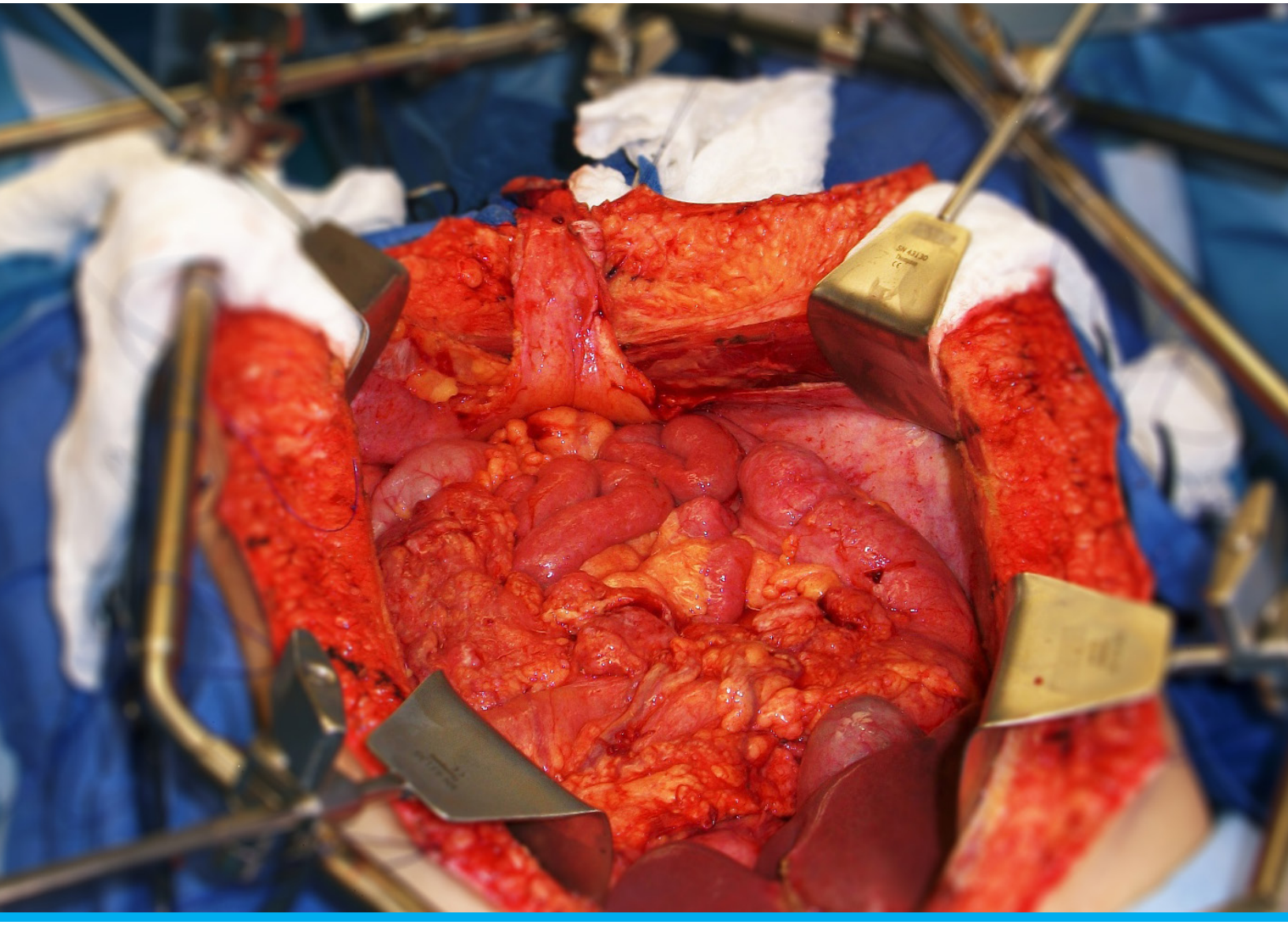
Thompson Retractor

Uncompromised Exposure™



Thompson Techniques:

HIPEC: OPENING AND CLOSING THE ABDOMINAL INCISION USING THE THOMPSON RETRACTOR

"The Thompson Retractor is of use at all times during cytoreductive surgery with HIPEC and is essential for an optimal result."

- Paul H. Sugarbaker, MD, FACS, FRCS

Paul H. Sugarbaker, MD, FACS, FRCS

Longtime champion user of the Thompson Retractor, Dr. Sugarbaker is a pioneer of the cytoreductive surgery plus HIPEC treatment for peritoneal metastases. He is Director of the Program in Peritoneal Surface Malignancy at Washington Cancer Institute since 1989. Dr. Sugarbaker is a strong critic of surgical tradition; he believes major changes in the technology of cancer resection are necessary. His theme, "It's what the surgeon doesn't see that kills the patient," summarizes the concepts behind many of his publications both in the peer-reviewed medical literature and in the lay press. In the opinion of Dr. Sugarbaker, perioperative intravenous and intraperitoneal are an essential part of cancer surgery to control the dissemination of malignant cells that often occurs as a result of surgical trauma.

