Figure 3 The purse string is drawn before the anchor suture is tied.

Figure 4 Immediate postoperative result.

Figure 5 Three-month postoperative result.

the neo-umbilicus. The excess skin is discarded and the defect in the linea alba is identified (Fig. 1). The hernial sac is reduced or excised and the defect is closed using four interrupted 3-0 absorbable sutures, with care to leave the lateral two sutures long. An anchor suture is then placed through the subcuticular superior part of the wound. The long lateral sutures are used to lift the fascia away from the underlying peritoneum enabling the anchor suture to be passed safely across the closed defect (Fig.

2) and finally through the subcuticular inferior part of the wound. A purse string suture is then used to close the skin defect (Fig. 3). The anchor suture is finally tied creating an umbilical depression (Fig. 4).

DISCUSSION

Over a period of 3 years, the senior author has repaired 20 congenital umbilical hernias using this technique. There have been no postoperative complications or recurrences and both patients as well as parents have been pleased with the aesthetic results (Fig. 5).

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Technique for changing a fine-bore suprapubic catheter to a long-term catheter

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BACKGROUND

In urinary retention, emergency suprapubic catheterisation is useful when urethral catheterisation has failed. Fine-bore catheterisation using a Seldinger technique is safer in less experienced hands, although wide-bore catheterisation using a trocar offers a longer term solution. Complications of suprapubic catheterisation include pain, bowel and vascular injury and urinary leakage with cystostomy formation. Cystoscopic suprapubic catheterisation is associated with 1.8% mortality and 19% 30-day, complication rates.¹ We describe a simple technique to change a fine-bore to a wide-bore catheter, under local or general anaesthetic.

TECHNIQUE

Inject the suprapubic site with local anaesthetic (20 ml 1% lidocaine). Fill the bladder with 100 ml of sterile water. Pass a guide wire through the fine-bore catheter into the bladder. Remove the fine-bore catheter, keeping the guide wire in place. Dilate the tract with a 16-F Nottingham dilator. Feed a lubricated

16-F, open-ended catheter, over the guide wire into the bladder and inflate the balloon. Remove the guide wire.

DISCUSSION

This technique is a useful tool for urologists and can be performed under local anaesthesia. It is particularly useful in the emergency setting and for high-risk patients who may not tolerate more definitive procedures.

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Intrapleural ropivacaine local anaesthetic spray as an adjunct in patients undergoing surgical pleurodesis

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BACKGROUND

Generation of pleural inflammation (pleurodesis) to prevent recurrence for pneumothoraces is established. It is performed by mechanically abrading or chemically irritating the pleurae during video-assisted thoracoscopic surgery (VATS). Regardless of method, patients experience significant chest wall pain that may impede full lung expansion because of a reluctance to cough or deep breathe. The use of the local anaesthetic ropivacaine (Naropin®, Astra Zeneca, 15 Stanhope Gate, UK) insufflated as a spray into the pleural cavity under vision has been routinely used by the senior authors with good analgesic effect. The technique has not been previously described.

TECHNIQUE

Following isolation of the lung and insertion of a VATS port, the pleural cavity and deflated lung are inspected. Typically, 10 ml ropivacaine 7.5 mg/ml, an amide local anaesthetic with less cardiotoxic effects than bupivacaine, is prepared. It is delivered into the pleural cavity in a Clerf-spray device (StorzMedical, AMC House, Park Royal, London, UK; Fig. 1). Insufflation is achieved by connecting the device to a high-volume, low-pressure device. The spray is directed over the inner chest-wall, mediastinal and diaphragmatic surfaces at the beginning of the procedure. The pleurodesis is performed after 10 min based on data from ropivacaine in peripheral nerve block studies.^{1–3}

Figure 1 Assembled spray device that can be easily inserted and directed through a VATS port.

DISCUSSION

The technique provides significant analgesic effects lasting up to 15 h. In addition, patients receive local anaesthetic infiltration to VATS port sites together with local anaesthetic intercostal nerve blocks. Patients also receive regular paracetamol-based enteral analgesia supplemented by intravenous opioid patient controlled analgesia. Audit of pain intensity scores and opioid consumption demonstrate significant reduction in both since the introduction of the technique.

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