Technical Section [TECHNICAL NOTES AND TIPS

The use of dual nasal trumpet stents to decompress keratocystic odontogenic tumours

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BACKGROUND

Decompression and marsupialisation for the resolution of oral and maxillofacial cysts was described by Patrsch in 1892.¹ Enucleation combined with decompression and marsupialisation for keratocystic odontogenic tumours has comparable results to more aggressive treatments with lower morbidity and preservation of important vital structures. In the mandible, there is a tendency towards spontaneous closure of the fistula and reformation of the cyst than the maxilla, particularly in the posterior mandible. Stable and reliable techniques to prevent spontaneous fistula closure and cyst reformation are advantageous.

TECHNIQUE

Two nasopharyngeal airways tubes (also known as nasal trumpets because of their flared ends) that are 2 mm different in internal diameter (e.g. 8 mm and 6 mm) are cut 5–10 mm from their flared ends (Fig 1). The cut distal end of the narrower cannula is inserted into the cut distal end of the wider cannula to create a stent flared at both ends (Fig 2). A 1-cm window is opened into the cystic cavity and the cyst is marsupialised (Fig 3). The narrower flared end is advanced into the cystic cavity and the stoma is kept open by

Figure 1

Figure 2

Figure 3

suturing in place the larger flared end to the mucosa of the oral cavity (Fig 4).

DISCUSSION

The use of double nasal trumpets, suitably cut and easily assembled, makes an excellent stent to prevent spontaneous closure of the fistula during the decompression process of the cyst.² The stent is economical,³ at less than £7 according to the NHS Supply Chain catalogue,⁴ and is easy to replace in the outpatient setting.⁵

References

1. Partsch C. Über Kiefercysten. *Dtsch Mschr Zahnheilk* 1892; **10**: 271–304.
2. Al-Benna S. A discourse on the contributions of evidence-based medicine to wound care. *Ostomy Wound Manage* 2010; **56**: 48–54.

Figure 4

Figure 1 A patient with drape crimping applied to adhesive disposable drapes

Figure 2 Elasticated retractors are clipped to the drapes with artery clips, which are secured parallel to the skin

Drape crimping: a novel technique for retracting skin flaps

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BACKGROUND

Elasticated retractors such as Lone star or Robsons have become established in various surgical subspecialties.^{1–4} The advantages over traditional techniques (e.g. sutures, fixed metal retractors) are that they are kept out of the surgical field and can be easily adjusted throughout the procedure. This prevents hampering of the surgeon's movements, maintains tension on the surgical site and is beneficial to wound healing through placing tension on the base, rather than apex, of the skin flap. Elasticated retractors can, however, pull the drapes forward, loosening tension and obscuring the operative area. Occasionally, bulky self-retainers are used to attach the elasticated retractors, but these are both costly and increase the set-up time for the operation.^{3,4} The technique described here was devised by the senior author

to solve this problem without these additional financial or operative time implications.

TECHNIQUE

Adhesive surgical drapes are crimped before being applied to the patient in either a square or alternative configuration (Fig 1). The skin incision is performed and the proximal hook of the elasticised retractors applied to the wound edges. Elasticated retractors are secured distally to the drape crimps with an artery clip, parallel to the skin (Fig 2).

DISCUSSION

The use of drape crimping spreads the retractile forces of the elasticated retractors across a wide area and prevents the retractors relocating towards the wound. This facilitates an optimal operating set-up by reducing interference in the surgeon's operating field and enabling the