Figure 1 Anteroposterior radiograph of the pelvis showing a fractured left femoral stem at the neck-stem junction

DISCUSSION

In revision hip arthroplasty, unpredictable prosthetic failures require innovation to tackle the unique problems encountered. Our method is a safe and efficient alternative for retrieving femoral components and is not associated with complications.

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Figure 2 Engagement of the distal end of a universal slap hammer in the recess created by the Midas Rex® MR7 pneumatic drill

a Midas Rex® MR7 pneumatic drill (Medtronic, Minneapolis, MN, USA) with its metal-cutting attachment, a circular recess is created in the shoulder of the femoral component. This strategy facilitates application of the distal end of a universal slap hammer (Fig 2). The component is retrieved with no associated bone loss, thereby negating the need for a femoral osteotomy.

Protection of soft tissue and avoidance of inadvertent neurovascular injury in repair of the distal biceps

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BACKGROUND

Rupture of the distal biceps tendon is not uncommon in middle-aged males during eccentric contraction of the biceps. Early surgical repair

Figure 1 Nasal specula used in the surgical technique described here. Specula are of standard design with a ratchet mechanism that can hold the blades in a certain position.

Figure 2 The nasal speculum is used to retract soft tissues in the surgical field. The speculum is placed onto the radial tuberosity, and provides direct access to the bone.

Figure 3 Insertion of the anchor device onto the pre-drilled radial tuberosity with the aid of the nasal speculum as a retraction device to protect neurovascular structures

is recommended for optimal functional outcome.¹ Various surgical techniques have been described to access the radial tuberosity, but some approaches increase the risk of neurovascular injury. Complications include injury to the lateral antebrachial cutaneous nerve, median nerve, posterior interosseous nerve, and brachial artery.^{2,3}

Repair is achieved by first drilling the radial tuberosity and reinserting the tendon using a fixation device. Here, we describe a simple and effective technique to prevent iatrogenic injury using a nasal speculum (Fig 1).

TECHNIQUE

An anterior incision is used to approach the radial tuberosity. Use of a nasal speculum is advantageous because the ratchet mechanism keeps the speculum open, thereby allowing the assistant to hold it

with one hand. The smooth, curved blades provide safe retraction of surrounding tissues and adequate space for insertion of instruments onto the radial tuberosity under direct vision (Fig 2). With this technique, drilling and insertion of the suture anchor is safe and effortless (Fig 3). The biceps tendon is secured with a Krackow stitch, and brought down onto the tuberosity while the forearm is flexed and supinated to its maximal extent.

DISCUSSION

The technique described here provides an efficient method of retraction while offering soft-tissue protection to surrounding structures and avoiding neurovascular damage. It reduces reliance on multiple retraction instruments and provides good vision. Mr Bhalaik has undertaken >50 repairs of the distal biceps tendon using this technique without any complications.

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Insertion of thermoexpandable metallic ureteric stents can be aided by ureteric predilation

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BACKGROUND

Thermoexpandable nickel-titanium stents, such as the Memokath™ 051 system (Pnn Medical, Kvistgaard, Denmark), are a viable solution for ureteric strictures in retroperitoneal fibrosis but the access system required for their deployment can be difficult to insert. We describe a simple technique that improves safety of insertion in such cases.

TECHNIQUE

After retrograde pyelography has been performed to determine stricture length (Fig 1), the desired size Memokath™ can be selected. A guidewire is then inserted through the stricture to the kidney under x-ray guidance (Fig 2) before advancing the Memokath™ access sheath over the guidewire. A tight distal ureter and/or stricture can prevent insertion of the access sheath owing to its relatively blunt tip and large calibre (14Fr). In this situation, the ureter can be dilated first over a guidewire using a 5Fr to 10Fr dual lumen ureteric access catheter (G17560 AQ-022510; Cook Medical, Bloomington, IN, US) (Fig 3) prior to Memokath™ 051 access sheath (Fig 4) and, eventually, stent insertion (Fig 5).