Figure 4 Prolene thread tied on the outside of the abdominal wall.

TECHNIQUE

Following the insertion of the camera (10–11-mm umbilical port), and the two operative ports (5 mm), in the epigastrium and laterally respecting the triangulation for the control of the gallbladder. A Prolene (Ethicon, Johnson & Johnson Intl. St-Stevens-Woluwe, Belgium) 2/0 stitch on a straight needle is passed through the abdominal wall under vision (Fig. 1) and then through the fundus of the gallbladder (Fig. 2) and back again through the abdominal wall and tied on the outside of the abdominal wall for retraction of the gall bladder fundus (Figs 3 and 4). The operation is completed in a routine fashion, and we use a 5-mm camera through the epigastric port to guide the extraction of the gallbladder in the endopouch through the umbilical port after cutting the Prolene stitch to release the gallbladder.

DISCUSSION

This simple technique allows reduction in the number and size of the used ports during routine laparoscopic cholecystectomies.

Arthroscopic knee washout

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BACKGROUND

Arthroscopic knee washout is employed to clear infection either in the native joint or following arthroplasty. Irrigation fluid is introduced into the joint using an arthroscopic port. Common practice involves occluding the end of this port with a gloved thumb to allow fluid to collect within the joint before being flushed away. This method results in spillage of saline and inad-

Figure 1 Arthroscopy port with irrigation attached and syringe end to one side.

Figure 2 End of syringe used to block port.

equately pressure build up. We describe a simple technique to avoid these problems.

TECHNIQUE

The patient is prepared and draped in the usual way. An antero-lateral portal is established, the blunt trocar is removed and the saline tubing connected. A 10-ml syringe is dismantled and the plunger section inserted into the end of the arthroscopy port (Figs 1 and 2). The syringe tube may be discarded. The saline is then switched on and allowed to wash through the knee joint and out via a second port in standard fashion.

DISCUSSION

This technique creates a water-tight seal around the end of the

arthroscopy port to ensure that no irrigation fluid is lost as back-flow out of the port. This allows the surgeon to concentrate on adequate wash-out of the entire joint. It also enables accurate assessment of the volume of fluid used and minimises saline spillage onto the floor of the operating theatre. This is a useful technique which helps to simplify the procedure and also improves theatre safety.

An alternative technique for mesh repair of an incisional hernia

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BACKGROUND

Incisional hernias are reported in up to 13% of patients who undergo primary abdominal incisions¹ and high recurrence rates of 25–90% three years following primary repair.^{1,2} Due to high recurrence rates many methods are described, commonly using a mesh that is placed in an on-lay, preperitoneal, or intraperitoneal position. Many patients find incisional hernias uncomfortable and aesthetically displeasing and, like any hernia, may lead to bowel obstruction. Meshes placed intraperitoneally despite being dual layered have a significant incidence of adhesion formation and fistulation into the bowel.³

TECHNIQUE

We suggest an on-lay mesh repair technique in an incisional hernia where it is possible to close the defect. The defect is closed primarily with a continuous 1 loop PDS suture incorporating a lightweight mesh (Ultrapro®; Ethicon, PO Box 1988, Livingston EH54 0AB, UK) within the suture line. This should reduce the

possibility of the suture cutting through tissues and, therefore, add strength to the repair at an early stage. Tacks (Versatek® Covidien, 154 Fareham Road, Gosport PO13 0AS, UK) are placed around the perimeter of the mesh to hold it flat (Fig. 1).

DISCUSSION

This method is similar to the on-lay mesh method; however, it incorporates the mesh into the repair of the defect. Twenty-five cases have been performed and followed up for 2 years with only one recurrence reported so far. We continue to follow-up these patients to gain long-term results. This method could be extended to close any laparotomy where an incisional hernia is deemed likely to occur such as in obese patients.

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A safe technique for olecranon osteotomy

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BACKGROUND

Olecranon osteotomy is a well-established technique, providing access to the distal humerus for reduction and fixation of intra-articular fractures.¹ The sigmoid notch of the proximal ulna articulates with the trochlea of the distal humerus and has two articular facets separated by the bare area. Ideally, the osteotomy should enter the joint at the bare area while ensuring the saw itself does not enter the joint, where it can damage the distal humerus.

TECHNIQUE

The fascia and muscle are elevated from the proximal ulna and the capsule of the elbow joint is opened both laterally and medially. The ulna nerve is identified and protected. A swab is pushed through, which is very easy when the distal humerus is fractured (Fig. 1). The swab then indicates the narrowest part of the ulna and, therefore, locates the bare area, allowing for a safe osteotomy with protection of the articular surface (Fig. 2). The osteotomy is completed with the use of an osteotome.

DISCUSSION

As the bare area lies at a relatively constant location,² at the narrowest part of the ulna, we advocate the use of a swab placed through the

Figure 1 Diagrammatic of on-lay mesh showing tacks and sutures.