A patient presenting with small bowel obstruction in the presence of an abdominal scar, suggesting that an adhesive band may be present, is an ideal case for a laparoscopic approach.

The first step is localization of the site of the initial obstruction. This is accomplished by a thorough physical examination and imaging to identify the area of maximal bowel distention using a plain abdominal X-ray and a CT scan to find a transition point. The laparoscope is inserted on the side opposite to the site of maximal intestinal distension.

It is possible in these cases to perform an open Hasson technique and insert a blunt trocar providing direct viewing of the intra-abdominal contents. One can however use an alternative technique for inserting the first trocar. Making a small skin incision and opening the layers of the fascia under direct vision provides access to the abdomen. A purse string is placed on the fascia using 2–0 suture, and a 10-mm port together with a video laparoscope is inserted while the surgeon’s left hand retracts the abdomen before insufflation. This allows the surgeon to visualize the intra-abdominal contents prior to insufflation, and ensures that the port and laparoscope are properly placed in the abdomen. The purse string is secured and insufflation is then begun, which generally puts the adhesive band under tension (Fig. 9.1).

Adequate working space is of paramount importance in the laparoscopic management of SBO. If the intra-abdominal pressure has reached a peak (15 mmHg) with the volume insufflated equal or less than 2 L, and provided the patient is well paralyzed, there is probably not enough working space due to the ileus. In this case, the operation should be converted to an open procedure.
The table is then tilted in order to retract the small bowel and increase the working space. It is possible to position the patient in Trendelenburg or reverse Trendelenburg and with either side up in order to create the appropriate space.

Once pneumoperitoneum is created, any adhesive band can be directly visualized. Mobilization with the laparoscope itself by breaking some of the loose bands can make room for the insertion of the second port, which is usually the port for the surgeon's right hand when the surgeon is standing opposite the area of maximum abdominal distension.

Insertion of a second port permits introduction of scissors, which is the best instrument for laparoscopic enterolysis. When one is performing enterolysis, it is safer not to use electrocautery, and although the harmonic shear can facilitate dissection, a sharp dissection is the best. In the case of bowel stuck to the abdominal wall, it is possible to remove a piece of fascia with the small bowel (Fig. 9.2). This is certainly safer than trying to free the small bowel from the abdominal wall and exposing it to serosal tears or unrecognized injuries. If severe, dense adhesions are encountered, it is impossible to complete a dissection without violating the bowel, and it is best to convert to an open procedure.

Once the first two ports are inserted, it is possible to sharply dissect the adhesive band from the abdominal wall. It is best to stay close to the abdominal wall and at a respectable distance from the intra-abdominal contents to avoid injury. It is also recommended to limit the use of cautery; the harmonic shears are probably safer in this setting once enough working space is available.

The third and final port is inserted in a triangulated manner to the video laparoscope (Fig. 9.3). This is used to insert a grasper, allowing the left hand to put the adhesive band under tension while the right hand removes the attachment. This will allow mobilization of the small bowel. Harmonic scissors can be used for this part.

**Fig. 9.1** Laparoscopic enterolysis: alternative technique to the open Hasson approach, for the insertion of the first trocar