Figure 1 Corporal puncture using a 22G venous cannula

Figure 2 Satisfactory positioning ensures the cannula rests in a single corporal body while avoiding injury to adjacent structures. A non-return valve with a Luer lock connector is attached.

Figure 3 The cannula is secured in position by suturing it to the foreskin. Routine circumcision is performed at the end of the procedure.

sited into either corporal body through the glans (Figs 1 and 2), taking care not to injure the penile urethra. Following adequate placement, the cannula is secured to the foreskin with a suture and a non-return valve with a Luer lock connector is attached (Fig 3). The penis is inflated using

50ml of normal saline. The syringe can then be detached, refilled and reattached without dismantling the cannula mechanism.

DISCUSSION

We have described a simple and reproducible technique for achieving a safe cavernosal puncture that allows repeated inflation of the penis without recurrent positioning of the primary needle. This method allows the surgeon to repeatedly inflate the penis during Peyronie's disease surgery while minimising the risk of haematoma formation.

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Arthroscopic removal of large loose body: an improved technique

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BACKGROUND

Henderson described the benefits of removal of loose bodies from the knee joint in 1916 using an open technique.¹ Removal of loose bodies is usually straightforward where a lesion is <1cm as it can be drawn through the arthroscopic portal.² However, larger lesions need a further incision, accessory portals or widening of the portal for removal.^{3–5} In addition, the use of hand instruments to reduce the size of the fragment can result in multiple small bodies that can be disseminated throughout the knee. This increases the operative morbidity and may necessitate closure of a formal incision with sutures. We describe a technique using triple puncture for an all arthroscopic removal of any loose body within the knee.

Figure 1 Loose body in knee joint

Figure 2 Loose body grasped with tool

Figure 3 Loose body reduced with shaver

Figure 4 Removal of loose body once reduced

TECHNIQUE

Three arthroscopy portals are made: one for viewing, one for grasping the loose body and one for introduction of a shaver. While the scrub nurse holds the camera, the surgeon grasps the loose body and manipulates it to the shaver (Figs 1 and 2). The loose body is then reduced to a suitable size (Fig 3) to enable safe removal through a standard arthroscopic portal (Fig 4).

DISCUSSION

The only potential danger with this technique is inadvertent damage to the grasper by the shaver. This can be avoided by good surgical technique. By using this operative technique, a large arthrotomy can be avoided.

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Ileoanal pouch: short mesentery? Lengthen the pouch

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BACKGROUND

Ileoanal pouch surgery is the preferred option following a proctocolectomy for ulcerative colitis and familial adenomatous polyposis, with the 'J' pouch favoured by most surgeons. The pouch is anastomosed to the anus following complete excision of the rectum and its mucosa.^{1,2} Techniques to lengthen the mesentery include pouch folding,³ mesenteric incisions and division.⁴ For a tension free anastomosis, the pouch should extend 6cm below the pubic symphysis.⁵ We describe a technique to lengthen the 'J' pouch that avoids mesenteric surgery.

TECHNIQUE

Most 'J' pouch enterotomies are made at the apex of the pouch, allowing introduction of the stapling device. This usually corresponds with the point on the ileum with the greatest reach. It was observed that once the pouch is created, extra dependency is obtained by closing the original enterotomy and recreating it approximately 4cm proximal to the apex on the antimesenteric border (Figs 1 and 2). This allows for an extra 4cm of reach. Even if the original enterotomy is made at the very tip of the apex, a further 2–3cm are achieved. This is due to the increased ability for 'stretching' of the surrounding bowel wall, no longer impeded by nearby mesentery.