Technical Section [TECHNICAL NOTES AND TIPS

Using mastoid swab to protect ureter during laparoscopic colectomy

R Durai, S Doughan

East Kent Hospitals University NHS Foundation Trust, UK

CORRESPONDENCE TO

Samer Doughan, E: s.doughan@nhs.net

Creative treatment of early buried bumper syndrome

MM Taher, NR Kosai, HS Gendeh

University Malaya Medical Centre, Malaysia

CORRESPONDENCE TO

Hardip Gendeh, E: hardip88@gmail.com

BACKGROUND

Laparoscopy is used increasingly for colonic resections and it reduces postoperative pain. We report a simple method of protecting the ureter during a laparoscopic colectomy.

TECHNIQUE

The patient is positioned and appropriate ports are inserted for the relevant laparoscopic resection. Medial to lateral mobilisation of the colon is performed. During the dissection, an appropriate vascular pedicle such the ileocolic or inferior mesenteric artery is identified and skeletonised. The dissection is deepened to identify the ureter. Once the ureter has been identified, a mastoid swab is placed on the ureter. The vascular pedicle is taken down with an appropriate method of the surgeon's choice such as vascular stapling. The swab may also be used to identify tissue planes and for blunt dissection. Once adequate mediolateral mobilisation has been achieved, lateral to medial mobilisation is carried out. During the dissection, the swab will be seen and the plane of dissection is clearly above the swab. Furthermore, the swab protects the ureter.

DISCUSSION

Use of a mastoid swab to cover the ureter during mediolateral dissection protects the ureter while stapling the vascular pedicle. When the same swab is left until the surgeon completes the lateral to medial dissection of the colon, it continues to protect the ureter, and the surgeon can make quick progress because the swab reveals the location and plane of the ureter. The swab is removed once the colon is fully mobilised. Mastoid swabs are commonly used for achieving haemostasis. In our unit, they are also used for protecting the ureter. It is not our discovery but it is a very useful technique.

BACKGROUND

Buried bumper syndrome (BBS) occurs if a percutaneous endoscopic gastrostomy (PEG) tube bumper becomes embedded in the gastric mucosa, which is usually a slow and progressive process. BBS is best identified early to allow manipulation of the button, thereby preventing closure of gastrocutaneous tract and peritonitis. We present an innovative technique for the treatment and management of early BBS in which manual adjustments have failed.

TECHNIQUE

An oesophagogastroduodenoscopy is undertaken under sedation to assess the patency of the tract in the gastric mucosa (Fig 1). Then, an endoscope is inserted through the existing PEG tube to pass through the external tube, acting as a guide for bumper

Figure 1 Oesophagogastroduodenoscopy demonstrating an inflamed mucosa. This is a sign of early buried bumper syndrome whereby the bumper of the percutaneous endoscopic gastrostomy tube is embedded deep in the gastric mucosa and is not visible. The orifice of the gastrocutaneous tract is visible.