

A novel technique for the per-anal extraction of spherical rectal foreign bodies

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BACKGROUND

It is desirable to remove rectal foreign bodies per-anally to avoid laparotomy and possible colostomy.^{1,2} Spherical objects can pose a specific problem due to difficulty in gaining purchase digitally or with an instrument. Obstetric forceps have been used previously³⁻⁵ but their positioning and extraction can be technically difficult and potentially traumatic. We present a technique whereby a single blade of a pair of Neville-Barnes forceps can be used easily to extract spherical objects.

TECHNIQUE

Under general anaesthesia with the patient positioned in lithotomy, the assistant should apply downward suprapubic pressure to move the object caudally. Following a digital rectal examination to identify the object's position, a well lubricated blade of the forceps is inserted using the left hand. The operator's right index finger is used to guide the blade over the anterior surface of the object. Once in position, the blade is used to apply pressure through the object so it comes into contact with the curved anterior surface of the sacrum. It is then removed slowly, maintaining pressure through the object, thus allowing extraction.

DISCUSSION

The use of a single obstetric blade in this way has not been described previously. It is a useful technique that uses the normal anatomy of the pelvis to the surgeon's advantage. Compared to a pair of obstetric forceps, a single blade can be positioned easily and should cause less trauma to the anal canal. This technique was used to extract a 7cm rubber ball from the mid-rectum, thus avoiding laparotomy and potential stoma.

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Technique for central aortic cannulation in extensive aortic dissection

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BACKGROUND

Cardiopulmonary bypass for aortic dissection repair is most frequently established via the peripheral arteries. Central cannulation in the context of aortic dissection was first described in 1998.¹ In this situation, the difficulty lies in determining whether the true lumen or the false lumen is being cannulated. Previous authors have described cannulation of the proximal aorta²⁻⁶ and confirmation of the wire in the true lumen by ultrasonography in a non-dissected segment of the distal aorta.⁶ However, this is not possible in complete dissection of the aorta down to the iliac bifurcation.

TECHNIQUE

In this situation, access to the descending aorta can be gained via the Seldinger technique and the wire carefully passed retrograde towards the aortic valve. Cannulation of the true lumen can be confirmed by transoesophageal echocardiography with the wire floating freely by the aortic valve. Once the position of the wire in the true lumen is confirmed, a cannula can be placed over the wire.

DISCUSSION

Extensive dissection of the aorta with concurrent contraindications for peripheral cannulation poses a particular problem for cannulation since it can be difficult to ensure cannulation of the true lumen. In these cases, the technique described above with proximal passing of the wire and confirmation of its position in the true lumen by transoesophageal ultrasonography can be a useful method.

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