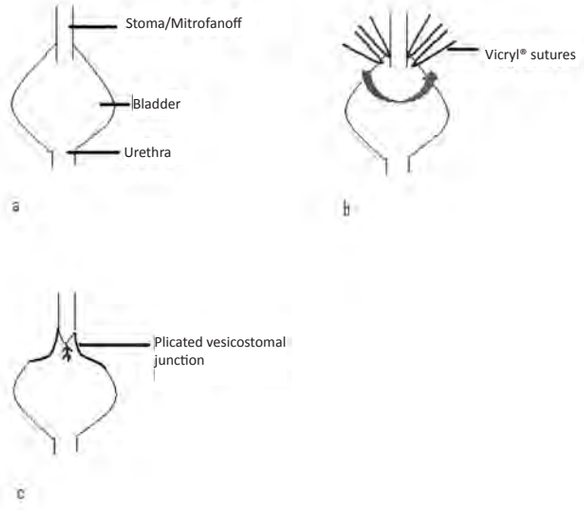

Figure 1 Formation of a bladder wrap: a) existing anatomy; b) sutures are placed at the vesicostomal junction into the detrusor; c) sutures are tied, plicating the junction.

TECHNIQUE

After dissection through the abdominal wall, the anastomosis between the bladder and stoma is identified. The lateral edges of the bladder are plicated around the anastomosis in a manner similar to that of a Nissen fundoplication using 3/0 Vicryl® sutures (Ethicon Inc, Somerville, NJ, US) (Fig 1). The surgeon must leave enough slack on the suture to ensure easy passage of a 12Fr LoFric® catheter (Astra Tech, Stonehouse, UK) into the bladder. Having had this procedure, three patients regained continence with a maximum follow-up of 16 months.

DISCUSSION

The technique achieves continence by acting as a compression valve around the proximal anastomosis as the bladder fills. This technique is described in the literature only in the prevention of vesicoureteric reflux in animals.[5] We advocate its use as first line management in patients with an incontinent vesicocutaneous diversion.

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Finger trocar: a safe method for entering the peritoneal cavity during laparoscopy in obese patients

R Durai, T Oke, M Siddiqui
South London Healthcare NHS Trust, UK

CORRESPONDENCE TO
Midhat Siddiqui, E: dr_durai@yahoo.com

BACKGROUND

We report an easy way of entering the peritoneal cavity in obese patients during laparoscopic antireflux surgery, which can be challenging.

TECHNIQUE

A transverse incision is made on the skin five finger breadths away from the xiphoid process in the midline. The incision is deepened until the anterior rectus sheath is located. A 10mm transverse incision is made on the anterior rectus sheath. Using the surgeon's finger in a rotating and dissecting manner as a trocar, the peritoneal cavity is entered. Then a 10mm non-bladed trocar port is inserted into the peritoneal cavity and pneumoperitoneum is created. Once the procedure is completed, the anterior rectus sheath defect is closed with size 3/0 polyglactin sutures on a J needle and the skin is closed.

DISCUSSION

In this method, finger tactile sensation guides entry into the peritoneal cavity, minimising injury to internal organs. This sensation is lacking in standard laparoscopic visual pneumoperitoneum creation techniques. Our method is safe and quicker than other methods. If the anterior rectus sheath incision is >10mm, the wound can leak gas. This can be minimised using a balloon or gel port. The incision on the rectus sheath should be precisely in the midline. Otherwise one will find the thick rectus muscle and posterior rectus sheath, which may provide resistance, and there is a risk of bleeding. When the posterior sheath is difficult to enter, an artery clip may be used carefully along the side of your finger to make a tiny hole or to provide countertraction by grasping it. An opening can then be created safely in the posterior sheath/peritoneum.