**Intestinal Resection and Anastomosis**

**Procedure**:

* Make a midline abdominal incision to access the peritoneal cavity.
* Locate and isolate the affected segment of the intestine with saline-moistened laparotomy sponges
* Locate, isolate and ligate the mesenteric vessels to the affected area.
* Place crushing clamps across the bowel at a 60o angle to the long axis of the bowel.
* Milk the contents of the intestines away from the clamp.
* Place a non-crushing clamp across the viable segments of the intestine to be anastomosed.
* Excise the affected segment of the intestine between the clamps.
* Place the first suture at the mesenteric border of the intestine.
* The second suture is place on the opposite end(anti-mesenteric border)
* Place simple interrupted sutures 1mm apart along the “near” side of the anastomosis. (sutures should be full thickness).
* Appose the “far” side in a similar fashion.
* Gently flush warm saline over the anastomotic site and adjacent lengths of the intestine.
* Check for leakage from the suture line.
* Close the defect in the mesentery with simple continuous suture pattern.
* Perform routine abdominal closure.

**Indications:**

* Bowel gangrene due to vascular compromise caused by mesenteric vascular disease, prolonged intestinal obstruction, intussusceptions, or volvulus
* Malignancy
* Benign conditions (eg, intestinal polyps, intussusception, roundworm infestation with intestinal obstruction)
* Infections
* Traumatic perforations
* Large perforations (traumatic) not amenable to primary closure

**Contraindications:**

* Severe sepsis
* Poor nutritional status (eg, severe hypoalbuminemia)
* Disseminated malignancy (multiple peritoneal and serosal deposits, ascites)
* Viability of bowel in doubt
* Fecal contamination or frank peritonitis