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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

Figure 3 Once the osteotome is in position, the gallipot is pushed down so it is semi-flush with the cement to be removed.

Figure 1 Angled angiography catheter with guidewire compared with conventional ureteric catheter

Angiocath used for retrograde cannulation of the transplant ureter

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BACKGROUND

Endourological retrograde cannulation of the transplant ureter may be required for diagnostic studies, ureteroscopy or stent insertion. This can be challenging owing to the angle of transplant ureter (TU) entry into the bladder dome or side wall. Normally, a guidewire and straight ureteric catheters placed through a rigid cystoscope are used to cannulate the native ureteric orifice but these are often inadequate to access the TU. A flexible cystoscope can be used to insert a guidewire into a difficult TU orifice. An alternative technique is presented using angled angiography catheters (Fig 1) placed via a rigid cystoscope.

TECHNIQUE

A variety of angled angiography catheters, usually used for radiological cannulation of the renal artery, need to be available. After cystoscopic evaluation of the TU orifice angle, the appropriate angled angiography catheter is inserted into the bladder using a rigid cystoscope. The TU orifice is then cannulated by advancing the curl of the angiography catheter beyond the orifice and subsequently withdrawing it over the orifice. Once cannulated, a guidewire can be passed through the angiography catheter to the transplant renal

pelvis. A second guidewire can be placed alongside to straighten the angle of the TU orifice and facilitate a variety of endourological procedures.

DISCUSSION

Angled angiography catheters are designed to negotiate the acute angle of entry from the aorta into the renal artery. Its design here is used to cannulate a TU orifice with difficult angles of entry into the bladder that may be inaccessible using conventional ureteric catheters.

The Tooting Tube: a bespoke high-arm sling for upper limb rehabilitation

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BACKGROUND

Upper limb surgery may lead to oedema,¹ which can be improved by elevation.² Traditional slings such as the triangular calico or all-purpose hand sling are cumbersome, time consuming to fit and offer inconsistent positioning.³ In order to address these limitations, we developed the 'Tooting Tube'.