A simple technique to make identification of the rectum easier when performing a posterior sagittal anorectoplasty

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Modified dissection scissors with a functional ligation aid

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BACKGROUND

Following publication of the initial paper in 1982, Peña's posterior sagittal anorectoplasty has become the technique of choice for the management of anorectal malformations.¹ Identification of the rectum can be difficult if it is a high anorectal malformation with the rectum under the coccyx. We describe a useful technique for aiding the identification of the rectum and avoiding injury to other structures such as the urethra or seminal vesicles.

TECHNIQUE

Prior to positioning the patient for the sagittal approach, a Foley catheter (typically 10Fr or 12Fr) is inserted into the mucus fistula and the balloon inflated with 3–5ml. This is then secured with tape and the patient is positioned prone for surgery.

An unscrubbed member of the team can then aid the identification of the rectum by insufflating air at the direction of the operating surgeon with a 50ml bladder-tip syringe. This makes the rectum more prominent and easily identifiable when proceeding with the sagittal dissection. We find 30–50ml is usually sufficient to dilate the distal bowel, with the inflated catheter balloon providing a reasonable seal around the catheter.

DISCUSSION

This is a simple, safe and effective technique that we have found very useful when performing this operation.

Reference

1. deVries PA, Peña A. Posterior sagittal anorectoplasty. *J Pediatr Surg* 1982; **17**: 638–643.

Figure 1

BACKGROUND

Scissors have been one of the most important tools of a surgeon's armamentarium for many centuries. Scissors are routinely used for the dissecting and cutting of tissues as well as sutures. Ligation of tissues or vascular pedicles is usually performed by a separate manoeuvre using sutures, clips, electrocautery or, more recently, ultrasonography.

Figure 1 Modification of the Metzenbaum scissors

Figure 2 Suture passed in the indentation grooves

TECHNIQUE

A simple modification of the Metzenbaum scissors consisting of a 1mm indentation in each blade at 1cm from the scissors' tip (Fig 1) allows the suture to be passed in the indentation grooves and around the pedicle intended to be ligated (Fig 2), without the need for using other instruments. Closing the blades enables the suture to be passed around the intended pedicle. With the suture around the desired pedicle, ligation can be performed manually with surgical ties. The modified scissors can complete the ligation manoeuvre by cutting the ligated pedicle.

DISCUSSION

The modification of the Metzenbaum scissors is cheap and relatively easy to perform. This modification is extremely useful in procedures where there is an abundance of vascular pedicles requiring ligation such as thyroid or axillary dissections. With these modified scissors the combined manoeuvre of dissection and ligation can be performed with essentially one instrument. It may also be useful when more expensive ligation options or surgical assistance are not available.

References

1. Carroll T, Ladner K, Meyers AD. Alternative surgical dissection techniques. *Otolaryngol Clin North Am* 2005; **38**: 397–411.
2. Dionigi G, Bacuzzi A, Boni L *et al*. Influence of new technologies on thyroid surgery: state of the art. *Expert Rev Med Devices* 2005; **2**: 547–557.

Figure 1 Tapes in-situ ready for abdominal wall closure

Achieving abdominal closure following emergency laparotomy in patients with connective tissue disorders

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BACKGROUND

Mass closure of emergency laparotomy wounds using suture material can lead to wound dehiscence with sutures 'cheese wiring' through friable tissues. Traditionally, 'deep tension' sutures have been used to relieve stress at healing edges in individuals for whom laparostomy may seem the only alternative.¹ We describe a novel technique that may be used to achieve abdominal closure in any patient with fragile tissues.

TECHNIQUE

Fasciocutaneous flaps are raised from rectus sheaths allowing for an onlay polyglactin mesh to bridge any exposed bowel as well as overlapping of the rectus sheaths. Instead of sutures, 0.5cm wide nylon tapes are passed through multiple opposing stab incisions at the flap attachments, from each wound apex toward the centre. These are tied sequentially, drawing the wound edges together to facilitate primary skin closure. Tapes and any residual sutures can be removed after 10–20 days.

Figure 2 Tension free closure achieved. Tapes were successfully removed at 12 days

DISCUSSION

The aetiology of wound dehiscence following emergency laparotomy is multifactorial, patients with connective tissue disorders being at