A novel technique for the per-anal extraction of spherical rectal foreign bodies

RJ Codd, TJ Havard

Royal Glamorgan Hospital, Llantrisant, UK

CORRESPONDENCE TO

Rhodri Codd, E: coddrrj@doctors.org.uk

BACKGROUND

It is desirable to remove rectal foreign bodies per-anally to avoid laparotomy and possible colostomy.^{1,2} Spherical objects can pose a specific problem due to difficulty in gaining purchase digitally or with an instrument. Obstetric forceps have been used previously^{3–5} but their positioning and extraction can be technically difficult and potentially traumatic. We present a technique whereby a single blade of a pair of Neville-Barnes forceps can be used easily to extract spherical objects.

TECHNIQUE

Under general anaesthesia with the patient positioned in lithotomy, the assistant should apply downward suprapubic pressure to move the object caudally. Following a digital rectal examination to identify the object's position, a well lubricated blade of the forceps is inserted using the left hand. The operator's right index finger is used to guide the blade over the anterior surface of the object. Once in position, the blade is used to apply pressure through the object so it comes into contact with the curved anterior surface of the sacrum. It is then removed slowly, maintaining pressure through the object, thus allowing extraction.

DISCUSSION

The use of a single obstetric blade in this way has not been described previously. It is a useful technique that uses the normal anatomy of the pelvis to the surgeon's advantage. Compared to a pair of obstetric forceps, a single blade can be positioned easily and should cause less trauma to the anal canal. This technique was used to extract a 7cm rubber ball from the mid-rectum, thus avoiding laparotomy and potential stoma.

References

1. Lake JP, Essani R, Petrone P *et al.* Management of retained colorectal foreign bodies: predictors of operative intervention. *Dis Colon Rectum* 2004; **47**: 1,694–1,698.
2. Kurer MA, Davey C, Khan S, Chintapatla S. Colorectal foreign bodies: a systematic review. *Colorectal Dis* 2010; **12**: 851–861.
3. Andrabi SI, Johnson NA, Malik AH, Ahmed M. Extraction of a rectal foreign body – an alternative method. *Ulus Travma Acil Cerrahi Derg* 2009; **15**: 403–405.
4. Haddad J, Ellenbogen G, Foschi N. Use of forceps in the extraction of foreign bodies from the rectum. *Rev Paul Med* 1971; **77**: 119–122.
5. Angrisani G. Extraction of a voluminous foreign body from the rectum with obstetrical forceps. *G Ital Chir* 1962; **18**: 169–174.

Technique for central aortic cannulation in extensive aortic dissection

TK Rajab¹, JD Schmitt², RP Gallegos¹

¹Brigham and Women's Hospital, Boston, MA, US

²Hannover Medical School, Germany

CORRESPONDENCE TO

Konrad Rajab, E: trajab@rics.bwh.harvard.edu

BACKGROUND

Cardiopulmonary bypass for aortic dissection repair is most frequently established via the peripheral arteries. Central cannulation in the context of aortic dissection was first described in 1998.¹ In this situation, the difficulty lies in determining whether the true lumen or the false lumen is being cannulated. Previous authors have described cannulation of the proximal aorta^{2–6} and confirmation of the wire in the true lumen by ultrasonography in a non-dissected segment of the distal aorta.⁶ However, this is not possible in complete dissection of the aorta down to the iliac bifurcation.

TECHNIQUE

In this situation, access to the descending aorta can be gained via the Seldinger technique and the wire carefully passed retrograde towards the aortic valve. Cannulation of the true lumen can be confirmed by transoesophageal echocardiography with the wire floating freely by the aortic valve. Once the position of the wire in the true lumen is confirmed, a cannula can be placed over the wire.

DISCUSSION

Extensive dissection of the aorta with concurrent contraindications for peripheral cannulation poses a particular problem for cannulation since it can be difficult to ensure cannulation of the true lumen. In these cases, the technique described above with proximal passing of the wire and confirmation of its position in the true lumen by transoesophageal ultrasonography can be a useful method.

References

1. Lijoi A, Scarano F, Dottori V *et al.* Stanford type A aortic dissection. A new surgical approach. *Tex Heart Inst J* 1998; **25**: 65–67.
2. Minatoya K, Karck M, Szpakowski E *et al.* Ascending aortic cannulation for Stanford type A acute aortic dissection: another option. *J Thorac Cardiovasc Surg* 2003; **125**: 952–953.
3. Khojenezhad A, Plestis KA. Cannulation in the diseased aorta: a safe approach using the Seldinger technique. *Tex Heart Inst J* 2006; **33**: 353–355.
4. Reece TB, Tribble CG, Smith RL *et al.* Central cannulation is safe in acute aortic dissection repair. *J Thorac Cardiovasc Surg* 2007; **133**: 428–434.
5. Inoue Y, Ueda T, Taguchi S *et al.* Ascending aorta cannulation in acute type A aortic dissection. *Eur J Cardiothorac Surg* 2007; **31**: 976–979.
6. Göbbölös L, Philipp A, Foltan M, Wiebe K. Surgical management for Stanford type A aortic dissection: direct cannulation of real lumen at the level of the Botallo's ligament by Seldinger technique. *Interact Cardiovasc Thorac Surg* 2008; **7**: 1,107–1,109.