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SURGICAL TECHNIQUE

Difficult hemostasis during rectal resection



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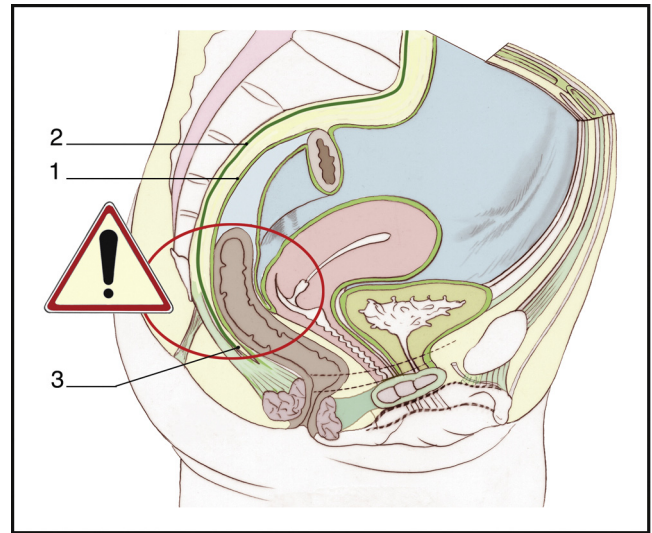
Presacral hemorrhage may arise during proctectomy with total mesorectal resection; it is an infrequent complication but can be very difficult to manage. We illustrate here a staged sequential approach for management of presacral hemorrhage.

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1 Anatomical description of dissection planes

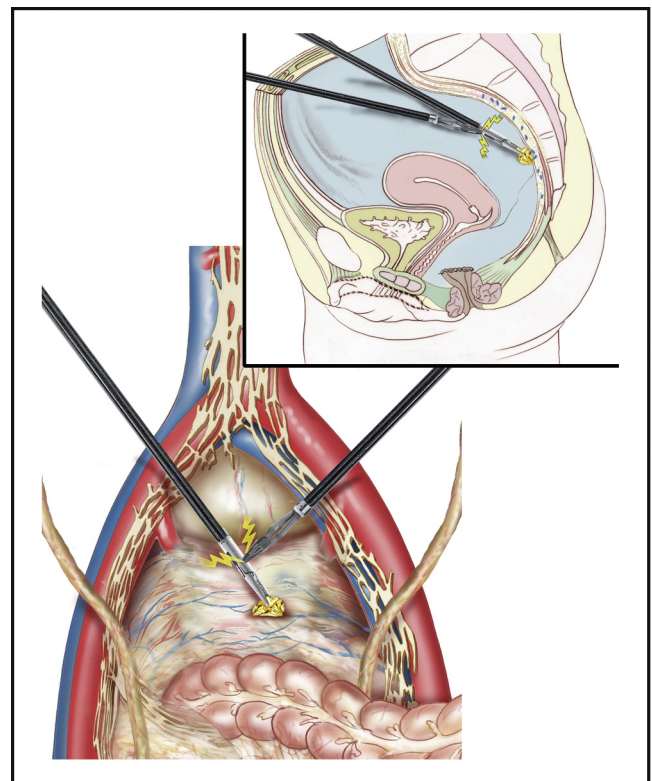
The best protection is meticulous dissection in the plane of the fascia recti with avoidance of all blunt manual dissection. Dissection should leave the visceral leaflet intact permitting complete mesorectal resection. At the level of the fourth sacral segment, the presacral leaflet fuses anteriorly with the visceral leaflet to encompass the mesorectum. These fused layers constitute the recto-sacral ligament; its division opens up the last phase of the liberation of the mesorectum. Forceful blunt dissection of this ligament may result in laceration or tearing of the presacral fascia resulting in venous bleeding that is difficult to control because of the complex interconnections between the superficial venous plexus with the deep sacral periosteum [2].

Retraction of injured veins may transform superficial bleeding into deep hemorrhage from the periosteum that is inaccessible to the usual hemostatic maneuvers since the bleeding vein gapes open due to its bony attachments. Faced with this sort of bleeding, the initial response must be temporary control by direct compression. Bleeding in most such cases can then be controlled by simple measures such as bipolar or monopolar electrocoagulation, argon laser, or individual suture ligations.



2 Haemostasis using electrocoagulation

If these measures fail to control the bleeding, electrocoagulation can be modulated by interposition of an omental patch between the bleeding site and the coagulation source [1]. An omental patch or flap is prepared and used to tamponade the zone of bleeding; monopolar coagulation can then be applied to the omental patch transmitting the energy through it. This technique permits transmission of coagulation energy more slowly and over a larger area than if it were transmitted through the tips of a coagulation forceps. In fact, coagulation through forceps often results in adherence between the metal of the forceps and the coagulation zone, resulting in re-bleeding when the instrument is removed.



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