Use of

2.4 Incision

An intra-

2.8 Insertion of trocar

The placement of the primary trocar requires the operating table to be at a comfortable height for the clinician to maintain control and downward pressure through the procedure. Ideally, the obturator is held in the palm of the dominant hand with the index finger extending down the shaft of the cannula to prevent deep displacement of the trocar once it is inserted into the peritoneal cavity. Clinicians with smaller hands may find this difficult and use both hands on the trocar. Initial placement of the trocar tip is perpendicular to skin using constant pressure and/or a twisting motion to have the obturator tip enter the peritoneal cavity. Having achieved this, further displacement to have the cannula within the peritoneal cavity may be performed by directing the trocar towards the centre of the pelvis. The pressure should be released once the cannula is within the peritoneal cavity. The obturator is then removed and a laparoscope inserted to ensure that the cannula is correctly placed within the peritoneal cavity and there is free flow of gas through the cannula if using this port for insufflation. At this time, a 360 degree evaluation of the peritoneal cavity is undertaken to inspect the abdomen prior to Trendelenburg positioning and check for inadvertent injury during placement.

2.9 Alternative Entry Sites

Clinicians should be aware of alternate sites for Veress needle placement including the left upper quadrant (Palmer's point); suprapubically, the right upper quadrant and transfundally through the uterus. Each of these locations has specific issues and the clinician should be familiar and comfortable with any site that they choose for Veress needle insertion.

Other suggested reading

1. A consensus document concerning laparoscopic entry techniques: Middlesbrough, March 19-20 1999.
   Anonymous Gynaecological Endoscopy. 8 (6) (pp 403-406), 1999. Date of Publication: 1999
2. Coming to TermsWith the Fact That the Evidence for Laparoscopic Entry Is as Good as It Gets Cuss, Bhatti and Abbott Journal of Minimally Invasive Gynecology (2015) 22, 332–341
3. Deffieux X, Ballester M, Collinet P, et al. Risks associated with laparoscopic entry: guidelines for clinical practice from the French College of Gynaecologists and Obstetricians. Eur J Obstet Gynecol Reprod Biol. 2011;158:159–166.
4. RCOG. Preventing entry-related gynaecological laparoscopic injuries. In: Green-top Guidelines. Green-

Appendices

Appendix A Endoscopic Surgery Advisory Committee (RANZCOG/AGES) Membership

Name	Position on Committee
Professor Jason Abbott	Chair, Representative AGES
Dr Stephen Lyons	Deputy Chair, Representative RANZCOG
Prof Yee Chit Leung	Representative RANZCOG
D Dr Martin Gerard Ritossa	Representative AGES
Professor Michael Permezel	Representative RANZCOG
Dr John Tait	Representative RANZCOG
Dr Stuart Salfinger	President AGES
Dr Vijay Roach	President RANZCOG

Appendix B Overview of the 2778 6403.2 2052 136.801 re W n q 43598 TJ 0 Tc 59.556.801j 0. f 4830 6682.8 4.800

Quality of information

The information available in Use of the Veress needle to obtain pneumoperitoneum prior to laparoscopy is intended as a guide and provided for information purposes only. The information is based on the Australian/New Zealand context using the best available evidence and information at the time of preparation. While the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) had endeavoured to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available. The use of this information is entirely at your own risk and responsibility.

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Third-party sites