Technical Section

TECHNICAL NOTES AND TIPS

A simple technique to ensure adequate moulding of a cast into the Edinburgh position

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BACKGROUND

First described by Professor James from the University of Edinburgh,¹ the Edinburgh position has been used to immobilise the injured hand for many years. The main aim of placing the hand in the Edinburgh position is to ensure the metacarpophalangeal (MCP) joint collateral ligaments are fully stretched in flexion and the interphalangeal (IP) joint collateral ligaments are maximally stretched in extension, thus preventing contraction from scar tissue. The ideal position is with the wrist in up to 30° degrees of extension, MCP joints in 90° of flexion and IP joints in full extension.² Incorrect immobilisation of the injured

hand can lead to shortening of the collaterals, resulting in major loss of hand function.³

TECHNIQUE

The patient has a cast or back slab applied in the usual manner. To achieve a satisfactory Edinburgh position, the clinician/plaster technician places his or her opposite hand held in a reciprocal Edinburgh position onto the volar aspect of the forearm with the second hand on the dorsum of the patient's hand to further mould the cast into a satisfactory position.

DISCUSSION

Hand injuries are common and the Edinburgh position is employed to ensure optimal protection and preservation of hand function. Initial assessment and treatment is often initiated by junior medical staff and, more commonly, nursing staff, who may have little experience of managing hand injuries. This technique allows moulding of the cast into a satisfactory Edinburgh position and can be taught easily to junior medical staff.

References

1. James JI. Fractures of the proximal and middle phalanges of the fingers. *Acta Orthop Scand* 1962; **32**: 401–412.
2. James JI. The assessment and management of the injured hand. *Hand* 1970; **2**: 97–105.
3. Sprague BL. Proximal interphalangeal joint injuries and their initial treatment. *J Trauma* 1975; **15**: 380–385.

Figure 1 Moulding into the Edinburgh position

A technique to elevate the seminal vesicles during robotic prostatectomy

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BACKGROUND

During robot assisted laparoscopic prostatectomy (RALP), the seminal vesicles (SVs) are usually elevated with the fourth arm prior to dissection posterior to the prostate and subsequent division of the pedicles. In order to retract the SVs, the fourth arm must release the bladder, which can permit bowel to fall into the operative field. We describe a simple method to retract the SVs that does not require repositioning the robotic arm.

TECHNIQUE

During RALP using a da Vinci® robot (Intuitive Surgical, Sunnyvale, CA, US), we retract the prostate towards the anterior abdominal wall by passing a suture through the hole in the end of the catheter using a

Figure 1 Seminal vesicles elevated using a V-Loc™ suture: The suture is passed through both seminal vesicles (lower midline arrow), superficially through the anterior abdominal fascia above the catheter (black arrow), around the catheter and through the loop at the end of the V-Loc™ suture (higher midline arrow), and then back through the anterior abdominal wall fascia (white lateral arrow) to secure it.

Carter-Thomason needle. The catheter is retracted and clamped over a swab just distal to the urethral meatus. Once the SVs have been mobilised, a 15cm V-Loc™ suture (Covidien, Mansfield, MA, US) is placed through both SVs, around the catheter, and anchored to the anterior abdominal wall (Fig 1). This technique is quick to perform and provides good retraction of the SVs. The use of the V-Loc™ suture saves time because no knot tying is required. The fourth arm maintains retraction of the bladder and prevents bowel from descending into the operative field.

DISCUSSION

This technique has proved particularly effective in the obese patient, where intrusion of bowel into the operative field can be a problem.

A simple stabilising technique for laparoscopic microwave ablation of liver tumours

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BACKGROUND

Microwave ablation (MWA) is an important therapeutic option in unresectable liver tumours.^{1,2} Although percutaneous MWA is considered the least invasive and preferred approach, laparoscopy-assisted MWA is a minimally invasive alternative for percutaneously inaccessible lesions.³ Standard laparoscopic ports (5mm) are not designed for MWA probes, which can lead to instability of the probe during ablation. We describe a simple technique to maximise probe stability during laparoscopic MWA.

Figure 1 Cannula inserted into right upper quadrant of abdomen

Figure 2 Microwave ablation probe introduced through cannula

TECHNIQUE

The skin is prepared and draped as standard for laparoscopic surgery. A 16G cannula is inserted in the right upper quadrant and secured to skin (Fig 1). The cannula is used as a probe introducer in place of a standard laparoscopic port (Fig 2). This allows a secure fit for the probe, acts as an anchoring point and is cheaper than a 5mm port.

DISCUSSION

Instability of MWA probes introduced via standard laparoscopic ports can lead to inadvertent thermal injuries. The described technique improves probe handling during laparoscopic MWA and reduces the potential risk of injury associated with probe instability. It also allows a more precise delivery of ablative energy into targeted lesions. However, further clinical studies are required to assess whether this technique confers any added clinical benefit.

References

1. Padma S, Martinie JB, Iannitti DA. Liver tumor ablation: percutaneous and open approaches. *J Surg Oncol* 2009; **100**: 619–634.
2. Rocha FG, D'Angelica M. Treatment of liver colorectal metastases: role of laparoscopy, radiofrequency ablation, and microwave coagulation. *J Surg Oncol* 2010; **102**: 968–974.
3. Gillams A. Tumour ablation: current role in the liver, kidney, lung and bone. *Cancer Imaging* 2008; **8 Spec No A**: S1–S5.