The Easier Construction Method of Terminal Stoma by Extraperitoneal Route Using Nelaton's Catheter

Author(s)
To, Kazuo; Takeshita, Hiroaki; Tominaga, Tetsuro; Arai, Junichi; Nonaka, Takashi; Kunizaki, Masaki; Hidaka, Shigekazu; Sawai, Terumitsu; Nagayasu, Takeshi; Ishikawa, Hiroshi

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The Easier Construction Method of Terminal Stoma by Extraperitoneal Route Using Nelaton’s Catheter

Kazuo Tō1, Hiroaki Takeshita2, Tetsuro Tominaga3, Junichi Arai1, Takashi Nonaka3, Masaki Kunizaki1, Shigekazu Hidaka1, Terumitsu Sawa4, Takeshi Nagayasu3, and Hiroshi Ishikawa1

1Department of Digestive Surgery, Sasebo City General Hospital
2Department of Digestive Surgery, National Hospital Nagasaki Medical Center
3Department of Surgical Oncology, Nagasaki University Graduate School of Biomedical Sciences
4Division of Nursing, Nagasaki University, School of Health Science, Faculty of Medicine

Introduction: Abdominoperineal resection is performed using laparoscopic techniques at many institutions. Few institutions construct the terminal stoma using the extraperitoneal route, mainly because of the difficulty of this approach. However, the extraperitoneal route for terminal stoma might be associated with a lower rate of complications when compared with the transperitoneal route. We construct the terminal stoma via the extraperitoneal route using Nelaton’s catheter. Materials and Surgical Technique: We call this technique the “Nelaton’s Catheter Hauling Technique”, which involves: 1) dissection of the extraperitoneal space using a intestinal spatula, 2) insertion of Nelaton’s catheter into the abdominal space via the extraperitoneal route, 3) capture of the tip of Nelaton’s catheter and pull it to the outside, 4) tying of the threads of the stump of the colon and the tip of Nelaton’s catheter, and 5) pulling up on Nelaton’s catheter to move the stump of the colon outside via the extraperitoneal route. Discussion: We believe that the use of this technique will contribute to the reduction of stoma-related complications.

Key words: extraperitoneal route, laparoscopic stoma construction, Nelaton’s catheter
Materials and Surgical Technique

Indications for this technique

Because the extraperitoneal route requires sufficient length to approximate the colon to the skin level, cases in which a sufficient length of colon could not be secured were excluded.

Construction of the terminal stoma via the extraperitoneal route using Nelaton’s catheter

After mini laparotomy of the stoma site, wound retract device [wound retractor] was attached, the tumor was resected to allow enough length to create the stoma via the extraperitoneal route. Four support sutures were placed at the stump of the colon, and the threads were tied into one knot. The stump of the colon and threads were then returned to the intraabdominal space. After detaching the wound retractor, blunt dissection of extraperitoneal space was performed using Kelly forceps. Next the intestinal spatula was inserted into the extraperitoneal space, and gently rotated to secure enough space to ligate the stump of the colon. Then, the Nelaton’s catheter was inserted into the dissected space as deep as possible, and the wound retractor was attached again. The tip of Nelaton’s catheter was grasped and pulled up to the outside and clamped (Fig.1). The stump of the colon was pulled up to the outside, and the tip of Nelaton’s catheter and threads (already mentioned) were connected and returned to the abdominal cavity (Fig.2). The wound retractor was detached, and Nelaton’s catheter was hauled up gently with the stump of the colon above the skin level (Fig.3). The stoma via the extraperitoneal route was constructed by laparoscopic procedure (Fig.4).

Figure 1: Tumor is already resected. First, the extraperitoneal space is dissected using an intestinal spatula. Second, the Nelaton’s catheter is inserted into the abdominal space via the extraperitoneal route.

Figure 2: The tip of the Nelaton’s catheter is grasped intracorporeally under pneumoperitoneum conditions and then pulled to the outside through the wound retractor. The threads of the stump of the colon and the tip of Nelaton’s catheter are tied.

Figure 3: By pulling up the Nelaton’s catheter, the stump of the colon is pulled outside the abdomen via the extraperitoneal route.

Figure 4: The stoma via the extraperitoneal route was constructed by laparoscopic procedure.
We do not believe it is necessary to close the peritoneal defect, as the small laparotomy is supported behind by the serosa of ligated colon. If the surgeon desires to close this defect, it can be sutured before pulling up the Nelaton’s catheter.

We have performed six surgeries using this technique, and the average time needed to create the stoma was approximately 30 minutes (Table 1).

Discussion

The increasing use of laparoscopic surgery has led to the omission of some vital procedures that are classically performed during open surgery. Closure of the mesenteric gap tends not to occur in the setting of laparoscopic surgery, as a large gap is associated with a low risk of internal hernia. However, similar to Petersen’s hernia (i.e., internal hernia occurring after laparoscopic total gastrectomy), recently cases of internal hernia have been described after colorectal laparoscopic surgery. This has prompted surgeons to attempt to close the mesenteric gap. Although not randomized controlled trials, some reports have suggested that the extraperitoneal route is associated with a reduced risk of stoma-related complications when compared with the transperitoneal route. We believe that our method is not inferior as compared with these methods and could create laparoscopic extraperitoneal stoma easily, simply and reasonably.

Because the length of the extraperitoneal route is longer than that of transperitoneal route, important attention is needed in regards to resection of the oral side colon. Only one case required re-operation due to partial necrosis of the stoma caused by intraoperative severe congestion (Table 1). We believe that this necrosis was due to the narrow dissection of extraperitoneal space rather than due to the operative procedure itself.

In conclusion, this “Nelaton’s Catheter Hauling Technique” enables construction of laparoscopic extraperitoneal stoma simply and easily without requiring special instruments. Therefore, we believe that this technique will contribute to reducing the risk of stoma-related complications.

<table>
<thead>
<tr>
<th>Case</th>
<th>Age/Sex</th>
<th>Disease/Location</th>
<th>Operation Procedure</th>
<th>Type of Stoma</th>
<th>Stoma Construction Time (min)</th>
<th>Complication</th>
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<tbody>
<tr>
<td>1</td>
<td>87/F</td>
<td>Rectal Cancer/PRb</td>
<td>Lap-APR</td>
<td>Colostomy</td>
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<td>no</td>
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<td>Lap-APR</td>
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<tr>
<td>3</td>
<td>80/M</td>
<td>Ulcerative Colitis</td>
<td>Lap-IPACA</td>
<td>Ileostomy</td>
<td>26</td>
<td>no</td>
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<tr>
<td>4</td>
<td>83/M</td>
<td>Rectal Cancer/Rb</td>
<td>Lap-APR</td>
<td>Colostomy</td>
<td>36</td>
<td>Congestion &amp; Partial Necrosis of Stoma</td>
</tr>
<tr>
<td>5</td>
<td>81/F</td>
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<td>Lap-APR</td>
<td>Colostomy</td>
<td>24</td>
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<td>Average 77</td>
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</tbody>
</table>

Lap-APR: laparoscopic abdominoperineal resection
Lap-IPACA: laparoscopic ileal pouch anal canal anastomosis
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