A rose by any other name – Hasson’s technique and its modifications

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Dear Sir

We read with interest the article by Dr Sadhu and colleagues [1] that details a technique of open insertion of laparoscopic cannula very much similar to the one we described and published in the Indian Journal of Surgery well over 9 years ago [2]. Both of us have since used it in more than 5000 patients without any instance of bowel or vascular injury. Having also taught the technique to several surgeon and gynecologist colleagues, we can vouch for its safety, simplicity and reproducibility.

Over the years we have refined our technique to make it applicable in patients of all body habitus. Some of the technical aspects are highlighted below.

- 1 In thin patients and in those with a lax abdominal wall (e.g. multi-parous women) it is easy to evert the umbilicus completely by grasping the bottom of the umbilical pit with a towel clip. After a vertical incision on the umbilical cicatrix or the “umbilical tube” a cannula with a blunt inner trocar can then be guided into the peritoneal cavity directly.
- 2 In most patients with a deep umbilicus and particularly in the obese, however, it is not always possible to evert

the umbilicus. In these patients we place a towel clip on one lip of the umbilicus that has been everted with a toothed forceps, and apply a strong upward traction. This produces the desired effect of making the umbilical tube prominent allowing its easy identification after the skin has been incised.

- 3 We have observed that the umbilical tubes vary greatly in their texture, toughness and the amount of extraperitoneal fat they cover. Muscular and obese men often have a fibrous tube. After its incision, it is essential to grasp the cut edges with toothed instruments (our preference is single-toothed, straight Kocher’s forceps) to provide counter traction that allows a blunt-tipped hemostat to gently pierce and stretch the posterior rectus sheath/peritoneum underneath.
- 4 If the hemostat fails to gain easy entry into the peritoneal cavity, the incision on the umbilical tube needs to be extended onto the area where the umbilical tube merges with the horizontally placed linea alba. During this step, the short curved end of a baby Deaver’s retractor retracts and protects the skin to avoid a “T” extension of the incision.
- 5 A fair proportion of obese patients (and some not so obese ones) have a thick pad of extraperitoneal fat beneath the umbilical tube. If the tip of the hemostat does not “walk into” the peritoneal cavity after the tube is incised and its edges are lifted upwards, it is unwise to use force for the fear of causing injury to a loop of bowel lying under the incision. In such instances, we advance the blades of Deaver’s retractors to the depth of the extraperitoneal fat so as to identify and pick up the posterior sheath/peritoneum with two Kocher’s forceps. This layer is then incised. Additional manoeuvres such slightly extending the transverse skin incision, insertion of a third retractor

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(a right-angled one) and shining the light from a cold light cable to the depth of the wound may be required to facilitate this step.

It is helpful for those mastering this technique of open insertion to keep these tricks in mind as their application enhances the safety and success of the procedure.

Finally, a word about the authors' suggestion that "it is time to consign classical Hasson's technique to the end of its natural life cycle". It is true that many of us have abandoned the originally described step of placing sutures on the fascia and no longer use the traditional Hasson cannula. Nevertheless, every time we use a "personal modification" of the open technique we must appreciate, admire and acknowledge Dr Harrieth Hasson, a pioneer way ahead of his time, who contributed substantially to

the safety of the very first step of laparoscopy [3]. As Johann Wolfgang von Goethe once said "Daring ideas are like chessmen moved forward; they may be beaten, but they often start a winning game."

References

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