

Cannulating a narrow pancreatic duct as part of a pancreaticoenteric anastomosis

J Broadhurst, A Takhar
University Hospital Southampton NHS Foundation Trust, UK

CORRESPONDENCE TO

Jack Broadhurst, E: jackbroadhurst@doctors.org.uk

Ultrasonography guided peritendinous anaesthetic infiltration in hamstrings autograft anterior cruciate ligament reconstruction

RP Walter, A Dhadwal, M Htyn, V Mandalia
Royal Devon and Exeter NHS Foundation Trust, UK

CORRESPONDENCE TO

Richard Walter, E: richwalter55@googlemail.com

When performing pancreaticoenteric anastomoses, the pancreatic duct is commonly cannulated with a paediatric nasogastric feeding tube. This transanastomotic stent is directed distally into the bowel to divert the flow of pancreatic enzymes away from the anastomosis. In a soft pancreas, the pancreatic duct can be too narrow to admit the smallest size (4Fr) feeding tube. More narrow lumen tubes like intravenous cannulas are too short to protect the anastomosis. A 22G cannula inserts snugly into the distal feeding tube (Fig 1A), which when trimmed creates a tapered tube (Fig 1B) that is easily inserted but still long enough to protect the anastomosis.

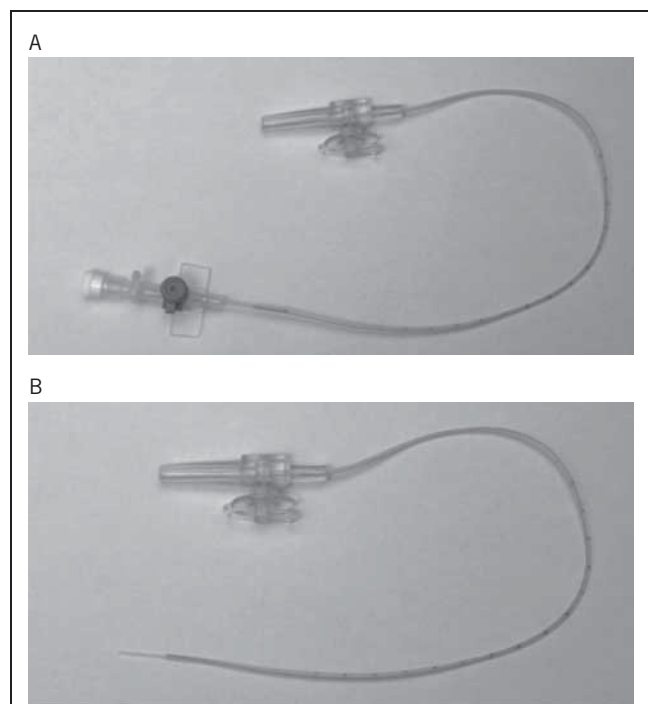


Figure 1 The 22G cannula is inserted into a 4Fr feeding tube (A). The cannula is then divided at the level of the injection port, leaving the tapered end (B).

BACKGROUND

In recent years, there has been a trend towards performing anterior cruciate ligament reconstruction as a day-case procedure.¹ In order to accomplish this, effective and early control of postoperative pain must be achieved, including at the graft harvest site.

TECHNIQUE

After a standardised anaesthetic is administered, comprising general anaesthetic and femoral nerve blockade for reconstruction site comfort, guided peritendinous injection of local anaesthetic is performed (Figs 1 and 2). Ultrasonography is used to visualise the gracilis and semitendinosus tendons from the pes anserine insertion proximally to a point 5cm beyond the musculotendinous junction. Under aseptic

