Packing of the pelvis following abdominoperineal excision of the rectum

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BACKGROUND

Abdominoperineal excision of the rectum for rectal or anal neoplasia or for inflammatory bowel disease may be surgically challenging. Despite widespread adoption of laparoscopic techniques, sophisticated energy devices and anatomical prone perineal dissection, difficult cases may result in pelvic bleeding and the requirement to terminate the procedure. Effective packing under these circumstances can be life saving. While this must achieve adequate tamponade, straightforward delayed removal without recurrence of bleeding must also be ensured. This can be a problem with the use of gauze packs.¹

TECHNIQUE

We describe a simple technique for achieving pelvic packing after rectal excision. A laparoscopic camera sleeve is introduced into the space in the pelvis via the perineal wound after closing the end of the polythene with a simple knot. A gynaecological roll of gauze is inserted into the sleeve and pushed into the pelvis until sufficient gauze has been introduced to fill the pelvis and to achieve the desired effect (Fig 1). The plastic ring can then be removed and the skin loosely apposed, incorporating the end of the packing for security (Fig 2). On re-exploration after 24–48 hours, the polythene covered packing is easily removed with little risk of trauma or recurrence of bleeding and closure of the perineal defect can be completed.

Figure 1 Insertion of gauze roll inside a laparoscopic camera sleeve

Figure 2 After packing, the skin is loosely apposed, incorporating the packing.

DISCUSSION

While rarely required, packing of the pelvis following difficult pelvic surgery may be life saving. Hasty packing with gauze on to raw surfaces may be traumatic during insertion and removal. A simple technique is described that appears safe and effective.

Reference

1. Germanos S, Bolanis I, Saedon M, Baratsis S. Control of presacral venous bleeding during rectal surgery. *Am J Surg* 2010; **200**: e33–e35.

Fine-tuning of blocking screws in long bone nailing

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BACKGROUND

Use of blocking screws in long bone nailing is a well recognised and versatile technique in fracture surgery.¹ Insertion of a blocking screw will divert the nail to facilitate fracture reduction and correct axial deformity. Blocking screws also enhance fracture stability by effectively narrowing the medullary canal and generating further points of fixation.² On occasion, blocking screw position can make reamer head or nail insertion beyond the blocking screw difficult or impossible, or (as seen in Figure 1) can lead to overcorrection of the deformity.