The use of a urinary catheter and rectal sponge to tamponade severe bleeding following TRUS prostate biopsy

HJ Bekarma¹, CJ Smart²

¹NHS Greater Glasgow and Clyde, UK

²Stockport NHS Foundation Trust, UK

CORRESPONDENCE TO

Holly Bekarma, E: hollybekarma@doctors.org.uk

BACKGROUND

Transrectal ultrasonography (TRUS) guided biopsy of the prostate has become the gold standard for prostate cancer biopsy assessment. It is a common procedure with thousands performed every year in the UK. Rectal bleeding following TRUS biopsy of the prostate is a recognised complication with an incidence of 2.2%; however, it is normally self-limiting.¹ Severe rectal bleeding has an incidence of 0.7% and may require rectal pressure from a finger, probe, catheter, or endoscopic haemostasis.² We describe a simple but effective technique to tamponade significant bleeding following the procedure using a Foley catheter and haemostatic rectal sponge.

TECHNIQUE

A 28Fr Foley catheter is passed through a rectal sponge and inserted with the guidance of a finger into the rectum. The catheter balloon is inflated with 20ml of water and provides effective tamponade of bleeding (Fig 1).

DISCUSSION

This is a simple and quick method to try without having to pack the rectum. It is usually tolerated well by the patient. Care must be taken with prolonged tamponade to avoid mucosal necrosis of the rectal wall.

These items are readily available in the theatre department and allow prompt management of significant bleeding following biopsy.

Figure 1 28Fr Foley catheter inserted in haemostatic rectal sponge with 20ml of water in balloon

References

1. Ecke TH, Gunia S, Bartel P *et al.* Complications and risk factors of transrectal ultrasound guided needle biopsies of the prostate evaluated by questionnaire. *Urol Oncol* 2008; **26**: 474–478.
2. Brullet E, Guevara MC, Campo R *et al.* Massive rectal bleeding following transrectal ultrasound-guided prostate biopsy. *Endoscopy* 2000; **32**: 792–795.

A timesaving technique for shaping of acellular dermal matrix in primary breast reconstruction

K Siddique, I Azmy

Chesterfield Royal Hospital NHS Foundation Trust, UK

CORRESPONDENCE TO

Khurram Siddique, E: sk.sid@hotmail.co.uk

None of the authors have any commercial interest in any of the products described in this technical note.

BACKGROUND

The use of an acellular dermal matrix (ADM) for inferolateral coverage of a tissue expander/implant in primary breast reconstructions has increased significantly.^{1,2} There are various techniques for inseting the ADM to the appropriate dimensions to suit individual cases. We report a novel technique of outlining the desired shape and cutting the ADM in a single action, allowing economy of movement and saving significant time. The technique has been developed using Strattice™ (LifeCell, Branchburg, NJ, US), a porcine dermal derivative.³

TECHNIQUE

Following skin/nipple sparing mastectomy, the pectoralis major is raised to create a pocket for the expander/implant. The prosthesis is placed in the pocket and the edge of the muscle pulled over the implant to show the extent of muscular coverage. A temporary template is drawn with an indelible marker pen on the expander/implant in situ (Fig 1). This can be transposed on to the Strattice™ by direct contact (Fig 2). The imprint of the ink on the Strattice™ is used as a guide to cut it to fit the appropriate size and dimensions (Fig 3),

Figure 1 Template being drawn on the expander/implant