RCS ADVANCING SURGICAL STANDARDS

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Bruce Campbell, Series Editor

Technical Section

TECHNICAL NOTES AND TIPS

EDITORIAL

Originality in the Technical Section

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This issue of the *Annals* contains letters about one recently published technical note and one tip, whose writers point out that they had published the same techniques some time ago.

The Technical Section was established ten years ago to fill something of a void in 'general' surgical journals, by providing a forum for publication of new and/or useful points of surgical technique. From the outset I knew that many submissions would not be truly original. I ask specialist reviewers: 'Is it novel, reasonable and/or sufficiently interesting to merit publication?' If they advise that a technique is one they have seen but that it is useful and seems not to be widely known, then I request that the authors add a few words to point out that the technique is not original. If reviewers state that a technique has been reported in another journal, then it is not accepted: but the *Annals* does depend on its reviewers for that knowledge and they may well not be aware of 'small' publications among the plethora of journals that now exist.

It certainly is disappointing to find that authors have not done a thorough literature search: there is little excuse for that nowadays. The Readers' Pages allow rapid publication of letters if that needs to be pointed out. They also allow authors to respond if they believe that their technique has subtle differences and the *Annals* encourages such exchanges. I see one aspect of the Technical Section as being a place for trainees to gain their early experience of publishing. If they fail to do a proper literature search and are exposed publicly for that, then it is a deservedly painful step in their learning. Their senior co-authors must also be acutely aware of their own responsibilities for checking final manuscripts and the processes used in their preparation.

My own unease in witnessing these exchanges is ameliorated just a little by the fact that it shows that surgeons are reading the Technical Section and noticing when notes and tips are not original.

A novel laparoscopic approach for the surgical management of buried bumper syndrome

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BACKGROUND

First reported in 1990, buried bumper syndrome (BBS) is a rare complication of long-term percutaneous endoscopic gastrostomy (PEG) feeding.[1] An overgrowth of gastric mucosa buries the internal bumper, resulting in luminal mechanical obstruction. The patient experiences discomfort and discharge from the exit site.[2] Where endoscopic techniques fail, laparotomy may become necessary for BBS.[3,4] We describe a laparoscopic technique for PEG dependent patients where attempts at endoscopic removal fail.

TECHNIQUE

A completely buried bumper is confirmed by endoscopy. The peritoneal cavity is accessed via three ports. The stomach is dissected away from the abdominal wall at the insertion site of the PEG tube. The portion of the stomach with the buried PEG bumper is divided with a 60mm endoscopic linear stapler (Echelon™ 60mm, Ethicon Endo-Surgery Inc, Cincinnati, OH, US) and removed through the umbilical port in an impervious bag (Fig 1). The staple line is checked endoscopically and a new PEG feeding tube placed using the standard technique.

DISCUSSION

Laparoscopic management of BBS has been reported previously by Ballester and Ammori, who describe a gastrostomy to remove the buried bumper and closure with intracorporeal suturing.[5] However, in our experience limited partial stapled resection of the stomach minimises operative time. It allows removal of inflamed fibrosed tissue along with the bumper and can be safely carried out in selected cases. This approach offers the advantage of combining PEG replacement with removal of the buried bumper, allowing early commencement of feeding.

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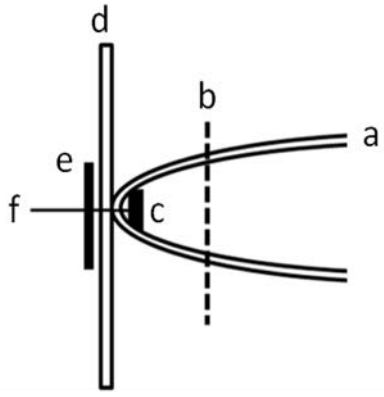

Figure 1 Schematic representation of the procedure (a = anterior stomach wall; b = staple line; c = internal buried bumper; d = anterior abdominal wall; e = external flange; f = percutaneous endoscopic gastrostomy tube)

Figure-of-eight 'iceberg stitch' facilitates easy removal of supraclavicular lymph nodes

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We describe a novel 'iceberg stitch' to facilitate easy removal of supraclavicular lymph nodes. The skin and platysma are incised over the lymph node. Using an artery clip, the fat pad is opened up. Once the lymph node is seen, a figure-of-eight stitch is applied on the visible part of it, using 3/0 monofilament polypropylene with a small atraumatic round body needle. The stitch is used as a stay so that the node can be dissected all around. A figure of eight makes the suture less likely to cut through. The overall risk of tumour seeding is minimised compared to using a tissue holding forceps and rupturing the capsule.

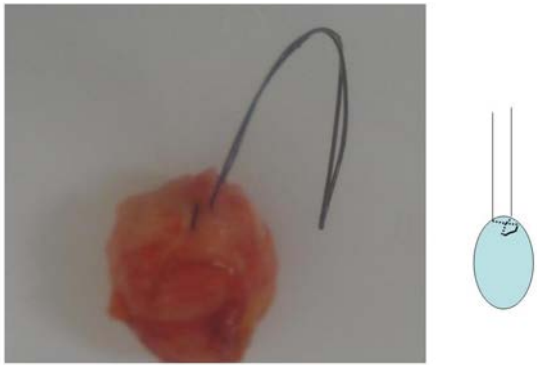

Figure 1 Supraclavicular lymph node that was removed using figure of 8 stitch. Subset shows diagrammatic illustration of the same.

A useful technique for retrieving the distal segment of a fractured femoral nail

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We report a technical tip for removing the distal portion of a fractured intramedullary femoral nail. Although retrieving the proximal portion of the implant is often easily achieved, the distal fragment presents a conundrum. We recommend the use of a 'bone corkscrew', most commonly used in hip hemiarthroplasty surgery.

Following removal of the proximal segment of nail, we advise passing the corkscrew through the same channel and engaging the distal segment with the corkscrew thread. To assist with the corkscrew grip within the implant, we further recommend leaving the distal locking bolt in position until satisfactory purchase has been achieved.

Figure 1 Corkscrew and distal fragment construct with (clockwise from top left) proximal fragment, distal locking bolt, set screw and lag screw