Technical Section

TECHNICAL NOTES & TIPS

TECHNICAL NOTES

Pharyngojejunal tubes for feeding after upper gastrointestinal surgery: the way forward

KASIM A BEHRANWALA, MARK FULLARD, JEREMY I LIVINGSTONE
Department of General Surgery, Watford General Hospital,
Watford, UK

CORRESPONDENCE TO

Kasim A Behranwala, E: kbehranwala@hotmail.com

BACKGROUND

Cervical pharyngostomy tubes are reported to be used for gastric feeding in patients undergoing head and neck surgery.¹ We describe a single technique, at oesophagectomy, achieving long-term gastric decompression and jejunal enteral feeding.

TECHNIQUE

A clamp is guided laterally over a finger into the pyriform recess, situated behind the posterior tonsillar pillar, inferior and medial to the greater cornu of the hyoid bone. An incision is made in the skin and subcutaneous tissue where the tip of the clamp is well defined and anterior to the carotid artery. The thyrohyoid membranous tissue is bluntly swept away at the tip of the clamp before making an incision in the pharyngeal mucosa. The tip of the feeding tube (Freka Trelumina Fr 16/9, 150 cm; Fresenius Kabi, Homburg, Germany) is grasped by the projected clamp, withdrawn out of the mouth, and then grabbed by the endoscopic grasping forceps. It is then placed endoscopically in the jejunum before being fixed with non-

absorbable sutures at the exit site in the neck. Enteric feeding can commence immediately (Fig. 1).

DISCUSSION

This technique requires collaboration with endoscopist. It avoids the creation of a technically difficult and time-consuming percutaneous jejunostomy, particularly in laparoscopic cases, along with its complications such as wound infection, dislodgement, haemorrhage, perforation, site leak, peritonitis and small bowel obstruction due to adhesions or volvulus. Endoscopy at the end of the surgery allows inspection of the viability of the gastric tube. The pharyngojejunal tube is easy to maintain, well tolerated and can be kept for several months.^{2,3}

References

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Whole gut intubation splinting – last refuge for the surgically desperate?

W AL SARA KBI, PG BENTLEY
Department of General Surgery, Kent & Sussex Hospital,
Tunbridge Wells, Kent, UK

CORRESPONDENCE TO

W Al Sarakbi, E: walsarakbi@hotmail.com

BACKGROUND

Recurrent episodes of small bowel obstruction secondary to adhesions are a common surgical dilemma. The hostile abdomen presents a challenge to the operating surgeon and carries a significant risk of morbidity and mortality. Previous reports described long tube gastrostomy with intestinal splinting for such cases.^{1,2} Purpose-made long gastric tube splints are often not available in the emergency situation. The following technique is presented as a surgical option.

TECHNIQUE

Oxygen tubing (length cut to measure) is secured with transfixion suture to the proximal (external) end of a 16-G nasogastric tube to form

Figure 1 Pharyngojejunal tubes for feeding *in situ*.

Figure 1 Gut splinting tube.

a long enteric splint (Fig. 1). During laparotomy and following division of adhesions in patients with a hostile abdomen, the composite tube is introduced trans-orally and then 'milked' by the surgeon into the duodenum and subsequently through the small and large bowel. The tube acts as a splint and prevents postoperative adhesions from kinking the small bowel at a sharp angle. The tube is kept *in situ* for 10–12 days allowing for adhesions to start forming without obstructing the lumen. The tube is then removed by withdrawal through the mouth. We have used this technique in five patients with recurrent small bowel obstruction due to adhesions with excellent results. We had no recurrence of small bowel obstruction in these patients, one of whom had had 15 previous laparotomies.

DISCUSSION

This technique offers an alternative to more invasive splinting described in the literature.^{1,3} Cases of obstructing extensive fibrous adhesions often require a non-orthodox surgical solution.

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Simple technique for retraction of the gall-bladder in laparoscopic cholecystectomy

HANY BALAMOUN, DEYA MARZOUK
Department of General Surgery, Queen Elizabeth The Queen
Mother Hospital, Margate, Kent, UK

CORRESPONDENCE TO

Hany Balamoun, E: hanyarmia80@gmail.com

BACKGROUND

Laparoscopic cholecystectomy has traditionally been done using

four laparoscopic ports. Recently, there has been a strong move towards reduced port cholecystectomy. The mid clavicular 5-mm port used in retraction of the fundus of the gall bladder is often the first that can be omitted.

Figure 1 A straight needle is passed through the abdominal wall under vision.

Figure 2 Needle is passed through the fundus of the gallbladder.

Figure 3 Needle is passed back again through the abdominal wall.