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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None of the authors have any commercial interest in any of the products described in this technical note.

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'.

Figure 1 Sling in situ

TECHNIQUE

A slit is cut up one side of the stockinette (Eesiban bandage stockinette; Sallis Healthcare, Nottingham, UK) approximately three-quarters of the required length, typically 110–150cm for an adult patient. The limb is inserted into the stockinette with the hand positioned on the contralateral shoulder (Fig 1). Sufficient stockinette length passes over the unaffected shoulder for posterior knot tying. The shoulder is held in a relaxed position with the elbow adducted. The proximal end of the stockinette cradles the enveloped elbow.

DISCUSSION

Benefits of the Tooting Tube sling include high elevation, uniform weight distribution and patient comfort. Patients may release the limb for clinical examination or washing (Fig 2). The safety pin of the traditional calico – which is not required in the Tooting Tube – may result in iatrogenic injury and inconsistent elevation. Material costs are comparable between the Tooting Tube and traditional triangular calico sling (40p per unit).⁴ Calculations are based on a 120cm piece of Eesiban bandage stockinette (EGJ166, NHS Supply Chain) compared with a single piece of triangular calico (EED022, NHS Supply Chain) and a safety pin (VWL004, NHS Supply Chain).

Each sling is designed, fitted and tailored for the individual patient. The Tooting tube sling has been used in over 1,000 patients as the sling of choice at the Department of Hand Surgery at St George's Hospital, London.

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Figure 2 Independent sling release

Tip to stitch the superior corner of the quadriceps tendon incision in knee arthrotomy

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A video demonstration showing how to perform this stitching technique is available at:

<http://youtu.be/Sb3nWai6OqI>

Minimally invasive knee surgery necessitates use of smaller skin incisions. Knee arthrotomy is typically performed using a medial parapatellar approach. The exposure is then facilitated by enlarging the quadriceps tendon incision. After the index procedure, it is sometimes difficult to close the superior corner of the quadriceps tendon incision as it is covered by skin. The technique involves placing a quadriceps stay stitch near the superior corner of the skin incision and delivering the superior corner of the quadriceps tendon incision into view to stitch it (Fig 1). This precludes the need for an assistant to stretch the skin with retractors and prevents quadriceps tendon defect.