An alternative non-suture method of fixing wound drains to simplify planned removal and reduce morbidity

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BACKGROUND

Surgical drains are used commonly in emergency, elective and day-case procedures across surgical specialties. Traditionally, fixing the drain involved a suture tying the drain to skin, a method carrying complications such as failure, premature removal, inflammation, bleeding, scarring and rarely skin necrosis. Removal of drains secured by stitches may be problematic outside of specialist nursing facilities and may prove an impediment to performing procedures in day-case units when use of drains is considered prudent. We have developed and employed a technique of affixing drains that has since been adopted by surgical practitioners.

TECHNIQUE

This simple procedure involves sandwiching drain tubes between layers of two clear adhesive C-View dressings (Maersk Medical, Redditch, UK). Half of each dressing is applied to the skin on either side of the drain with the midline of each adhesive touching the base of the drain. The remaining free halves are joined up with the dressing from the opposite side, encasing the drains in a sterile mesentery (Fig 1). The dressing can be continuous with part of it securing the wound. A transparent and oxygen permeable membrane allows

Figure 2 Final result

inspection of wounds and straightforward removal of drains without disruption of the main wound dressing. Firm attachment allows more than one drain to be secured. Figure 2 shows the final result.

DISCUSSION

With the increasing rate of day-case procedures, we present a new, non-sutured and easy-to-manage solution for securing wound drains that can facilitate drain management and removal in the community or primary healthcare environment.

How to manage gallstone spillage during laparoscopic cholecystectomy

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Figure 1 Application of dressing

BACKGROUND

Complications secondary to intra-abdominal gallstone spillage through an iatrogenic perforation of the gallbladder during laparoscopic cholecystectomy are well reported.¹ These include intra-abdominal abscesses, wound sinuses, adhesions or septicæmia^{2,3} and may occur many years after the cholecystectomy.⁴ Short of a laparotomy, the surgeon should attempt to remove all gallstones.² However, operating time is inevitably prolonged while attempting to extract individual stones with an intra-abdominal specimen bag. The stones are often too large to be suctioned. Furthermore, it may be difficult to close the gallbladder perforation to prevent further spillage. We describe a technique to collect gallstones if the gallbladder is perforated during a laparoscopic cholecystectomy.

TECHNIQUE

If the gallbladder is perforated, a 4" x 3" piece of gauze is introduced into the abdomen via the 12mm epigastric port. The gauze is opened