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.

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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

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

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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

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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

of the IABP on the contused myocardium can lead to improvements in cardiac function and decreases in inotropic requirements, thus allowing a concomitant decrease in the use of vasoactive drugs. An IABP is indicated in cardiogenic shock in severe myocardial contusion refractory to vasoactive drugs. An IABP is contraindicated in patients with a concurrent aortic injury or irreversible brain damage.

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Laparoscopic relief of meralgia paraesthetica

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BACKGROUND

Meralgia paraesthetica is caused by entrapment of the lateral femoral cutaneous nerve of the thigh by the inguinal ligament as it crosses it near the anterior superior iliac spine (ASIS). It can present as anterior and lateral thigh pain/paraesthesia, exacerbated by activity. Failure of conservative medical treatment usually leads to patients undergoing open surgical decompression. This is performed through a 3–4cm infrainguinal incision centred on the ASIS, locating the nerve and dividing the inguinal ligament. However, the nerve is present only 85.8% of the time inferior to the ASIS¹ and only 58% of the time medial to the ASIS.²

Figure 1 Lateral femoral cutaneous nerve, inferior to the inguinal ligament

Figure 2 Divided inguinal ligament

These anatomical variations mean that the open technique may either lead to inadvertent division of the nerve or inadequate exposure. We have developed a laparoscopic technique that takes into account these potential problems.

TECHNIQUE

A 10mm infraumbilical port and two 5mm ports are inserted in the same location as one would for a laparoscopic inguinal hernia repair. The nerve is often visible through the translucent peritoneum, which is incised near the insertion of the inguinal ligament to the ASIS (Fig 1). The nerve is released by dividing the posterior leaf of the inguinal ligament and any fibrous attachments to the nerve with the aid of the hook diathermy (Fig 2).

DISCUSSION

We have used this technique on several patients who experienced immediate relief from their symptoms and continue to be pain free a year after surgery. The technique can be performed as a day case, is easily learnt and allows anatomical variability to be accommodated.

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