continuous suture up the wound to the proximal end. Once the proximal end is reached no knot is tied. Instead, the suture is simply turned back on itself and the continuous suture is continued back down the wound until the suture has passed two-thirds of the way down to approximately the level of the patella. At this point two bites are taken in the soft tissue to one side of the wound at 180 degrees to one another in order to lock the suture. The suture is then simply cut flush with the tissue. The superficial wound is closed in a conventional manner with a 2-0 braided polyglycolide suture (Vicryl) to approximate the wound edges and, finally, with clips to the skin.³

DISCUSSION

This provides a solid and reliable approximation of the deep tissues without any knot. This has been used by the authors for two years and has had led to excellent results with no cases of wound dehiscence.

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Control of postoperative bleeding following a procedure for prolapse and haemorrhoids: a novel technique

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BACKGROUND

The majority of bleeding can be controlled by direct compression and using a tamponade effect. In an emergency situation, a common effective method is application of direct pressure by hand. This approach is not suitable for post-haemorrhoidectomy bleeding. Published data highlight a variable rate of postoperative bleeding, from 6% to 25%.^{1,2} We describe a novel technique for providing localised pressure, utilising materials that are freely available on most surgical wards or in the emergency department.

TECHNIQUE

A well lubricated large bore, 3-way catheter is introduced carefully above the staple line. The catheter balloon is inflated with 30ml of sterile water and pulled backwards against the staple line; the balloon acts as a tamponade. Two 100ml metronidazole infusion bottles are secured by suture to the first catheter port. The second port is connected to a catheter bag and the third port spigotted. The two attached metronidazole bottles are left hanging over the bed side, maintaining constant uniform traction. The advantage of the catheter channel is to drain any emerging bleeding

Figure 1 The catheter channel in situ

above the staple line and this is left in situ for 24 hours.

DISCUSSION

We have not come across this technique for control of postoperative procedure for prolapse and haemorrhoids (PPH) bleeding being described in the literature. It is effective, quick and practical. We have used this method in six patients who developed post-PPH bleeding. The haemorrhage was controlled in five patients; one patient needed to go back to theatre. In our experience it is an effective technique in controlling post-PPH haemorrhage.

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TECHNICAL TIPS

New technique of optimal size skin incision for laparoscopic port insertion

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The optimal-sized skin incision for laparoscopic port insertion facilitates easy manoeuvrability of the port while reducing potential air leaks and results in smaller scars.

After infiltration of local anaesthetic, the port, without the trocar, is pushed against the anterior abdominal wall at the site of proposed port

insertion, imprinting the skin (Fig. 1). For oblique-ended ports, the incision is made across the width of the imprint (Fig. 2). The diameter of the imprint of an oblique-ended 5-mm port is 8 mm; thus an incision across this provides a wound circumference of $2 \times 8 \text{ mm} = 16 \text{ mm}$, equating with the circumference of a 5-mm port.

Figure 1 Imprint on the skin made by port without the trocar.

Figure 2 Skin incision extending across the width of the imprint.

Alternative method for placement of seton sutures in fistula-in-ano

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Placement of seton sutures is often difficult, requiring the passage of a large knot through the fistula tract. This can be avoided by feeding the end of a 0 polypropylene suture through the groove on the inner curve of a Lockhart-Mummery probe. The other end of the suture is again passed through the tract, leaving both free ends at the external opening. This creates a loop at the internal opening through which a vascular sling is placed. The suture is drawn through and the sling tied loosely. The knot is secured with a silk stitch to prevent it slipping.

The digital age: a new trick

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To apply tubular finger dressings effectively either a wireframe or finger bob is necessary. These are often not readily available or unclean. A plastic syringe can fulfill the same role. The cost of wireframes varies from £5 to £30. Plastic syringes cost between £0.20 and £0.50. A plastic syringe can also be discarded if contaminated by the wound.

The plunger is removed and the flange around the plastic syringe is cut off using heavy scissors (Fig 1). The tubular dressing is mounted on the syringe in a similar way to the wireframe (Fig 2). A 60ml syringe is suitable for all the digits.

Figure 1 A wireframe and syringe

Figure 2 Tubular dressings applied to a wireframe and a syringe