Technical Section [TECHNICAL NOTES AND TIPS

Closed reduction of femoral fractures using an L-shaped arm retainer

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The use of henna as a semipermanent skin marker to indicate the site of application for ultrasonography bone stimulation

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Closed reduction of femoral fractures for intramedullary nailing can be difficult. Techniques include the strategically placed bump, axillary crutch and F-tool. However, these have disadvantages including difficulty in adjusting, sterility and radio-opacity.

We propose using an L-shaped arm retainer. Sealing it in a sterile drape provides a readily available reduction tool that is radiolucent and atraumatic. Its right-angle L-shape allows indirect reduction of the fracture by pushing of the surgeon's abdomen/thorax against its broad base and the narrow end against the thigh in the appropriate orientation (Figure 1). This frees up the surgeon's hands and avoids exposure to radiation.

Figure 1 L-shaped arm retainer wrapped in a sterile drape and crepe bandage being demonstrated as a closed reduction tool on a patient with a femoral shaft fracture undergoing intramedullary nailing

BACKGROUND

The use of ultrasonography stimulation to accelerate bone healing following fractures is widespread in orthopaedic trauma.¹ The site of the non-union, where the ultrasonography probe should be applied, is identified and marked in clinic by the surgeon. When performed with a surgical marker pen, this mark fades following washing and has to be reapplied on a regular basis. The use of henna (readily available from any art shop) to mark the position of a stoma preoperatively has been reported.² We describe its use as a semipermanent marker to demonstrate the site of application of an ultrasonography bone stimulator probe.

Figure 1 Clinical photograph showing the henna paste marking on the patient's hand, indicating the site where the ultrasonography probe should be applied in a patient with a symptomatic scaphoid non-union

TECHNIQUE

Screw the nozzle on to the henna paste tube. Clean and dry the skin where the henna paste is to be applied. Using the skin marking drawn by the physician as a template, apply the henna paste accurately on to the marked location and leave to dry (Fig 1). Once dry, the henna paste can be washed off or allowed to flake off.

DISCUSSION

By following these instructions, the skin mark for the ultrasonography transducer will last approximately two weeks and it can be reapplied as the mark fades. This technique can be employed in all circumstances where ultrasonography bone stimulation is used at a fracture site. The use of henna paste in this context is safe, cost effective and time saving, and it is a readily available solution to an increasingly common problem.

References

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‘Harrier’ technique to close a penoscrotal incision following insertion of an inflatable penile prosthesis

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The Scott retractor provides excellent intraoperative exposure when inserting an inflatable penile prosthesis. However, the tubing can be inadvertently punctured when suturing the fascial layers and dartos layers at the end of the procedure. The ‘Harrier’ technique uses the

principle of vertical lift off, similar to the RAF Harrier jump jet. Once the inflatable penile prosthesis has been inserted, the assistant can lift the Scott retractor vertically and at the same time, the pump is pulled down in the scrotum (Fig 1). The tubing then remains clear of the layers to be closed and the retractor hooks are adjusted as each layer is closed.

A useful technique for intraosseous sutures to promote early rehabilitation

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BACKGROUND

The use of intraosseous sutures is common practice in orthopaedics. Their use has been advocated in repair following splitting of the iliac apophysis with subperiosteal exposure in paediatric approaches to the hip, as well as in abductor repair following hemiarthroplasty and external rotator repair in total hip arthroplasty.¹ The use of intraosseous sutures provides bony healing and a stronger repair, minimising the risk of suture pull-out and repair breakdown.² The placement of these sutures can be technically difficult and can subsequently lead to bending or fracture of the curved needle, which can result in increased operative time and cost.³ There is very little in the literature regarding techniques for intraosseous suture placement despite being common in orthopaedic practice.

TECHNIQUE

Grasp the suture needle adjacent to the base of the needle holder jaw, close to the tip of the needle (Fig 1). Once the needle has made contact with the bone, use the contralateral thumb to apply constant,

Figure 1 Insertion of inflatable penile prosthesis with the Scott retractor lifted up and the pump pulled down which allows the implant tubing to remain clear of each layer to be closed

Figure 1 Technique for grasping the suture needle adjacent to the base of the needle holder jaw close to the tip of the needle for enhanced control