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

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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.

Figure 4 Prolene thread tied on the outside of the abdominal wall.

TECHNIQUE

Following the insertion of the camera (10–11-mm umbilical port), and the two operative ports (5 mm), in the epigastrium and laterally respecting the triangulation for the control of the gallbladder. A Prolene (Ethicon, Johnson & Johnson Intl. St-Stevens-Woluwe, Belgium) 2/0 stitch on a straight needle is passed through the abdominal wall under vision (Fig. 1) and then through the fundus of the gallbladder (Fig. 2) and back again through the abdominal wall and tied on the outside of the abdominal wall for retraction of the gall bladder fundus (Figs 3 and 4). The operation is completed in a routine fashion, and we use a 5-mm camera through the epigastric port to guide the extraction of the gallbladder in the endopouch through the umbilical port after cutting the Prolene stitch to release the gallbladder.

DISCUSSION

This simple technique allows reduction in the number and size of the used ports during routine laparoscopic cholecystectomies.

Arthroscopic knee washout

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BACKGROUND

Arthroscopic knee washout is employed to clear infection either in the native joint or following arthroplasty. Irrigation fluid is introduced into the joint using an arthroscopic port. Common practice involves occluding the end of this port with a gloved thumb to allow fluid to collect within the joint before being flushed away. This method results in spillage of saline and inad-

Figure 1 Arthroscopy port with irrigation attached and syringe end to one side.

Figure 2 End of syringe used to block port.

equately pressure build up. We describe a simple technique to avoid these problems.

TECHNIQUE

The patient is prepared and draped in the usual way. An antero-lateral portal is established, the blunt trocar is removed and the saline tubing connected. A 10-ml syringe is dismantled and the plunger section inserted into the end of the arthroscopy port (Figs 1 and 2). The syringe tube may be discarded. The saline is then switched on and allowed to wash through the knee joint and out via a second port in standard fashion.

DISCUSSION

This technique creates a water-tight seal around the end of the