



## A review article on the use of Palmer's point in gynaecological laparoscopy

**Dr Tabassum Khan, ST6 O&G**

Mr Amarbaj Chandock, Consultant Gynaecologist  
University Hospitals Birmingham, UK  
Tabassumkhan@doctors.org.uk

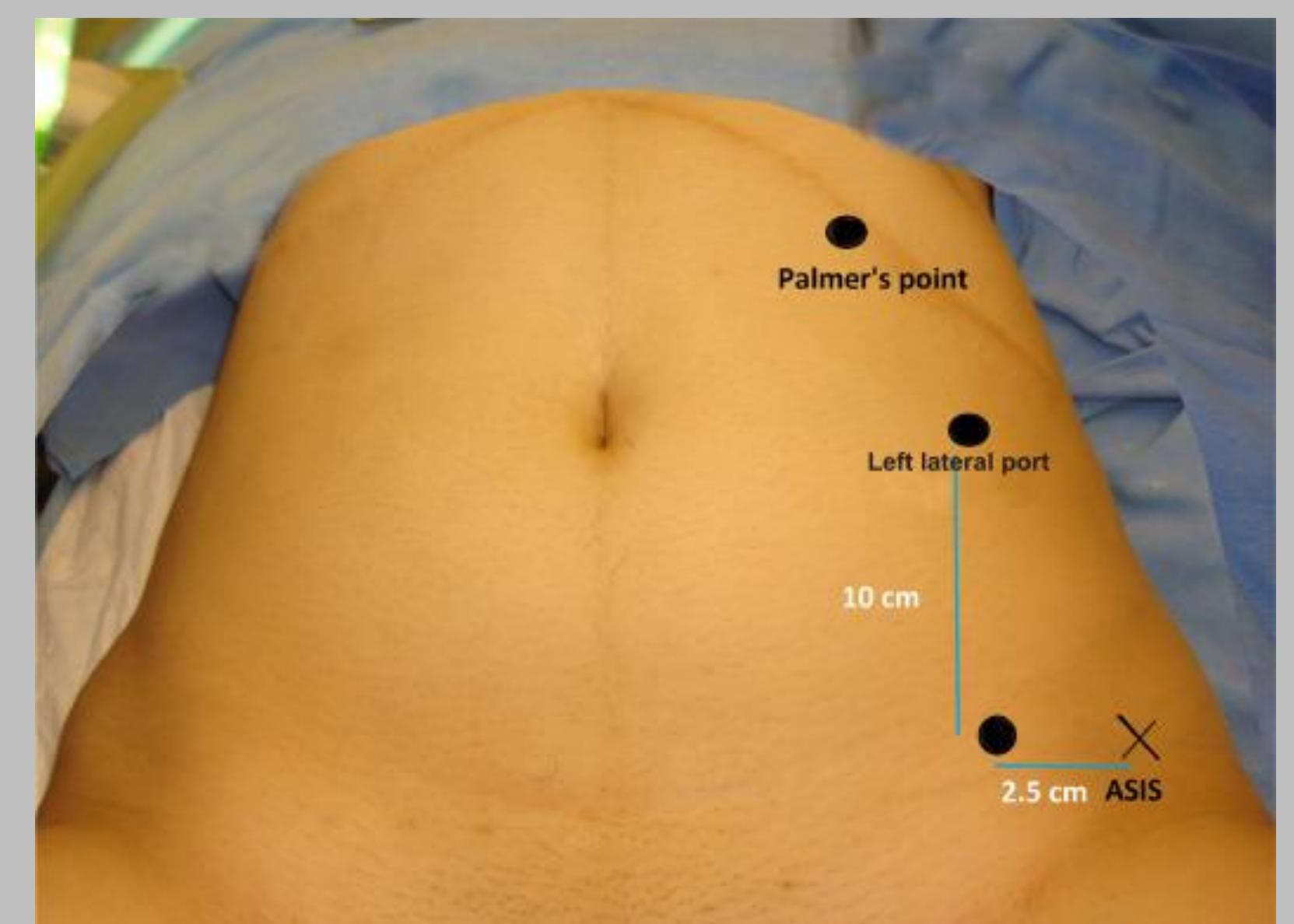


### Introduction

- Palmers (1940) advocated this entry as visceral adhesions are least likely to be found
- Advocated by RCOG where cases of midline adhesions likely to be high
- Palmers point entry allows a birds eye view of the midline and the pelvis allowing for safe electrosurgery and adhesiolysis
- It's a useful access point when performing omental biopsies in staging laparoscopies for gynaecological malignancies
- Allows for visualisation of the umbilicus and assessment for adhesiolysis
- Primary Palmers point entry has been used for a 2 year practice period by a of a single surgeon, using palmers primary port entry site in oncology and emergency gynaecology cases
- No reports of port site hernia or injury to viscera/blood vessels with good surgical views and operative outcomes

### Palmer's point entry technique

- Entry can be with direct optic entry or veress needle followed by trochar
- 5-10mm port site
- 2cm below the left subcostal margin in the midclavicular line
- Veress needle/trochar always inserted at a 90 degree angle regardless of BMI
- 3 clicks with the veress needle
- 2 sheath layers with one peritoneal layer
  - Anterior rectus sheath fascia
  - Posterior rectus sheath fascia
  - Peritoneum
- Optic entry layers visualised
  - skin
  - subcutaneous fat
  - external oblique aponeurosis
  - internal oblique aponeurosis
  - transversalis muscle fibres
  - extraperitoneal fat/peritoneum
- Avoid in cases of splenomegaly
- Nasogastric tube required to deflate the stomach before trochar insertio



### When to use palmers point entry

- Previous midline laparotomy
- Pelvic pathology that extends to or above the umbilicus
- Very thin patients
- Very obese patients
- After multiple failed attempts at umbilical entry
- Primary port insertion in oncology cases
- Large umbilical hernia
- Suspected midline adhesions or bowel involvement



### Discussion

- Palmers point entry allows a bird eye view of the pelvis
- It allows for visualisation of the umbilicus and assessment for adhesiolysis
- Multiple 5mm ports used allow for movement of the camera during the surgery to enhance adhesiolysis and optimum surgical view
- Due to location and 2 sheath layers, less likely to have port site hernia compared to primary umbilical ports
- It is useful in large ovarian/uterine masses rising to the level of the umbilicus as it allows visualisation without direct primary injury with trochar insertion
- Useful port placement for drainage of large ovarian cysts followed by midline ports for excision
- Currently underutilised in gynaecological practice as primary port site
- Enhances and allows more cases to be managed laparoscopically minimising conversion to laparotomy due to midline adhesions
- A culture shift needed with more education/hands on courses for gynaecologists for technique and utilisation of this port

### Declaration of interest

None to declare

### References

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