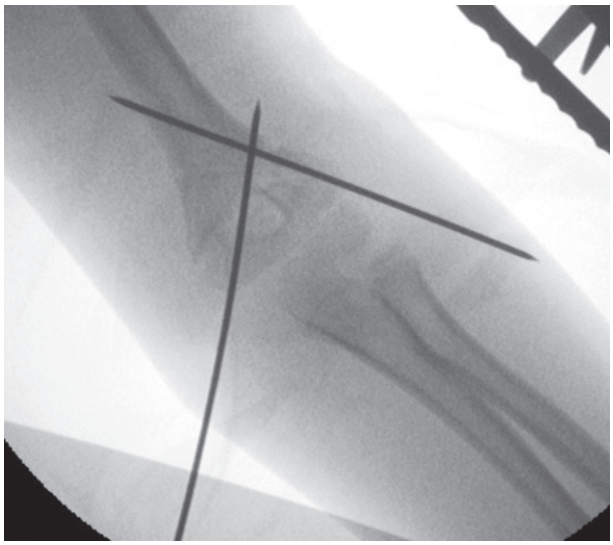

Figure 2 Final X ray with transverse K-wire removed.

closed manipulation and K-wire insertion.[1] This report describes a technique designed by MA Bari where an additional K-wire may be inserted to aid reduction.

TECHNIQUE

The patient should be prepared as for a standard manipulation and insertion of K-wires. Closed manipulation should attempted. If this is not successful in restoring anatomy, the additional K-wire may be inserted as described below. A 2-cm incision should be made over the medial epicondyle with the elbow extended and deepened to the bone with meticulous attention to preservation of the ulna nerve. A 2-mm (1.6 mm in young children) K-wire should then be inserted from medial to lateral (under X-ray control) passing through the trochlea and through the capitellum. It should then be passed out through the skin to provide a bar: this can be used to provide both traction and torque to the distal fragment allowing reduction to be easily achieved. Once satisfactory reduction is accomplished, traditional crossed K-wires should be passed using the 2-cm wound used for the medial K-wire. The transverse K-wire is now removed leaving the fracture held by the two standard K-wires.

DISCUSSION

The transverse K-wire is used both as a traction pin and a joystick to provide a useful tool in the reduction of these fractures allowing more accurate reduction of the fracture, and closed reduction of fractures that would traditionally require open reduction.

Reference

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Single-port laparoscopic appendicectomy

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BACKGROUND

The next step towards 'scar-less' surgery utilises a modified single-port inserted through the umbilicus achieving excellent cosmetic results. This modification of laparoscopic surgery is currently being adopted in various elective general surgical procedures.[1,2] Appendicectomy is one of the most commonly performed emergency laparoscopic procedures and provides an excellent training opportunity. In our institution, 26 appendicectomies (17 females) have been performed over a 6-month period.

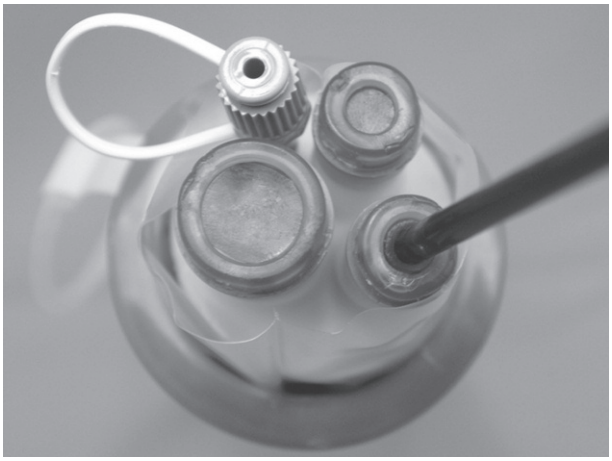

Figure 1 The tri-channel R-port.

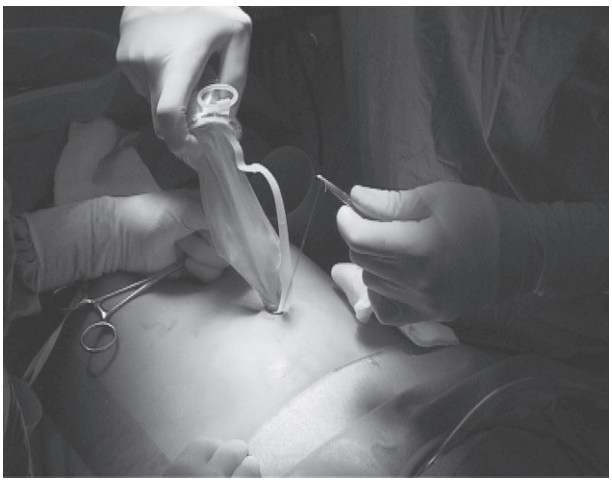

Figure 2 Intra-umbilical port insertion.

