Colonoscopic assisted trephine stoma in children with chronic constipation

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BACKGROUND

In extreme cases, faecal diversion is required for children with chronic constipation and megarectum. Formation of a proximal 'trephine' sigmoid colostomy avoids the need for and the associated morbidity of a formal laparotomy. We describe a technique that combines intraoperative unprepared colonoscopy with a diverting 'trephine' sigmoid colostomy.

TECHNIQUE

The stoma site is marked preoperatively. Under anaesthesia, the patient is positioned in the supine frog leg position. The surgeon inserts a flexible colonoscope, and makes an assessment of the unprepared megarectum, sigmoid and proximal colon. Bright light transillumination (Fig 1) and finger indentation are used to assess the location and mobility of the sigmoid colon. The stoma site is established after consideration of the preoperative mark and the position of the transillumination. A trephine stoma is performed as described by Senapati and Phillips.¹ The sigmoid loop containing the colonoscope is easily located and delivered into the wound (Fig 2). The assistant then slowly withdraws the colonoscope to confirm which end is distal (Fig 3). An end colostomy is formed, with a non-dissolving marking suture left on the distal stump (Fig 4). The

Figure 2 The sigmoid loop containing the colonoscope is located easily.

Figure 1 Bright light transillumination identifies the location of the sigmoid colon.

Figure 3 The assistant withdraws the colonoscope slowly to confirm the distal limb.

Figure 4 A non-dissolving suture marks the distal stump for easy identification.

colonoscope can be used for washout of the distal colon and rectum at the end of the procedure.

DISCUSSION

This minimally invasive technique has been used successfully in adults over the past decade.^{2,3} Our modified technique allows the paediatric surgeon to assess the megarectum and rapidly identify the correct bowel loop, and avoids inadvertent maturation of the wrong end of the divided colon.

References

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Modified intradermal ‘figure-of-eight’ suture for cosmetic closure of umbilical port site incision

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BACKGROUND

One of the desired outcomes of any laparoscopic surgery is better cosmesis. While the recent trend seems to be towards needleless port closures, superiority of one technique over another is still being debated.¹ The umbilicus is a very common port site but the literature lacks data dedicated to its cosmetic closure. Moreover, the structural elevation of the umbilical mound/fold adds to the difficulty in accurate skin approximation without compromising the umbilical aesthetics. We have developed a simple, rapid and easily reproducible technique of umbilical port site incision closure.

TECHNIQUE

Any suitable monofilament suture material may be used but we prefer Monocryl® (Ethicon, Somerville, NJ, US). While the contralateral skin edge is ‘tented’ up with a toothed forceps, the needle pierces the subdermal tissue at the 3 o’clock position and is retrieved at the 9 o’clock position (Fig 1A). In between these two punctures, it traverses

Figure 1 The modified intradermal ‘figure-of-eight’ suture: The ‘contralateral’ intradermal stitch (A). The ‘ipsilateral’ intradermal stitch (B). The appropriate skin approximation (C). The ‘on-table’ scar; note that the shape of the umbilical mound is regained (D). The ‘figure-of-eight’ suture configuration; note that both the thread ends need to be pulled caudally (E).