Figure 2 The wire is passed through the needle

Figure 1 Intraoperative photograph of incision site following localisation with sonography and preoperative marking of the lesion with the patient standing

Intraoperative ultrasonography localisation of intramuscular abdominal lipomas

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BACKGROUND

Ultrasonography is used frequently to determine the site and size of abdominal lipomas prior to surgery. These lesions are often easily palpable on standing. However, they may disappear when the patient lies supine.

TECHNIQUE

A portable ultrasonography scanner is used intraoperatively with the patient supine to confirm the location of the lesion. This often differs noticeably from the position marked preoperatively (Fig 1). Once the skin is incised, the probe can be reapplied, and the ultrasonography images are greatly improved without overlying skin and fat between probe and lesion (Fig 2). The lesion can then be clearly identified and excised.

DISCUSSION

It is common practice to mark patients standing up prior to surgery. From experience, we know these markings would be different if done with the patient supine. We also know that location of

pathology can vary with patient position, especially in patients of larger body habitus.

Intraoperative sonography has been described in other clinical settings such as detection and characterisation of focal liver lesions.¹ It has also been shown to aid localisation of non-palpable breast malignancies in breast conserving surgery.²

Portable ultrasonography machines are readily available in theatre for accurate placement of regional anaesthesia. We advocate the use of intraoperative ultrasonography guided localisation of such lesions; it ensures accurate visualisation of deeper lesions, and helps to minimise operative time and unnecessary dissection.

Figure 2 The lesion is visualised easily on intraoperative imaging

Reference

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Improving exposure in posterior cervical surgery: the elastoplasty

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The approach to the posterior cervical spine is challenging in patients where adipose tissue creates skin creases in the mid or lower cervical region. This technique eliminates creasing, aiding the approach and closure, facilitating optimal healing and reducing the risk of irregular scarring.

In the prone position, two lengths of elastoplast are adhered from the scapular region longitudinally to the buttock and posterior thigh region. Tension is applied in a caudal direction as the tape is affixed. A third length of elastoplast is applied transversely across the first two (Fig 1), to prevent slipping and alteration of the surgical field.

Figure 1 The elastoplasty technique

Preventing cement fragments in revision arthroplasty from escaping the sterile field

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Using a standard orthopaedic osteotome to remove cement in revision arthroplasty can result in fragments flying out of the wound in an uncontrollable fashion. These fragments have been known to strike non-sterile theatre equipment (eg overhead lights, theatre masks, surgeons' faces) and can land back into the sterile field, increasing the risk of surgical site infections. We have developed a simple and cost effective technique to prevent these cement fragments from leaving the sterile field. It involves placing the osteotome through an upturned, clear, sterile plastic gallipot (Fig 1) that is then placed over the cement to be removed (Figs 2 and 3). Any cement fragments flying away will strike the inside of the gallipot and will be well contained.

Figure 1 Standard osteotome placed through an upturned, sterile, clear gallipot ready to be placed over the desired area

Figure 2 Positioning of the osteotome/gallipot construct over a cement spacer in revision knee surgery