Figure 1 Computed tomography before the procedure with arrow showing bladder stones (top) and afterwards with arrow showing suprapubic catheter tip (bottom)

urologists working simultaneously with separate video monitors and equipment.² We believe laser lithotripsy is the most effective bladder stone fragmentation method because it enables stone fixation against the bladder wall. The combined endoscopic technique is safe, quick and effective for patients with multiple intermediate sized bladder stones.

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Avoiding open reduction and internal fixation in the intramedullary nailing of subtrochanteric femoral fractures

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BACKGROUND

Subtrochanteric femoral fractures commonly present with significant displacement and are difficult to reduce (Fig 1). They can be pathological and are likely to increase in prevalence owing to bisphosphonate use and an ageing population.¹ Intramedullary nailing of subtrochanteric fractures is considered the gold standard of treatment and because of the deforming forces, many surgeons advocate open reduction for all displaced fractures.² Closed reduction would minimise soft tissue and fracture site disturbance, and we describe a technical tip for this.

TECHNIQUE

With the patient in the lithotomy position, a 26Fr resectoscope is inserted transurethraly, followed by percutaneous suprapubic puncture. The suprapubic tract is dilated and a 30Fr Amplatz sheath inserted for nephroscope access. Through a 6Fr ureteric catheter, a 365µm laser fibre is passed via the nephroscope. Holmium yttrium aluminium garnet laser (2J and 5Hz) is used to break the larger stones into smaller fragments, which are removed by rigid graspers through the nephroscope. Residual debris is cleared by Ellick evacuation through the resectoscope. A 16Fr suprapubic and urethral catheter is inserted, and removed after 24 hours. Computed tomography prior to and following the procedure is shown in Figure 1. The total operative time is less than 60 minutes.

DISCUSSION

This approach has been described previously in the literature but was advocated for the treatment of large bladder stones with two

Figure 1 Lateral (A) and anteroposterior (B) plain radiography of a pathological subtrochanteric fracture of the left femur

Figure 2 Lateral view of the proximal femur demonstrating the reduction of the deformity with a ballspike retractor and an underarm crutch

TECHNIQUE

First, correct the shortening with a traction table. A ballspike reduction tool is introduced under radiographic guidance through a percutaneous anterolateral incision, lateral and inferior to the anterior superior iliac spine (to avoid the lateral cutaneous nerve of the thigh). This is then used to depress the proximal part of the fracture while a crutch placed under the leg at the distal fracture site provides a counteracting force (Fig 2). This allows the guidewire to be passed across the fracture site

Figure 3 Intraoperative imaging of successful closed reduction of the left hip with ballspike retractor and underarm crutch with anteroposterior (A) and lateral (B) views prior to intramedullary nailing and anteroposterior (C) and lateral (D) views after nailing

and enables the procedure to be completed without need for formal open reduction. Care must be taken not to leave the crutch in place for an extended period of time as this risks compressing the sciatic nerve.

DISCUSSION

Open reduction of this fracture type is well documented and produces satisfactory results.² The technique described can reduce surgical trauma and operative time without compromising the fracture reduction (Fig 3).

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Use of anterior cruciate ligament guide in Lisfranc injury fixation

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BACKGROUND

Lisfranc fracture dislocation fixation is technically demanding surgery. After obtaining anatomic reduction, a screw is inserted in line with the Lisfranc ligament, which runs obliquely at an angle of 50–60° from the

Figure 1 Placement of the anterior cruciate ligament guide