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

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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.

Figure 1 Use of blocking screws for intramedullary nail fixation may lead to overcorrection of axial deformity.

Figure 2 Fine-tuning of blocking screws in overcorrection of axial deformity

TECHNIQUE

If the blocking screw prevents reamer head or nail passage beyond it or overcorrects the deformity it is possible to back the blocking screw out so that it becomes unicortical (Fig 2). This reduces (but does not eliminate) the efficiency of the blocking screw prior to completing the procedure.

DISCUSSION

This fine-tuning technique is easily performed and more expedient than completely resiting the blocking screw. Once the nail has been locked proximally and distally, the screw can be removed if it is no longer required. Alternatively, if the surgeon wishes to retain it as an additional point of fixation for enhanced fracture stability, it may need to be exchanged for a shorter screw.

References

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Combined endoscopic approach for patients with multiple bladder stones

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BACKGROUND

Bladder stones account for 5% of all urinary tract stones and are caused by bladder outlet obstruction, neurogenic voiding dysfunction, infection or foreign bodies.¹ While small bladder stones can be managed effectively by transurethral methods and larger stones by open approaches, there is debate as to the best method for managing patients with multiple intermediate sized stones. An effective combined endoscopic approach for the treatment of such patients is described.