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.

RECONSTRUCTION OF A BLAST INJURY HAND WITH A RETROGRADE FOREARM FLAP - A CASE REPORT FROM WAR RIDDEN GROZNY.

Sir,

A case of reconstruction of a hand of a construction worker who was injured in a blast injury is described. The case was done in Chechnya when the authors were on a reconstructive surgery mission to the war ridden city of Grozny.

A 23 year old left-hand dominant construction site worker sustained blast injury to his left hand which resulted in open comminuted fractures of the distal phalanges of thumb, index and ring fingers, open fracture of proximal phalanx of ring finger with extensive soft tissue defect of the palm and the volar aspects of index and ring fingers. Fortunately the tendons and neurovascular bundles were intact (Fig.1).

The hand required radical debridement, skeletal stabilization and soft tissue cover to make it functional. The operating theatre conditions were far from ideal because of the war situation. There was no electricity and a diesel generator provided some power. Head light arrangements with a fibre-optic cable and portable cold light source were used. A portable bi-polar diathermy machine was available. Since there was no anaesthetic apparatus, intravenous infusion anaesthesia and ketamine was used. Despite the poor infrastructure an attempt was made to reconstruct the hand with the help of a reverse radial artery forearm flap. The ring finger was fixed with a long injection needle. The thumb was shortened to the limit of viability and the stump closed. A suitable radial forearm flap based on a distal pedicle was raised and rotated to the palm to cover the defect (Figs. 2 & 3). The donor site was reduced in size and the raw area was split skin grafted. The post-operative period was uneventful and wounds healed primarily.

(Fig. 2) Wounds debrided and the flap raised prior to inserting.

Good operation-room facilities are ideal for performing reconstructive surgery, but by sacrificing a certain amount of comfort, major reconstructive procedures are possible in a war situation. Salvage procedures on limbs, particularly for the hand are justified in such circumstances since post-operative care in such cases is not as complex as in other cases of prolonged surgery.
involving thoracic or abdominal viscera. Primary skin-cover for such injuries are perhaps the simplest means of treating them even in demanding situations of war.

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TISSUE EXPANSION AND BREAST IMPLANTS FOR BREAST RECONSTRUCTION IN POLAND’S SYNDROME - WOUND HEALING PROBLEMS

Sir,

We would like to draw the attention of our readers to problems in wound-healing which we encountered while treating a 22 year old girl with congenital absence of the left breast. There was no family history of similar deformity. Examination revealed a hypoplastic nipple-aerola-breast complex and absence of pectoral muscles. A diagnosis of Poland’s syndrome was entertained, even though most of the other deformities that are associated with this condition were not found.

The skin and subcutaneous tissues appeared normal. It was decided to put in an expander under the skin, through a submammary incision and later replace it with a silicone gel breast prosthesis. An expander was first inserted after adequate undermining. Necrosis of the superior edge of the incision was noticed in the immediate post operative period. Since there was no infection or tension, secondary suturing was undertaken and the wound healed. Two weeks after the expansion had been completed the expander was removed, and a breast prosthesis was placed inside the cavity.

The patient was discharged after suture removal. During follow-up, it was noted that the wound had broken down in the centre of the suture line exposing the implant. Once again it was noted that there was no tension in the suture line nor any infection. We wondered if the healing was inherently poor in these cases because of hypoplasia of subcutaneous and cutaneous elements.

A search of available literature was made to determine whether such wound problems were indeed an inherent characteristic of Poland’s syndrome and whether flap reinforcement prior to the insertion of the prosthesis was necessary. Wound dehiscence following expansion has been attributed to rapidity of expansion, placement of the expander under scarred tissues and areas prone to trauma or frequent movement and technical error. In our case none of the above factors appeared to be responsible for the dehiscence, so it was assumed that an inherent hypoplasia of skin and subcutaneous tissues was the main reason for this complication, abetted by the prior tissue expansion which further decreases the dermal thickness and subcutaneous adipose tissue.

While implants have been placed subcutaneously in the breast and elsewhere successfully, in a case of Poland’s syndrome, however normal the cutaneous tissues of the chest may appear, we would prefer to be cautious prior to tissue expansion or introduction of breast implants. We now feel that a latissimus dorsi myocutaneous flap alone or combined with the placement of prosthesis may be a better proposition.

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References

GRACILIS MUSCLE FLAP FOR FECAL INCONTINENCE

Sir,

We have treated 5 children in the age range of 10-15 years who had anal incontinence following surgical repair of imperforate anus in infancy and wish to share our experience. We used the ‘gracilis sling technique’ as originally described by Pickrell1.

All the 5 patients had already had an initial