Figure 1 Laparoscopic clip being applied to the twisted suture material

holder while supporting the tissue. Multiple rotations of the needle holder allow a 'twist' of suture to be created flush with the tissue. A laparoscopic clip applicator can then be introduced through another port and a clip placed at the base of the twist to prevent this unravelling, maintaining tension in the suture line (Fig 1).

Avoiding fluid loss from an unused portal during hip arthroscopy

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During hip arthroscopy, more than one portal may be placed at a time. In order to avoid fluid loss from an unused portal, obturators can be used to block the arthroscopic cannula. However, these can be bulky and interfere with camera movements. Inserting the rubber bung from a 5ml syringe to occlude the end of the 5.0mm hip access cannula offers an easy and low profile method to temporarily block the outflow (Fig 1).

Figure 1 Rubber bung on cannula (arrow)

The use of unicondylar cement spacers as a bone preserving measure in two-stage revision knee arthroplasty

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Unicondylar arthroplasty revision can be associated with extensive bone loss.¹ However, revision can also be performed where the bone loss is not extensive. We recommend application of unicondylar cement spacers in two-stage revision rather than a single large cement spacer, which is often associated with more extensive bone resection. The first stage procedure involves careful removal of the components, where possible attempting to avoid excessive local bone loss, although extensive debridement of all infected tissue and removal of all artificial

Figure 1 Intraoperative photograph of unicondylar cement spacer and postoperative anteroposterior x-ray of the same cement spacer

tissue also needs to be performed at the first stage. Following this, heavily antibiotic loaded cement is placed to fill the local defects and shaped to be congruent on either side of the joint, reminiscent of the normal condylar profile. This simultaneously permits functional knee movement and combats infection in preparation for the second stage (total knee replacement). Figure 1 shows intraoperative and postoperative images of the cement spacer.

References

1. Sarraf KM, Konan S, Pastides PS *et al.* Bone loss during revision of unicompartmental to total knee arthroplasty: an analysis of implanted polyethylene thickness from the National Joint Registry data. *J Arthroplasty* 2013; **28**: 1,571–1,574.

Subchondral bone purchase can aid femoral head extraction

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A fundamental component of displaced intracapsular hip fracture surgery is the removal of the broken, avascular femoral head. This is generally achieved by inserting a corkscrew device into the femoral head through its cancellous surface and performing an extraction maneuver. Our experience of this process has often resulted in loss of purchase, as the corkscrew threads pull out of the femoral head's cancellous bone, and the subsequent need for re-insertion. This can cause femoral head fragmentation, making both the subsequent extraction and measurement more difficult.

Note the insertion point is well away from the articular edge.

Figure 1 Femoral head extraction with the cork-screw device inserted through the articular surface and dense subchondral bone

The senior author has adopted a method for femoral head extraction that incorporates the denser peri-articular subchondral bone.

TECHNIQUE

The hip is exposed through a standard approach.

A Cobb or similar device is applied to the femoral head's fracture surface, rotating the femoral head within the acetabulum. A standard corkscrew device is placed on the articular surface of the head well proximal to the articular margin, and tapped to secure fixation. Care is taken during insertion not to injure the local soft tissue and is angled to lever the calcar portion away from the acetabulum.

The extraction maneuvers are identical as before, except that the purchase is palpably far greater (Figure 1).

DISCUSSION

Both bone volume and trabecular thickness are greatest near the subchondral region of the femoral head.¹ The technique described takes advantage of this increased purchase, and has proven successful on the primary extraction attempt over a period of 7 years during all but two hip hemiarthroplasties.

References

1. Issever AS, Burghardt A, Patel V *et al.* A micro-computed tomography study of the trabecular bone structure in the femoral head. *J Musculoskelet Neuronal Interact* 2003; **3**: 176–184.

Use of non-absorbable nasal packs as a platform for microvascular anastomosis

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BACKGROUND

Common practice currently involves using a dental roll or tonsil swab as a platform for microvascular anastomosis. This reduces the working distance and avoids working at depth when performing an anastomosis from the internal mammary vessels with a free deep inferior epigastric perforator (DIEP) or transverse rectus abdominis myocutaneous (TRAM) flap for breast reconstruction. There are challenges involving the shape and stability of the dental roll and variation in the contour of the tonsil swab for microvascular work. We describe a technique that utilises a readily available Merocel[®] nasal pack (Medtronic, Minneapolis, MN, US) as an absorbent, stable platform on which to carry out vascular anastomosis to a free DIEP/TRAM flap in the intercostal cavity (Fig 1).

TECHNIQUE

The Merocel[®] pack is expanded with normal saline, and subsequently cut and adjusted to the required size depending on the working distance and depth of the wound. The coloured background is sited on to the Merocel[®] pack to provide a stage for microvascular