Figure 1 The increase in length obtainable by creating a new opening 4cm proximal to the apex on the antimesenteric border, compared to the original opening

Figure 2 The new longer pouch: Sutures are in place where the original enterotomy was closed

DISCUSSION

With the described technique all subsequent pouches have reached to the dentate line without the need for mesenteric manoeuvres. Mesenteric manipulation risks vascular compromise. We have experienced no complications related to this technique. It is simple to perform and increases reach by approximately 4cm, which is comparable to other techniques.⁵

References

1. Onaitis MW, Mantyh C. Ileal pouch-anal anastomosis for ulcerative colitis and familial adenomatous polyposis: historical development and current status. *Ann Surg* 2003; **238**(6 Suppl): S42–48.
2. Parks AG, Nicholls RJ. Proctocolectomy without ileostomy for ulcerative colitis. *Br Med J* 1978; **2**: 85–88.
3. Byrne CM, Uraiqat AA, Phillips RK. A systematic stapling defect – a potential cause of ‘anastomotic’ leak after restorative proctocolectomy. *Colorectal Dis* 2008; **10**: 286–288.
4. Burnstein MJ, Schoetz DJ Jr, Collier JA, Veidenheimer MC. Technique of mesenteric lengthening in ileal reservoir-anal anastomosis. *Dis Colon Rectum* 1987; **30**: 863–866.
5. Smith L, Friend WG, Medwell SJ. The superior mesenteric artery. The critical factor in the pouch pull-through procedure. *Dis Colon Rectum* 1984; **27**: 741–744.

Safe and inexpensive alternative to suture passer

JD Kosy, IT Sharpe

Royal Devon and Exeter Hospital, Exeter, UK

CORRESPONDENCE TO

Jonathan Kosy, E: jonkosy@yahoo.co.uk

BACKGROUND

As the name suggests, the suture passer is used to achieve solid fixation of structures, often removed during the operative approach, by pulling an anchoring suture through an osseous tunnel. In addition, the suture passer can be used to pass tendons and other soft tissue structures through bone during reconstructive procedures. The expense of this single use instrument has been highlighted and a potentially dangerous alternative suggested.

Figure 1 Loop of nylon suture passed through drawing-up needle

Our method is inexpensive, successful and uses materials available in all theatres.

TECHNIQUE

A loop of nylon suture is passed through a blunt ended 18G drawing-up needle (Fig 1). Leaving a 5mm loop protruding from the end, this is passed through the tunnel. The suture or tendon for reattachment is passed through the loop and pulled back through the tunnel (Fig 2).

Figure 2 Needle (with suture loop) passed through metatarsal head

DISCUSSION

We have successfully used this technique in passing the extensor digitorum tendon through the metatarsal head during a modified Cobb–Stainsby procedure.² This technique works the same way as the suture passer and can be set up by the scrub nurse. Cost saving is important in the current economic climate. The previously published technique of passing a suture, on a straight needle, through the tunnel (blunt end first)¹ exposes the surgeon and operating team to the risks of handling a sharp. Our technique can be utilised for any procedure where the suture passer is commonly used and has already found favour with our hip unit in repairing the posterior approach.

References

1. Shaikh N, Guryel E, Acton K. A useful and economical suture passer. *Ann R Coll Surg Engl* 2008; **90**: 526.
2. Trimble KT, Talbot NJ, Parsons SW. A modification to the Stainsby technique for arthritic or dislocated metatarsophalangeal joints of the lesser toes. *J Bone Joint Surg Br* 2005; **87**: 370. **TECHNIQUE**

TECHNIQUE

A 2/0 polyglactin suture on a straight needle is inserted through a 2mm skin incision into the peritoneal cavity and two separate bites are made on the antimesenteric border of the proximal loop of bowel. A suture passer is then used to pull the needle out through the skin incision. This technique is repeated on a distal segment of bowel. The two sutures are pulled up towards the abdominal wall and the metal introducer for the feeding catheter inserted through the abdominal wall (Fig 1). The jejunum is then cannulated under vision with the two sutures held under tension to prevent the bowel from falling away from the anterior abdominal wall. The feeding catheter is inserted under vision to ensure the catheter is advanced distally and the sutures are tied transfascially, allowing the feeding tube to lie in a snug tunnel.

Between April and August 2010 this technique was performed on 19 consecutive patients with no tube-related complications or blockages.

DISCUSSION

Our technique obviates the need for laparoscopic suturing and is quick, simple and effective.

Reference

1. Mistry RC, Mehta SS, Karimundackal G, Pramesh CS. Novel cost-effective method of laparoscopic feeding-jejunostomy. *J Minim Access Surg* 2009; **5**: 43–46.

A simple technique for cannulation of the jejunum during laparoscopic feeding jejunostomy

OA Khan, SKC Toh, S Mercer

Queen Alexandra Hospital, Portsmouth, UK

CORRESPONDENCE TO

Omar Khan, E: omarkhan@iname.com

BACKGROUND

Laparoscopic insertion of a feeding jejunostomy is a common but technically demanding operation. One of the most difficult aspects is the percutaneous cannulation of the jejunum. While previous authors have described techniques involving laparoscopic insertion of a purse string suture around the entry site of the jejunum,¹ this can be technically challenging and time consuming. We describe our experience of a simple technique for this step in the procedure.

Figure 1 Cannulation of the jejunum with the proximal and distal segments of bowel suspended under tension between two transfascial sutures

Role of intra-aortic balloon pump in myocardial contusion

T Vu, KD Stahl, JA Asensio

Department of Surgery, University of Miami School of Medicine, Miami, Florida, US

CORRESPONDENCE TO

Thai Vu, E: tvu@med.miami.edu

BACKGROUND

Although uncommon, severe myocardial contusion can lead to acute myocardial failure. Intra-aortic balloon pump (IABP) counterpulsation is the first choice for mechanical assistance in cardiogenic shock refractory to vasoactive drugs. Apart from isolated case reports, its use in severe blunt cardiac injuries has been rarely reported.

TECHNIQUE

Routine insertion of the IABP is usually carried out via the femoral artery with placement in the descending thoracic aorta distal to the left subclavian artery via a modified Seldinger technique. The location of the tip is confirmed via a chest x-ray or fluoroscopy. Alternative access routes include the subclavian and axillary arteries. To achieve optimal effects of counterpulsation, inflation and deflation cycles must be correctly timed to the patient's cardiac cycle.

DISCUSSION

The IABP is beneficial in the failing, contused/stunned myocardium as it increases myocardial oxygen delivery and decreases myocardial oxygen demand by decreasing the left ventricular afterload. Secondary beneficial effects include increasing cardiac output, left ventricular ejection fraction, stroke volume and coronary perfusion pressures. The IABP also decreases the heart rate and systemic vascular resistance. The effects