During difficult laparoscopic cases, the follow technique can be used to obtain and optimise the operative view (demonstrated here during a cholecystectomy)

Video 1 A novel method of 'hands-free' laparoscopic retraction.

BACKGROUND

Recent years have seen a trend towards laparoscopy for many different procedures.^{1,2} Although the laparoscopic route confers several advantages, it can make surgery more technically challenging. Obtaining a good view with clear access to the operative field is vital. Multiple laparoscopic retraction techniques have been described, with many requiring constant manual input.^{3,4} We describe an inexpensive, adjustable method of laparoscopic retraction which, after setup, can be left 'hands free'.

TECHNIQUE

A small incision is made in the skin a short distance away from the operative site. A 5-mm port is introduced obliquely angled away from the site of interest. The port can then be turned towards the tissue to be retracted (this manoeuvre is against resistance) and a blunt pledget dissector placed. The port will try to revert to its original angle due to the elasticity of the abdominal wall. This places the blunt pledget dissector under tension, which provides constant retraction. The position of the blunt pledget dissector can be easily adjusted to maintain and optimise the operative view (Video 1).

DISCUSSION

This technique is simple to perform, requires only routine equipment and can greatly enhance the surgeon's view and access in more complex cases (for example, patients who are obese). It can be used across a wide range of laparoscopic procedures and frees up the operator. Use of a blunt instrument helps prevent injury of the retracted tissue. Although it requires placement of an additional port site, this is more than justified by increased intraoperative safety.

References

1. Eurostat. Statistics Explained. Surgical operations and procedures statistics. Luxembourg: Eurostat. 2017 http://ec.europa.eu/eurostat/statistics-explained/index.php/Surgical_operations_and_procedures_statistics (cited August 2018).

2. Richards MK, Mcateer JP, Drake FT *et al*. A national review of the frequency of minimally invasive surgery among general surgery residents: assessment of ACGME case logs during 2 decades of general surgery resident training. *JAMA Surg* 2015; **150**(2): 169–172.
3. Vargas-palacios A, Hulme C, Veale T, Downey CL. Systematic review of retraction devices for laparoscopic surgery. *Surg Innov* 2016; **23**(1): 90–101.
4. Ladwa N, Sajid MS, Pankhania NK *et al*. Retraction techniques in laparoscopic colorectal surgery: a literature-based review. *Colorectal Dis* 2013; **15**(8): 936–943.

Technical tip when performing a dynamic hip screw in a below-knee amputee: novel use of foot holder

A Hassan, S Shah, J Dartnell

Department of Trauma and Orthopaedic Surgery, Maidstone and Tunbridge Wells NHS Trust, Pembury, Royal Tunbridge Wells, UK

CORRESPONDENCE TO

Abdul Hassan, E: arhassan87@gmail.com
doi 10.1308/rcsann.2018.0165

To perform a successful dynamic hip screw in a patient with an extracapsular neck of femur fracture, an adequate reduction of the fracture is essential. In a below-knee amputee, this can be difficult. We report a novel method of achieving success. Instead of the foot

Figure 1 Rotated foot holder.

Figure 2 Correct positioning before the application of wool.

Figure 3 Correct positioning after the wool is applied.

holder remaining in its upright position, it is rotated 180 degrees, with the base of the foot holder pointing upwards. The knee joint is then placed in the foot rest and strapped as normal. This provides a strong construct for a successful reduction.

Figure 4 Final operative position immediately post-procedure.

Minimal access perineal urethrostomy using percutaneous nephrolithotomy skills to complete holmium laser enucleation of the prostate

M Eylert, C Bates

Urology, Royal Gwent Hospital, Newport, South Wales, UK

CORRESPONDENCE TO

Maike Eylert, E: maike.eylert@doctors.org.uk
doi 10.1308/rcsann.2018.0155

BACKGROUND

Access for complete endoscopic prostate enucleation requires a perineal urethrostomy in 1% of large prostates.¹ We describe a technique to gain extra length and manoeuvrability at the bladder neck by way of minimally invasive perineal access, rather than formal open urethrostomy.

TECHNIQUE

One should start the holmium laser enucleation of the prostate (HoLEP) as usual, but if access to the most proximal portion proves impossible, advancing an intravenous canula under endoscopic vision from the perineum into the bulbar urethra allows a guidewire to be passed into the bladder. Advance a ureteral access sheath over the wire into the bladder, as this has the required flexibility. Remove the guidewire and replace with a rigid percutaneous nephrolithotomy guidewire to straighten the path into the bladder without causing injury. Next, pass Storz telescopic dilators (Karl Storz Endoscopy UK