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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GYNAECOMASTIA REVISITED

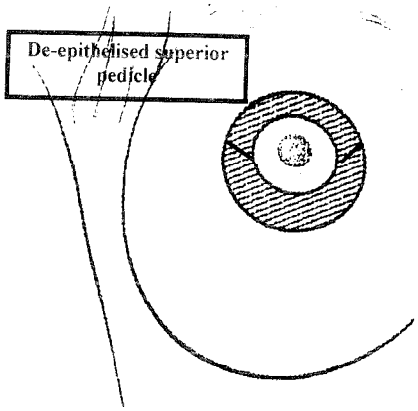
Sir,

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.

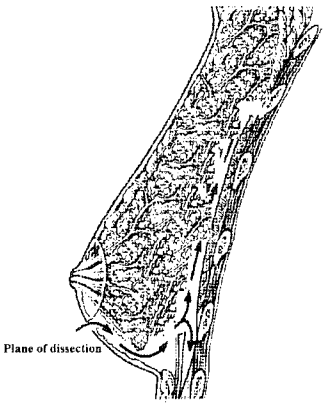
Numerous operations have been described to correct true gynaecomastia. The sheer volume of techniques described show that all the techniques are less than perfect. Very few highlight methods of getting the contour right.

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.

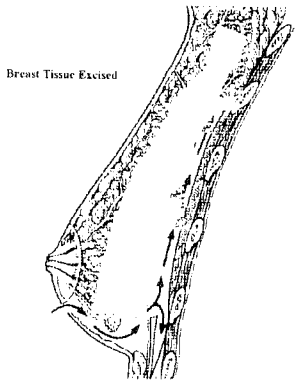
The Superior pedicle is de-epithelised. Through the inferior incision a lower flap of adequate thickness is raised to reach the submammary fold. The breast is now lifted off the pectoral fascia and excision carried out (Fig. 2). The thickness of upper flap is maintained uniformly by bimanual palpation. 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

technique is that since thickness of remnant breast issue is felt by bimanual palpation (rather than guessing) the chances of error are less. Moreover slight amount of unevenness on posterior breast is masked by breast tissue lying over it and is less noticeable.This modification also reduces the unevenness which is more evident with superficial excision.

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IS PRIMARY RADICAL NOSE CORRECTION REALLY NECESSARY?

Sir,

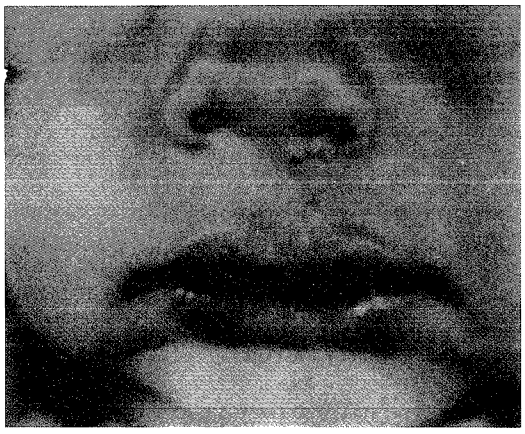
"Always searching, never achieving perfection" is very apt for those of us who have surgically treated the cleft lip patients and experience continued frustrations with the aesthetic results of primary surgery. I have approached this problem for the past 2 years and have found continuing satisfaction.

The nose is the single most challenging component of the cleft lip complex, based on the view that the nasal deformity is secondary to the abnormal forces acting on the alar cartilage. I attempted nasal correction exclusively by extensive muscle mobilisation and nasal floor repair. This has been found adequate for a good aesthetic appearance of the nose in most cases.

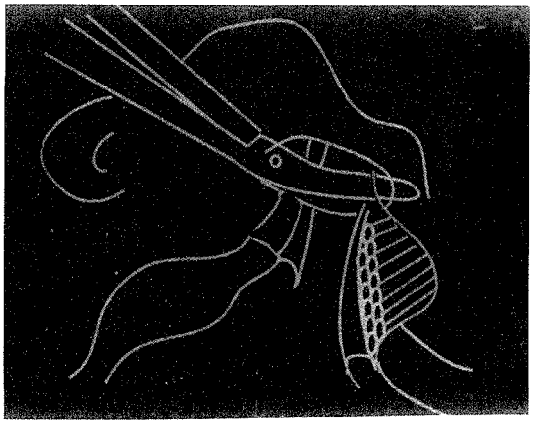
To Millard's technique the following modifications were added

1. Rotation flap does not curve under the columellar base, but follows the direction of the philtral column on the non cleft side, so as to preserve the natural ridge of the lip. Lateral advancement incision does not curve under the alar base as the radical dissection of the muscle carries the alar base inwards. C flap is inserted across the nostril sill and not used for columellar lengthening, there by providing an adequate tissue for nasal floor closure (Fig 1 & 2).

(Fig - 1) Pre-operative view



(Fig - 2) 5th Post operative day



(Fig - 3) Muscle backcut