

Technical Section

TECHNICAL NOTES AND TIPS

The genitofemoral nerve block: a method for hemiscrotal anaesthesia at the bedside

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BACKGROUND

Sensory innervation to the scrotum arises from the genital branch of the genitofemoral nerve, travelling with the spermatic cord through the inguinal canal en route to the scrotum. It lies immediately lateral to the spermatic cord as it emerges from the superficial inguinal ring and is involved in the efferent arm of the cremasteric reflex. This causes distortion and apparent shrinkage of the scrotal surface area, and ascent of the ipsilateral testis. Many surgeons use local infiltration rather than regional anaesthesia. The scrotal anatomy makes it favourable for regional local anaesthetic nerve blocks to be used when repairing or incising the scrotal skin.

TECHNIQUE

The spermatic cord is identified immediately lateral to the pubic tubercle. The area for injection, including the scrotum, is sterilised. The spermatic cord is then stabilised and medialised using the non-dominant hand, and 5ml of 1% lidocaine is injected subdermally, immediately lateral to the cord, superficial to the bone.¹ Negative aspiration prior to injection ensures non-penetration of the peritoneum or femoral vessels.

DISCUSSION

The genitofemoral nerve block provides hemiscrotal anaesthesia, allowing painless manipulation and intervention in an area that is prone to changes in texture and superficial skin anatomy. This method of regional anaesthesia thereby eliminates problems with handling scrotal skin during the time of anaesthetic infiltration, which may occur on stimulation of the cremasteric reflex. This method also minimises the risk of injury to the male genitalia.

Reference

1. Sasaoka N, Kawaguchi M, Yoshitani K *et al*. Evaluation of genitofemoral nerve block, in addition to ilioinguinal and iliohypogastric nerve block, during inguinal hernia repair in children. *Br J Anaesth* 2005; **94**: 243–246.

Seldinger method for intraoperative cholangiography: a practical approach

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BACKGROUND

Manipulation of a catheter into the cystic duct for successful intraoperative cholangiography can be made difficult by the tortuosity of the cystic duct and the spiral valves of Heister.¹ We describe a technique to eliminate these problems and allow successful positioning of the catheter within the cystic duct.

TECHNIQUE

A Steriseal Horner needle (Optech Diagnostic & Surgical, East Melbourne, Australia) is guided through the abdominal wall and placed adjacent to the incision created in the cystic duct. The cholangiogram catheter is passed through the needle to protrude through its laterally placed end opening (Fig 1). This opening angulates the catheter tip, allowing it to be easily negotiated into the cystic duct.

If the catheter cannot be manipulated into an adequate position within the duct, a Zebra® straight tip guidewire (0.035in x 150cm, Boston Scientific, Miami, FL, US) can be fed through the catheter and passed further into the duct. The position of the wire can be checked

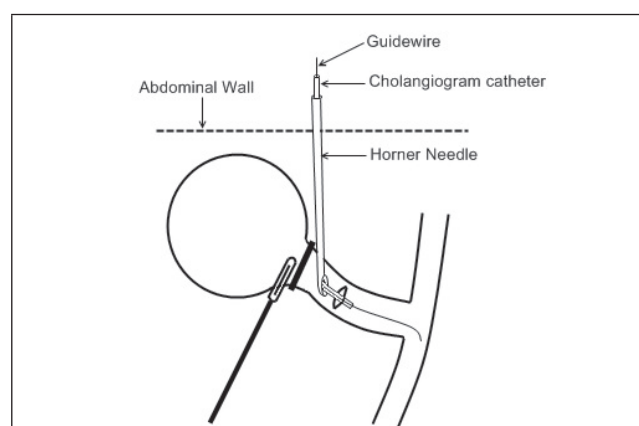


Figure 1 Position of cholangiogram catheter and needle

with an x-ray image intensifier. The catheter can then be passed over the top of the guidewire in a Seldinger fashion. Once in the correct position, it is secured with a clip, and the guidewire and Horner needle are removed successively.