Figure 3 Bariatric laparoscopic grasping forceps

Figure 4 The grasping forceps is manipulated towards the broken screw (A). Using the image intensifier, the claws are closed around the broken part (B). Finally, the broken screw is retrieved from the medulla (C)

knowledge, our technique has not been described elsewhere. We report a cost effective, reproducible, bespoke and safe technique that is effective in our hands.

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Correcting varus malreduction in extracapsular fractures of the neck of the femur using a temporary external fixator

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BACKGROUND

Extracapsular fractures of the femoral neck are increasingly being managed with cephalomedullary nails (CMNs).¹ Varus malreduction is a recognised complication of such devices, leading to reduced offset and defunctioning of the abductors, and increasing of the moment arm across the fracture, risking gait disturbance, non-union and metalwork failure. We describe a simple and efficient method for both correcting and maintaining the varus deformity while the surgeon and assistant prepare the femur and position the CMN, using two Schanz pins and a single external fixator bar.

TECHNIQUE

After routine setup and preparation of the patient on the traction table, place a 4.5mm Schanz pin through the greater trochanter into the anterior femoral head (Fig 1). Applying a force in the caudal direction allows correction of the varus deformity (Fig 2). A second Schanz pin is subsequently placed from lateral to medial in the distal femur, slightly anterior or posterior to the medullary canal. With the reduction initially obtained and held by hand, these pins can then be linked with a single external fixator bar, thereby maintaining the deformity correction (Fig 3). Following this, the CMN can be inserted in the standard technique and

Figure 1 Insertion of proximal Schanz pin

Figure 2 Correction of varus deformity with caudally directed force

Figure 5 Insertion of the neck guidewire

Figure 3 The external fixator in action

Figure 6 Insertion of the blade prior to Schanz pin removal

Figure 4 Insertion of shaft guidewire

locked proximally (Figs 4–6), before removal of the temporary external fixator and distal locking of the nail (Fig 7).

DISCUSSION

Several techniques have been described to help surgeons reduce the risk of varus malreduction,^{2–4} and modern CMNs are designed with a lateral bend to allow trochanteric entry and avoid varus. However, these focus on entry point and rely on the surgeon achieving a good closed reduction. In some cases (eg severely comminuted or reverse oblique fractures), this correction is unachievable, and closed and open reduction techniques might be required, increasing operative time, blood loss and infection risk. Our method eliminates varus malalignment as well as freeing up the hands of both the surgeon and the assistant to insert the fixation device. We have described this technique using a long CMN but it could equally be applied to a short CMN.

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Tip for maintaining sterility in antegrade on-table colonoscopy

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For patients who require an on-table antegrade colonoscopy, a sterile laparoscopic camera cable plastic cover can be used to cover the colonoscope and maintain sterility of the operative field (Fig 1). The cover can be retracted and replaced as the scope is introduced and removed from the colon. Additional drapes maintain sterility of the field with just a change of gloves and removal of drapes rather than time consuming re-prepping and draping. This technique was recently used by the authors during a case where the patient's colon could not be visualised prior to surgery owing to an impassable stricture.

Figure 1 Sterile colonoscopy cover

An innovative and cost-effective method for the targeted delivery of autologous bone grafts in foot and ankle surgery

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BACKGROUND
Autologous bone grafts and bone graft substitutes are widely used in foot and ankle surgery in the treatment of osteochondral defects, during fusion and for other bone voids. Surgery is often performed arthroscopically or using the mini-open technique. This can be challenging because of limited access and narrow joint space. Several devices are available to deliver synthetic bone grafts but there are none for autologous grafts. We have developed an innovative and cost-effective method for the delivery of autologous bone grafts in foot and ankle surgery (the graft syringe).

Figure 1 The syringe loaded with the bone graft