Figure 1 Seminal vesicles elevated using a V-Loc™ suture: The suture is passed through both seminal vesicles (lower midline arrow), superficially through the anterior abdominal fascia above the catheter (black arrow), around the catheter and through the loop at the end of the V-Loc™ suture (higher midline arrow), and then back through the anterior abdominal wall fascia (white lateral arrow) to secure it.

Carter-Thomason needle. The catheter is retracted and clamped over a swab just distal to the urethral meatus. Once the SVs have been mobilised, a 15cm V-Loc™ suture (Covidien, Mansfield, MA, US) is placed through both SVs, around the catheter, and anchored to the anterior abdominal wall (Fig 1). This technique is quick to perform and provides good retraction of the SVs. The use of the V-Loc™ suture saves time because no knot tying is required. The fourth arm maintains retraction of the bladder and prevents bowel from descending into the operative field.

DISCUSSION

This technique has proved particularly effective in the obese patient, where intrusion of bowel into the operative field can be a problem.

A simple stabilising technique for laparoscopic microwave ablation of liver tumours

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BACKGROUND

Microwave ablation (MWA) is an important therapeutic option in unresectable liver tumours.^{1,2} Although percutaneous MWA is considered the least invasive and preferred approach, laparoscopy-assisted MWA is a minimally invasive alternative for percutaneously inaccessible lesions.³ Standard laparoscopic ports (5mm) are not designed for MWA probes, which can lead to instability of the probe during ablation. We describe a simple technique to maximise probe stability during laparoscopic MWA.

Figure 1 Cannula inserted into right upper quadrant of abdomen

Figure 2 Microwave ablation probe introduced through cannula

TECHNIQUE

The skin is prepared and draped as standard for laparoscopic surgery. A 16G cannula is inserted in the right upper quadrant and secured to skin (Fig 1). The cannula is used as a probe introducer in place of a standard laparoscopic port (Fig 2). This allows a secure fit for the probe, acts as an anchoring point and is cheaper than a 5mm port.

DISCUSSION

Instability of MWA probes introduced via standard laparoscopic ports can lead to inadvertent thermal injuries. The described technique improves probe handling during laparoscopic MWA and reduces the potential risk of injury associated with probe instability. It also allows a more precise delivery of ablative energy into targeted lesions. However, further clinical studies are required to assess whether this technique confers any added clinical benefit.

References

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