ROLE OF TENSOR FASCIA-LATA MYOCUTANEOUS FLAP IN FUNGATING GROIN GLANDS*

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SUMMARY

Seven cases of fungating groin glands with moderately differentiated histology were treated by wide excision. The resultant raw area was covered with T. F. L. Myocutaneous Flap. Post-operative lymphorrhoea, a usual serious problem in groin block dissections, was not seen. This may be because of the fact that T. F. L. Myocutaneous Flap rapidly absorbs lymph after groin block dissection.

Cancer of the penis is a fairly common condition affecting Hindu males in their third and fourth decades. Due to ignorance and fear, these patients present themselves when the disease is already advanced.

Sometimes, the patients present themselves when the disease is limited to the glans penis with hardly any metastatic glands in the groin. In such instances, these patients are subjected to partial or total amputation depending upon the local conditions. He is advised to report back for review of the inguinal nodes after 4 to 6 weeks. This is done with the idea that after the infected primary has been removed, the infected glands would resolve. The patients usually do not abide by these instructions. They only come with fungating groin gland masses.

For all practical purposes these cases (Fig. 1) are advanced and inoperable. If we decide to treat them, the surgery is formidable. The femoral vessels are exposed at the end of block dissection and large area of the skin measuring about 5" x 8" is lost. This raw area needs full thickness cover. Under our circumstances, the best thing that we can do, is to switch the origin of Sartorius medially and stich it to the inguinal ligament, infront of the femoral vessels, thus obtaining a muscle cover for the femoral vessels. After this, the whole raw area is covered by a split thickness skin graft.

These wounds are very difficult to heal. There is tremendous amount of lymphorrhoea, soaking the dressings miserably for a period of 3 to 4 weeks. In addition, this kind of surgery, which is only palliative in its aim, will have to be followed by radio-therapy. The radiotherapist will hesitate to give full dosage of radio-therapy due to poor skin condition. For these reasons majority of the surgeons refuse to treat such cases.

When we do not treat such a case, he is likely to die from femoral artery blow-out. Secondly, these patients are in their third and fourth decades of life—a relatively younger age group. Thirdly, this disease (Cancer penis) is relatively a slowly progressive one, recurs locally and very rarely metastasizes to lungs and bones.

So even with fungating groin glands, the benefit of palliative surgery should be given to these patients.

Availability of tensor fascia-lata myocutaneous flap, as a cover, prompted us to take up this project.

Material and Methods

During the period of 2 years, 7 cases of fungating groin glands were treated.

Technique of Operation: Wide excision of skin and fungating groin glands was carried out. Femoral sheath was opened. Long saphenous vein was divided and ligated near the cribiform fascia. This dissection was difficult and isolation of femoral vessels was carefully carried out. The defect was measured and the tensor fascia-lata myocutaneous flap was marked out and checked (Fig. 2). It was rotated into the defect and stitched. A suction drain was brought out through the abdominal skin. For the purpose of setting the flap properly into the defect back cut in the flap could be extended almost to the point of making this an island flap. The flap was set into the defect (Fig. 3), and the raw donor area was covered with a split thickness skin graft.

Fig 1. Showing fungating groin glands.

Fig 2. Showing inguinal node block dissection
T. F. L. Myocutaneous flap raised.

Fig 3. Showing T. F. L. myocutaneous flap set into the defect and the donor area covered by split thickness graft.

Fig 4. Same patient three months later.
Fig. 1: Shows appearance of the incision, 15 days after removal of tubercular groin glands, lymphorrhoea is obvious.

Fig. 6: A drop of lymph oozing from the biopsy incision.

Post-operative period: The fluid in the suction drain varied in amount from 50 cc-150 cc over a period of 3-5 days. The wounds healed very well (Fig. 4.) and the patients could be submitted to radiation in the 3rd post-operative week.

Looking at the wound, the radiotherapist was ready to give even 6000 rads to these cases.

Observations and Discussion

Advantages of T. F. L. Myocutaneous Flap:
1. It provided an excellent and easily performable cover for the raw area produced by groin block dissection.
2. The femoral vessels were very well protected.
3. The wound healed in about 2 to 3 weeks time.
4. The lymphorrhoea, the usual scourge of groin block dissection was not seen.
5. Post-operatively full course of radiation could easily be given.

Magnitude of the problem of lymphorrhoea:
After removal of groin glands, troublesome lymphorrhoea occurs for a period of 3-4 weeks. Here are two illustrations to emphasize this point. Fig. 5. shows appearance of the incision, 15 days after removal of tubercular groin glands, lymphorrhoea is obvious. Fig. 6.—A drop of lymph oozing from a biopsy incision 15 days after operation.

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