Rubber Band Division Of The Posterior Colostomy Wall

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Natural and traumatic colostomies have been known to man for a long time. Although the method of temporary colostomy has been standard for years, refinements in technique leading to improvement in the ultimate design, value and comfort of the colostomy continue to evolve. Our presentation is concerned with a simple technique of division of the posterior wall of the loop colostomy using a 2 to 3 inch office rubber band.

The points in favor of completely dividing the loop colostomy are total exclusion of the fecal current, possibly a decreased incidence of pericolostomy hernia and better molding of the colostomy stoma. The posterior wall does not need to be left intact solely to make for easier closure of the colostomy. Acceptance of the methods of intraperitoneal closure of the colostomy have done away with the various crushing clamps and preoccupation with the spur. No longer are the advantages of extraperitoneal closure so weighty.

Division of the posterior colostomy wall may be accomplished in several ways. Indeed, at our Hospital the following variants are used:

1. No division of the posterior wall.
2. Division with cautery.
3. Division with a sharp instrument (usually scissors) after a Kelly clamp has been applied across the wall to crush the tissue.

Of the three methods, the third is the most frequently employed.

Most of the divisions are the duty of the resident surgeon. When performed in the patient's room with poor lighting and other inconveniences, the problems of nuisance bleeding and discomfort are often encountered. This in turn may frighten the patient and result in an overall uncomfortable situation. When hemorrhage does occur, it must be controlled with suture ligatures. Several of these sutures

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Figure 1

TECHNIQUE OF DIVISION OF THE POSTERIOR COLOSTOMY WALL

a. Glass rod present. Anterior wall of colon previously divided.
b. Glass rod removed and ordinary rubber band placed through opening.
c. Rubber band tied snugly.
d. Tension obtained on rubber band loop by applying O-rings used for hemorrhoid ligation. These supply the necessary tension to secure necrosis and prevent the knots from coming untied.
DIVISION OF COLOSTOMY WALL

are sometimes required. It is said that the posterior colostomy wall may be divided without pain to the patient, but this is not true and some patients develop nausea and vomiting. Undoubtedly, this is a result of traction on the mesentery during manipulation. To simplify the procedure and avoid pain, nausea and bleeding, we have devised the following method.

The division is carried out on or about the twelfth day (Fig. 1). The colostomy bag or dressing is removed, then the glass rod. After this, the end of an office rubber band is snugly ligated with several square knots. Finally, small hemorrhoid bands are applied with the Barron hemorrhoid ligator, as many as necessary to tighten the large rubber band securely. This obviates the awkward necessity of trying to get enough tension by the original knots in the rubber band. These small bands also help keep the knots from slipping loose. If the tension is insufficient to obtain the desired effect, a second application of hemorrhoid bands in two to three days will augment the tension to the necessary level. The rubber band around the bowel results in pressure necrosis. Thus, bleeding is minimized. The soft necrosed tissue is transected by the rubber band usually in three to six days. In the meantime, a colostomy bag may be applied without difficulty. After transection the rubber band may be removed if it has not already been displaced. The procedure is quick and entails little or no discomfort to the patient. Results during the past eight years have been highly satisfactory and superior to other methods of division of the posterior colostomy wall.

A review of the literature reveals no recording of similar experience. The application of pressure to cause necrosis resulting in partial division of the bowel wall is not new. Various crushing clamps were previously used with this intention though for slightly different purposes. The technique is simple and easily performed without anesthesia. It is presented as an alternate way of dividing the posterior wall of a colostomy.

REFERENCES


