LETTERS

Technical Note on Vacuum Assisted Closure-Basket Fixation of Scrotal Skin Grafts

Gabriel Djedovic, Peter Kronberger, Gerhard Pierer, Ulrich Michael Rieger

Department of Plastic, Reconstructive and Aesthetic Surgery, Innsbruck Medical University, Innsbruck, Austria

Correspondence: Ulrich Michael Rieger
Department of Plastic, Reconstructive and Aesthetic Surgery, Innsbruck Medical University, Anichstrasse 35, 6020 Innsbruck, Austria
Tel: +43-512-504-80088, Fax: +43-512-504-22735, E-mail: ulrich.rieger@uki.at

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With great interest, we have read the publication "The Vacuum Assisted Closure (VAC)-Basket for Easy Fixation of Scrotal Skin Grafts" by Huettinger et al. [1]. The authors describe their experience with a self-constructed vacuum-assisted closure basket for fixation of split-thickness skin grafts in the urogenital area for defect coverage after Fournier's gangrene.

We would like to congratulate the authors for their superior result in the case reported. At our institution, we have long-standing experience in the treatment of defects of the noted area after both traumatic and infectious tissue loss, as we serve as a tertiary referral center providing care for the whole of Western Austria and Northern Italy. In our experience, we feel that following Gillies' principle of reconstructing "like with like" [2] in selected minor scrotal defects such as the one depicted by Huettinger et al. [1], a bilateral thigh lift with permanent fixation sutures to the pubic branches can yield excellent

Fig. 1.
The patient presented with scrotal and perineal tissue loss after debridement of dead tissue following Fournier's gangrene.

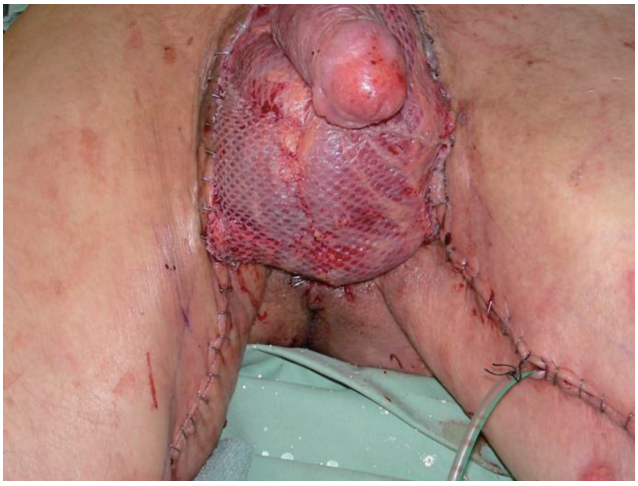

Fig. 2.
Defect coverage was carried out using bilateral gracilis muscle flaps rotated by 180 degrees around their proximal pedicles. Coverage of the muscle flaps was performed by meshed split-thickness skin grafts.

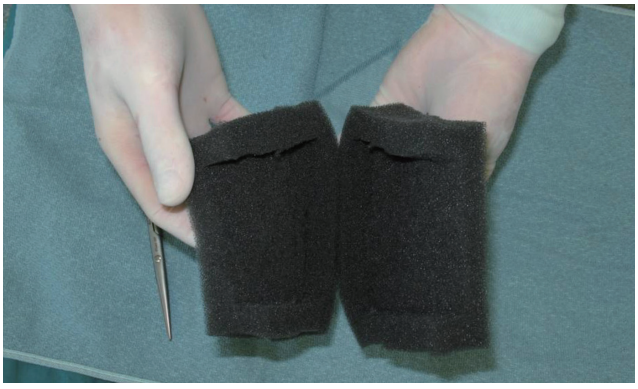

Fig. 3.
Split-thickness skin grafts were fixed immediately by the "sandwich technique".

Fig. 4.
Appearance of the urogenital region after application of the vacuum-assisted wound dressing.

Fig. 5.
Final appearance of the urogenital region after 3 months.

functional and aesthetic results [3]. In case of more extensive defects involving both scrotal and perineal skin loss, we favor split thickness skin grafts for defect coverage. As noted by Huettinger et al. [1], graft fixation remains a challenge. We have developed a VAC fixation technique, the so-called "sandwich technique" [4], that we have used successfully for many years now. We feel that it is well worth sharing with the reader, given its ease of application and superior outcome. We would like to present an illustrative case:

A 47-year-old male was referred to our institution after debridement in the scrotal and perineal area for treatment of Fournier´s gangrene in another hospital (Fig. 1). Defect coverage was carried out using bilateral gracilis muscle flaps rotated by 180 degrees around their proximal pedicles. Immediate coverage of the muscle flaps was performed by split-thickness skin grafts (Fig. 2), which were fixed immediately by the aforementioned "sandwich technique" (Figs. 3, 4). The final outcome 3 months postoperatively is shown in Fig. 5.

We agree with Huettinger et al. [1] that VAC fixation in the perineal area provides all-important factors for excellent graft take. With our alternative fixation method, the risk of shearing and tearing forces on the grafts leading to graft loss may be minimized. Our clinical results support this finding.

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Letters

Hidden Sentinel Node in Cutaneous Melanoma

Francesco Segreto, Daniele Tosi, Giovanni Francesco Marangi, Alfonso Luca Pendolino, Stefano Santoro, Pierluigi Gigliofiorito, Paolo Persichetti

Department of Plastic and Reconstructive Surgery, Campus Bio-Medico University of Rome, Rome, Italy

Correspondence: Pierluigi Gigliofiorito
Department of Plastic and Reconstructive Surgery, Campus Bio-Medico di Roma University, Via Alvaro del Portillo 200, 00128 Rome, Italy
Tel: +39-06.22541.1220, Fax: +39-06.22541.1936, E-mail: p.gigliofiorito@unicampus.it

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Sentinel lymph node (SLN) biopsy is a well-established staging method for melanomas. Several techniques have been described to identify the first lymph node receiving lymphatic flow from the primary tumor. Injection of 99mTc-nanocolloid into the tumor bed followed by lymphoscintigraphy provides a road map for the surgeon. However, in a variable percentage of cases, the sentinel node may remain undiscovered during this procedure [1]. This problem is well-known with regard to the identification of lymph nodes in the head and neck, where the complex anatomy as well as the presence of vital structures renders lymphatic mapping a challenging procedure [2].

Hence, we would like to share our experience in this field by describing the case of a 40-year-old woman who was referred to our department for a 1.33-mm-thick melanoma of the upper external quadrant of the left breast (Fig. 1). Previous surgical excision had been followed by histopathologic analysis reporting an infiltrating

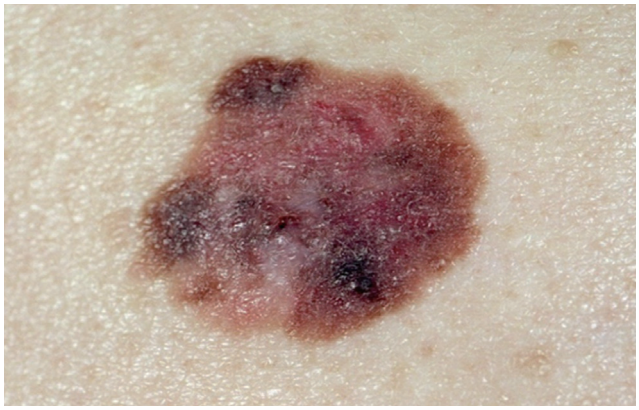

Fig. 1.
Melanoma of the upper external quadrant of the left breast.