A

B

Figure 1 (A) Assembly of traction weights, wrist splint and adhesive tape and (B) application of traction device.

often relies on taping weights directly to the patient's arm using adhesive dressings.

TECHNIQUE

We constructed a novel traction device by combining a standard Futuro-type wrist splint with traction weights (Futuro brand; Beiersdorf, Hamburg, Germany). The metallic strut of the wrist splint provides a firm base onto which the weights are attached using strong fabric adhesive tape (Fig. 1). The device allows traction weights to be added or removed whilst in use. Traction

does not rely on direct contact between skin and adhesive tape thus minimising the risk of skin damage through shearing force. If scapular manipulation is required to complete the shoulder reduction, a single operator can still perform this.

DISCUSSION

All patients reported the device to be comfortable and none suffered adverse effects as a result of the device. The traction device was easy to apply, adjust and was readily constructed from materials available in the accident and emergency department.

References

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'Needle adhesiolysis' prior to port insertion during laparoscopy

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BACKGROUND

Performing laparoscopy in patients who have had previous abdominal surgery is often made more hazardous due to the presence of intra-abdominal adhesions. The umbilical port can usually be inserted safely under direct vision using an open technique; however, adhesions commonly form between bowel and the anterior abdominal wall, preventing visualisation of the anterior abdominal wall in order to insert secondary ports.

TECHNIQUE

A needle mounted on a syringe to use as a handle is inserted through the anterior abdominal wall under direct vision of the laparoscope. This needle is then advanced through the adhesions and the side of the bevelled tip of the needle used to incise the adhesions (Fig. 1). This can be repeated, inserting the needle in different places, until sufficient adhesiolysis has been performed to allow visualisation of the abdominal cavity distally and safe insertion of a secondary port under direct vision of the laparoscope. Once another port is safely in place, an instrument can be passed to divide any remaining adhesions.

Figure 1 Using a needle to incise intra-abdominal adhesions. Arrow head points to the tip of a needle passed through the abdominal wall.

CONCLUSION

We have found this to be a simple technique which makes laparoscopic port insertion in the presence of adhesions safer.

The spouted colostomy

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BACKGROUND

In 1952, Professor Bryan Brooke described his technique for everting an ileostomy in order to minimise skin excoriation, which continues to be used today.¹ The classical method of colostomy formation involves suturing the cut end of the bowel directly to the skin resulting in a flush stoma.² We propose the eversion-technique be used for the end colostomy in order to spout the colostomy in a similar fashion to the Brooke ileostomy. This allows easier and more effective application of a stoma appliance.

TECHNIQUE

The end of the bowel wall is sutured to the skin by means of a 3/0 absorbable suture. The suture first passes through the skin,

Figure 1 Diagrammatic representation of the proposed technique.

followed by a seromuscular bite taken 1.5 cm proximal to the end of the bowel; the suture is then passed through the full thickness of the end of the bowel wall. Four of these sutures are placed at quarterly intervals and then secured. Additional sutures are placed as required between these points passing solely between skin and the end of the bowel (Fig. 1).

DISCUSSION

Not only does the Brooke ileostomy help prevent skin excoriation, it also facilitates the application of a closely approximated appliance to the base of the stoma, thereby minimising ingress of fluid under the free edge of the stoma appliance which may subsequently lead to leakage. This benefit can also be achieved with the formation of a spouted colostomy, allowing easier fitting of a stoma appliance and minimising the risk of leakage associated with any liquid effluent. This technique has received favourable feedback from stoma therapists locally.

References

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2. Kirk RM. *Basic Surgical Techniques*, 5th edn. Edinburgh: Churchill Livingstone, 2002.

EDITOR'S COMMENT

The editor would like to invite comments on this particular Technical Note. Why, in particular, has colostomy not always been performed in this way (like ileostomy)?