



**Fig. 1.** Computed tomography abdomen in lung (a) and soft tissue (b) windows demonstrating pneumatosis coli (PC) in the ascending colon (AC) and gas within the intrahepatic portal veins (PG).

receiving chemotherapy, and patients with acquired immunodeficiency syndrome.<sup>1,2</sup> Because of a blunted systemic inflammatory response, typical manifestations of abdominal sepsis such as fevers, tachycardia, peritonism, leukocytosis and high CRP may be absent or delayed.<sup>2,3</sup> Overreliance on these parameters may lead to misdiagnosis and undertreatment resulting in increased patient morbidity and mortality. Clinicians at all levels must develop a heightened index of suspicion for potential abdominal surgical emergencies when faced with non-specific abdominal pain in these patient cohorts. Early CT imaging and timely exploratory laparotomies may save lives.

## References

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Dear Editor,

## Novel method for non-traumatic creation of a colostomy

Particularly in obese patients, creating a loop colostomy or other fecal diversion can be challenging. Gentle tissue handling while pushing or pulling the bowel through a thick abdominal wall is essential so as not to risk the blood supply. Often, the bowel is abraded passing through fascia and muscle resulting in a bruised bowel segment. Post-operatively, this stoma may turn purple-black, making viability of the ostomy site questionable.

We present a technique for non-traumatic creation of the colostomy. First, a site is chosen with skin and fascia in native position. A circular skin incision and cruciate fascial incision are made. The fascia is stretched wide enough for two fingerbreadths – or large enough for the bowel to pass.

At this point, a disposable polymer retractor (Alexis C-section retractor, Applied Medical, Rancho Santa Margarita, CA, USA) is placed in the ostomy site. The retractor consists of two flexible rings and a polymer cylinder between the rings. The internal ring is placed in the abdomen. The outer ring is placed on traction and rolled down to the level of the skin, thus providing exposure and circularization of the incision. We employ the medium size Alexis retractor. The Alexis widens the ostomy site and also provides a substantial amount of lubrication when moistened.

The bowel segment is brought to the ostomy site (See Fig. 1). A Penrose or Babcock is useful to lift the bowel. It is passed upwards through the disposable retractor. Given the slippery nature of the retractor, it passes easily. Once the bowel is passed through the ostomy site, a heavy gauge scissors is used to cut the internal ring. The retractor then slips out without difficulty.

The resultant ostomy is pink, having been delivered through the abdominal wall in a non-traumatic manner. The decreased friction



**Fig. 1.** Alexis placement. Skin and fascia brought to native position; the Alexis retractor is placed in the future ostomy site. The loop of bowel is easily brought through the abdominal wall. Gentle tissue handling and the non-abrasive retractor result in a clearly viable, pink stoma site.

provided of the Alexis leads to less abrasion, tissue handling and bruising.

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Dear Editor,

### Burns caused by plaster of Paris splints

When I first encountered such a burn to a forearm many years ago, no one was sure whether it was heat or chemical cause (in retrospect it was clearly a thermal burn).

The letter in *ANZ Journal of Surgery*<sup>1</sup> explains the relevance of the temperature of the dipping water, the thickness of and inadequate wetting of the plaster of Paris, cooling by ventilation, poor vascular supply and decreased thermal regulatory action

due to local anaesthesia. Use of an ice pack is suggested and it is pointed out that patients' complaints of pain must not be ignored.

With respect to causation, I wish to add exsanguination using a tourniquet which prevents protective cooling by blood flow if left on for an appreciable time after application of a plaster of Paris splint. I have seen a burn that required debridement of a thin layer of superficial calf muscle prior to grafting. This burn followed the application of a thick plaster of Paris splint to a lower limb following tendon repairs: the tourniquet was not released until the surgeon was satisfied that the plaster had hardened sufficiently to maintain the position of the ankle.

It is often appropriate to delay release of a pneumatic tourniquet until supporting dressings (including a plaster of Paris splint) have been completed, but deflation of the tourniquet should not be delayed longer than absolutely necessary and, of course, close attention should be paid to all of the comments and advices in the excellent letter to which this brief communication relates.

### Reference

1. Quinn T, Wasiak J, Cleland H. Deep dermal burns following the application of a plaster of Paris backslab. *ANZ J. Surg.* 2012; **82**: 380–1.

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Dear Editor,

### Lost and sliced valve-plasty catheter

A 66-year-old female was suffering from mitral valve stenosis. She was under the care of the cardiologist. It was decided that she requires percutaneous valve plasty of the mitral valve. A specially designed catheter was used for this procedure (Endry's Transeptal Catheter, Soft polyethylene 8.5 French size, 69.8 cm length, William Cook Europe APS, Sandetb, DK 4632, Bjaeverskov, Denmark). This catheter has been in use for years in this centre. The interventional cardiologist introduced the catheter via the right common femoral vein. During the procedure, the catheter snapped and attempts at retrieval by snaring the catheter via the left iliac vein approach managed to get the catheter to the lower inferior vena cava (IVC) and left iliac veins. At this stage, it was clear on the screen that the catheter has broken into several pieces and would not be possible to extract it. The vascular surgeons were called, an on-table plain X-ray of the pelvis showed a long catheter in the left side of the pelvis (external and common iliac veins) going up to the paravertebral region (in the IVC). It was noted that the catheter was sliced into several pieces (Fig. 1a, 'arrows').

A retroperitoneal left inguinal approach was used to explore the left iliac vessels. Most pieces were retrieved from the left iliac vein (Fig. 1b). One piece remained in the lower part of the IVC about 3 cm above the confluence of the iliac veins. Attempts to retrieve it via the left iliac vein failed. It was retrieved via a 1-cm venotomy in the IVC after proximal and distal occlusion with a sponge-on-sticks