

Figure 2 The MAGNA-FINDER® device



Figure 3 Shotgun injury to the hand, showing entry point along with the direction of travel and resting position of the shot as determined by the MAGNA-FINDER®

TECHNIQUE

Ferromagnetic shot can be located using a MAGNA-FINDER® (Allergan, Irvine, CA, US) device (Fig 2). This is included with Natrelle® (Allergan) breast expanders/implants that contain an integrated injection port. The MAGNA-FINDER® is placed over the entry wound, advanced and repositioned. When orientated perpendicular to the skin surface in two orthogonal planes, the magnet overlies the projectile. A line drawn from the entry point to this resting position indicates the track of the projectile to be explored (Fig 3).

DISCUSSION

This technique, using a cheap device that is available in most plastic surgery units, reduces the need for radiographic shot location, limits incisions and may reduce operative time. However, the MAGNA-FINDER® will not identify non-ferromagnetic projectiles such as lead shot.

References

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Use of rigid ureteroscope in the endoscopic assessment and management of urethral strictures

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BACKGROUND

Endoscopic surgery is used commonly in treating urethral strictures.¹ Prior to endoscopic treatment, it is important to assess the location, length and severity of the stricture.² Conventional techniques to assess stricture(s) are ascending and descending urethrography. Magnetic resonance imaging and ultrasonography are also used.³ We describe a technique that can be performed at the time of surgery.

TECHNIQUE

A short, semirigid 7.5Fr ureteroscope is used to inspect the urethra. An assessment is made of the anatomical site, extent and density of the stricture. This helps plan the extent of the incision required to open up the stricture. A guidewire is then inserted through the working channel of the ureteroscope into the bladder under direct vision to perform the procedure safely. An optical urethrotome is used to incise the stricture in the normal way. A 16Fr open tip urethral catheter can then be inserted over the guidewire. This obviates the need to use the split sheath over the optical urethrotome.



Figure 1 An endoscopic view of a stricture through a ureteroscope

DISCUSSION

We claim no originality for this technique but we are not aware of any previous description in the literature. Use of a paediatric cystoscope in the diagnosis and management of urethral stricture disease has been described previously.⁴ However, they are not available in most of the adult urology units in the UK. We usually use a short, semirigid ureteroscope to inspect the urethra as it gives a better assessment of the stricture(s) before any endoscopic treatment is undertaken. We therefore recommend the use of a ureteroscope prior to optical urethrotomy in all patients.

References

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3. Kim B, Kawashima A, LeRoy AJ. Imaging of the male urethra. *Semin Ultrasound CT MR* 2007; **28**: 258–273.
4. Figueroa JC, Hoenig DM. Use of 7.5F flexible pediatric cystoscope in the staging and management of urethral stricture disease. *J Endourol* 2004; **18**: 119–121.



Figure 2 The distance is marked on the rasp inserter handle

Accurate femoral stem depth insertion in total hip replacement

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A video of this technical paper can be viewed at:

A video demonstration of this technical paper can be viewed at <http://youtu.be/yTZ5evOtSOE>.

If you would like to submit a video of a technical tip, please visit our submissions page for instructions: <http://www.rcseng.ac.uk/publications/submissions>



Figure 3 The correct depth of insertion is checked against the greater trochanter intraoperatively

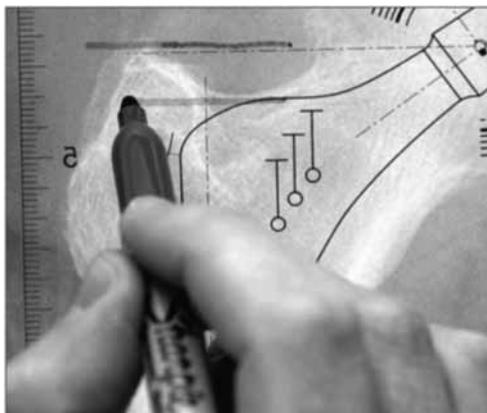


Figure 1 The depth of stem insertion is templated preoperatively

Leg length discrepancy in total hip replacement is a cause of patient dissatisfaction, litigation and biomechanical problems. The use of a cemented, collarless femoral stem allows complete control of depth of stem insertion. We present a technical tip to aid stem depth insertion. The preoperative radiograph is templated as normal and the distance from the shoulder of the prosthesis to the tip of the greater trochanter is measured (Fig 1). This distance is then transposed on to the stem inserter handle (Fig 2) and referenced to the greater trochanter intraoperatively (Fig 3), ensuring rasp and stem depth match the templated position.