Technical Section

TECHNICAL NOTES AND TIPS

TECHNICAL NOTES

A simple method of securing the safety wire during ureteroscopy

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BACKGROUND

Some experts no longer use a safety wire during routine ureteroscopy but most urologists advocate a safety guidewire to avoid complications,^{1,2} especially in complex cases.

TECHNIQUE

We describe a technique for securing the safety guidewire during ureteroscopy. Once the safety guidewire is placed, it is curled and secured to the drape using a haemostat (Fig 1). Then a towel that has been soaked in sterile water is draped across the curled safety wire.

Figure 1 Safety wire secured to the drape with a haemostat

DISCUSSION

This technique is quick and simple. The haemostat secures the safety wire to the drape and the wet towel ensures that the wire does not move with further manipulation during the ureteroscopy and stone basketing. The wire can later be used to aid placement of a ureteral stent at the end of the case.

References

1. Flam TA, Malone MJ, Roth RA. Complications of ureteroscopy. *Urol Clin North Am* 1988; **15**: 167–181.
2. Chang R, Marshall FF. Management of ureteroscopic injuries. *J Urol* 1987; **137**: 1,132–1,135.

Vacuum-assisted sterile drainage of large post-operative seromas: the Royal Marsden technique

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BACKGROUND

Operations involving regional lymph node dissection or extensive soft tissue surgery may result in a post-operative seroma. Such collections can cause localised pain, restricted mobility, wound dehiscence, infection and occasionally mask recurrence of the index pathology. Closure of dead space and post-operative drains are used routinely but seromas remain common. Our method provides a simple sterile technique for aspirating large volumes quickly in an outpatient setting.

Figure 1 Dismantled 2ml syringe, vacuum drain connecting port and white needle prior to assembly

TECHNIQUE

Once the optimal site for seroma drainage is identified and the skin surface cleaned, the equipment is assembled (Fig 1). The plunger is removed from a 2ml syringe (Terumo UK Ltd, Egham, TW20 9AW) and the empty casing placed tightly onto an untrimmed connecting port from the distal end of a vacuum wound drainage system (Van Straten Medical, Nieuwegein, Netherlands) with 20KPa (600mmHg) of negative pressure. A 16G white needle (Becton, Dickinson UK Ltd, Oxford OX4 4DQ) is connected to the syringe (Fig 2). The needle is placed percutaneously into the seroma cavity and the vacuum released. Given correct needle place-