Dr. Sugarbaker has published more than 1000 scientific articles and book chapters. Additionally, he has writen numerous textbooks. Most recently, he published a textbook and video atlas entitled *Cytoreductive Surgery and Perioperative Chemotherapy for Peritoneal Surface Malignancy.*

The Thompson Retractor provides Uncompromised Exposure for HIPEC treatment. Reputed for its rigidity, versatility, and flexibility, it has been utilized in the common open-abdomen HIPEC treatment or "Coliseum Technique" as pioneered by Dr. Paul Sugarbaker.

Introduction

The Thompson Retractor is essential for maintaining exposure of the contents of the abdomen and pelvis during open abdominal surgery. However, it also facilitates opening and closing a midline abdominal incision. The Thompson Retractor must be placed prior to performing the abdominal incision. Skin traction sutures elevate the skin and subcutaneous tissue to facilitate the fascial incision directly through the linea alba. If separations of the anterior and posterior rectus sheath occur, they are repaired prior to fascial closure. During closure of the fascia exposure of the linea alba with the skin traction sutures facilitates accurate placement of fascia only sutures. Optimal exposure of abdominal wall structures while opening and closing a long midline abdominal incision will minimize the incidence of incisional hernia. The Thompson Retractor and skin traction sutures are required.

Figure 1

The Thompson Retractor has been positioned after the abdomen is prepped and draped prior to performing the abdominal incision.

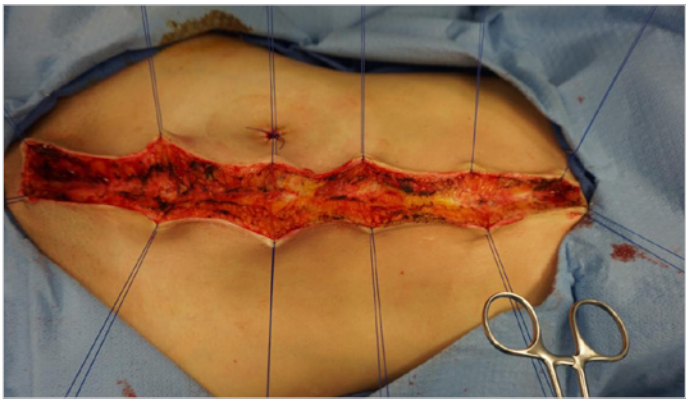


Figure 2

Skin traction sutures provide strong elevation of the wound edges and clear exposure of the linea alba.

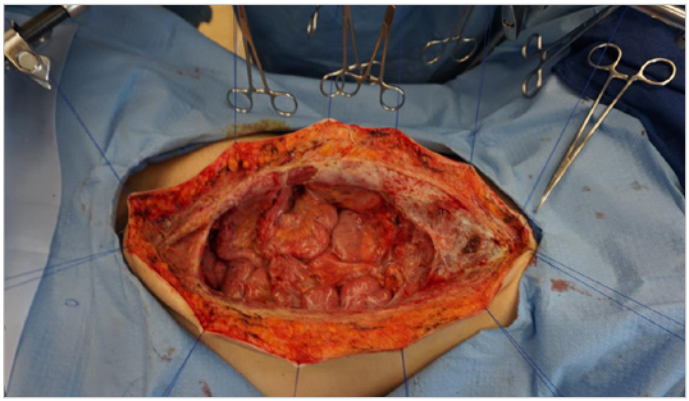


Figure 3

With the skin edges elevated by skin traction sutures, the fascial edge is clearly exposed.

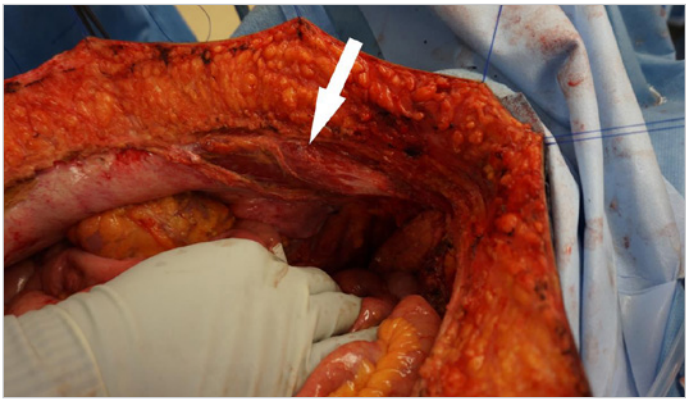


Figure 4

In opening an old midline incision, the linea alba may need to be excised. If this occurs the anterior and posterior rectus sheath are separated and the rectus abdominis muscle exposed (identified by an arrow).

