Technical Section [TECHNICAL NOTES AND TIPS

An easy technique for removal of a light bulb from the vagina

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doi 10.1308/rcsann.2016.0028

Sometimes a light bulb is used to masturbate. If the light bulb becomes stuck in the vagina, it can be a challenge to remove it. Traction on the light bulb creates a vacuum and risks breaking the glass into pieces. The entrance of the vagina is too small to use obstetric forceps. The trick is to insufflate air in the vagina and perform traction at the same time. This can be achieved by inserting a bladder catheter to insufflate air while simultaneously performing traction on the screw thread of the bulb. An alternative option is to perform an episiotomy to enlarge the entrance to the vagina.

A technique to visualise the urethral meatus in difficult male catheterisations

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doi 10.1308/rcsann.2016.0030

The glans and urethral meatus cannot always be visualised during male catheterisation because of oedema or phimosis, meaning the prepuce cannot be pulled back.¹ In this case, 'blind' catheterisation is attempted, which can increase trauma to the glans and/or urethral meatus.

We propose using a nasal speculum to visualise the glans and urethral meatus by inserting both flanges, without force, into the preputial opening and widening the space gently to allow access to the urethral meatus. The catheter can then be guided in the space between the two flanges into the urethral meatus and catheterisation can proceed as normal.

Reference

1. Villanueva C, Hemstreet GP. Difficult male urethral catheterization: a review of different approaches. *Int Braz J Urol* 2008; **34**: 401–412.

The three-point landing in mandibular orthognathic surgery – a modified technique

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BACKGROUND

The 'three-point landing' involves maintaining an increased curve of Spee in the mandibular arch in the presurgical phase of treatment. Surgical advancement of the distal segment of the osteotomised mandible is subsequently undertaken, concomitantly increasing the lower face height. Contact is achieved between the anterior teeth and the terminal molars bilaterally. The lateral open bites are closed post-operatively, by extruding the mandibular premolar and canine teeth.

The traditional technique involves the placement of a lower full-thickness steel archwire with an accentuated curve of Spee. At some stage in the postoperative period, the surgical splint is removed and the lower archwire is changed to a round steel archwire with a reverse curve. This extrudes the mandibular premolar and canine teeth.¹ The potential problems with this approach are discomfort for the patient in removing a full-thickness archwire in the early postoperative period, the considerable hampering encumbrance and oral hygiene hazard of maintaining the splint, and missing the potential accelerated tooth movement in the immediate postoperative period.²

Figure 1 Photograph of the immediate postoperative period with elastics in situ. It is best to avoid crimping surgical hooks on to a nickel-titanium archwire, which could potentially deform. Kobayashi ligatures are therefore placed on the brackets to facilitate intraoperative intermaxillary fixation (IMF). Care is required not to debond the brackets during placement of the IMF.

Figure 2 Closure of lateral open bites within eight weeks

TECHNIQUE

A modified approach is to place a mandibular 0.017" × 0.025" flexible nickel-titanium archwire in the immediate presurgical period. Kobayashi ligatures may be placed on the brackets to facilitate intraoperative bimaxillary fixation. The splint is removed towards the end of the surgical procedure and the occlusion is checked for a solid three-point landing. Light bilateral box elastics are placed intraoperatively or directly after surgery, which will begin active extrusion immediately (Figs 1 and 2).

DISCUSSION

This modified technique reduces both treatment time and patient discomfort.

References

1. Proffit WR, White RP, Sarver DM. *Contemporary Treatment of Dentofacial Deformity*. St Louis: Mosby; 2003.
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Technique to test flexor hallucis longus after Akin osteotomy

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BACKGROUND

An Akin osteotomy is commonly performed to correct hallux valgus interphalangeus. The flexor hallucis longus (FHL) tendon passing plantar to the proximal phalanx is at risk when performing this osteotomy. We describe a method of assessing the integrity of the FHL intraoperatively.

TECHNIQUE

After the Akin osteotomy has been stabilised, the foot is dorsiflexed passively while observing whether there is reciprocal toe plantarflexion.

The presence of this tenodesis effect of the FHL suggests integrity. Conversely, if this is not seen, further exploration of the FHL is indicated.

DISCUSSION

When lacerations occur distal to the knot of Henry, the FHL is unable to function as a flexor.¹ It also has a role in maintaining the medial longitudinal arch of the foot. Failure to reconstruct acutely may result in unbalanced extension of the toe and development of a flatfoot deformity.²

Recognition of a FHL injury intraoperatively is not obvious and this is often picked up later in the rehabilitation period. We have described a simple intraoperative test to help identify a possible injury to the FHL, which would lead to immediate reconstruction if present and therefore reduced morbidity.

References

1. LaRue BG, Anctil EP. Distal anatomical relationship of the flexor hallucis longus and flexor digitorum longus tendons. *Foot Ankle Int* 2006; **27**: 528–532.
2. Lee HS, Kim JS, Park SS *et al*. Treatment of checkrein deformity of the hallux. *J Bone Joint Surg Br* 2008; **90**: 1,055–1,058.

Novel method for retrieval of a well-fixed fractured femoral component after total hip replacement

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BACKGROUND

Fractures of femoral components are complications of revision total hip arthroplasty.¹ Prevalence of such complications is 0.23–11%, but the consequences can be devastating.² Extraction of fractured femoral components is a demanding undertaking that can be detrimental to remaining host bone.

Several techniques have been described to address this complex issue before revision: (i) drilling of the exposed part of the femoral stem and attachment of a threaded extraction device;³ (ii) surface undercutting with an extraction device; (iii) femoral trephine methods; (iv) creation of a femoral cortical window; (v) extended femoral osteotomy;⁴ extraction by retrograde nail impaction.⁵ Here, we describe a technique that we employ in revisions of failed cementless, extensively porous, coated femoral components that have fractured at the neckstem interface (Fig 1).

TECHNIQUE

The proximal femoral component is visualised. An orthopaedic burr and a femoral osteotome are used to surround the component. Using