Figure 2 Use of the fiberoptic nasendoscope as a guide light for the puncture site

DISCUSSION

Secondary tracheo-oesophageal puncture following laryngectomy, as described by Singer and Blom, has a proven track record in providing voice rehabilitation.^{1–3} This technique has since been modified; the use of an endotracheal tube has been described previously by Maniglia and Cannon.^{4,5} The advantages of this technique are that it is useful in technically difficult patients, it allows direct visualisation of the oesophageal lumen during puncture and stenting of the distal oesophagus is possible. The equipment is readily available, and compared with a gastroscope, the flexible nasendoscope has a narrower diameter and is therefore easier to pass in a narrow oesophagus.

References

1. Singer MI, Blom ED. An endoscopic technique for restoration of voice after laryngectomy. *Ann Otol Rhinol Laryngol* 1980; **89**: 529–533.
2. Lukinovic J, Bilic M, Raguz I *et al*. Overview of 100 patients with voice prosthesis after total laryngectomy – experience of single institution. *Coll Antropol* 2012; **36 Suppl 2**: 99–102.
3. Saurajen AS, Chee NW, Siow JK *et al*. Tracheoesophageal puncture outcomes and predictors of success in laryngectomised patients. *Ann Acad Med Singapore* 2000; **29**: 452–456.
4. Maniglia AJ. Voice rehabilitation after total laryngectomy: a flexible fiberoptic endoscopic technique for tracheoesophageal fistula. *Laryngoscope* 1982; **92**: 1,437–1,439.
5. Cannon CR. Using an endotracheal tube in difficult secondary tracheoesophageal puncture: a novel technique. *Otolaryngol Head Neck Surg* 2001; **125**: 117–119.

A novel method for securing intraoperative nasopharyngeal suction

M Pankhania, S Mitchell, D Bowyer

Shrewsbury and Telford Hospital NHS Trust, UK

CORRESPONDENCE TO

Duncan Bowyer, E: duncan.bowyer@sath.nhs.uk

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BACKGROUND

A clear operative field can be difficult to obtain during endonasal surgery. We describe a customised use of the AMT Bridle™ (Applied Medical Technology, Brecksville, OH, US) system,¹ marketed for nasogastric tube fixation, for securing an Argyle™ (Covidien, Dublin, Ireland) post-nasal space suction catheter (PNSSC), which has a valuable role in managing intraoperative bleeding.

TECHNIQUE

The nose is prepared using a topical local anaesthetic and vasoconstrictor. The AMT Bridle™ is inserted using the attached magnetic introducers and pulled through once magnetic union is achieved in the nasopharynx, leaving the tape slung behind the septum (Fig 1). A PNSSC is inserted and the position confirmed endoscopically (Figs 2 and 3). The catheter is secured externally with the provided clip (Fig 4).

Figure 1 Diagrammatic representation of technique for inserting AMT Bridle™ tape

MI = magnetic introducer; ETO = Eustachian tube orifice

Figure 2 Magnetic introducer for AMT Bridle™ tape in postnasal space

BT = bridle tape; PNSSC = postnasal space suction catheter

Figure 3 Endoscopic confirmation of PNSSC and AMT Bridle™ tape slung behind the vomer bone

DISCUSSION

Bleeding during elective or emergency endonasal surgery may impede the surgeon in a number of ways, including the need to swap instruments for suction or vasoconstrictor soaked neurosurgical patties. Our technique can be performed quickly. It allows the surgeon to maintain the field of vision without frequently swapping instruments for suction. A throat pack is essential in eliminating aspiration. This may be of particular use in endoscopic sphenopalatine artery ligation. One pitfall is that should additional suctioning be necessary, the catheter needs to be detached and reattached if a second suction device is unavailable. Our technique uses commonly stocked equipment and is resistant to unwanted displacement. The unit cost for the AMT Bridle™ system is currently £80.

Figure 4 AMT Bridle™ tape and postnasal space suction catheter secured at the anterior nares

Reference

1. The AMT Bridle™ Nasal Tube System. Applied Medical Technology. <http://www.amtinnovation.com/bridle.html> (cited June 2014).

Reattaching the surgical thread to a needle: a problem solved

O Tillo

University Hospitals Birmingham NHS Foundation Trust, UK

CORRESPONDENCE TO

Omar Tillo, E: omartillo@nhs.net

BACKGROUND

Occasionally, suture threads pull out from the needle swage or break by accidental cutting/direct manipulation of the needle. In some scenarios (eg tendon repair, skin closure with a continuous non-degradable subcuticular suture), thread breaks may necessitate restarting a lengthy procedure. Although rare, these situations are familiar to most surgeons.

Using the simple technique presented here, the broken thread can be attached to a temporary hypodermic needle, thereby allowing the surgeon to continue suturing.

TECHNIQUE

A hypodermic needle of appropriate gauge (Table 1) is broken at the base by gentle and repetitive bending. Acute bending should be avoided because it is likely to obstruct the lumen. The proximal end of the thread is passed into the broken end of the hypodermic needle.