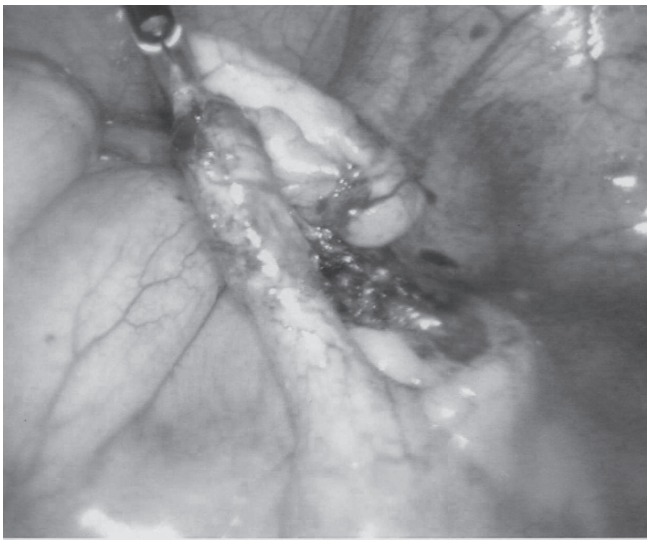

Figure 3 Safe dissection of mesoappendix is possible even with straight instruments.

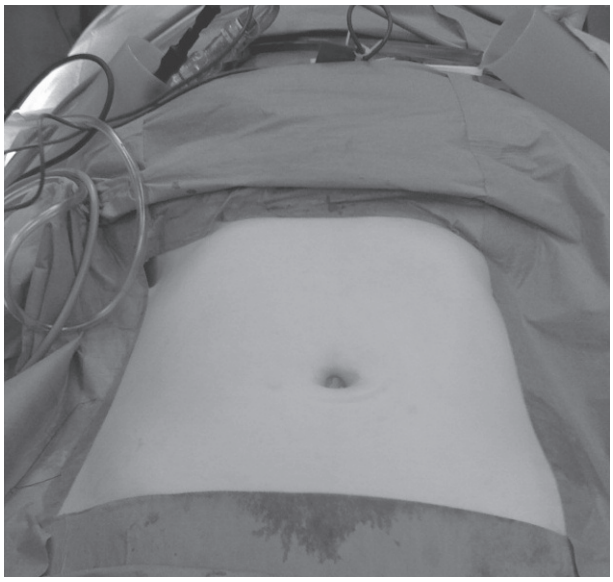

Figure 4 Incision immediately postoperatively.

TECHNIQUE

The patient is placed in the Trendelenburg position with gentle downwards left tilt, with assistant and surgeon on patient's left and scrub nurse on the right. We use a tri-channel flexible port (2 mm × 5 mm, 1 mm × 10 mm) for the procedure (Fig. 1). Incision should be intra-umbilical so that postoperative scar is well hidden (Fig. 2). Due to a single entry point, the left- and right-hand instruments cross at the point of entry to the peritoneal cavity; therefore, the surgeon must remember that their left hand is operating the instrument on the right side of the screen. Roticulating instruments are commercially available but re-useable straight hook diathermy and graspers are suitable in most cases hence reducing cost. Conventional endoloops are used to ligate the appendix base (Fig. 3). The inflamed appendix is removed inside the port minimising the chance of wound contamination. Additional 5-mm ports can be added in case of difficulty; however, this has not been necessary so far in our experience. The 12-mm transumbilical incision is closed under vision with 1–2 PDS sutures.

DISCUSSION

The potential advantages of this technique are improved cosmesis (Fig. 4), reduced pain and port-related complications. Appendicectomy provides the ideal initial training operation for single-port surgery and appears to have a short learning curve. Our early results have not shown any potential disadvantages over the traditional laparoscopic technique.

References

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2. Canes D, Desai MM, Aron M, Haber G-P, Goel RK, Stein RJ *et al*. Transumbilical single-port surgery: evolution and current status. *Eur Urol* 2008; **54**: 1020–30.

Use of a dental tool to remove excess cement in unicompartmental knee arthroplasty

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BACKGROUND

Excess retained cement following unicompartmental knee arthroplasty (UKA) is a well-recognised complication. It may result in pain,[1,2] impingement,[1,3] loose body symptoms,[2] vascular problems[3] and damage to the prosthesis or structures within the lateral compartment.[4] Symptomatic patients require additional surgery to manage such complications.[1–5] We describe the use of a tool normally used in dental surgery in order to avoid these problems.

TECHNIQUE

The senior author (NWB) uses a 'flat plastic' dental instrument. The tool has blunt ends aligned at 90º to each other (Fig. 1) which are perfectly angled to allow the rapid removal of excess cement from the femoral component and the posterior aspect of the tibial tray during prosthesis insertion (Fig. 2). It can be manoeuvred easily to break off excess bits of cement and also to retrieve them by sweeping around the prosthesis from back to side. It is also used to assess alignment of the tibial tray medially and posteriorly to feel for over or under hang.