Cannulating a narrow pancreatic duct as part of a pancreaticoenteric anastomosis

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Ultrasonography guided peritendinous anaesthetic infiltration in hamstrings autograft anterior cruciate ligament reconstruction

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When performing pancreaticoenteric anastomoses, the pancreatic duct is commonly cannulated with a paediatric nasogastric feeding tube. This transanastomotic stent is directed distally into the bowel to divert the flow of pancreatic enzymes away from the anastomosis. In a soft pancreas, the pancreatic duct can be too narrow to admit the smallest size (4Fr) feeding tube. More narrow lumen tubes like intravenous cannulas are too short to protect the anastomosis. A 22G cannula inserts snugly into the distal feeding tube (Fig 1A), which when trimmed creates a tapered tube (Fig 1B) that is easily inserted but still long enough to protect the anastomosis.

Figure 1 The 22G cannula is inserted into a 4Fr feeding tube (A). The cannula is then divided at the level of the injection port, leaving the tapered end (B).

BACKGROUND

In recent years, there has been a trend towards performing anterior cruciate ligament reconstruction as a day-case procedure.¹ In order to accomplish this, effective and early control of postoperative pain must be achieved, including at the graft harvest site.

TECHNIQUE

After a standardised anaesthetic is administered, comprising general anaesthetic and femoral nerve blockade for reconstruction site comfort, guided peritendinous injection of local anaesthetic is performed (Figs 1 and 2). Ultrasonography is used to visualise the gracilis and semitendinosus tendons from the pes anserine insertion proximally to a point 5cm beyond the musculotendinous junction. Under aseptic

Figure 1 Ultrasonography guided peritendinous administration of anaesthetic