

by means other than a nasoenteric tube are often ill, malnourished and poor surgical risks. The laparoscopic technique may not be suitable. We use feeding jejunostomies as part of our standard surgical practice for upper gastrointestinal surgery (1) and, in essence, employ the same technique for patients requiring long-term enteral nutrition in whom a percutaneous endoscopic gastrostomy is not suitable.

Under local (or general) anaesthesia, a muscle-splitting incision is made in the left upper quadrant lateral to the rectus sheath. Depending on the shape and build of the patient, this incision can be as little as 4 cm in length. The proximal jejunum is identified and a size 14 biliary T-tube inserted into the intestine, about 20 cm distal to the duodenojejunal flexure. As it is intended to leave the tube in long term, a relatively non-absorbable suture material (eg Maxon®) is used as a purse-string around the tube and as an anchor to the anterior abdominal wall. The time taken to perform this procedure is usually quicker than the equivalent laparoscopic technique, it causes minimum inconvenience to the patient, and feeding can commence the next day.

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Modification to dissecting/ligature forceps

We read with interest Mr Minasian's description of modified curved forceps (*Annals*, November 1997, vol 79, p465), which remain open by means of a spring, to facilitate ligation and division of vessels. We agree that a specially designed instrument is useful for this purpose and we routinely use a similar device, Barraya forceps (Fig. 1), to assist in the dissection of the pulmonary vessels and bronchi at the hilum during lung resection. The instrument has a reverse ratchet mechanism between the handles to maintain the jaws in the open position. It would doubtless be helpful in other situations, on both sides of the diaphragm.

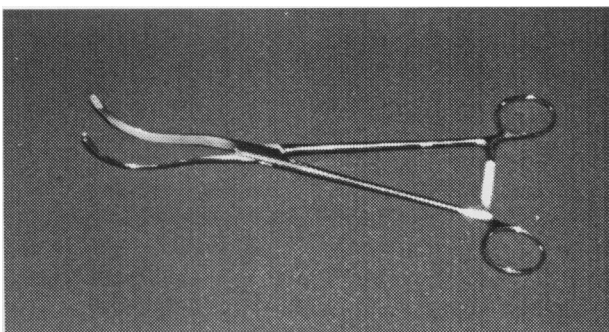


Figure 1. Barraya forceps with a reverse ratchet mechanism to hold the jaws open.

Our Barraya forceps were 'liberated' from a hospital in France in 1992. We have only one example, but the hospital in question has many Barraya forceps of several sizes. Although we do not know the manufacturer, we believe Professor Jean-François Velly (Service de Chirurgie Thoracique, Hôpital Xavier-Arnoz, Pessac, Bordeaux, France) may be able to provide further details.

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Protocol violation in deep vein thrombosis prophylaxis

I was very interested to read the recent article by George *et al.* (*Annals*, January 1998, vol 80, p55) on the administration of heparin prophylaxis. The application of guidelines or protocols in general is an important issue, particularly as they are becoming increasingly more popular in many hospitals.

I was pleased to note that the authors referenced my original paper in their discussion, but a thorough literature search would have revealed a subsequent article (1). The results of this latter study were also published in the *Nursing Times* (2). The authors kindly note that the initial paper drew attention to the problem of poor compliance with established protocols for the administration of both heparin and antibiotic prophylaxis. However, it is not correct to state that we did not address these issues further, albeit at a later date. The latter article was a prospective study over several months at Addenbrooke's Hospital, Cambridge, in 1993/1994. We showed an improvement in the administration of prophylactic drugs by the education of junior staff and the addition of prophylactic drugs to the preoperative checklist. The nursing staff completed the checklist and had a key role to play. They were required to contact the surgical resident if prophylactic drugs or thromboembolic stockings had not been prescribed. Unlike George *et al.* we found that clinical practice could be significantly improved. Subsequently, Byrne *et al.* (3) achieved an improvement in prophylaxis uptake by combining a deep vein thrombosis risk assessment form with regular nursing review of the prescription chart on the ward rounds. We accept that there is still scope for considerable improvement and that certain 'at risk' groups of patients, such as those undergoing emergency surgery or not undergoing surgery, need to be clearly identified. This is a subject that should be emphasised at the induction of new medical and nursing staff and is eminently suitable for ongoing internal audit. It is hoped that this would lead to a gradual raising of both awareness and standards of care.

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