Figure 1 Compressing the frenular vessels with gauze.

tion on the Plastibell. A strip of ribbon gauze 1 cm wide and 1–2 cm long is introduced between the Plastibell ring and the dorsal aspect of the glans using a dissecting forceps. The gauze pushes the ventral aspect of the glans against the ring and compresses the frenular vessels (Fig. 1). Bleeding should stop immediately. The gauze usually falls out when the child passes urine. The temptation to pack an excessive length of gauze should be resisted or the urethral meatus will be obstructed.

DISCUSSION

In the UK, infants are rarely circumcised in hospital. Many hospital practitioners are unfamiliar with the Plastibell device and, consequently, infants with post-Plastibell circumcision bleeding tend to be transferred to paediatric surgeons for exploration under general anaesthetic. We feel that this can be avoided in most of the cases by using the technique described.

References

1. Mahomed A, Zapparackaite I, Adam S. Improving outcome from Plastibell™ circumcisions in infants. *Int Braz J Urol* 2009; **35**: 310–4.
2. Ben Chaim J, Livne PM, Binyamini J, Hardak B, Ben-Meir D, Mor Y. Complications of circumcision in Israel: a one year multicenter survey. *Isr Med Assoc J* 2005; **7**: 368–70.
3. Palit V, Menebhi DK, Taylor I, Young M, Elmasry Y, Shah T. A unique service in UK delivering Plastibell circumcision: review of 9-year results. *Pediatr Surg Int* 2007; **23**: 45–8.

Laparoscopic mesh measurement

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BACKGROUND

The laparoscopic method of ventral incisional hernia repair is becoming increasingly popular.¹ Mesh placed within the peritoneal cavity

Figure 1: Instrument inserted to distal margin of hernial defect.

Figure 2 Instrument withdrawn demonstrating defect length (X cm).

needs to be composite, with a non-adherent coating or PTFE to minimise adhesions to the bowel.² These composite mesh products are far more expensive than regular polypropylene alternatives and, therefore, require judicious use.

TECHNIQUE

We present a simple method of hernial defect measurement using a grasper as a gauge. Once the pneumoperitoneum is established, along with insertion of the operating ports, the surgeon should be presented with a clear view of the defect for repair. By inserting a grasper to the distal aspect of the hernial defect and placing a finger on the shaft of the instrument as it enters the port the measuring process begins (Fig. 1). Subsequent withdrawal of the instrument to the proximal hernial margin will show the length of the defect along the shaft of the grasper (Fig. 2). This distance can be quantified using the measure on surgical marker pens. The process can be repeated in as many different orientations as required in order to gain an accurate measurement of the defect.

DISCUSSION

Selection of the correct sized mesh with an appreciation of mesh shrinkage is important to minimise both cost and the risk of hernia recurrence. In contrast to open procedures, it is often difficult to measure hernial defects accurately, particularly in the obese.

Varying degrees of magnification provided by the laparoscope/camera combination and the aspect ratio of the display can distort the image viewed by the surgeon making intra-operative measurements difficult.

References

1. Sajid MS, Bokhari SA, Mallick AS, Cheek E, Baig MK. Laparoscopic versus open repair of incisional/ventral hernia: a meta-analysis. *Am J Surg* 2009; **198**: 64–72
2. Eriksen JR, Gögenur I, Rosenberg J. Choice of mesh for laparoscopic ventral hernia repair. *Hernia* 2007; **11**: 481–92.

Large bowel enema through colostomy with a Foley catheter: a simple and effective technique

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BACKGROUND

Constipation in patients with colostomy is common. Large bowel enema through a colostomy is a real challenge. As there is no sphincter activity around the colostomy, spillage during instillation and ineffective occlusion of lumen following it are two major

Figure 1 Lubricated Foley catheter tip is guided through the stoma beyond the parietal wall.

Figure 2 Inflated balloon should snugly fit to parietal wall before instillation.

difficulties faced. A simple and cost-effective technique is described here to resolve these problems.

TECHNIQUE

We use a well lubricated Foley catheter (14–16-Fr) for delivering phosphate enema through the colostomy to cleanse constipated colon. The tip of the catheter is passed beyond the parietal wall into the colon, under the guidance of little finger through the stoma (Fig. 1). The balloon is inflated below the fingertip. Then, the catheter is pulled up slowly until the balloon snugly fits against the parietal wall (Fig. 2). The enema is delivered into the bowel through the catheter and the outlet is clamped. The catheter is taken out by deflating the balloon after 10 min. Stoma bag should be placed immediately as the effect is instantaneous.

DISCUSSION

‘Colostomy tips’ which are available for delivering enema may cause inadvertent injury or perforation during intubation.^{1,2} Lubricated Foley catheter tip under digital guidance prevents this situation. This is readily available and does not demand special expertise. This method stops spillage of enema fluid and holds the fluid inside the bowel like a ball valve. In our experience, it is a useful method.

References

1. Williams JT, Scott RL. New universal colostomy tip for barium enemas of the colon. *AJR Am J Roentgenol* 2003; **180**: 1330–1.
2. Hoffman E, Macht A. Traumatic perforations of colostomies. *Am J Surg* 1954; **87**: 140–2.