7 In Theatre

The anaesthetic

The choice of anaesthetic is not terribly important for simple cases and can be left to the preference of the anaesthetist. Spinal anaesthesia is used for most of my cases, but one anaesthetist prefers to work with ketamine alone, and this works well. The patient may, however, become restless during longer operations using ketamine.

Instruments

For simple fistulae, the following are all that are needed (Figure 23):

- Auvards speculum
- good-quality dissecting scissors
- toothed dissecting forceps
- Allis tissue forceps
- artery forceps
- metal catheter
- small probe
- No. 15 blade (not illustrated)

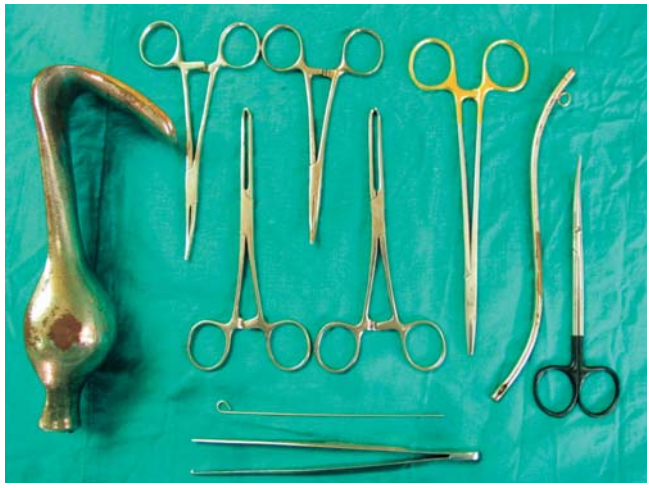

Figure 23 Instruments for simple fistula repair.

Sutures and needles (Figure 24)

Non-absorbable sutures should never be used, because a stone may form in the bladder much later.

The choice of suture may be determined by what is available. Plain catgut dissolves too fast but chromic catgut is fine. 2/0 or 3/0 Vicryl (or Dexon) would be the first choice of most surgeons, if available. For closure of the bladder, half-circle 25 mm round-bodied needles are best. For more advanced fistula work, eyed J needles are a great help. A larger cutting needle is used for suturing the vagina.

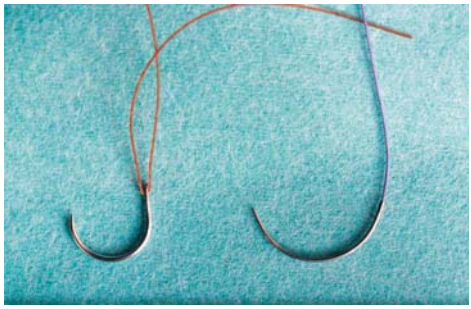

Figure 24 Needles for fistula repair: an eyed J needle mounted with 2/0 catgut and a swaged 25 mm half-circle needle with 2/0 Vicryl.

Operating table

An operating table that tilts and has shoulder rests (Figure 25) is essential for the full range of fistula surgery, but is *not* essential for simple fistulae.

Figure 25 Tilting operating table with shoulder rests.

Lighting

A simple spotlight is sufficient (Figure 26). Note that poor lighting is not an excuse for not proceeding – one famous surgeon operates by daylight because the electricity supply is so erratic. If necessary, simply operate close to a large window (Figure 27).

