Technical Section [TECHNICAL NOTES AND TIPS

A novel cabling technique

L Oliver-Welsh, L Hamilton, N Slater

Maidstone and Tunbridge Wells NHS Trust, Tunbridge Wells
Hospital, Pembury, Tunbridge Wells, UK

CORRESPONDENCE TO

Lucy Oliver-Welsh, E: lucyoliver-welsh@hotmail.co.uk
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BACKGROUND

Cables are widely used in trauma and orthopaedics and the traditional technique advocates only a single use per cable. Over the past year in Tunbridge Wells Hospital, we have used 70 Biomet cables (Zimmer Biomet) with 32 sleeves and 12 cable plates. This new technique enables each cable to be used at least twice. If we predict that cables were used in multiples of two, this technique would save our hospital £5,625. Applied nationally in the same way, there is potential for a £2.5 million saving.

TECHNIQUE

Instead of feeding the cable to the mid-point, we advocate that, on the first pass, you leave one long arm and one short arm on the ten-

Figure 1

Figure 2

Figure 3

sioner (Fig 1). This leaves you with a reasonable length of cable to reuse. With one 'good' uncut end and one 'bad' cut end (Fig 2).

On the second pass, feed the uncut 'good' end of the cable through the clip before passing around bone via the pointed tip of the cable introducer. Remove the introducer and pass the 'good' end through other side of clip (Fig 3). These stages can be repeated (Fig 4) as long as one end of the cut cable is 'good' enough to fit through clip (Fig 5).

Figure 4

Figure 5

DISCUSSION

This technique can be applied to any cabling system. Variables to consider include bone diameter, presence of a plate, tensioner design and initial length of cable. This simple technique requires no extra effort and can save on cost and operative time.

'Reverse guide wire' technique for placement of anterior column/superior pubic ramus screw in pelvis and acetabular surgery

TH Tosounidis, PV Giannoudis
NIHR Leeds Musculoskeletal Biomedical Research Unit, Leeds General Infirmary, Leeds, UK

CORRESPONDENCE TO
Theodoros Tosounidis, E: ttosounidis@yahoo.com
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We present a novel technique for placement of an antegrade anterior column/superior pubic ramus screw. After identification of the entry point, the guide wire is inserted into the iliac bone to a depth of 2–3 mm using the obturator outlet and the inlet fluoroscopic views (Fig 1).¹ It is then withdrawn and reversed so the blunt end functions as the leading end, and reinserted. It is subsequently advanced with light hammering (Fig 2). The risks of cortex penetration and injury of the surrounding structures are minimized since the blunt end can bounce to the cortical bone and is self-redirected into the canal.

Reference

- 1. Bishop JA, Routt ML Jr. Osseous fixation pathways in pelvic and acetabular fracture surgery: osteology, radiology, and clinical applications. *J Trauma Acute Care Surg* 2012; **72**(6): 1,502–1,509.

Figure 1 (a) Obturator oblique and (b) inlet intraoperative fluoroscopic views demonstrating the insertion of the guide wire at the entry point for the fixation of the anterior column of a transverse and posterior wall acetabular fracture. The guide wire is advanced only for 2–3 mm

Figure 2 The guide wire is then reversed and, using the same views (a and b), is advanced using light hammering to the superior anterior column/superior pubic ramus