plunger should be removed. The tourniquet is stretched and applied to the syringe (Fig 2), which subsequently engages the target finger (Fig 3). The tourniquet can be rolled proximally without insulting distal injuries (Fig 4).

DISCUSSION

This technique is inexpensive and conceptually straightforward. Although commercially available finger-dressing applicators could be used in a similar fashion, they are often not sterilised. This technique is ideal for distal avulsion-type or crush injuries of the fingers.

A folded up treatment sheet is preferable to a sandbag

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doi 10.1308/rcsann.2016.0214

Patients are often positioned using sandbags in orthopaedic surgery. However, sandbags are radio-opaque and therefore obscure image intensifier images. We recommend the use of treatment sheets,* folded up and taped together (Fig 1). As well as being radiolucent, we find them advantageous in terms of affording better grip (sandbags have a tendency to slip away from the patient), and being cheap, quick and easy to create. They are also disposable, which may help prevent infection transmission.

*Footnote requested by the Technical Section Editor:

Treatment sheets are often referred to incorrectly as 'incopads'; however, they have an important difference. An incontinence pad is used to keep an incontinent patient dry, in order to prevent skin breakdown. Although a treatment sheet absorbs fluid, it still feels wet to the touch and therefore cannot be used for this purpose.

Figure 1 A folded up treatment sheet next to a sandbag

An emergency back-up light source for flexible cystoscopy can be found in most of our pockets

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doi 10.1308/rcsann.2016.0233

Background

A recent Medline search showed 390 articles which mention 'iPhone' in either the title or abstract. The majority of these make use of the camera to perform telemedicine or even fundoscopy.¹ No publications to date mention the use of a smartphone as a light source.

A flexible cystoscopic-assisted catheter insertion is often the last option before more invasive procedures such as a suprapubic catheterisation or rigid cystoscopy under general anaesthesia in emergency situations. Therefore, failure when using equipment remotely can be time consuming and may necessitate more invasive procedures. Here, we present a novel light source, a smartphone, for use with a flexible cystoscope.

Technique

When confronted with a light lead that does not fit the light source, light source failure or if a conventional light source is not available, ask an assistant to turn on the 'flashlight' on a smartphone. Place the proximal end of the light lead over the light source and hold it in place (Fig 1).

Discussion

The flashlight provides ample light to place a guidewire during urethroscopy and subsequent catheter insertion. When equipment fails or is unavailable, this technique negates the need for a conventional light source, allowing safe urethral visualisation, guidewire insertion and catheterisation.

Figure 1 Smartphone light source

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Tensioned fine wire for proximal femur traction table reduction in amputees

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doi 10.1308/rcsann.2016.0263

Fractures of the neck of femur are associated with high morbidity and mortality, and are a common problem, particularly among the elderly population. Management can include open reduction and internal fixation using a traction table. Patients with above-the-knee amputations provide a technical challenge in terms of traction table positioning and fracture reduction. Current options include placing a Denham pin or a Steinmann pin with a diameter of 4–5mm through the distal femur to enable traction of the residual limb.

Figure 1 Photograph of tensioned fine wire in place and Ilizarov half ring to allow traction and rotational control. 58×78mm (220×220 DPI)

Figure 2 Ilizarov half ring attached to traction table via a traction cord. It allows a unimpeded lateral view of hip using an image intensifier. 88×66mm (220×220 DPI)

Technique

We propose using a tensioned fine wire 1.8mm in diameter and an Ilizarov half ring to enable skeletal traction of the proximal femoral fracture. The smaller diameter wire has a limited biological footprint and causes less damage to the soft tissues and bone than the wider Denham and Steinmann pins.

This technique can be especially useful in cases with a very short residual limb. A fine wire is passed through the distal femur and tensioned (110 Nm) to an Ilizarov half ring (Fig 1). The half ring can be used to provide traction as well as rotational control, and is attached to the routine traction table attachment using traction cord (Fig 2).

Discussion

The advantages to this simple technique are that both AP and lateral image intensifier images can be taken intraoperatively, as per a routine dynamic hip screw fixation, and it allows safe positioning for the patient, with satisfactory application of traction and rotational control. It also causes minimal injury to the bone and soft tissues.