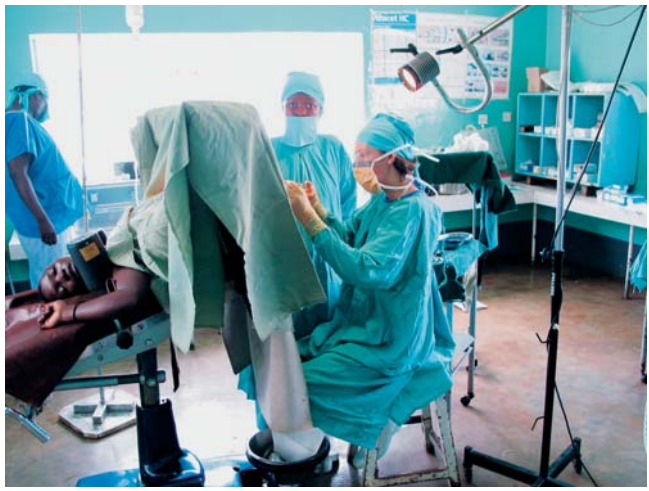

Figure 26 Operating spotlight.

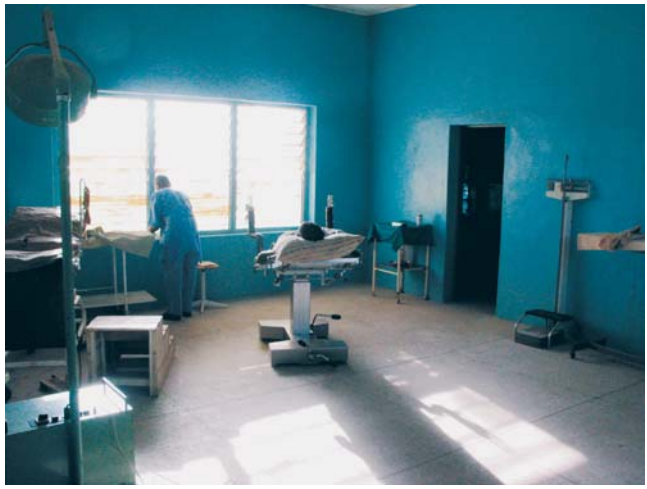

Figure 27 Operating by daylight.

Patient's position on the table

Even if the table will not tilt head down, make sure that the buttocks are well over the end of the table, the hips well flexed and the feet supported high out of the way (Figure 28).

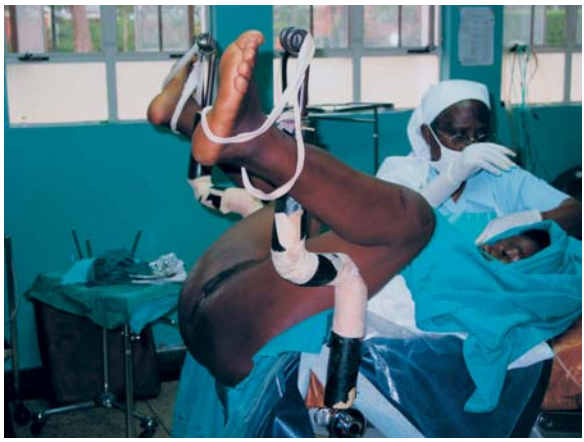

Figure 28 Patient positioned on the table.

Surgeon's position

Is the surgeon sitting comfortably (Figures 29 and 30)?

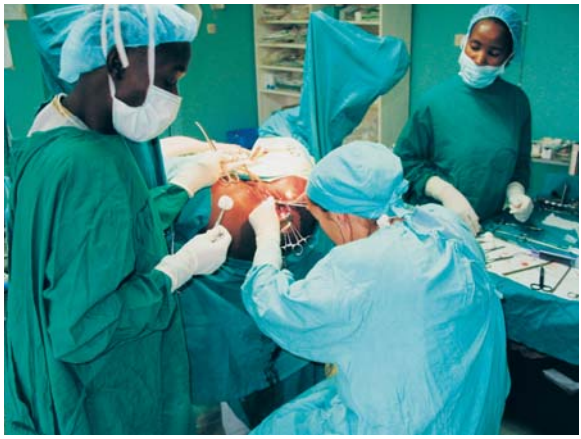

Figure 29 This surgeon is most uncomfortable: the table is too low.

Figure 30 This is much better. Note the artery and Allis forceps clipped to the drapes.