Figure 1 Diagrammatic representation of the procedure.

describe a simple method to relocate the silk suture to a different exit wound in a controlled manner rather than blindly 'win-king' a finger in the abdomen to catch the silk suture and pull it through the mid-line incision.

TECHNIQUE

At the end of the procedure following undocking of the surgical da Vinci robot (Intuitive Surgical, Sunnyvale, CA, USA), the camera port is removed and an index finger inserted via this wound into the abdominal cavity to identify the end of the laterally placed 12-mm port. The port is completely occluded with the tip of the finger. The laparoscopic sucker is inserted via the 12-mm port and pushed against the tip of the finger while the finger retreats and guides the tip of the sucker out of the mid-line incision. The tip of laparoscopic needle holders are then inserted into the hollow end of the sucker tip and used to push the sucker back out of the 12-mm port. The end of the specimen bag silk suture is then grasped in the laparoscopic needle holders which are then pulled back through the mid-line incision, together with the silk suture (Fig. 1 above). This incision may then be enlarged to allow delivery of the specimen bag. The technique may be adapted for other laparoscopic procedures.

DISCUSSION

This technique has proved effective and efficient to relocate the silk suture to a different exit wound in a controlled manner.

A simple technique to control bleeding after Plastibell circumcision

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BACKGROUND

The Plastibell technique is commonly used to circumcise infants in the community for cultural and religious reasons.¹ Bleeding occurs in 3–10% of cases in reported series,^{2,3} although this may be reduced by careful technique.¹ Bleeding usually arises from the frenulum; however, as the frenular vessels are hidden inside the Plastibell, the site of the bleeding is unclear and external compression is ineffective. We describe a simple technique to control frenular bleeding after Plastibell circumcision.

TECHNIQUE

Resuscitation is imperative. Babies often present after several hours of continued bleeding and blood transfusion may be necessary. To assess the wound, the penis is stabilised by gentle trac-

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.

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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.