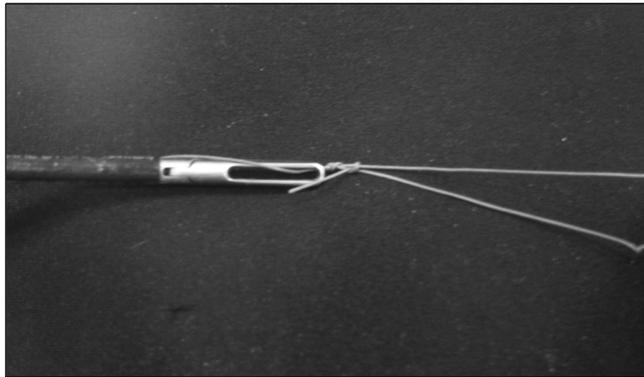
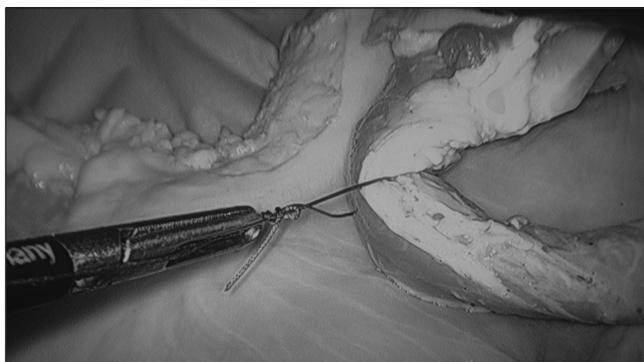


the fenestration of the mobile jaw of a Johan forceps (Fig 1). The jaws of the forceps are then loosely approximated behind the knot to act as the knot pusher (Fig 2) and this ensures smooth delivery of



**Figure 2** Tip of Johan forceps in close approximation with the knot

the ligature (Fig 3). Care is needed to ensure the jaws are not closed too tightly as the serrations may shred the suture material. We have found the optimal suture to be a size 1 Vicryl® suture (Ethicon Inc, Somerville, NJ, US), which balances knot security with thread robustness and strength. Monofilaments are an alternative.

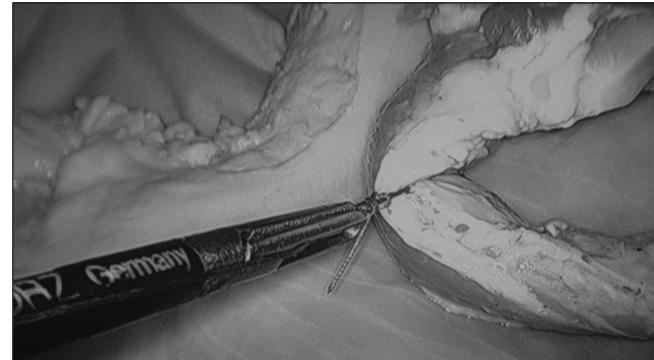


**Figure 3** Johan forceps tip acting as a guide to help controlled placement of knot

The advantage of passing the standing end through the fenestration as shown is that the knot is always easily retrieved should the forceps and standing end become misaligned during the pushing process. The technique is equally applicable to loops created extracorporeally and used in a lasso fashion for pedicle ligation (Fig 4) and for sutures passed intracorporeally but tied extracorporeally. In the latter case, greater care is required to define the standing end during the knot tying process.

**DISCUSSION**

The self-created endoloops are reliable, safe and cost effective.<sup>3</sup> The base of the appendix can be secured safely without the need for expensive commercial endoloops or a knot pusher, thereby significantly reducing costs. This technique is also adaptable for the creation of extracorporeal knots for ligation in continuity as might be desired for



**Figure 4** Secure and precise placement of knot at the desired site for ligature tightening

tying off an appendicular artery. Our technique has the added benefits of secure knot placement at the correct anatomical site with the help of a Johan forceps, which has not been described previously.

**References**

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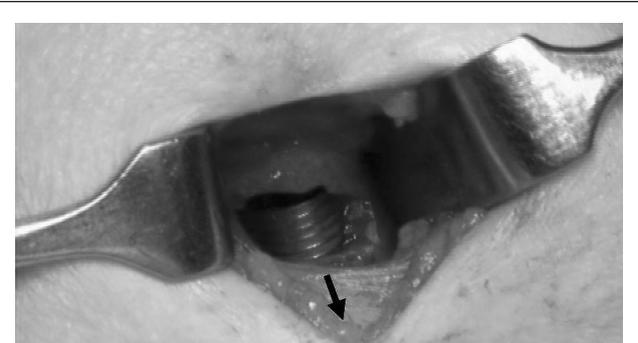
**A simple way to allow continuous ventilation during tracheostomy**

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During open tracheostomy, formation of the tracheal window may puncture the endotracheal tube cuff inadvertently. This causes loss of



**Figure 1** Operative photograph showing tracheostomy: The endotracheal tube has been advanced caudally to ensure the cuff is safe when forming the tracheal window.

the controlled airway, necessitating rapid and accurate tracheostomy tube placement. This could induce anxiety in both the anaesthetist and surgeon. In our practice we advance the endotracheal tube before fashioning the window so the cuff is distal to the tracheostomy site. Mucosal damage is avoided by deflating the cuff slightly before advancement and subsequent reinflation. There is a risk of unilateral ventilation (albeit only for a short time) if the tube is advanced too far. This technique allows more controlled tracheostomy placement.

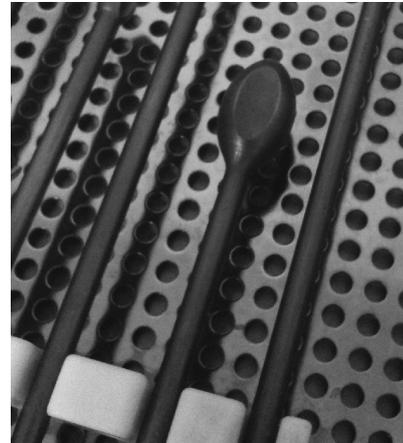
**Localised bone grafting of acetabular cysts during total hip replacement**

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Bone cysts are commonly found when preparing the acetabulum during a total hip replacement (Fig 1). We describe a simple yet effective technique of localised bone grafting using the Exeter™ (Stryker, Newbury, UK) plug trials already available when using the Exeter™ total hip system (Fig 2).

The Exeter™ plug trials used to measure cement restrictors can be employed to pack bone graft into cysts. They are supplied in diameters from 6mm to 20mm and allow the surgeon to choose the appropriate sized plug trial to fit the bone cyst for optimal impaction. The long T-handle allows this technique to also be applied in overweight patients with deeply located acetabuli.



**Figure 2** Exeter™ plug trial head is ideal for bone graft impaction within cyst



**Figure 1** Anteroposterior x-ray of right hip with a superiorly located acetabular cyst