TECHNIQUE

The bone graft is harvested and morcellised. A standard plastic hypodermic syringe is now chosen. The syringe size depends upon the size of the lesion. Usually, for arthroscopic techniques, we use a 1-ml syringe. In open surgery, a larger syringe can be used. The needle end of the syringe is removed using a sharp scalpel blade and the syringe is manually loaded with the bone graft with the plunger pulled back (Fig 1). The syringe is introduced using the arthroscopic portal or open joint access. Using the syringe plunger, the bone graft is delivered into the desired area. The same technique is used to deliver antibiotic pellets into bone voids or into the medullary canal in the treatment of infection.

DISCUSSION

This technique is simple, effective, and customisable depending on the void. It allows targeted delivery of a measurable amount of bone graft with no wastage. The technique can be used in other small joints and in endoscopic surgery. A similar technique has been previously described in knee surgery.¹

Reference

1. Espinoza C, Ellis HB, Wilson P. Arthroscopic delivery of cancellous tibial autograft for unstable osteochondral lesions in the adolescent knee. *Arthrosc Tech* 2014; **3**(3): e339–e342.

Prevention of iatrogenic chemical burns during tourniquet controlled hand surgery

M Horner, RW Trickett
Cardiff and Vale University Health Board, UK

CORRESPONDENCE TO
Matthew Horner, E: m.horner@doctors.org.uk
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Chemical burns secondary to skin preparations leaking beneath a pneumatic tourniquet are a rare but significant iatrogenic complication.¹ We outline a simple technique to prevent this injury, particularly during surgery where exposure of the elbow area below a tourniquet is required. Additional surgical wool is looped just below the distal end of the tourniquet (Figs 1a and 1b) to prevent leakage of preparation. The wool is removed prior to tourniquet inflation, leaving a narrow area free from preparation (Figs 1c and 1d). We have observed no complications using this technique, and it is a simple and effective alternative to commercially available tourniquet drapes.

Figure 1 Stepwise application of wool tourniquet protector for cubital tunnel surgery

Reference

1. Dickinson JC, Bailey BN. Chemical burns beneath tourniquets. *BMJ* 1988; **297**: 1,513.

Management of laser fibre during ureterorenoscopy and laser lithotripsy

J Jenkins, T Youngsmith, J Henderson
Urology Department, Cheltenham General Hospital,
Cheltenham, UK

CORRESPONDENCE TO
James Jenkins, E: james.jenkins@glos.nhs.uk
doi 10.1308/rcsann.2018.0091

BACKGROUND

Laser lithotripsy of calculi in the urinary tract is a well-established treatment modality for calculi in all parts of the urinary tract. Laser fibres are necessarily long (200 cm) to reach between the laser machine and the end of the ureteroscope. The disadvantage of this length is the potential for the fibre to touch nonsterile surfaces, thus requiring replacement at significant cost.

Figure 1 Fibre lying over patient's leg with damp swab

Figure 2 Fibre sheath attached to leg drape with fibre in place

TECHNIQUE

A damp swab is placed over the top of the laser fibre on the patient's elevated leg (Fig 1). This allows the fibre to move back and forth but prevents it from falling on to the floor. A modification of this method involves cutting a 20-cm length from the plastic sheath packaging of the fibre and securing it to the drape over the leg (Fig 2). These two techniques can be combined to control redundant fibre length.

Lone Star retractor and elastic band compression dressing for urethroplasty

A Chetwood, J Aspinall

Urology Department, Royal Adelaide Hospital, Adelaide, South Australia

CORRESPONDENCE TO

Andrew Chetwood, E: andrewchetwood@doctors.org.uk
doi 10.1308/rcsann.2018.0092

Following urethral mobilisation, there is a period of inactivity while buccal mucosal graft harvest occurs during urethral reconstructive

Figure 1 Sterile elastic bands providing compressing to packs covering the wound

surgery. During this time, we apply sterile elastic bands across the already sited Lone Star retractor to provide compression to packs covering the perineal wound (Fig 1). This gives the ideal compression for haemostasis without risking damage to the underlying tissues. Other surgeons might find this technique useful for other types of perineal surgery.