A simple technique for intraoperative decompression of obstructed bowel

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Uterine flap: a simple method to reconstruct perineal defect following extralevator abdominoperineal resection in women

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BACKGROUND

The gross dilatation encountered frequently during emergency surgery for bowel obstruction, especially when colonic, can present a hindrance to safe mobilisation and progression. We describe an established technique to effectively decompress gaseous distension. Although employed by many surgeons, this has not to our knowledge been reported in the English literature, warranting formal reiteration.

TECHNIQUE

With its plunger removed, a 10ml syringe is inserted into a 21G (green) needle and the sucker is detached temporarily from the suction tubing. The free end of the suction tube is then slid into the empty barrel of the syringe; the negative pressure exerted is sufficient to keep the apparatus united. The needle is passed through the serosa of the obstructed bowel and traversed 1–2 cm submucosally, before being directed through the mucosa and into the dilated lumen. Decompression of the gaseous component is gradually achieved before decannulation leaves a small, 'self-sealing' defect in the bowel wall (Fig 1).

DISCUSSION

This frequently employed, simple technique provides effective decompression, particularly of the gaseous component during emergency surgery for obstruction, rendering safer and easier manipulation of the bowel.

Figure 1 Decompression of obstructed bowel using the needle, syringe barrel and suction tubing assembly

BACKGROUND

The extralevator type of abdominoperineal resection of the rectum (ELAPR) has become the gold standard for low rectal cancer when the anal sphincter cannot be preserved or preservation is inappropriate. Reconstruction of the perineal defect following ELAPR can be difficult, often requiring complex procedures. We report a simple method of reconstructing the perineal defect in a female patient with a uterus.

TECHNIQUE

We first perform the abdominal part of the operation in the Lloyd-Davies position. The patient is then placed in a prone jack-knife position and an ELAPR is carried out. The uterus is retroverted and stitched to the perineal defect at the perimeter using interrupted polydioxanone sutures (Fig 1). A subcutaneous suction drain is inserted. The subcutaneous tissues layer and skin are approximated with absorbable sutures and interrupted nylon sutures respectively.

Figure 1 A retroverted uterus (on the left with an instrument pointing to it and the vagina on its right) is used to fill the gap in the perineum

DISCUSSION

This method is useful in women who have completed their family and still have a mobile retrovertible uterus. We have used it successfully in more than ten consecutive patients. We do not claim that this technique is original but it is useful, can be learnt easily, saves operating time and does not require an expensive prosthesis. The uterus is a highly vascularised organ, resistant to infection, and the chances of wound dehiscence are rare. This technique is a valuable alternative to complex procedures in dealing with a perineal defect following an abdominoperineal resection of rectum in women.