

TECHNIQUE

Pass a drill guide through the jig used for inserting proximal screws. Leave the drill guide in position against the limb. This can now be used to align the C-arm. Position the C-arm distally and adjust its position until it is parallel to the drill guide in its orbital and swivel axis. This will give near perfect alignment to the distal locking holes. Finer adjustments may be needed under image intensifier guidance to gain the final position. Once satisfactory alignment is achieved, insert the distal screws as usual.

DISCUSSION

This simple technique is effective, saves time and reduces radiation exposure to both the patient and surgeon. This technique is free as it uses standard equipment that comes with the nail.

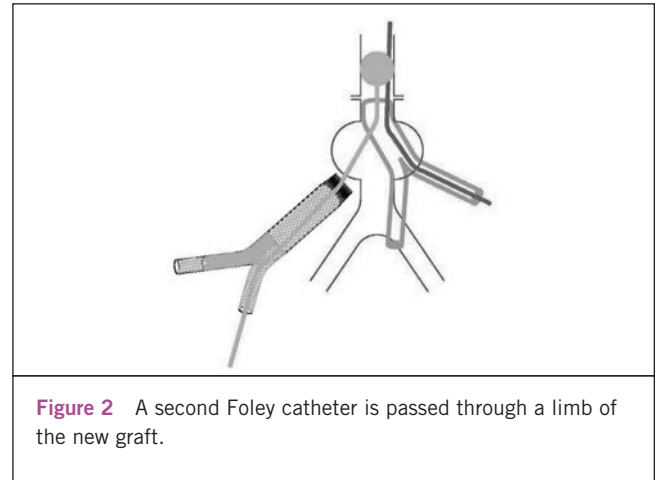


Figure 2 A second Foley catheter is passed through a limb of the new graft.

Explantation of aortic infrarenal stent graft

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This technique has helped us to achieve proximal control during stent graft explantation. A large Foley catheter is inserted through a disconnected limb of stent graft and placed in the suprarenal aorta. Inflation of the balloon provides proximal control (Fig 1). The proximal

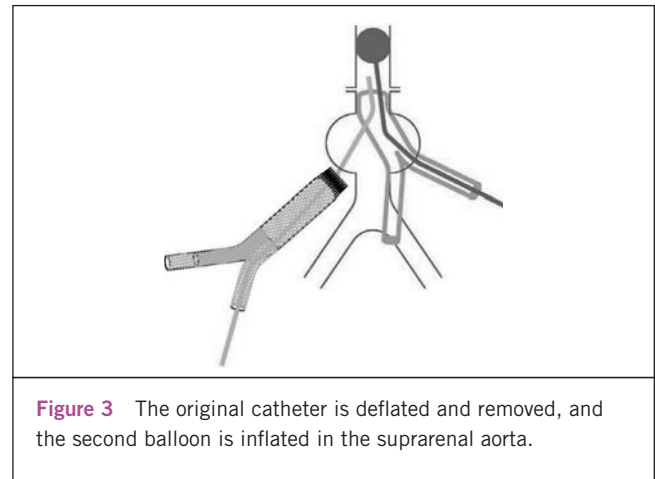


Figure 3 The original catheter is deflated and removed, and the second balloon is inflated in the suprarenal aorta.

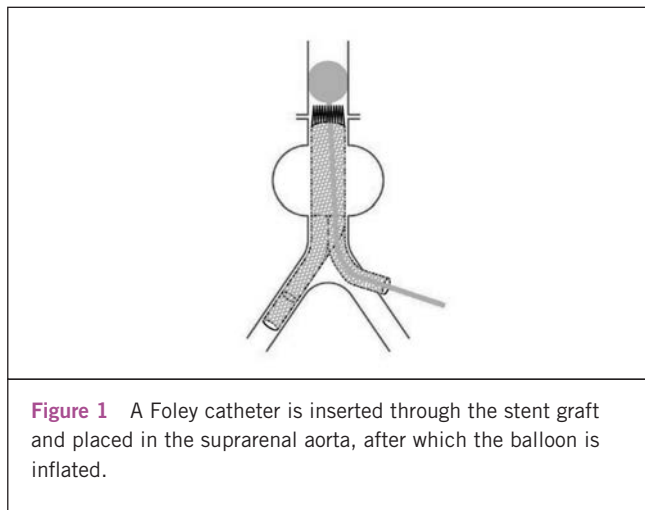


Figure 1 A Foley catheter is inserted through the stent graft and placed in the suprarenal aorta, after which the balloon is inflated.

end of the stent graft is extracted from the aorta. If another graft is used, proximal anastomosis is carried out with the balloon inflated. To complete the anastomosis a second Foley catheter is passed through a limb of the new graft (Fig 2). While the original catheter is deflated and removed, the second balloon is inflated in the suprarenal aorta (Fig 3) and the anastomosis completed.

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A technique for optimal manipulation of rotation of the flexible ureterorenoscope

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BACKGROUND

Three different types of movement are required to perform flexible ureterorenoscopy: insertion/retraction, rotation and deflection of the tip. Many trainee urologists struggle to manipulate the rotation of the scope. We describe a technique for optimally controlling this rotation.

TECHNIQUE

When performing ureterorenoscopy, the scope is extended in a straight line (Fig 1) rather than held in a curved position (Fig 2). By applying