Technical suggestions

Technique for passing shunt tubing subcutaneously. Graham Martin, F.R.C.S., M.R.C.P.

The passage of long lengths of tubing subcutaneously is a frequent procedure in shunting for hydrocephalus in adults. The following method simplifies the passage of the tubes. A 13 B.S.W. gauge needle, as used for an airway in intravenous infusion bottles, is bent to a convenient curve. The end is blunted but the bevel retained. This is passed subcutaneously and the suction tubing attached to the end. The shunt tubing is sucked up the blunted needle which is then withdrawn, leaving the shunt tube in its track.

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The use of Gelfoam paste in anterior cervical fusion. Zia E. Taheri, M.D.

Control of the extreme vascularity of vertebral bone has historically been a problem in anterior cervical procedures where a bone dowel is used to achieve fusion and bone wax is contraindicated. When sterile Gelfoam powder is mixed with sterile saline to a thick paste consistency, a smooth hemostatic agent is readily at hand. This paste can be applied to the side walls to control bleeding whenever the drill is removed to clear the area of bone dust and to ascertain depth. When the drilling is completed, a final application can be made just prior to inserting the bone dowel. This thin layer of Gelfoam paste does not in any way affect the bone graft and indeed it may enhance the migration of cells. I have found that 1 gm of sterile Gelfoam (Upjohn Company) mixed with 4 cc of sterile saline gives the optimum consistency. The advantages of Gelfoam paste appear to be twofold: unlike bone dust, the paste is uniformly smooth; and it permeates the trabeculae causing rapid hemostasis.

At first I used sterile thrombin solution instead of sterile saline as a vehicle. Two patients suffered anaphylactic reactions, which necessitated injections of epinephrine during surgery to restore adequate blood pressure. With the subsequent use of sterile saline, there have been no untoward reactions.

I have used Gelfoam paste in over 300 anterior cervical operations during the past 8 years with excellent results. The rate of fusion in these patients has been followed by x-ray and shows no difference from that experienced in the previous 4 years when the same operative procedures were used without Gelfoam paste. Apparently the paste is readily absorbed by the body and within a short period of time no trace of it remains to interfere with the fusion.

While Gelfoam paste is most applicable to anterior cervical fusion procedures, there is no reason why it cannot replace bone wax in other operative situations.

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