TECHNIQUE

The method employs the use of water-based lubricant jelly, such as K-Y® Jelly (Johnson & Johnson, New Jersey, US) or Instillagel® (CliniMed Ltd, Buckinghamshire, UK). The viscous nature of the gel allows application to the metalwork and surrounding soft tissues. It also 'catches' any particulate matter produced. Both the abovenamed jellies are water soluble and non-toxic, allowing them to be washed from the wound. The clear and colourless nature allows visualisation of the soft tissues and metalwork, and its high water content serves as a lubricant, which in theory may reduce the heat generated by the burr. We apply a thin layer of gel to the plate and surrounding soft tissues prior to cutting the plate. The majority of the gel containing the metal particles is removed using a McDonald elevator. The wound is then washed out with copious amounts of normal saline.

DISCUSSION

We have found this method useful in reducing wound contamination by particulate metal debris and feel that it is applicable in any situation in which such debris is produced.

Replacing the suprapubic catheter that has 'fallen out'

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BACKGROUND

The suprapubic catheter (SPC) that 'falls out' or cannot be reinserted following a routine change is a common urological problem that requires urgent attention. If not replaced promptly, the suprapubic track may close, necessitating a further procedure to reintroduce the catheter, usually at a later date. It is estimated to cost £2,400 to insert an SPC in theatre as an inpatient or £462 as a day case.¹

TECHNIQUE

The Mediplus (High Wycombe, UK) system² uses the Seldinger technique to introduce an SPC. An 18G needle is passed into the bladder, down which is threaded a rigid guidewire with a flexible tip. The needle is removed and a trochar with a peelable sheath is passed over the guidewire. The guidewire and trochar are removed and the catheter is inserted.

For the SPC that has fallen out it may not be possible to pass the Mediplus guidewire down the track due to its rigid upper portion. A Sensor® PTFE-Nitinol guidewire with a hydrophilic tip (Boston Scientific, Natick, Massachusetts, US) can usually be passed safely down the track and into the bladder. The Mediplus trochar can then be passed over this guidewire, with its tapered construction providing dilatation of the track, allowing the sheath to be used to replace the catheter in these difficult cases.

DISCUSSION

We have used the Mediplus system to replace SPCs in the emergency department and on the ward that otherwise could not be reinserted. It was comfortable for the patient, safe and has not generated any further procedures or hospital visits.

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Laparoscopic reinsertion/exchanges of peritoneal dialysis catheters using the modified Y-TEC® system

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BACKGROUND

The trend for the insertion of a peritoneal dialysis catheter (PDC) has moved from open surgery to laparoscopic or peritoneoscopic approaches,^{1–3} which offer advantages such as safer placement, fewer postoperative complications, longer functional survival and lower leak rates.^{1,4,5} We describe a modified Y-TEC® (Medigroup Inc, Oswego, Illinois, US) technique for dealing with problems that could be encountered during reinsertion/exchange.

TECHNIQUE

A 1cm incision is made in the left/right upper quadrant and a 5mm or 10mm laparoscopic port is introduced via open surgery. Following this, either one or two 5mm ports (depending on the complexity of the case) are inserted under vision, placing these in positions that, after removal, can be used for introducing the Y-TEC® trochar and sheath towards the pelvis (usually 1cm below/lateral to the umbilicus and planned exit site). The trochar is removed and the sheath is dilated using dilators from the kit. A PDC is introduced through the sheath and the tip is placed in the pelvis, manipulating it into desired position. The cuff implanter is used to bury the cuff into rectus muscle. The 5mm port is removed and the PDC is tunnelled out through the port exit site (Figs 1–3).

Figure 1 Approach and port positions

Figure 2 Catheter exchange; use of 5mm port as exit site

Figure 3 Confirmation of catheter position

DISCUSSION

The technique described allows the PDC to be inserted and tunnelled out through the well planned, working 5mm port site, keeping incisions to a minimum. In addition, the working ports can be used to deal with possible problems encountered in previous surgery such as an extensive laparoscopy (especially with previous peritonitis), assessing the feasibility of peritoneal dialysis, performing a biopsy of the peritoneum for encapsulating peritoneal sclerosis, dealing with adhesions and replacing/exchanging displaced PDCs into the pelvic sump (Figs 1–3).

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An innovative technique for removal of a broken intramedullary hip screw

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Figure 1 Guidewire with distal hook and broken intramedullary hip screw nail

Figure 2 Guidewire hooked into distal intramedullary hip screw hole

BACKGROUND

Intramedullary hip screw breakage is an uncommon occurrence, with a reported incidence ranging from 0.2% to 5.7%.¹ Removal of a broken intramedullary nail is difficult, particularly the distal fragment.^{2–4} We describe a cheap, simple and novel technique using readily available instruments on a single patient.

TECHNIQUE

First, the proximal part of the nail, the lag screw in the femoral head and the distal locking screws are removed, leaving the distal fragment of the intramedullary nail. Next, using a heavy pair of forceps and wire cutters, a 1.0mm x 1,000mm guidewire is bent twice and the tip shaped into a hook (Fig 1). This is inserted into the nail. The double bend on the shaft against the lumen of the nail acts as a spring mechanism to allow the tip to engage positively into the distal oval screw hole (Figs 2 and 3);