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

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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

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

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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

Figure 2 Template transposed on to the Strattice™

Figure 3 Ink imprint on the Strattice™ being used as a guide to cut it

Figure 4 Strattice™ being sutured to the edge of the pectoralis major and the chest wall

ensuring allowance for slight overlap. The cut Strattice™ is then sutured superiorly to the edge of the pectoralis major and inferolaterally to the chest wall with 2/0 polydioxanone (Fig 4).

DISCUSSION

Optimal aesthetic outcomes can be achieved in immediate implant-based reconstruction with the use of ADM. Our technique of cutting the Strattice™ precisely according to the ink template is reliable, quick, safe and easily reproducible.

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Effortless tension for Thomas splints

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BACKGROUND

The Thomas splint has stood the test of time immobilising femoral fractures, reducing haemorrhage, improving pain and facilitating transport. This is due to its simplicity, ease of application, few complications and non-invasive nature.¹

Traditionally, twisting the distal cord around a tongue depressor creates tension. It can be difficult to produce the desired amount of tension, and twisting the tongue depressor between the bars of the splint can be slow and cause pain. We describe a simple system of knots and pulleys, allowing effortless, controlled, straight line traction to be used on Thomas splints.

Figure 1 Cords wrapped around splint in normal fashion