References

1. Dunn J, Kusnezov N, Bader J *et al.* Long versus short cephalomedullary nail for trochanteric femur fractures (OTA 31-A1, A2 and A3): a systematic review. *J Orthop Traumatol* 2016; **17**: 361–367.

2. Westacott DJ, Bhattacharaya S. A simple technique to help avoid varus malreduction of reverse oblique proximal femoral fractures. *Ann R Coll Surg Engl* 2013; **95**: 74.

3. Hak DJ, Bilal C. Avoiding varus malreduction during cephalomedullary nailing of intertrochanteric hip fractures. *Arch Orthop Trauma Surg* 2011; **131**: 709–710.

4. Haidukewych GJ. Intertrochanteric fractures: ten tips to improve results. *J Bone Joint Surg Am* 2009; **91**: 719–729.

Tip for maintaining sterility in antegrade on-table colonoscopy

N Green, MER Williamson, J Bunni
Royal United Hospitals Bath NHS Foundation Trust, UK

CORRESPONDENCE TO
Nikki Green, E: nikki.green5@nhs.net
doi 10.1308/rcsann.2018.0094

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 colonoscope cover

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

D Gorbacev, A Pillai
Trauma and Orthopaedics Department, University Hospital of South Manchester NHS Foundation Trust, Wythenshawe, Manchester, UK

CORRESPONDENCE TO
Dmitrij Gorbacev, E: dmitrij.gorbacev@nhs.net
doi 10.1308/rcsann.2018.0090

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

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
doi 10.1308/rcsann.2018.0096

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