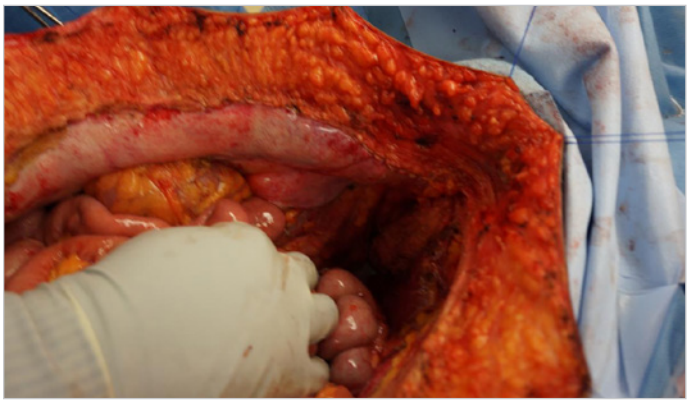


Figure 5

Reapproximation of anterior and posterior rectus sheath is performed with a continuous absorbable suture.

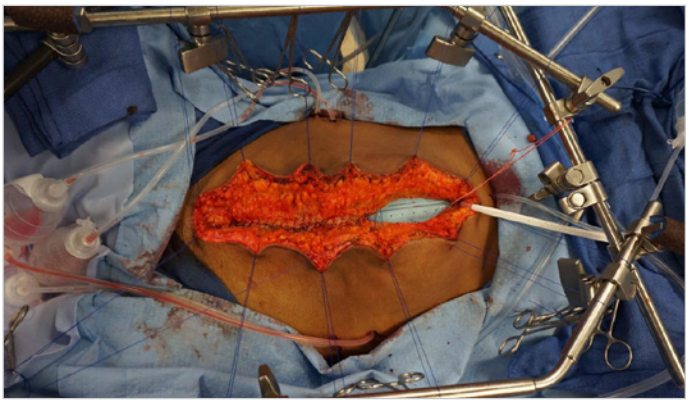


Figure 6

For the abdominal closure skin traction sutures are loosened to allow fascial edges to come together but retain skin traction for fascial exposure. A visceral retractor is in place beneath the fascial closure and is ready for removal

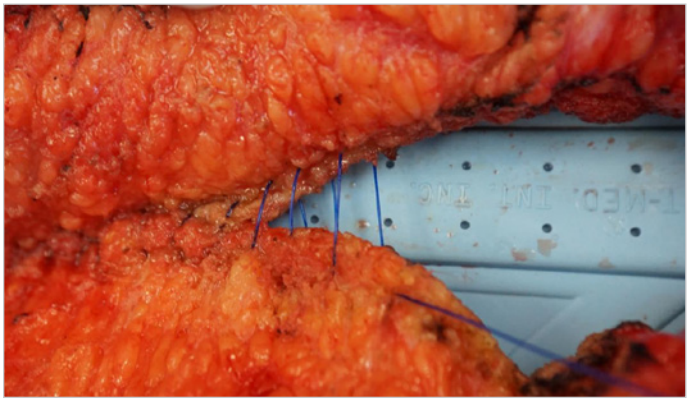


Figure 7

Running suture using small bites through midline fascia only markedly reduce the incidence of incisional hernia.

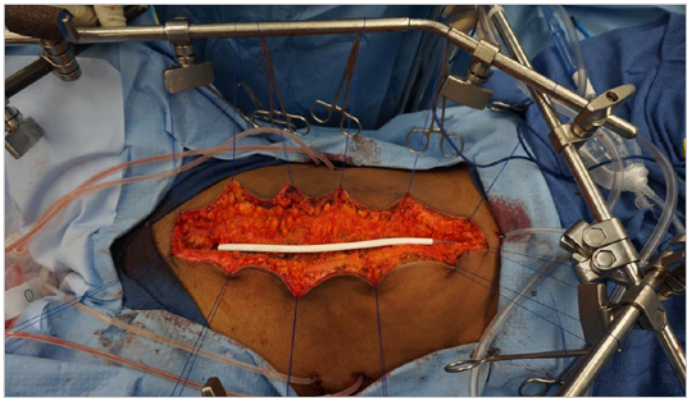


Figure 8

A closed-suction drain is usually placed in the subcutaneous space. It is removed on the fourth postoperative day.

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10341 East Cherry Bend Road
Traverse City, Michigan 49684
phone: 231.922.0177
fax: 231.922.0174
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EC REP **Emergo Europe**
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