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Letter to the Editor and Brief Communications

This section contains letters to the editor which deal with matters that are published in the journal and brief communications on all aspects of plastic surgery. The views, opinions and conclusions expressed in this section represent the personal opinion of the writers and not those of the Editorial Board or the Association of Plastic Surgeons of India.

SEQUENTIAL INTERMITTENT PNEUMATIC COMPRESSION THERAPY FOR LYMPHOEDEMATOUS LEGS.

Sir,

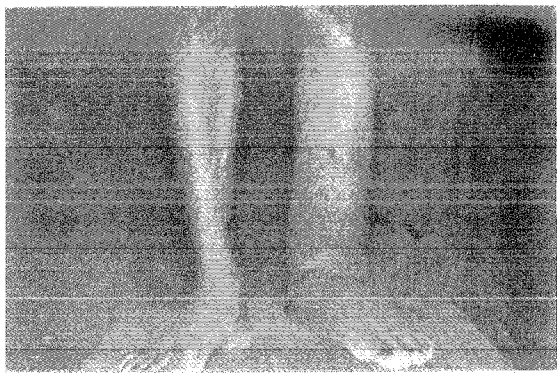
Management of lymphoedematous lower limbs continues to be problematic. The various modalities of treatment available at present, mostly offer temporary relief for these patients. Permanent "cure" for this condition still eludes the surgeons and researchers alike. Of the available non-surgical techniques, limb elevation, compression and pressure garments are popular. We have developed a relatively cheap and easily reproducible technique for Sequential Intermittent Pneumatic Compression Therapy. The patients can practice this at home itself.

Materials required:

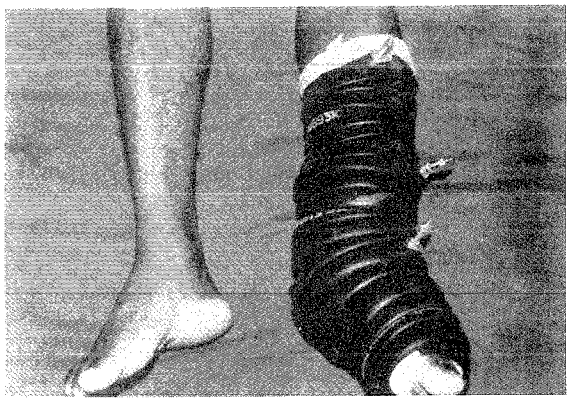
1. Three cycle tubes with the valves intact and both the ends sealed.
2. Cycle pump to inflate the tube.
3. Cotton rolls to encircle the limbs.

The tubes are inflated sequentially starting from below upwards. The inflation is stopped when the patient reports pain and is maintained for 5 minutes. After 5 minutes deflation is proceeded with in the reverse order. Initially it is done once daily and later twice daily. Once the limb measurement remains static, either pressure garment or surgery may be contemplated.

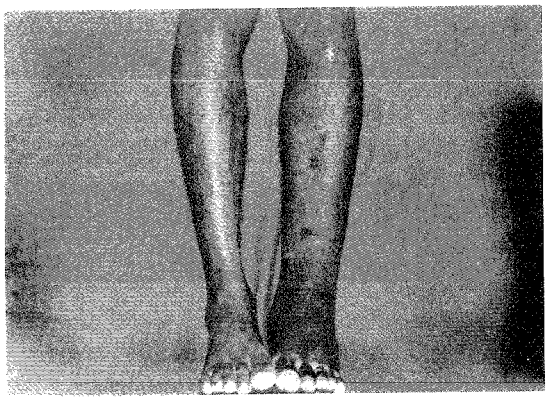
Intermittent use of an elastic or light rubber bandage increases tissue hydrostatic pressure and the return of oedematous fluid through the lymphatics[1]. Compression devices have been



(Fig - 1) - Filarial lymphoedematous leg and foot



(Fig - 1 B) - Cycle tubes applied and inflated. (In practice, the tubes should be covered by an encircling bandage)



(Fig - 1 C) - After completion of the compressive therapy

described, which either deliver uniform pressure over the limb or are quite expensive[3].

In our technique only cycle tubes and linen are used, which are easily available in the market and are cheap. This can be done by the patient, after one or two days of hospital stay to learn the procedure. It is suitable for both early and advanced stages of the disease.

We therefore advocate widespread use of this simple, effective and economic technique.

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2. **Jensen A, Miller TA.** Lymphoedema of the extremities. In: Text book of Plastic, Maxillofacial & Reconstructive Surgery. Gregory S Georgiade, Nicholas G Georgiade, Ronald Riefkohl and William J Barwick Eds. Vol. 2, 2nd edition. Williams & Wilkins, 1992:1279-1296.

GYNAECOMASTIA REVISITED

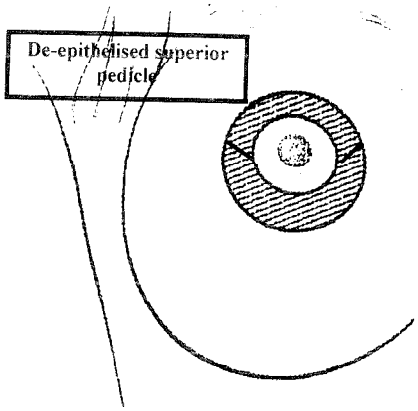
Sir,

Gynaecomastia correction is one of the more common cosmetic procedure that aesthetic surgeons are called upon to perform in males. Pseudogynaecomastia due to excess fat can be effectively treated by liposuction.However, with true gynaecomastia contour irregularities can occur.

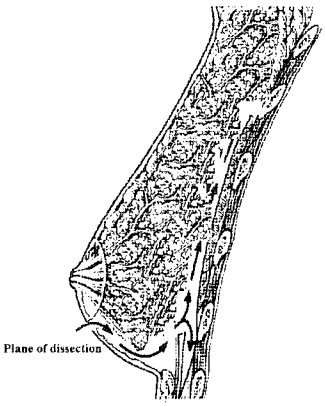
Numerous operations have been described to correct true gynaecomastia. The sheer volume of techniques described show that all the techniques are less than perfect. Very few highlight methods of getting the contour right.

I would like to describe a modified Davidson's[4] incision to obtain good contour. The amount of breast tissue to be excised is drawn out. A circumareolar incision 1 to 1.5cm width away from areolar margin is drawn as per Davidson (Fig. 1). Further parallel circles are drawn to mark the chamfering edges. Local anaesthetic agent with adrenaline is injected with a spinal needle.

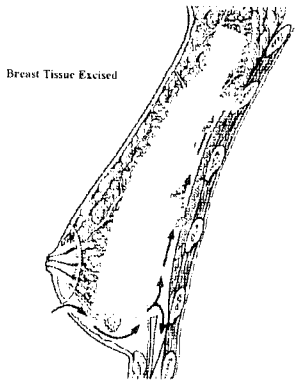
The Superior pedicle is de-epithelised. Through the inferior incision a lower flap of adequate thickness is raised to reach the submammary fold. The breast is now lifted off the pectoral fascia and excision carried out (Fig. 2). The thickness of upper flap is maintained uniformly by bimanual palpation. This method prevents saucerisation, as the operator can gauge skin thickness easily (Fig.3).



(Fig - 1)



(Fig - 2)



(Fig -3)

This technique is a further improvement to Davidson's tecchnique. For very large breasts the areolar diameter is brought to the standard size by a subcuticular suture.The advantage of this