

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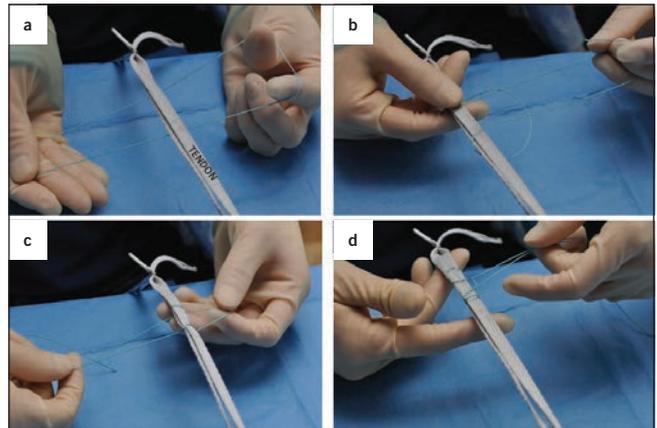
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We describe a method for tying a self-locking knot to apply tension to a free tendon end for hamstring graft anterior cruciate ligament reconstruction. This is faster, safer and easier than Whip stitching and

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.<sup>1,2</sup> A number of devices have been described that provide dynamic external fixation, allowing rehabilitation during the period of stabilisation.<sup>3,4</sup> 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).