

Figure 1 Holding the flexible ureterorenoscope extended in a straight line, gentle traction is applied at opposing ends of the scope in a 'Christmas cracker' motion.



Figure 2 Holding the flexible ureterorenoscope in a curved position

gentle opposing traction with each hand in a 'Christmas cracker' motion this can be optimally achieved.

DISCUSSION

Many surgeons default to holding the scope in a curved position. Due to the length and the ever decreasing calibre of modern scopes, the transmission of torque is reduced, resulting in decreased rotation of the tip in response to movements of the hand. Consequently, the operator resorts to excessive movements in a 'windscreen wiper' motion. Using this technique improves the ability of the surgeon to control the rotation of the scope and to perform flexible ureterorenoscopy with economy of movement in a safe and efficient fashion.

Modified mattress suture

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Traditional mattress sutures prove difficult to remove when the knot becomes buried in swollen tissue. We describe a suture with the benefits of a mattress suture that can be removed more easily:

1. Starting on the 'near-side', cross the wound twice as per a regular horizontal mattress suture, leaving the loop proud.
2. Pass one free end through the loop and pull to the near-side of the wound.
3. Tie on the near-side, ensuring suture material of the loop bridges the outside of the wound.
4. This will remain easily accessible for removal regardless of swelling (Fig 1).



Figure 1 Modified mattress suture

A 'homemade' snare for endovascular procedures

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BACKGROUND

Snares have considerable utility during elective and urgent endovascular procedures.¹ Endovascular snares are expensive, costing be-

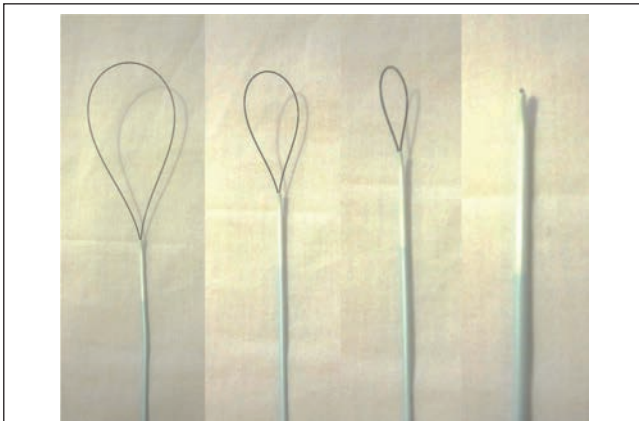


Figure 1 The 'homemade' endovascular snare, shown from open (left) to closed (right)

tween £150–£200 per unit, and may not always be readily available when required, particularly in an urgent setting.

TECHNIQUE

A 'homemade' snare can be fashioned using a 0.018" (0.46mm; external diameter) hydrophilic guidewire (eg ZIPwire®; Boston Scientific, Natick, MA, US; unit cost £18) and a 0.038" (0.97mm; internal diameter) endovascular catheter (eg Torcon NB®; Cook Medical, Bloomington, IN, US; unit cost £10). The stiff end of the guidewire is passed into the catheter until it emerges at the tip. It is then reversed and passed back into the tip to re-emerge at the catheter hub (Fig 1). The size of the snare is controlled by pulling on the two ends of the catheter at the hub.

DISCUSSION

A 0.038" catheter accommodates a 0.038" guidewire snugly. The two ends of the 0.018" guidewire amount to 0.036", allowing 0.002" (0.05mm) for ease of movement in the catheter. This approach may be used with a straight or curved-tipped catheter, the latter allowing the snare to be more easily 'directed' in the vessel. At a total cost of less than £30, this inexpensive snare is a helpful option during endovascular procedures.

REFERENCE

1. Wolf F, Scherthaner RE, Dirisamer A *et al.* Endovascular management of lost or misplaced intravascular objects: experiences of 12 years. *Cardiovasc Intervent Radiol* 2008; **31**: 563–568.

A knot quicker and easier than Whip stitching in anterior cruciate ligament reconstruction

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We describe a method for tying a self-locking knot to apply tension to a free tendon end for hamstring graft anterior cruciate ligament reconstruction. This is faster, safer and easier than Whip stitching and

is secure enough to feed the graft through bone tunnels.

The suture is folded and the tendon is laid on top (Fig 1a). The suture ends are then fed over the tendon and through the loop (Fig 1b). This is repeated (Fig 1c). The end result is shown in Figure 1d. The knot is pulled tight and a square knot is tied around the tendon to secure it.

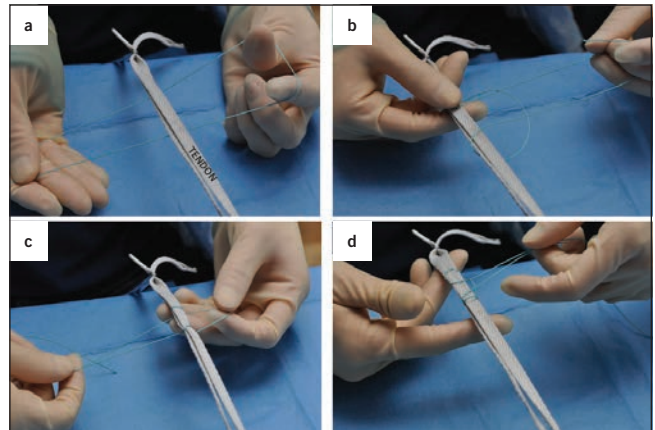


Figure 1 Method for tying a self-locking knot

Prevention of extension lag using a sling attachment for Ligamentotaxor® devices in complex proximal interphalangeal joint injuries

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BACKGROUND

Fracture subluxations at the proximal interphalangeal joint can be difficult to treat and variable in their outcome.^{1,2} A number of devices have been described that provide dynamic external fixation, allowing rehabilitation during the period of stabilisation.^{3,4} The Ligamentotaxor® device (Arex, Palaiseau, France) has been in use at our institution since 2008 and good results have been achieved. It was recognised that a small number of patients develop an extension lag at the distal interphalangeal joint while a Ligamentotaxor® device is in situ during treatment of fractures in the proximity of the proximal interphalangeal joint.

TECHNIQUE

The sling attachment shown was devised in our unit. It is quick and simple to apply to the frame. It is manufactured from Velcro® and Orfit thermoplastic (Wijnegem, Belgium), and is easy to remove for exercise (if appropriate). It does not affect the normal functioning of the frame.

1. Warmed Orfit thermoplastic is bonded onto 'loop' Velcro® approximately 2cm from one end.
2. The Velcro® strip is secured around one of the distal portions of the spring at the level of the distal phalanx (Fig 1).