The use of FRED® to reduce intraoperative spectacle fogging

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Bespectacled surgeons are familiar with the annoyance of intraoperative fogging, reducing visibility and surgical effectiveness. Most surgeons combat the risk of fogging with surgical tape applied to the upper edge of their mask, sticking it to their skin, which can cause irritation. FRED® (Covidien, Dublin, Ireland) is a widely used antifog solution that prevents misting of endoscopes intraoperatively. There is often surplus solution, which can be used to prevent misting of surgeon's spectacles. A single application to both sides of spectacle lenses will last for an entire day, preventing the need for irritating surgical tape.

Figure 2 Ball is visible at the entry point

Calibration of the small bowel in stricture-forming small-bowel Crohn's disease

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BACKGROUND

In 1932, Crohn, Ginzburg and Oppenheimer described a disease of the terminal ileum 'characterised by a process that frequently leads to

Figure 3 Ball is 'chased' along the lumen of the small bowel

Figure 1 Ball is introduced into the enterotomy

stenosis of the lumen of the intestine'.¹ Surgical treatment of Crohn's disease is now based on conservation (rather than resection) of the bowel.² Strictureplasty plays an important part in this strategy.³

TECHNIQUE

Several methods have been reported for the assessment of strictures. We advocate the use of a medical-grade 20-mm steel ball to calibrate the small bowel in Crohn's disease. This technique has been described previously,^{4,5} but not used widely.

An enterotomy is made at the site of an obvious stricture. The ball is inserted into the lumen of the small bowel (Figs 1 and 2). Soft bowel clamps are positioned proximally at the duodenal-jejunal flexure and distally on the small bowel. Then, the steel ball is 'run' along the length of the small bowel (Fig 3). The passage of the ball is impeded by the stricture. Strictureplasty can be carried out as necessary and the ball can continue to be run until all strictures have been identified and treated. The ball is then returned to the original enterotomy, extracted, and the final strictureplasty at the site of the enterotomy completed.

DISCUSSION

This is a quick, safe and easy technique that enables the surgeon to be confident that the entire length of the small bowel is free from significant strictures when undertaking a structured assessment in patients with stricture-forming small-bowel Crohn's disease.

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Maximising vacuum drainage prior to wound closure

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Vacuum drains are used frequently in surgery to remove fluid accumulations and close dead spaces. Vacuums are only achieved by attaching a receiving device and opening the drainage tube to negative pressure. However, air from the cavity often fills the bottle, reducing the residual pressure of the receiving device and impairing its function. We overcome this problem by fitting a sucker tube

Figure 1 Vacuum drainage using a disposable 10ml syringe with the plunger removed

inside an empty 10ml syringe barrel with the drain connected to the syringe tip (Fig 1). This technique removes dead space prior to drain connection, with the added advantage of being a useful sucker where a Yankauer suction tip may be too large.

A simple technique to improve the administration of nerve root blocks

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Nerve root injections require radiographic imaging and good technical skill. We describe a simple method to aid planning the administration of lumbar nerve root injections with the use of biplanar fluoroscopy.

Axial magnetic resonance imaging at the level of the target nerve root is used. An empirical angle of inclination of 60° is created from the nerve root to the skin of the back with the apex enabling the lateral entry point to be determined (Fig 1). The transforaminal injections are then performed with the simple expedient of a skin marker line at the appropriate lateral distance from the midline for needle entry.

Figure 1 Method to aid planning the administration of lumbar nerve root injections