Technical Section [TECHNICAL NOTES AND TIPS

Novel role of the Harris femoral head gauge as an areola marker in breast procedures

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The Harris gauge is used to determine the prosthetic size in an Austin–Moore hemiarthroplasty, but its use has decreased with changes to current practice. We have identified a novel role for the gauge following a suggestion by an experienced theatre practitioner.

The gauge offers a range of diameters (38–63mm; Figures 1, 2). The nipple position is marked and the desired areolar diameter is identified. The plate is placed on the planned areola location, ensuring that the planned nipple position is central. A marker is used to draw the circumference, the gauge is removed and an incision made on the outer edge of the marking.

Figure 2 The range of diameters available for measuring femoral head and nipple-areolar diameter.

Figure 1 Close up image of Harris gauge with the different diameters shown.

ON-Q pain relief system insertion technique: intraoperative insertion of a pre-peritoneal catheter for continuous local anaesthetic infusion

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The efficacy of postoperative analgesia remains crucial in reducing early postoperative complications.¹ Intraoperatively inserted catheters allowing continuous local anaesthetic infusion into laparotomy wounds are regaining popularity, with more effective devices being introduced.²

Our video demonstrates the technique for insertion of a ON-Q® Pain Relief System (B Braun Melsungen AG, Germany) into an abdominal wound.

Precise catheter insertion is performed under visual and tactile guidance. It is postulated that fewer opioids are required, including

from patient-controlled analgesia, thereby reducing ileus. This may facilitate earlier discharge and reduce the need for the insertion of epidural catheters, which have potentially more serious complications.

References

1. Wu CL, Raja SN. Treatment of acute postoperative pain. *Lancet* 2011; **377**: 2,215–2,225.
2. Bell R, Ward D, Jeffery J *et al*. A Randomized controlled trial comparing epidural analgesia versus continuous local anesthetic infiltration via abdominal wound catheter in open liver resection. *Ann Surg* 2019; **269**: 413–419.

Acromioclavicular joint biological resurfacing using ArthroFLEX® graft

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BACKGROUND

Acromioclavicular joint arthropathy is a common cause of shoulder pain. A simple and effective treatment for this condition is excision of the distal clavicle.¹ For the majority of patients this procedure is successful and uncomplicated. Some patients present postoperatively with a stable clavicle and acromioclavicular joint, but there is a tender area localised over the remnant distal clavicle. We describe a novel solution to this clinical presentation, based on the principles of an interposition graft.

Figure 1 Exposed distal end of clavicle. Previous resection confirmed as adequate. The coracoclavicular ligaments are intact; the clavicle and acromioclavicular joint are stable.

Figure 2 ArthroFLEX® (Arthrex, LifeNet, Munich) graft is sized and shaped into a 'T' to fit the distal end of the clavicle.

TECHNIQUE

A standard open approach to the distal clavicle is employed (Fig 1). An ArthroFLEX® (Arthrex, LifeNet, Munich) graft (acellular human dermal allograft) is cut in a 'T' shape according to the size of the clavicle (Fig 2). A bone tunnel is drilled in the distal end of the clavicle (anterior to posterior). FiberTape® (Arthrex, Munich) is passed through the bone tunnel and through each end of the cross-bar of the T shaped graft (Fig 3). The FiberTape is then looped under the clavicle and tied. Vicryl is used to complete a 'purse-string' effect (Fig 4).

DISCUSSION

The ArthroFLEX graft is familiar to shoulder surgeons through its use for superior capsular reconstruction and it seemed the ideal material for this clinical scenario. This description highlights that using innovative materials in alternative anatomic areas, based on the more traditional principles of interposition graft can create a useful, novel technique.

Reference

1. Novak PJ, Bach BR, Jr, Romeo AA. Surgical resection of the distal clavicle. *J Shoulder Elbow Surg* 1995; **4**: 35–40.