Figure 4 This 44mm No. 0 broach can easily bypass the isthmus, unlike the 37.5mm No. 0 broach

By performing this sequence of events, the narrow femur distal to the metaphyseal shaft junction is rasped first, which will help facilitate the 37.5mm No. 0 rasp and stem if required. This is demonstrated in figures 3 and 4.

Being aware of this will help when dealing with proximal tight canal femurs to help minimise any untoward intraoperative complications and aid in the smooth, easy preparation of the femur.

DISCUSSION

This technique has proved effective and efficient in safely and adequately preparing the narrow femur to accept a more appropriate size stem in both total hip replacement and hemiarthroplasty. This technique does not require any extra equipment and is therefore cost neutral.

Dealing with multiple renal arteries in live donor kidney transplants

P Leighton, M Hoff, ML Nicholson, NK Russell
Addenbrooke's Hospital, Cambridge, UK

CORRESPONDENCE TO

Michael Nicholson, E: mln31@cam.ac.uk
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BACKGROUND

Transplant surgeons are increasingly making use of live donor kidney transplants with multiple renal arteries.¹ A number of techniques are available and the reconstructive options can be complex in the absence of an arterial aortic patch.²⁻⁵ Here, we describe the use of a recipient internal iliac artery to create the equivalent of an aortic patch for the anastomosis of multiple renal arteries in live donor kidney transplantation.

TECHNIQUE

The recipient internal iliac artery is mobilised and after ligation and suture at its origin and bifurcation, a suitable section is excised. On the back-table, under cold storage conditions, the explanted internal iliac is incised along its length and opened out to create an arterial

Figure 1a The three renal arteries anastomosed to the internal iliac patch

Figure 1b The reperfed kidney with a patch sutured onto the recipient left external iliac artery

Figure 1c Reconstructed image of the postoperative computed tomography angiogram demonstrating patency of external iliac arteries and three renal arteries

patch. Three size-matched ostia are fashioned in the arterial patch using skin punches and the three renal arteries are then anastomosed to the patch using fine interrupted vascular sutures (Figure 1a). The kidney is implanted by anastomosing the reconstructed arterial patch end to side to the recipient external iliac artery (Figures 1b and 1c).

DISCUSSION

The described reconstruction uses recipient arterial tissue to fashion an arterial patch. Refrigerator-stored deceased donor artery could also be used as an alternative. An important advantage of this technique is that the exacting anastomosis of small vessels can be performed meticulously on the back-table under cold conditions and this removes any time pressure from the surgeon. The subsequent recipient arterial anastomosis is more straightforward and quicker than alternative techniques where multiple renal arteries are implanted directly.

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Self-retaining retraction technique for axillary lymph node dissection for breast surgeons

A Humphreys, A Patel, R Hunt

Gloucestershire Hospitals NHS Foundation Trust, Cheltenham, UK

CORRESPONDENCE TO

Alex Humphreys, E: a.humphreys3@nhs.net
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BACKGROUND

Breast cancer operations have continued during the COVID-19 pandemic. However, with junior doctors redeployed to cope with the anticipated change in service, we describe a novel approach to the ‘assistant-free axillary clearance’. The Omni-Tract® (Minnesota Scientific, St Paul, MN, US) is a recognised retraction device for abdominal, inguinal and axillary access,¹ particularly for general and vascular surgery, and has even been described to assist in abdominoplasty.² It is a device commonly found and available in general theatres, but its use has not been documented for axillary access for breast surgeons.

TECHNIQUE

The Omni-Tract® arm is attached to the surgical table at the level of the contralateral shoulder. The angled arm (17.8cm x 40.6cm [3732]) is placed at the level of the clavicles with enough height to protect the anaesthetic airway. The patient is then formally prepped and draped. Next, the SnapClamp® blade holder (4040) is attached to the angled arm over a sterile drape and the splanchnic retractor

Figure 1 The angled arm and the splanchnic retractor