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.

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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

Figure 2 Insertion of the intraosseous suture

gentle, axial pressure to the jaws of the needle holder. This enables the correct required force with simultaneous control to minimise any micromovement of the needle, which can lead to bending or fracture. Once the needle has advanced, the needle holder is moved a couple of millimetres further back and the manoeuvre is repeated as the needle progresses through the bone (Fig 2).

DISCUSSION

We present this novel and time efficient technique that uses inexpensive materials and applies basic orthopaedic surgical principles to achieve optimal repair. This can enable early aggressive rehabilitation while reducing the risk of repair breakdown.⁴

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Using a surgical spoon for safe thoracotomy closure in minimally invasive direct coronary artery bypass surgery

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Minimally invasive direct coronary artery bypass involves anastomosis of the left internal mammary artery to the left anterior descending artery via a small left anterior thoracotomy. This incision is closed by reapproximation of the ribs with interrupted pericostal sutures. We place a stainless steel surgical spoon (Figure 1, top), under the costal surfaces of the opened intercostal space, such that the curve of the needle follows the concave spoon surface as the tissue 'bite' is taken (Figure 1, bottom). This prevents inadvertent injury to the heart and lungs underneath and additionally facilitates needle manipulation within the limited confines of a mini-thoracotomy.

Figure 1 (top) Stainless steel surgical spoon used to facilitate thoracotomy closure after minimally invasive direct coronary artery bypass surgery; (bottom) intraoperative photograph showing a surgical spoon (arrow) placed under the superior rib of the opened intercostal space following minimally invasive direct coronary artery bypass. The needle is passed just over the superior aspect of the rib and over the surface of the surgical spoon underneath, preventing injury to underlying structures.