Blind hydrophilic guidewire for difficult urethral catheterisation

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BACKGROUND

The inability to pass a urethral catheter is a common urological emergency. A flexible cystoscope is not always available for direct visualisation, insertion of a guidewire and railroading of a catheter in the event of a difficult catheterisation. We describe a technique using a hydrophilic guidewire (Glidewire®; Terumo, Somerset, NJ, US; Fig 1) that may reduce the need to perform emergency suprapubic catheterisation in cases where the cystoscope is not available immediately.^{1,2}

TECHNIQUE

Insert a soft ended hydrophilic guidewire through the urethral meatus following the application of topical local anaesthetic and wetting of the wire with sterile water. Advance the guidewire down the urethra as far as it will go. This is unlikely to cause urethral trauma owing to

the flexible, soft nature of the tip. If the wire is feeding through steadily, it is safe to presume the wire is in the bladder. If the wire cannot pass, it will recoil out of the meatus. If this occurs, pass the guidewire back down and manipulate it gently by rotating it at the point at which resistance is felt, which in turn will hopefully enable it to glide past the point of obstruction.

Pass an open ended catheter over the guidewire. Alternatively, use a cannula needle to pierce a hole at the end of the catheter, ensuring no disruption to the balloon. This will enable a standard catheter to be fed over the guidewire.

DISCUSSION

We have found this technique to be successful in most cases. Multiple attempts are not advised and documentation is imperative.

DECLARATION

The authors have no conflicts of interest. Other soft hydrophilic guidewires may be used but the authors only have expertise with the Terumo Glidewire®.

References

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Figure 1 The Terumo Glidewire®

A novel use of an anterior cruciate ligament FlipCutter® in intramedullary nailing to minimise soft tissue damage

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

We present the use of a single-use anterior cruciate ligament FlipCutter® (Arthrex, Naples, FL, US) for intramedullary nailing in adolescent femoral and adult tibial fractures. This technique allows for a percutaneous approach with the FlipCutter® in neutral mode as a guidewire. The FlipCutter® is deployed to allow retrograde reaming (available in 6–13mm diameters), thereby creating a proximal entry point (Fig 1). This is performed under image intensifier guidance and reaming is stopped once the cortex has been breached. The FlipCutter® can be reverted to neutral and removed without any of the soft tissue damage associated with conventional drills or reamers.

Figure 1 Retrograde reaming of tibial nail entry portal with a deployed anterior cruciate ligament FlipCutter® under an image intensifier

A technical tip to aid closure of the short external rotators in the posterior approach to the hip

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Repairing the capsule and the short external rotators through drill holes is a popular method when using the posterior approach to the hip. Many surgeons use an expensive suture passer to pull through the stay sutures. Our method negates the need for that. A size 5 Ethibond® pack (Ethicon, Somerville, NJ, US) contains four sutures. Three are used to tag the posterior structures as stay sutures. The fourth has the curved needle straightened and passed retrograde through the drill holes (Fig 1). The loop of the thread can then 'lasso' the stay sutures and draw them out of the trochanter individually by pulling them through the drill holes.

Figure 1 Illustration of technique

Use of an expanded lateral hip view to assist guidewire placement during dynamic hip screw fixation

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BACKGROUND

Hardware failure following dynamic hip screw fixation for peritrochanteric neck of femur fractures most commonly involves anterosuperior cut-out of the compression screw from the femoral head.¹ Baumgaertner showed that a 'tip-apex' distance of less than 25mm significantly reduced the likelihood of cut-out.² Accurate guidewire placement in the femoral head prior to screw insertion is therefore critical.

TECHNIQUE

Following fracture reduction and a lateral approach to the proximal femur, the guidewire is aligned on anteroposterior image intensifier view with the centre of the femoral head using an angled guide. An expanded lateral view of the femoral neck is obtained prior to guidewire insertion (Fig 1). This is achieved by an alteration in the angle of the image intensifier or by a small increase in the distance between the x-ray tube and hip being screened to allow visualisation of the whole femoral head and neck, including the proximal femoral shaft. In larger patients, the view may be more limited but the neck-shaft junction and most of the femoral head can still be visualised. Following satisfactory alignment, the guidewire is driven into the