Trocar injury of abdominal wall vessels: a simple method to stop the haemorrhage

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BACKGROUND

Misplaced laparoscopic ports can lead to brisk bleeding from traumatised abdominal wall vessels, with a reported incidence of 0.15%.¹ Significant blood loss may occur until definitive haemostasis is achieved. We describe a simple temporising measure to stop the bleeding, allowing a calm approach for a definitive repair.

Figure 1 Kii® GelPort® balloon trocar: internal balloon (A), external gel seal bolster (B)

TECHNIQUE

The original port is removed and a Kii® GelPort® balloon trocar (Applied Medical UK Ltd, London EC2N 1HQ) is introduced through the same incision. The internal balloon is inflated with air and the external gel seal bolster is locked tight against the skin surface (Fig 1). This unique port allows compression of the vessel against two static surfaces and leads to arrest of bleeding through direct compression. When the bleeding is under control, the vessel can be ligated by extracorporeal or intracorporeal suturing, open cut-down and ligation or more novel methods such as angiographic embolisation.²

DISCUSSION

Planned and careful trocar placement can reduce the incidence of this complication. It is therefore advisable to place lateral ports lateral to the rectus, visualise superficial vessels by transillumination of the skin and

deep vessels by direct laparoscopic inspection. Nevertheless, injuries to vessels do occur. This method affords you enough time to make a definitive repair without significant blood loss. An alternative would be to use the balloon of a Foley catheter; however, it will only allow compression against one surface and may not be as effective.

References

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2. Lavery S, Porter S, Trew G *et al*. Use of inferior epigastric artery embolization to arrest bleeding at operative laparoscopy. *Fertil Steril* 2006; **86**: 719.

How much neck extension would you require?

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BACKGROUND

Neck extension in an anaesthetised patient aids many head and neck surgical procedures and is traditionally achieved with a shoulder bolster. Unfortunately, once the patient is draped, any adjustment to extension involves lifting the patient to reposition the bolster, which is cumbersome and time consuming.

TECHNIQUE

An innovative way of adjusting neck extension is with a pressure infuser bag placed under the shoulder as part of initial patient positioning. The bag is then inflated using the attached handheld pump, which extends the neck to the required degree (Fig 1). Placing a padded sheet over the bag (eg an incontinence pad) is advised to reduce risk of fragile skin damage, particularly if greater inflation is required and for longer procedures.

Perioperatively, the degree of neck extension can be altered with minimum disruption by using the handheld pump to adjust the amount of inflation. We recommend that a periodic assessment of inflation is

Figure 1 Bag inflated using pump to provide required neck extension