TECHNIQUE

A specific chin-strap is commercially available. This system has an aperture for the airway and Velcro straps for fastening; however, it only has one-point fixation, which regularly necessitates additional stabilisation with a crêpe bandage (Fig. 1). Furthermore, they individually cost £12.92. We estimate our annual cost to be more than £6400, based on ~500 procedures per year. The senior author (RHA) felt that this arrangement could be improved, and developed the idea of utilising the back-strap from the sling that the patient will be placed into at the end of the procedure. A 2-cm slit is cut longitudinally at the half-way point of the strap to allow passage of the airway, it is then passed through the buckles on either side of the headboard; finally, the ends of the strap attached to each other across the forehead with Velcro (Fig. 2).

DISCUSSION

Not only is this method more secure by providing two-point fixation, it is fully adjustable, it is quicker to apply and to release, and it remains usable as the back-strap at the end of the procedure if required and no extra cost has been incurred.

Low-cost laparoscopic paediatric inguinal hernia repair simulator

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BACKGROUND

Laparoscopic repair of paediatric inguinal hernia is becoming increasingly popular.¹ One of the techniques used involves the application of a purse-string suture around the patent deep inguinal ring and intracorporeal knot tying. We propose a simple, low-cost simulator to practice these skills.

TECHNIQUE

The simulator is constructed from a 20-cm × 10-cm piece of cardboard and a surgical glove. The cardboard is folded and stapled to form a wedge. Four holes are made in one of the long surfaces of the wedge to mimic the deep inguinal ring. The glove is split down the sides and the thumb and excess material is removed. The finger stalks are pushed through the holes and the glove secured with staples (Fig. 1A). The base of the simulator is fixed with double-sided adhesive tape to the floor of a laparoscopic pelvi-trainer and suturing is practiced. The simulator is removed once suturing is completed for evaluation (Fig. 1B).

DISCUSSION

There has been increasing awareness that the acquisition of new

Figure 1 (A) The laparoscopic simulator; (B) inspection of satisfactory purse-string suture *in situ*.

procedural skills should be undertaken outside the operating theatre.² Intensive simulator training has been shown to improve operating time and accuracy in paediatric surgery.³ We suggest that this low-cost simulator may be used to acquire and maintain requisite skills necessary for laparoscopic paediatric inguinal hernia repair.

References

1. Saranga BR, Arora M, Baskaran V. Minimal access surgery of pediatric inguinal hernias: a review. *Surg Endosc* 2008; **22**: 1751–62.
2. Najmaldin A. Karl Storz Lecture. Skills training in pediatric minimal access surgery. *J Pediatr Surg* 2007; **42**: 284–9.
3. Poulakis V, Witzsch U, De VR, Dillenburg W, Moeckel M, Becht E. Intensive laparoscopic training: the impact of a simplified pelvic-trainer model for the urethrovaginal anastomosis on the learning curve. *World J Urol* 2006; **24**: 331–7.

Fat retraction in laparoscopic surgery

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BACKGROUND

In laparoscopic surgery, views of the left upper quadrant may be impaired by omentum (Fig. 1). Access to the angle of His, which

is crucial for both laparoscopic fundoplication and laparoscopic gastric banding, is difficult in the obese. We describe a technique to retract fat during laparoscopic procedures.

TECHNIQUE

Using the most lateral port in the left upper quadrant, a 2-0 nylon

Figure 1 Omentum obscuring access to the angle of His.

Figure 2 Several bites of omentum are taken in the stitch.

Figure 3 The suture is clipped externally to maintain traction.

Figure 4 View prior to fat retraction.

Figure 5 View subsequent to fat retraction.

suture is used to pick up several bites of the greater omentum lying between the spleen and greater curve of the stomach (Fig. 2). The suture is then removed through the 11-mm port so that both ends are extracorporeal. The port is removed and replaced alongside the suture. Under direct vision, the suture is put under tension to retract the greater omental fat and clipped externally (Fig. 3). Access to the angle of His is thereby improved (Figs 4 and 5).

DISCUSSION

The senior author (MR) has used this method successfully for 15 years with no serious intra- or postoperative complications. One cautionary note is to ensure retraction is undertaken under direct vision to avoid tearing any adhesions to the spleen. The technique is a safe and simple method of fat retraction that can significantly improve surgical access to the angle of His during complex laparoscopic procedures.

ECG electrode for tracheostome closure following decannulation

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BACKGROUND

Following decannulation, closure of the tracheostome is imperative for successful phonation. The current accepted method of closure is through the use of an occlusive dressing over several layers of eye-pad gauze. It is universally recognised that the occlusive dressings never provide a sufficient seal and an air leak invariably occurs when coughing or talking. Many patients strug-

Figure 1 A suitable ECG dot.

Figure 2 Occlusion of stoma with ECG dot.

gle to locate and form an effective seal when occluding their stoma.

TECHNIQUE

In our unit, an ECG electrode or dot has been used for approximately 7 years to cover the tracheostome following decannulation. The metal stud is carefully placed centrally over the stoma with apposition of the skin edges. If there are excessive tracheal secretions, eye-pad gauze is placed first, followed by an occlusive dressing, and then the ECG dot.

DISCUSSION

The simple method we describe ensures a rapid and effective way of ensuring skin closure of the tracheostome. The discreet metal centre of the ECG dot provides the patient with a target for finger application and delivers additional sensory and proprioceptive feedback. The self-adhesive backing is of the appropriate size, and provides a firm material onto which to apply pressure (Fig. 1). This enables patients to locate their stoma readily and easily and occlude it with an effective seal for phonation and coughing (Fig. 2). ECG dots used are readily available on most wards and are cheap, e.g. the 3M RedDot™ costs 14 pence each (3M UK, Cain Road Bracknell, UK).

A novel technique for humeral head retrieval

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BACKGROUND

Four-part fracture dislocations of the proximal humerus are a common surgical problem (Fig. 1). They are usually treated with a hemi-arthro-