Technical Section

TECHNICAL NOTES & TIPS

Authorship and writing for the Technical Section

Authorship

There has been a trend towards increasing numbers of authors on Technical Notes and Tips: this sometimes seems excessive and unreasonable. A simple technical idea usually has one originator (or perhaps two, as a product of discussion) and it is then common to supervise a trainee in writing it up. That means that a tip or note might reasonably have two or three authors. Submissions are becoming more frequent with four or five names above them. This needs to be fully justified. I have started to write to any lead author who has more than two co-authors asking for a full explanation of the contribution of each and will do so increasingly. I advise that any submissions with more than three authors should be accompanied by a letter giving those details.

Writing

Submissions of 100 or 250 words should be perfect. Especially if they are being used to increase the experience (and CV) of trainees, senior authors should be sure that they are faultless. The shoddy presentation of some of the submissions we receive is difficult to excuse – the more so when there are a number of authors, each of whom should have read the final manuscript. Each author bears personal responsibility for its content and quality. I write some fairly blunt letters to the authors of short submissions with imperfect text and (commonly) references that are not cited in proper Vancouver style. I would like to remind all authors (not least senior ones) of their responsibilities to check that manuscripts are perfect. That ought to be easy with such short submissions.

Bruce Campbell

Editor, Technical Section

TECHNICAL NOTES

Single port laparoscopic cholecystectomy – overcoming technical problems

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BACKGROUND

A modified single port with three working channels inserted through the umbilicus allows cholecystectomy leaving no visible scar. (Fig. 1). Based on our experience of more than 100 single-port procedures, we describe how to overcome the potential technical issues.

TECHNIQUE

Equipment

Ports containing multiple (2 × 5 mm, 1 × 10 mm) working channels

are used through a single umbilical incision. A variety of curved/roticulating 5-mm instruments and clip applicators are available. Occasionally straight instruments will suffice.

Figure 1 The Tri-port (formerly known as R port) Olympus.

Case selection

Body mass index (BMI) below 30 kg/m² is best. Due to increased distance from the umbilicus to the gallbladder, long bariatric instruments are required in patients with high BMI.

Positioning

Modified Lloyd Davis allows surgeon and assistant to work together allowing full range of movement. Surgeon should be positioned between the legs with assistant sitting on the left side.

Avoidance of instrument crowding

A long 5-mm 30° scope occupies less space in the port and positions assistant away from the surgeon. Instruments of varying lengths prevent surgeon's right and left hand from colliding.

Triangulation

The left- and right-hand instruments naturally cross at the single point of entry to the peritoneal cavity; therefore, the surgeon must remember that their left hand is operating the instrument on the right side of the screen.

Retraction

Placing a suture on a straight needle through the abdominal wall, passing through the fundus or Hartmann's pouch in case of thickened and non-compliant gallbladder provides additional retraction. In case of difficulty or unclear anatomy, additional ports should be used or convert to a standard laparoscopic operation.

DISCUSSION

Single-port, 'scarless' cholecystectomy is safe provided basic principles are adhered to. Conversion to conventional laparoscopy is easy and patients must be consented for this.

The use of dental wire to facilitate tendon passing through the pulley mechanism

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BACKGROUND

Permanent division of flexor tendons in the hand is associated with significant morbidity. They are, therefore, usually repaired or reconstructed; in doing so, they must be passed under the pulley

Figure 1 Dental wire passed through the pulley.

Figure 2 Withdrawal of dental wire.

Figure 3 Proximal tendon and core suture has passed through the pulley.

mechanism to prevent bow-stringing. Careful handling of the tendon is needed to avoid crush injury and handling with clamps, clips or forceps is best avoided. Consequently, a number 8 paediatric feeding catheter is traditionally used. The catheter is passed from the distal to proximal under the pulley, sown to the tendon and then withdrawn so that the tendon passes under the pulley. The catheter then has to be removed from the tendon end leading to trauma whilst this lengthy process increases the tourniquet time. We propose the use of dental wire as a cheap alternative that prevents such complications.

TECHNIQUE

A core suture is made through the proximal tendon in the standard manner. A length of dental wire is curved around to make a U-shaped tip, passed under the tendon pulley and the core suture