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.