Figure 1 Staged model-building process

DISCUSSION

This model has been used in the Royal College of Surgeons Core Skills in Laparoscopic Surgery course since its regional inception as an alternative to costly synthetics and cheaper, glove-based alternatives, which suit non-formal continuing training.^{1,2} Also used within the College Clinical Skills in Emergency Surgery course, it is mounted over a patient return electrode and set on a corkboard with board pins, enabling electrosurgical dissection. Mechanical vibration devices and laparoscopic scissors can also be used to dissect the mesosalpinx.

References

1. Oliver JC, Carty NJ, Wakefield C. Low-cost model for laparoscopic appendectomy in a webcam simulator. *Bull R Coll Surg Engl* 2010; **92** (4): 122–125.
2. Shingler G, Ansell J, Goddard S *et al*. Piloting the ISCP Surgical Skills Assessment: the Wales Deanery experience. *Bull R Coll Surg Engl* 2013; **95** (1): 1–4.

Increased safety of surgical glove application: the under/over method

PH Sugarbaker

Center for Gastrointestinal Malignancies, Program in Peritoneal Surface Oncology, MedStar Washington Hospital Center, Washington, DC, USA

CORRESPONDENCE TO

Paul H Sugarbaker, E: Paul.Sugarbaker@medstar.net
doi 10.1308/rcsann.2017.0145

INTRODUCTION

Surgical gloves are a necessity when performing abdominal surgery not only to protect the patient from bacterial contamination but also to protect the surgeon and surgical assistants from biological fluids. One site for interruption of the barrier between biological fluids in the open abdomen and the surgeon is the interface of the surgical gown and the surgical gloves at the wrist. In the under/over method for double-glove application, the first pair of gloves are positioned under the surgical gown (Figs 1 and 2) and the second pair are positioned over the cuff of the surgical gown and secured with self-adherent wrap (Figs 3 and 4). The under/over method prevents contact of the cuff of the surgical gown with the wrist skin and reduces the possibility of exposure of the surgeon to biological fluids during abdominal surgery.

Figure 1 After the surgeon scrubs and dries their hands, the first pair of surgical gloves (under gloves) are applied and the upper part of the glove advanced to the lower forearm.

Figure 2 The surgical gown is put on and care is taken to advance the cuff of the surgical gown only to the level of the upper palm/lower wrist.

Figure 3 The outer gloves are then put on and the upper portion of the surgical gloves is stretched to the level of the mid-forearm, over the top of the surgical gown.

Figure 4 The outer gloves are secured at the level of the mid-forearm using a self-adherent wrap. The wrap is applied equally one-and-a-half times around the forearm to the gown and surgical glove.

Endourological management of misplaced urethral catheter after radical prostatectomy

S Shillito, A Bourdounis

Pennine Acute Hospitals NHS Trust, Crumpsall, Manchester, UK

CORRESPONDENCE TO

Andreas Bourdounis, E: Andreas.Bourdounis@pat.nhs.uk
doi 10.1308/rcsann.2017.0146

BACKGROUND

Following radical prostatectomy, a urethral catheter is commonly kept 3–14 days to allow healing of the vesicourethral anastomosis.^{1,2} Early, inadvertent removal (less than 3 days) because of suspected blockage and attempted blind recatheterisation may lead to incorrect placement

Figure 1 Sagittal view of contrast-enhanced computed tomography of abdomen and pelvis; the misplaced catheter is visible with the balloon inflated below the level of the bladder neck.

Figure 2 Intraoperative fluoroscopic guidance of hydrophilic guide wire coiling inside the urinary bladder past the misplaced catheter with inflated balloon.

of the catheter. We describe an endourological technique to safely reposition the urethral catheter and preserve the anastomosis.

TECHNIQUE

Contrast computed tomography demonstrates the catheter under the now disrupted anastomosis (Fig 1). Under general anaesthesia in the lithotomy position, a hydrophilic guide wire is advanced under fluoroscopic control, alongside the misplaced catheter and into the bladder with the balloon inflated (Fig 2).³ An open ended 5-Fr ureteric catheter is negotiated over the hydrophilic wire and a retrograde study confirms correct position. Through that catheter, a stiff guide wire replaces the