Technical Section [TECHNICAL NOTES AND TIPS

Management of injury to ducts of Luschka during cholecystectomy

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Aberrant biliary ducts in the gallbladder bed are called ducts of Luschka. The ducts are a significant source of bile leakage after cholecystectomy.^{1–5} We have encountered two different types of these ducts: one draining directly into the gallbladder (type 1), and the other running along the gallbladder bed and draining into the hepatic duct (type 2) (Fig 1). Using videos (available online as supplementary material), we demonstrate the procedures employed to manage injuries of these ducts.

Video 1 shows an injury to a type 1 duct of Luschka. The duct was injured at its point of connection to the gallbladder (marked 'A' in Fig 1). After removal of the gallbladder, a slight outflow of bile from a slender filament on the gallbladder bed was noted. The filament was clipped and the bile leak stopped.

Video 2 shows the first of two injuries to a type 2 duct of Luschka. The duct was injured at its central part, near the hepatic duct (marked 'B' in Fig 1).

Video 3 shows a second injury to a type 2 duct. The duct was injured at its peripheral part (marked 'C' in Fig 1). After removal of the gallbladder, bile leakage was observed from a specific region on the gallbladder bed. Sutures were placed to close the duct stump and the bile leak ceased. There were no postoperative complications.

Figure 1 The two types of ducts of Luschka: one draining directly into the gallbladder (type 1), and the other running close to the gallbladder and draining into the hepatic duct (type 2). The red arrows indicate where the ducts of Luschka were injured during cholecystectomy

If bile is noted and an injury to the duct of Luschka is observed, the injured duct should be closed with a clip or suture to prevent postoperative bile leakage. Knowledge of these rare injuries to ducts of Luschka would be helpful for surgeons.

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Indirect reduction screws: a technique to aid reduction in intramedullary nailing

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BACKGROUND

When undertaking intramedullary nailing of tibial long bone fractures, obtaining a satisfactory reduction and overall alignment is key to achieving a successful outcome.

TECHNIQUE

This technique relies on an amenable fracture pattern and a wide enough canal and metaphysis in the malreduced segment to allow movement to obtain adequate correction. Following nail insertion and locking of one metaphyseal end, residual malalignment is assessed.

Residual misalignment can be improved in the acute period by removal of distal screws and medialisation or lateralisation of the nail distally, resulting in hinging at the narrowest area of the distal segment and restoration of acceptable overall alignment. For example, Fig 1a shows a nail with unacceptable valgus misalignment. A drill can be aligned at the nail distally (through a separate lateral stab incision) and the lateral cortex and passage drilled. A long screw can then be aimed and inserted, with continued insertion after impaction on the solid surface of the nail resulting in initial translation of the nail within the metaphysis – a 'pushing' effect (Fig 1b). Once the

Figure 1 Revision of tibial fracture with indirect reduction screws.

nail contacts the cortex at the narrowest part of the malreduced segment, continued 'pushing' results in hinging of the nail at that cortical fulcrum and reduction of the overall misalignment. In this example, two indirect reduction screws were left in place while appropriate locking and blocking screws were inserted and then removed (Figs 1c,d).

DISCUSSION

'Pushing' screws can be used in minimising residual deficits in both coronal and sagittal planes in long bones such as the tibia.

Novel use of air in laser ablation of bladder transitional cell carcinoma

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BACKGROUND

Local anaesthesia laser ablation of superficial bladder tumours using 0.9% NaCl for irrigation is well established. We describe a novel technique using air insufflation.

TECHNIQUE

A flexible cystoscope is introduced into the bladder, after inserting 2% lidocaine lubricating gel per urethra. A 50-ml Luer Lock syringe is attached to the flexible cystoscope to initially empty the bladder of urine and subsequently introduce 100–200 ml air. Laser ablation of the tumour is subsequently undertaken.

This technique proffers two main advantages:

- > Improved vision as light is better transmitted in air than fluid; imperative in cases of bleeding.

- > More effective vapourisation of tumour, as the laser is not absorbed by air.

Abscess drainage without the mess

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ABSTRACT

A technique to reduce mess and odour in abscess drainage is presented.

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TECHNICAL TIP

Abscess drainage can be a messy and odorous affair. This procedure reduces mess and contains odour while providing an excellent microbiological sample. Assess the abscess volume and request an appropriately sized syringe. Remove the plunger and set aside. With the syringe ready in your non-dominant hand, thumb over the spouted end, puncture the abscess with a knife and express the pus into the open end of the syringe. Carefully replace the plunger. This sample can then be left contained or syringed directly into a sample pot. Go on to open and manage the abscess cavity as normal.

Stripped screwhead removal – a simple glove technique

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TECHNICAL TIP

Removing screws with stripped heads can prove challenging and can have the operating surgeon sending for various screw extraction sets. We describe a simple and low-cost method we have used in vivo. When met with a stripped screw head in which no screwdriver purchase can be obtained, simply cut a section from a sterile glove, place it over the screwhead and insert the screwdriver tip. This pushes the glove material into the screw head while gripping to the tip of the screwdriver, thus allowing slow and steady unscrewing of the screw. This technique is shown in the video clip.

[https://www.dropbox.com/s/hci4voNyink5yq/Screw Removal.mp4?dl=0](https://www.dropbox.com/s/hci4voNyink5yq/Screw%20Removal.mp4?dl=0)