Figure 1 Postoperative picture of a patient who underwent a right popliteal to dorsalis pedis artery bypass and amputation of a gangrenous hallux. Incision is 1.5 cm medial to the dorsalis pedis artery (solid line). The dotted line shows the pathway of the vein graft and X marks the level of the graft penetrating the interosseous membrane.

DISCUSSION

The authors have used the above measures in six patients without encountering any wound complication. In the event of wound dehiscence, the graft will still be covered and protected by the lateral fascio-cutaneous flap.

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A simple, safe and cost-effective technique for closure of difficult laparoscopic port sites

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BACKGROUND

Port site herniation and Richter's type of strangulation of the bowel is a recognised complication following laparoscopic procedures.^{1,2} Hand suturing of port sites can be difficult, especially in obese patients. A simple, safe, quick and cost-effective technique is described.

Figure 1 Diagrammatic illustration of the technique.

TECHNIQUE

After removal of the port, the modified aneurysm needle (bent to a 'J' shape), threaded with an appropriate suture, is passed into the abdomen through the port site incision. The needle is then turned 90° and the eye is forced through the peritoneum and sheath from inside the abdomen, by pulling on the handle at an angle (Fig. 1A). The eye of the needle with the suture loop emerges. One arm of the suture loop is drawn out. The instrument (still threaded) is then drawn back into the peritoneum cavity, turned 180° and forced through the opposite side sheath, as described above. The suture is then withdrawn to free the needle (Fig. 1B). The tip is then drawn back into the peritoneal cavity and needle eased out.

DISCUSSION

Various techniques have been described: some require expensive disposable instruments,³ whilst others need intraperitoneal threading of the needle, which can be time consuming and risk injury to intraperitoneal structures.⁴ Aneurysm needles are readily

available and re-usable. In our hands, the needle is placed blindly, but this method can be performed under laparoscopic vision. The technique is straight-forward to learn.

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Creating retroperitoneal space for retroperitoneoscopy using RÜSH® bladder hydrodistension catheter

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BACKGROUND

Creating a retroperitoneal space is an important early step in retroperitoneoscopy.¹ Commercially, there are balloon-dissection devices designed for this purpose (Auto Suture; Tyco Healthcare, Norwalk, CT, USA). However, we describe the use of a disposable 16 Ch RÜSH® bladder hydrodistension catheter (RÜSH Inc., High Wycombe, Bucks, UK) as a cheap, safe and effective alternative (Fig. 1).

TECHNIQUE

The patient is placed in the lateral decubitus position. A small incision is made below the tip of 12th rib into the retroperitoneal

Figure 1 RÜSH® hydrodistension catheter and 60-ml catheter syringe

space. The catheter, with a maximum balloon capacity of 1500 ml, is guided by a finger into the retroperitoneum. A total of 800 ml of normal saline is instilled into the catheter using a catheter syringe. The saline is then aspirated with suction, and the catheter removed, before laparoscopic ports are inserted.

DISCUSSION

We have completed 40 retroperitoneoscopies (22 nephrectomies, 10 pyeloplasties, 8 ureterolithotomies) using this technique, and adequately created retroperitoneal space in all cases. There were no peritoneal injuries or complications. Balloon rupture occurred in one patient, the fragments were easily retrieved retroperitoneoscopically. The catheter has significant cost benefit over the balloon-dissection device – £56.79 versus £164.97, respectively. Furthermore, the hydrodistension catheter is licensed for intracorporeal inflation with saline up to 1500 ml; alternative methods described using a surgical glove finger tied to the end of a catheter¹ or Foley catheter balloon² are not. The catheter is made of latex, so caution should be taken for possible latex allergy. In conclusion, we have found this to be a safe and cost-effective technique for establishing the retroperitoneal space prior to laparoscopic surgery.

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