Figure 4 Barium thread, braided into the device, allows identification on X-ray.

2. Ball CG, Lord J, Laupland KP, Gmora S, Mulloy RH, Ng AK *et al*. Chest tube complications: how well are we training our residents? *Can J Surg* 2007; **50**: 450–8.
3. Melamed E. Locking plastic tie – a simple technique for securing a chest tube. *Prehosp Disast Med* 2006; **22**: 344–5.
4. Rashid MA. A simple technique for anchoring chest tubes. *Eur Respir J* 1998; **12**: 958–9.
5. O'Flynn P, Akhtar S. Effective securing of a drain. *Ann R Coll Surg Engl* 1999; **81**: 418–9.

Goldfinger™ – a simple method of delivering a circular stapler anvil for laparoscopic Roux-en-Y gastric bypass

RN Williams, CD Sutton, DJ Bowrey

Department of Surgery, Leicester Royal Infirmary, University Hospitals Leicester, Leicester, UK

CORRESPONDENCE TO

RN Williams, E: robert.n.williams@uhl-tr.nhs.uk

BACKGROUND

Laparoscopic Roux-en-Y gastric bypass requires formation of a gastrojejunostomy that is often fashioned using a circular stapler. Accurate placement of the anvil whilst avoiding trauma to

Figure 1 Staple line gastrotomy fashioned with harmonic scalpel.

Figure 2 Spike with 2/0 polypropylene suture re-attached to anvil.

Figure 3 Goldfinger™ passed through staple line and lateral gastrotomies.

the stomach is essential. We describe a technique that facilitates smooth delivery of the anvil head into the stomach using a Goldfinger™ (Ethicon, UK).

TECHNIQUE

A gastrotomy is created above the mid-point of the transverse staple line in (what will become) the gastric pouch using a harmonic scalpel or alternative energy source (Fig. 1). A 25-Fr anvil is introduced into the abdomen using the stapler handle via a dilated port site; use of a 25-Fr stapler ensures adequate closure of

Figure 4 Traction on in-line Goldfinger™ starts delivery of anvil through staple line.

the pouch gastrotomy. The anvil and its spike are connected within the abdomen having first tied a short extracorporeal loop of 2/0 polypropylene to the anvil spike (Fig. 2). A small lateral gastrotomy is created and the Goldfinger™ delivered through the stomach (Fig. 3). The anvil is connected to the Goldfinger™ using the polypropylene loop and the Goldfinger™ straightened and pulled back through the stomach to deliver the anvil through the staple line (Fig. 4). The polypropylene loop can be used as a useful retractor whilst the remainder of the gastric pouch is fashioned.

DISCUSSION

This method provides smooth delivery of the anvil head and prevents the tip of the anvil spike from traumatising the rugal folds of the stomach.

TECHNICAL TIPS

Combined laparoscopic peritoneal dialysis catheter insertion and epigastric hernia repair to avoid delaying dialysis

Yasha Juhari, Michael L Nicholson

Division of Transplantation Surgery, Leicester General Hospital, Leicester, UK

CORRESPONDENCE TO

Yasha Johari, E: yashajohari@doctors.org.uk

We describe a simple technique to repair simultaneously an epigastric hernia and laparoscopically site a peritoneal dialysis catheter (PDC) without the need to delay dialysis. An open dissection is performed to achieve a pneumoperitoneum by placing camera port through the hernial sac (Fig. 1). With the patient in the Trendelenberg position, a second incision is made and a PDC on an introducer is sited percutaneously into the pelvic sump.

Figure 1 Laparoscopic port insertion through ventral hernial defect to allow simultaneous peritoneal tube placement and hernia repair.

After the cuff is placed anterior to the peritoneum, the PDC may then be tunnelled laterally. The camera port is removed and the defect repaired with 1/0 nylon.

A simple technique to achieve effective suction during laparotomy

Valentina Lefemine, Anish Patel, Taha R Lazim
Royal Gwent Hospital, Newport, UK

CORRESPONDENCE TO

Valentina Lefemine, E: valefemine@yahoo.it

Figure 1 A 9 x 9 inch sterile gauze is wrapped around the Poole sucker.