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

Figure 3 Intraoperative fluoroscopic guidance of new 18-Fr urethral catheter over a stiff guide wire inside the urinary bladder.

Figure 4 Final fluoroscopic image of appropriately placed urethral catheter with the balloon inflated at the level of the anastomosis.

hydrophilic wire before removing the old catheter. A two-way 18-Fr silicon catheter is passed urethrally over this guide wire using a 16-gauge intravenous cannula and the balloon is inflated past the vesicourethral junction (Figs 3 and 4).

DISCUSSION

We describe a noninvasive technique to enable the restoration of a disrupted anastomosis after radical prostatectomy. The critical step in this technique is to leave the balloon of the misplaced catheter inflated, so that a hydrophilic guide wire is more likely to be negotiated through the correct passage into the bladder. Using an intravenous cannula to assist catheter introduction over a guide wire is a well-described technique.^{4,5}

References

1. Patel R, Lepor H. Removal of urinary catheter on postoperative day 3 or 4 after radical retropubic prostatectomy. *Urology* 2003; **61**: 156–160.
2. Tiguert R, Rigaud J, Fradet Y. Safety and outcome of early catheter removal after radical retropubic prostatectomy. *Urology* 2004; **63**(3): 513–517.
3. Olson L, Esler R, Gunendran T. Blind hydrophilic guidewire for difficult urethral catheterisation. *Ann R Coll Surg Engl* 2014; **96**(8): 629.
4. Tang VC, Bott SR. A better way to insert urethral catheter with guide-wire. *Ann R Coll Surg Engl* 2006; **88**(7): 693.
5. Henderson J. Feeding a urethral catheter over a guide wire using an intravenous cannula. *Ann R Coll Surg Engl* 2012; **94**(1): 64.

Fine wire frame foot plate positioning

A King¹, N Ball², N Heidari³, A Hughes¹

¹Royal Devon and Exeter NHS Foundation Trust, Exeter, UK

²Royal Orthopaedic Hospital NHS Foundation Trust, Birmingham, UK

³Royal London Hospital, London, UK

CORRESPONDENCE TO

Andrew King, E: andrewking27@gmail.com
doi 10.1308/rcsann.2017.0150

When applying a foot plate with tensioned wires as part of a hindfoot circular frame, it is desirable to place the foot plate parallel to the weight-bearing axis of the foot. This can be difficult to achieve using a reference wire/ring first technique. We present a method for positioning the foot plate in the desirable weight-bearing plane before application to the foot with wires.

The lid of an equipment tray is employed as a simulated weight-bearing surface. The assistant holds this flat surface and the foot plate. The foot plate rests parallel to the flat surface with the aid of three temporary two-hole rancho cubes (Fig 1). The foot is placed in the simulated neutral weight-bearing position in the desired position within the foot plate. The surgeon then places two transverse wires, tensioning and securing these to the foot plate (Figs 2, 3 and 4). If necessary, the position of the plate can be imaged in the lateral plane to ensure that it is in the correct position before definitive fixation placement (Fig 5).

Figure 1