techniques involve a dorsal approach with dorsal plating; complications include scarring, stiffness and tendon attrition. I describe a Kirschner wire used in an intrafocal (Kapandji) manner to reduce temporarily and hold fragments during volar locking plate application. The intrafocal wire is inserted into the fracture site at an acute angle; the fragment is levered into position under imaging. The volar locking plate is applied and the wire removed thus avoiding long-term disruption to dorsal structures (Fig. 1).

Figure 1 The K-wire is inserted dorsally and levers the dorsal fragment(s) into position while the volar plate is applied.