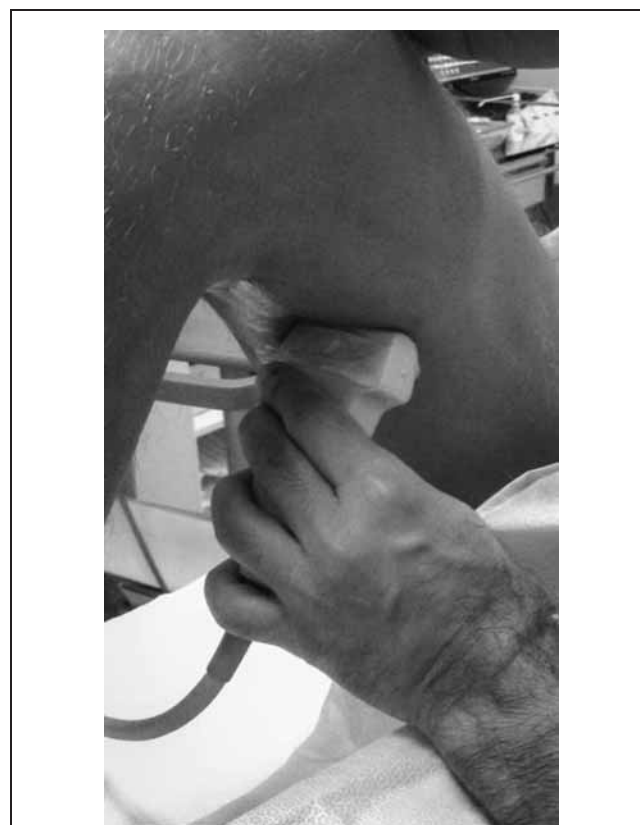


Figure 1 Ultrasonography guided peritendinous administration of anaesthetic

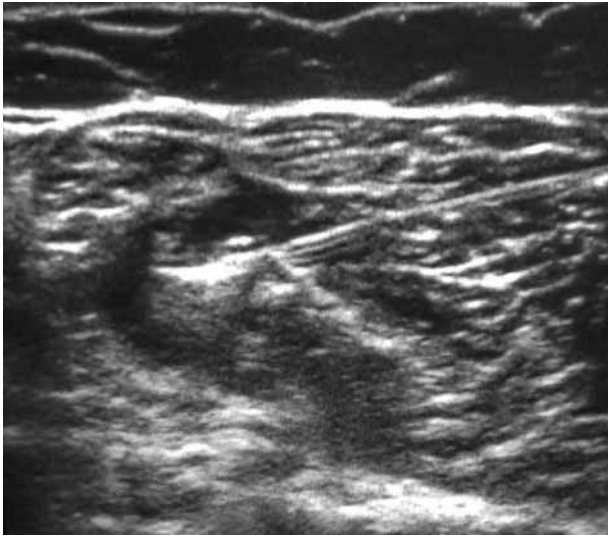


Figure 2 Ultrasonography showing the tip of the hypodermic needle in the peritendinous tissue

conditions, a syringe and needle are used to administer 30ml of 0.25% bupivacaine with 1:200,000 adrenaline percutaneously to the peritendinous tissues, avoiding intratendinous injection. Tendons are harvested intraoperatively using an open ended tendon stripper.

DISCUSSION

Previous reports have described techniques to administer local anaesthetic to the hamstrings tendon bed via the harvest tract after graft harvest.^{2,3} In these descriptions, the injection was given via a blunt device such as a suction catheter or arthroscopic shaver sleeve into the donor site space, without image guidance. The use of ultrasonography guidance allows anaesthetic to be introduced to the target site with improved accuracy. In addition, it allows the safe use of a hypodermic needle, allowing peritendinous tissue infiltration rather than simple filling of a dead space. We have performed this technique without complication in 14 patients. Postoperative pain scores were uniformly low and all were discharged successfully as day cases.

References

1. Khan T, Jackson WF, Beard DJ *et al*. The use of standard operating procedures in day case anterior cruciate ligament reconstruction. *Knee* 2012; **19**: 464–468.
2. Bushnell BD, Sakryd G, Noonan TJ. Hamstring donor-site block: evaluation of pain control after anterior cruciate ligament reconstruction. *Arthroscopy* 2010; **26**: 894–900.
3. Logan JS, Elliott RR, Wilson AJ. A new technique for hamstring donor site blockade in anterior cruciate ligament reconstruction. *Ann R Coll Surg Engl* 2011; **93**: 326.

A trochanteric sparing technique for stem removal in revision hip arthroplasty

S Aftab, D Basu, D Jagajeevanram

West Hertfordshire Hospitals NHS Trust, UK

CORRESPONDENCE TO

Syed Aftab, E: s.m.e.aftab@gmail.com

BACKGROUND

Extended trochanteric osteotomy is a commonly used technique for retrieving a previously implanted femoral stem. While it is safe and provides good access, there are associated complications including subsidence¹ and non-union.² An intact greater trochanter and circular rim in which to implant a revision stem would potentially lead to better outcomes. It has been suggested that trochanteric sparing osteotomies may be desirable.³ We describe a technique that reliably provides access to an implanted stem, aiding removal while avoiding osteotomy of the greater trochanter, maintaining bone stock and an intact circular rim.

TECHNIQUE

The femur is exposed and the osteotomy site marked (Fig 1). A window with a rectangular base is created using a drill and saw. It is



Figure 1 The femur is exposed and the osteotomy site marked