replaced every 2–3 days, as the sebum produced by the patient's nose reduces adhesion.

DISCUSSION

Ulceration of the nares is associated with a nasogastric tube being present for a protracted period, specifically one that has been taped too firmly, failing to allow it to migrate with deglutition. This results in pressure necrosis of the edge of the nostril as shown in Figure 1, and an unsightly notch shaped defect with permanently impaired cosmesis. The same mechanism leads to painful ulceration of the soft palate, with pain on swallowing, and a consequent risk of impaired nutrition. This can easily be avoided by allowing the nasogastric tube to move on swallowing, and this technique combines secure attachment of a nasogastric tube with avoidance of nasal and soft palate ulceration.

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Laparoscopic gastrostomy insertion, a safe and simple technique

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BACKGROUND

The insertion of a percutaneous endoscopic gastrostomy (PEG) tube can be complicated by the presence of malignancy or neurological disorders of the upper gastrointestinal tract. In these cases, a feeding gastrostomy is traditionally inserted by laparotomy carrying significant morbidity from wound infections and intraperitoneal leaks. Laparoscopic insertion using extracorporeal fixation minimises these risks and is simple to perform.

TECHNIQUE

The procedure can be performed under local or general anaesthesia. A 10-mm port is inserted below the umbilicus under direct vision.

Figure 1 The anterior gastric wall is grasped and brought through the port site.

Pneumoperitoneum is created with a CO₂ pressure between 5–10 mmHg. The table is tilted 20° in the head-up position and a 10-mm port introduced under direct vision over the position of the anterior gastric wall. The gastric wall is grasped with a toothed grasper and brought through the port site whilst deflating the abdomen (Fig. 1). Once exteriorised, the gastric wall is secured with two babcocks. Two 2-0 vicryl purse strings are inserted and a gastrostomy formed in the centre using a number 11 blade. The orifice is widened using an artery clip and a feeding tube inserted. The balloon or flange of the feeding tube should then be positioned behind the inner vicryl purse string. The stomach wall is then secured to the anterior abdominal wall with the remaining suture. Pneumoperitoneum is recreated to check for bleeding and to confirm the correct positioning of the tube.

DISCUSSION

This technique can be used by surgeons with limited laparoscopic experience, with minimal risk to the patient.

A simple technique for templating of mesh for acetabular reconstruction

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BACKGROUND

Revision hip arthroplasty often requires the reconstruction of large acetabular defects. One technique by which this can be