Figure 2c Peroneal tendon graft harvest: final peroneus brevis tendon graft.

Figure 3b Tendon tenolysis: tensioning of the tibialis posterior with forceps while the Smillie knife is slid down to release adhesions.

Figure 3a Tendon tenolysis of tibialis posterior and flexor digitorum longus due to tibialis posterior rupture, with retraction and adhesions of the proximal stump.

Using nylon tape to aid the formation of loop stomas

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BACKGROUND

When delivering bowel through the abdominal wall for loop stoma formation, the bowel can be traumatised by the use of instruments and digital traction. This technique allows for atraumatic bowel delivery.

TECHNIQUE

This technique can be used to create any loop stoma, both open and laparoscopic. The example used is a laparoscopic loop ileostomy.

The desired loop for stoma formation is identified and the orientation confirmed. A mesenteric window, close to the edge of the bowel and avoiding vessels is created using blunt dissection with a Maryland (Fig 1). A 30-cm length of nylon tape is introduced; one end is grasped with the Maryland (Fig 2) and withdrawn through the mesentery, resulting in one end of tape either side. The two ends are grasped with a ratcheted instrument to create a sling at the point to be delivered (Fig 3).

Figure 1 Creating a mesenteric window close to the edge of the bowel and avoiding vessels using blunt dissection with a Maryland.

Figure 3 The two ends are grasped with a ratcheted instrument to create a sling at the point to be delivered.

Figure 2 A 30-cm length of nylon tape is introduced and one end is grasped with the Maryland.

The stoma hole is made through the abdominal wall. The grasper is identified and the two ends of tape delivered with gentle traction allowing for atraumatic bowel delivery. The orientation of the bowel is confirmed and the stoma formed in the usual fashion.

DISCUSSION

Loop stoma formation is a common procedure in emergency and colorectal surgery. This simple technique, which, to the authors' knowledge,

has not been previously described, results in bringing the bowel loop accurately and efficiently through the abdominal wall in an atraumatic fashion. In our series, there have been no incidents of mesenteric vascular injury or bleeding. The technique requires minimal expenditure and is easily reproducible.

Lidocaine analgesia for removal of vacuum-assisted closure dressings

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Bedside removal of the reticulated polyurethane foam used in vacuum-assisted closure can be very painful despite the use of interface dressings to reduce wound bed adherence. We describe a simple pre-procedural step at the bedside where a bolus of lidocaine 1% (3 mg/kg) is injected through the occlusive dressing overlying the foam 15 minutes prior to removal. The adaptor is first closed and suction canister turned off. Next, the dressing is cleansed using an alcohol wipe and finally the lidocaine is injected. This extra step reduces requirements for analgesia and can obviate the need for general anaesthesia in small to medium-sized wounds.