Removal of paediatric flexible nails using upper fine root dental extraction forceps

D Avis, R Scott, S Walsh

Dorset County Hospital NHS Foundation Trust, UK

CORRESPONDENCE TO

Duncan Avis, E: duncanavis@hotmail.com

Migrated colonic stent removal from the rectum at examination under anaesthesia

J Steinke¹, N Symons¹, A Watson², T Cumming¹

¹Homerton University Hospital NHS Foundation Trust, UK

²Barts Health NHS Trust, UK

CORRESPONDENCE TO

Jacqueline Steinke, E: jacquelinesteinke@me.com

Paediatric flexible nail removal can be more difficult than one may anticipate owing to tissue and bone overgrowth or the overzealous insertion of the nail. They are often left flush with the bone and therefore standard pliers cannot get a grip. We have found that the use of dental extraction forceps allows a firm, distal hold, enabling removal of flexible nails when very little is visible (Fig 1). The curved inner surface of the forceps allows a firm grasp on the end of the nail. Although bone nibblers have a similar shape, they are easily damaged compared with the more robust dental forceps.

Figure 1 Dental extraction forceps removing a flexible nail from a synthetic bone

BACKGROUND

Colonic stents are used for malignant strictures presenting with obstruction or as primary palliative management. Migration is a known complication of intraluminal stents, which often impact in the rectum when they are left-sided.¹ Self-expanding metal stents employ splayed ends for anchoring. If migrated, however, traction on the stent risks trauma to the rectal wall or sphincters when removal is attempted.² We describe a simple technique for removal of a migrated colonic stent from the distal rectum under general anaesthesia.

TECHNIQUE

In the lithotomy position, a digital rectal examination is performed cautiously with a double gloved finger. The full circumference of one end of the stent is freed gently from the rectal mucosa and eased manually through the sphincters. An 8cm length of 30Fr Robinson drain is cut. A purse string suture is inserted around the protruding end of the stent (Fig 1) and grasped with an instrument passed through the drain (Fig 2). The drain is advanced over the distal end of the stent, collapsing it into the lumen (Fig 3). Without caudal traction on the stent, the Robinson drain is advanced over it into the anal canal. The proximal end collapses into the Robinson drain and then the entire assembly can be removed from the anus atraumatically.

Figure 1 Purse string suture around distal stent

Figure 2 Grasping purse string suture through drain

Figure 3 Drain advanced into anal canal and collapsed stent being removed via drain

DISCUSSION

Techniques for endoscopic or fluoroscopic retrieval of displaced colonic stents have been described.^{1,3} The technique described here is available to the surgeon with a theatre but no radiology or endoscopy at his or her disposal. The simple concept of collapsing the stent to its predeployment state prevents trauma during removal.

References

1. Wholey MH, Ferral H, Reyes R *et al.* Retrieval of colonic stents from the rectum. *Cardiovasc Intervent Radiol* 1997; **20**: 477–480.
2. Lopera JE, De Gregorio MA. Fluoroscopic management of complications after colorectal stent placement. *Gut Liver* 2010; **4**: S9–S18.
3. Stone CD, Lichtenstein DR. A novel technique for endoscopic removal of a migrated colonic stent. *Gastrointest Endosc* 2001; **54**: 522–524.

Adrenaline hip joint infiltration before portal placement can be used to diminish intra-articular bleeding and improve arthroscopic view during further capsulotomy

JA Jansen¹, A White²

¹Rijnland Hospital Leiderdorp, Netherlands

²Southend University Hospital NHS Foundation Trust, UK

CORRESPONDENCE TO

Joris Jansen, E: j.jansen@rijnland.nl

BACKGROUND

Portal placement in hip arthroscopy can be challenging owing to bleeding after arthroscope introduction, making further capsulotomy and additional portal placement more difficult.

TECHNIQUE

In order to diminish intra-articular bleeding at the beginning of the procedure, adrenaline can be used. After intra-articular needle placement with fluoroscopy, 1ml adrenaline (1:1,000) diluted in 5ml normal saline is infiltrated into the hip joint. This adrenaline solution is left inside for one minute before further portal development is undertaken.

DISCUSSION

Although never published in hip arthroscopy, intra-articular injection of adrenaline with local anaesthetic has been described in knee arthroscopy over 20 years ago.¹ Combined injection with adrenaline was found to be safe to establish clear arthroscopic view during anterior cruciate ligament reconstruction.² Adrenaline irrigation during arthroscopic knee surgery can also reduce the need for tourniquet usage in 50% of cases.³ A prospective randomised, double blind and placebo controlled study showed significantly reduced intra-articular bleeding with adrenaline irrigation during shoulder arthroscopy.⁴ Visual field clarity during arthroscopy, rated on a visual analogue scale, was shown to be better in the adrenaline irrigation group. No cardiovascular adverse reactions were observed.

In a more recent prospective, randomised, double blind study with 130 knee arthroscopy patients, adding adrenaline to injection fluid was associated with less bleeding at portal sites, shorter arthroscopy time, less irrigation fluid usage and better arthroscopic view.⁵ No significant changes in heart rate, mean arterial pressure or any other complications were reported.

References

1. Gyrn JP, Olsen KS, Appelquist E *et al.* Intra-articular bupivacaine plus adrenaline for arthroscopic surgery of the knee. *Acta Anaesthesiol Scand* 1992; **36**: 643–646.
2. Furia JP, Zambetti GJ. An injection technique to create a bloodless field in arthroscopically assisted anterior cruciate ligament reconstruction. *Am J Sports Med* 1992; **20**: 406–409.
3. Olszewski AD, Jones R, Farrell R, Kaylor K. The effects of dilute epinephrine saline irrigation on the need for tourniquet use in routine arthroscopic knee surgery. *Am J Sports Med* 1999; **27**: 354–356.
4. Jensen KH, Werther K, Stryger V *et al.* Arthroscopic shoulder surgery with epinephrine saline irrigation. *Arthroscopy* 2001; **17**: 578–581.
5. Karaoglu S, Dogru K, Kabak S *et al.* Effects of epinephrine in local anesthetic mixtures on hemodynamics and view quality during knee arthroscopy. *Knee Surg Sports Traumatol Arthrosc* 2002; **10**: 226–228.