

4 SURGICAL THERAPEUTICS AND OPERATIVE TECHNIQUE

This incision can also be used in male subjects for the performance of a superior ileo-rectal anastomosis in cases of cancerous occlusion of the sigmoid flexure. The patient is usually placed in the Trendelenburg position, the incision terminating a few centimetres below the umbilicus.

The technique of the first and second stages—viz., skin incision and protection of the field of operation—is the same as described above for the supra-umbilical incision.

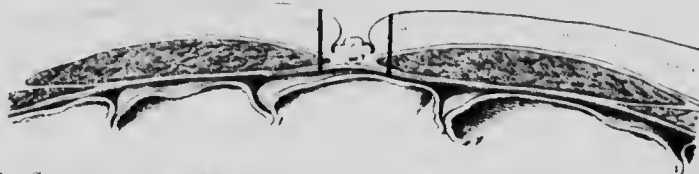


FIG. 5.—SECTION OF THE ABDOMINAL WALL IN THE SUPRA-UMBILICAL REGION WHERE THE WIDTH OF THE LINEA ALBA VARIES FROM 10 TO 15 MILLIMETRES.

The incision may pass on either side of the umbilicus.

THIRD STAGE.—Owing to the fact that the disposition of the linea alba changes in this region, the technique of the incision and repair of the abdominal wall is different.

Incision of the Linea Alba.—In the lower four-fifths of the subumbilical region the rectus muscles are joined together in the middle line by their inner borders, which are very thick. Between the two muscles is a thin aponeurotic partition, which extends from the junction of the two anterior aponeuroses to that of the two posterior. These are reduced to a thin fibrous

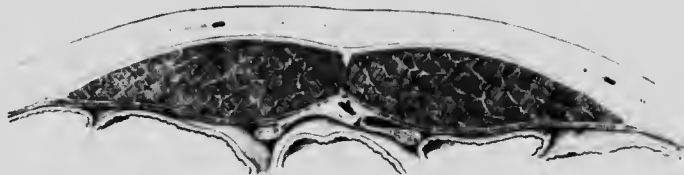


FIG. 6.—HORIZONTAL SECTION OF THE ANTERIOR ABDOMINAL WALL IN THE SUBUMBILICAL REGION.

The rectus muscles are only separated from one another by a thin aponeurotic partition. The incision opens one of the two muscular compartments.

layer. In fact in the lower four-fifths of the subumbilical region the greater part of the fibrous fascia of the united great and small oblique pass in front of the rectus. It follows that the bistoury must necessarily open the sheath of either rectus.

The sheath of the rectus is incised, in suturing, to obtain a better coaptation of surfaces.

Two hooked forceps draw outwards the edges of the aponeurotic incision,