TECHNIQUE

The required skin excision is marked preoperatively in the standing position. For the procedure, the patient is positioned supine. The arms are abducted and secured so the patient can be sat up intraoperatively (Fig 1).

The areola is reduced, the inferior dermal flap de-epithelialised (Fig 2) and the mastectomy performed, at the level of the gland. The dermal flap is dissected from the parenchyma, retaining a thin layer of subdermal fat including the deep dermal vascular plexus (Fig 3).

The wounds are closed in the dermal and subcuticular planes using 2/0 Vicryl® (Ethicon, Somerville, NJ, US) and 3/0 Monocryl® (Ethicon). The patient is sat up and the new nipple position selected. A 'button-hole' is created for the nipple (Fig 4) and this is sutured with a subcuticular, continuous, periareolar suture (4/0 Monocryl®).

DISCUSSION

The utility of a periareolar approach is limited by the required amount of skin and tissue to be resected. At many institutions, the alternative for moderate to large breasts is mastectomy with a free nipple graft. This renders the nipple insensate and liable to depigmentation.

The technique described above is suitable for excisions up to 700g. It maintains nipple sensation and erectile function in >70% of cases (unit data) while still resulting in a masculine chest (Fig 5).

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Real time ultrasound guided insertion of Veress needle in obese patients

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BACKGROUND

Creation of pneumoperitoneum is the first step in laparoscopy and is often done blindly using a Veress needle. Although generally safe, this technique may be associated with life threatening complications such as injury to bowel and intra-abdominal vessels, especially in obese patients.[1–3] We describe a simple technique of ultrasound guided visual insertion of a Veress needle.

TECHNIQUE

The stomach is decompressed by an orogastric tube. The ultrasonography probe is tilted, rotated or both to improve visualisation of the three layers of the abdominal wall (Fig 1). With an oblique orientation on the abdominal wall, the muscle planes are identified and the Veress needle is inserted. (We use Palmer's point for insertion [Fig 2].) The progression of the needle is assessed by

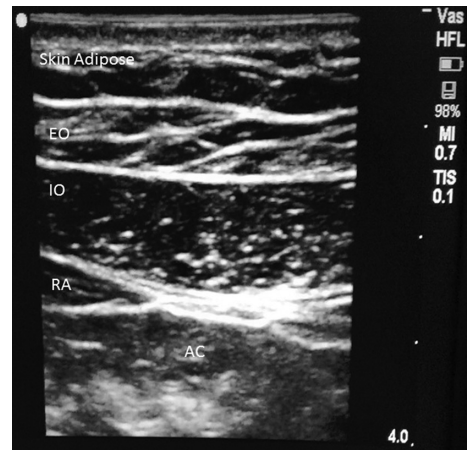

Figure 1 The layers of the abdominal wall are well visualised even in morbid obese patients using real time ultrasonography

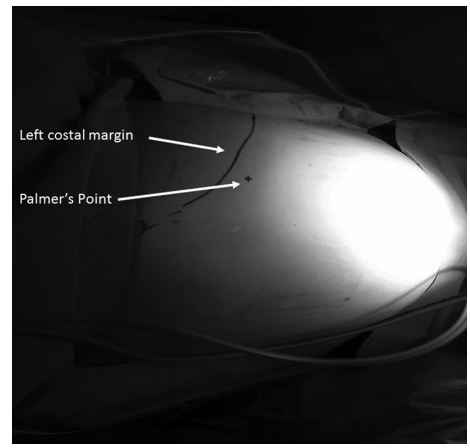

Figure 2 Palmer's point is our preferred site for Veress needle insertion, lying two fingerbreadths below the left subcostal margin in the midclavicular line

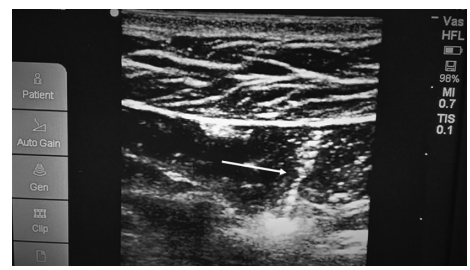

Figure 3 The path of the Veress needle (arrow) is visualised using real time ultrasonography

ultrasonography (Fig 3). Once the tip is in the peritoneal cavity, insufflation is begun and can be visualised as a hypoechoic shadow around the tip of the Veress needle.

DISCUSSION

We have standardised this technique in 53 patients who underwent weight loss surgery without any complications. Use of this method eliminates the blind steps of Veress needle insertion (two blind entries and one blind gas insufflation).[4] This technique holds promise for decreasing the risks and improving the safety of trocar insertion without requiring costly optical devices.

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Blood on screwdriver tip to aid screw insertion at depth

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Figure 1 With the tip of the screwdriver covered in blood, the screw is engaged more securely and able to better resist the effects of gravity

BACKGROUND

In performing a total hip arthroplasty, many surgeons undertake screw fixation of the acetabular component. While inserting the screw at depth, it sometimes proves difficult to ensure that the head of the screw remains engaged on the tip of the screwdriver. This may result in dropping the screw into the acetabulum or elsewhere within the surgical field. To address this problem, many medical manufacturers have designed instruments to stabilise and hold the screw on the screwdriver; for example, the Stryker 'screw holding forceps' (Stryker, Newbury, UK). The use of these instruments may prove cumbersome and occupies both of the surgeon's hands. We describe a simple alternative method to prevent the screw falling off the end of the screwdriver.

TECHNIQUE

The tip of the screwdriver is briefly placed into a drop of blood, such that the surface of the tip is completely covered (Fig 1). The screw can then be attached to the screwdriver and subsequently inserted into the acetabulum without the requirement for an additional stabilising instrument.

DISCUSSION

This simple technique aids attachment of the screw to the screwdriver tip for screw insertion at depth, thus allowing the surgeon the free use of one hand. We have observed that it is more difficult to intentionally drop a screw, with the use of force, when the technique is used. This phenomenon may be explained by the interrelated concepts of capillary action and liquid adhesion.[1]

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