Technical Section

TECHNICAL NOTES & TIPS

TECHNICAL NOTES

Endoscopic fixation of rectal decompression tube for sigmoid volvulus

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BACKGROUND

The principle of non-operative decompression of sigmoid volvulus was introduced by Bruusgaard in 1947¹ and has remained the initial procedure of choice in patients without peritonitis.^{2,3} Traditionally, a rectal tube is placed with the aid of a rigid sigmoidoscope to achieve decompression of the sigmoid volvulus and reduce short-term recurrence. Flexible sigmoidoscopy may be a safer technique to achieve decompression, and also allows direct visualisation of the mucosa to exclude ischaemia. The difficulty, however, is the placement and maintaining the position of a rectal tube.

TECHNIQUE

We describe a method for the short-term fixation of a rectal tube. Initially, decompression of the volvulus is performed with flexible

Figure 2 Sigmoid volvulus.

Figure 1 Demonstration of method of endoclip fixation of rectal tube.

Figure 3 Flatus tube *in situ* with endoscopic clip visible.

Figure 4 Fixation of suture attached to rectal tube within sigmoid colon.

sigmoidoscopy. To enable placement of the rectal tube, an absorbable suture is tied in a loop through the distal aperture of the rectal tube. The flexible sigmoidoscope pulls the rectal tube 'piggy-back' style to an appropriate position in the sigmoid colon. An endoscopic clip applicator is passed through the biopsy channel of the endoscope; the loop of suture tied to the rectal tube is placed in the jaws of the endoclip. The rectal tube is placed under direct vision and the attached suture is fixed to the colonic mucosa with the endoclip (Figs 1 and 4). This allows secure fixation of the rectal decompression tube thereby minimising short-term recurrence. The tube can be later removed easily in the ward by maintaining firm traction.

DISCUSSION

This method allowed resolution of sigmoid volvulus in four patients in our unit thus far (Figs 2 and 3) without morbidity or complications. This method allows safe and secure placement of a rectal tube under direct visualisation.

References

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2. Friedman JD, Odland MD, Bobrick MP. Experience with colonic volvulus. *Dis Colon Rectum* 1989; **32**: 409–16.
3. Peoples JD, McCafferty JC, Scher KS. Operative therapy for sigmoid volvulus. *Dis Colon Rectum* 1990; **33**: 643–6.

Paediatric umbilical hernioplasty

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BACKGROUND

Techniques used to repair congenital umbilical hernias, that do not involve raising complex skin flaps, often result in the loss of the umbilical depression.^{1–3} This report describes a straightforward method for paediatric umbilical hernioplasty that we feel enables a good repair and achieves an acceptable cosmetic outcome.

TECHNIQUE

The umbilical skin is lifted and a circular incision is made leaving approximately 0.5 cm of skin for the construction of

Figure 1 Discarding the excess skin enables clear access to the hernial defect.

Figure 2 The anchor suture traverses the closed defect.