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

Figure 1 The use of an intra-operative template (disposable tray) to fashion an acetabular reconstruction mesh.

Figure 2 Template over the mesh.

Figure 3 Mesh was fashioned using the template.

Figure 4 Mesh comfortably seated in the acetabulum without any soft tissue damage.

achieved is to use mesh and impaction bone grafting. The mesh is cut using shears and has to be repeatedly inserted and removed until the desired shape is achieved. The trimmed mesh is difficult to handle with sharp edges. Multiple glove punctures are common, with potential for a sharps injury to the surgeon, and bacterial contamination of the mesh. The sharp edges also catch awkwardly on the surrounding soft tissues and skin during insertion and removal, causing damage. We suggest a templating technique, which minimises these problems.

TECHNIQUE

An estimate of the required size of mesh is made by measuring the acetabular defect using a flexible ruler. A provisional template is then cut from a flat sheet of moldable plastic. We have found a disposable sterile instrument tray on which the mesh cutter is packaged on by our local sterile services department to be ideal (Disposable instrument tray, DeRoyal). The template is then offered up to the acetabulum and trimmed until the desired shape is achieved. The metal mesh can then be easily cut to the correct shape using the template, and only has to be handled once during insertion.

DISCUSSION

The plastic template is easy and safe to handle when manoeuvring it in and out of the wound. A mesh of the appropriate shape is reliably produced without the hazards of repeated handling. No additional cost is added to the procedure. The use of a template minimises the risk of inadvertently wasting an expensive mesh by accidentally cutting it too small. We now routinely use this technique in acetabular reconstructions requiring mesh.