Figure 4 The two retractors are held apart to expose the posterior rectus sheath.

used to pick up and incise the posterior rectus sheath and the parietal peritoneum. The port is screwed into place with the polyglactin stay sutures fixed over its wings.

DISCUSSION

This simple technique of spooning the Langenbeck retractors over each other through the same split in the muscle fibres provides an avascular, relatively atraumatic technique for placement of the robotic camera port. The technique may be used for other laparoscopic procedures where a port needs to be placed through the rectus muscle.

A rapid and reliable technique for emergent, decompressive colostomy

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BACKGROUND

Megacolon complicating another illness and closed loop colonic obstruction are surgical emergencies. These debilitated patients have high surgical risk.¹ A technique for rapid, decompressive colostomy is described.

TECHNIQUE

The skin is incised (4–6cm) transversely over the right upper rectus abdominis muscle. A cruciate opening is made in the anterior rectus sheath, the muscle split at the junction of its lateral and middle thirds, and the posterior sheath and peritoneum opened. A small

Alexis® (Applied Medical, Rancho Santa Margarita, CA, US) retractor is positioned in this incision. The proximal transverse colon, identified by the omentum, is delivered. The omentum can be fenestrated or the bowel needle decompressed if required. The mesocolon is pierced with a haemostat, and a Foley catheter drawn around the bowel and clipped. The colon is reduced into the abdomen and the retractor removed over the catheter. The fascial defect occasionally needs suture plication. Traction on the catheter safely delivers the bowel again. A stoma bridge, inserted into the catheter's open end, is guided through the mesocolon without injury. The loop colostomy is opened as usual.

DISCUSSION

This technique ensures adequate access to deliver the colon and form a snug stoma without any other incisions. The procedure takes approximately 25 minutes. The stoma is made to the right of the middle colic artery so as not to jeopardise future colorectal anastomosis. It is especially useful for debilitated patients who would not tolerate a midline laparotomy and for malignant disease that requires specialist expertise (that is not immediately available), further staging or neoadjuvant treatment.²

References

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Painless removal of suction drains

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Suction drains are used across many surgical specialties and can be a helpful route for delivering postoperative anaesthesia.¹ Patients commonly complain of pain on removal of such drains, some stating it is the most uncomfortable part of their surgical experience.

With the exception of cranial, spinal, pericardial and intra-articular drains, delivering ropivacaine (2mg/kg) directly into the drainage tube a few minutes prior to removal gives safe and excellent analgesia. This also delivers local anaesthetic directly to the operative site around 24 hours after the procedure, enabling more effective physiotherapy and mobilisation with potential for shorter inpatient stays.

Reference

1. Kambam JR, Hammon J, Parris WC, Lupinetti FM. Intrapleural analgesia for post-thoracotomy pain and blood levels of bupivacaine following intrapleural injection. *Can J Anaesth* 1989; **36**: 106–109.