



Short reports and correspondence

Breast-reduction surgery and obesity

Sir,

In response to the recent letters from Laing¹ and McGregor² referring to our qualitative study of breast-reduction patients,³ I should like to clarify our conclusions regarding body weight considerations. We do not at all dispute that overweight and obese patients should be required to lose weight prior to surgery in order to reduce anaesthetic and surgical risk, or that for those of very high BMI, operative risk may outweigh benefit. This consideration can be applied to all surgical procedures, but purchasers of healthcare do not use body mass index as a specific exclusion criterion for every operation. For breast reduction, purchasing restrictions appear to have been applied (by some purchasers) on the grounds that patients who, on presentation, fall above the normal BMI range are unlikely to gain any long-term benefit from the operation. The issuing of exclusion lists to Primary Care providers may result in some overweight/obese patients being unable to gain access to this surgery, whatever their ability to lose weight. Our survey obtained patients' views of benefits, including weight concerns, 2 years after their operation. We were led to the opinion that the BMI exclusion criterion is not based on good evidence.

Yours faithfully,

Valerie Shakespeare BSc, PhD,

Research Fellow/Clinical Scientist, Laing Laboratory for Plastic Surgery and Burn Research, Glanville Centre, Salisbury District Hospital, Salisbury SP2 8BJ, UK.

References

1. Laing H. Obesity and breast reduction surgery. *Br J Plast Surg* 1999; 52: 597–8.
2. McGregor JC. Breast reduction – rationed or rational? *Br J Plast Surg* 1999; 52: 511.
3. Shakespeare V, Postle K. A qualitative study of patients' views on the effects of breast-reduction surgery: a 2-year follow-up survey. *Br J Plast Surg* 1999; 52: 198–204.

DOI: 10.1054/bjps.1999.3316

Split skin grafting fixation for multiple small burn wound areas. A dual technique using tissue glue and staples

Sir,

We describe a technique of securing meshed skin grafts with histoacryl (butyl-2-cyanoacrylate) tissue glue combined with stapling.

Securing skin grafts with sutures is a time consuming procedure,¹ particularly in multiple small burn wounds, a disadvantage that has been responsible for the widespread use of skin staples in fixing skin grafts. The removal of staples following successful graft take is painful and often a

frightening experience for the paediatric patient. The introduction of tissue adhesives has made this experience avoidable, providing the surgeon with an acceptable alternative to skin staples.²

We believe the combined use of staples and tissue adhesive to be the gold standard technique in applying meshed skin grafts in certain patients.

This technique involves anchoring the graft at either end of the defect with single staples, subsequently cutting the graft to the desired shape and size. Following this temporary fixation of the graft with staples, the histoacryl glue is applied between the staples. The temporary staples are then removed when the glue has set.

We have found this technique to make tissue gluing easier. It is much kinder to the patient and may also have an aesthetic advantage as there are no staple marks. It is most useful in patients with multiple, different sized full thickness burns. The cost of histoacryl is comparable to the number of staples for multiple small burn wounds, although the cost difference may well be significantly greater for larger burns.

In conclusion, histoacryl tissue glue and staples offer many advantages and very few disadvantages over stapling or suturing techniques alone in skin grafting multiple small burn wounds. We would recommend it for its ease of use and patient comfort.

Yours faithfully,

Ardeshir Bayat BSc(Hons), MRCS(Eng), AFRCS(Ed),
Senior House Officer

Edward Jason Kelly FRCSI,
Specialist Registrar

Kenneth William Dunn BSc(Hons), FRCS(Plast),
Consultant Burns, Plastic and Reconstructive Surgeon

Department of Burns, Plastic and Reconstructive Surgery,
Withington Hospital,
Nell Lane,
West Didsbury,
Manchester M20 2LR, UK.

References

1. Craven NM, Telfer NR. An open study of tissue adhesive in full-thickness skin grafting. *J Am Acad Dermatol* 1999; 40: 607–11.
2. Kamer FM, Joseph JH. Histoacryl. Its use in aesthetic facial plastic surgery. *Arch Otolaryngol* 1989; 115: 193–7.

DOI: 10.1054/bjps.1999.3305

Placement of sutures in tendon repairs

Sir,

Your article 'Placement of sutures in tendon repair' (Boyce DE, Srivastava S, *Br J Plast Surg*, 1999; 52: 511) was interesting and thought provoking. It is well known that the epitendon suture facilitates tendon glide, contributes to the strength of the surgical repair and helps prevent gapping.¹

Using in situ hybridisation techniques it has also been shown that the epitenon cells are responsible for most of the native type 1 collagen in the tendon repair site during the first 2 weeks,² with an additional role in early phagocytosis and cellular migration.³ The epitenon is a distinct anatomical layer with a separate and varied physiological function compared to the tendon core. There is thus compelling evidence for a layered closure in tendon repair.

The authors have described a case where the epitenon suture needle damaged the core suture resulting in its rupture. This may be a previously under-recognised cause for early tendon rupture. We propose a modification to prevent this disastrous complication to straightforward tendon repairs. The core stitch should be tied only after the epitenon suture is almost completely placed, allowing for integrity of the core suture to be tested. The epitenon suture is then completed.

Yours faithfully,

Adam R Meir BA(Oxford), Clinical Fellow in Plastic Surgery

C. E. Koshy MS, DNB, FRCS, Senior Clinical Fellow in Plastic Surgery

Department of Plastic Surgery,
The Royal London Hospital,
Whitechapel, London E1 1BB, UK.



Figure 1—Nylon tape is wound around finger.

References

1. Wade PJF, Wetherell RG, Amis AA. Flexor tendon repair: significant gain in strength from the Halstead peripheral suture technique. *J Hand Surg* 1989; 14B: 232–5.
2. Gelberman RH, Amiel D, Harwood F. Genetic expression for type I procollagen in the early stages of flexor tendon healing. *J Hand Surg* 1992; 17A: 551–8.
3. Manske PR, Gelberman RH, Vande Berg JS, Lesker PA. Intrinsic flexor-tendon repair: a morphological study in vitro. *J Bone Joint Surg* 1984; 66A: 385–96.

DOI: 10.1054/bjps.1999.3287

A novel method of ring removal from a swollen finger

Sir,

It is not uncommon for a surgeon attending to a patient with a hand injury to encounter a ring that has been inadvertently left in situ on one of the fingers. Secondary to oedema, the ring may be found non-removable despite gentle traction and lubrication. In the end, removal may necessitate the use of ring cutters.

Previous authors have described non-destructive methods of removal using elastic tourniquets.^{1,2} We have successfully utilised nylon ribbon tape as a compressive device to reduce finger swelling to aid ring removal. The method employed is as follows: first, one end of a length of nylon tape is threaded under the ring to lie proximal to it. Next, the tape is wound firmly around the finger from just distal and adjacent to the ring until the fingertip (Fig. 1). The proximal end of the tape is then lifted and unwound around the finger. The action of the unwinding tape propels the ring, which will advance and slide over the taped finger (Fig. 2). The procedure is well tolerated by most patients without the aid of anaesthesia but if patient discomfort is a concern, a ring block may be administered prior to ring removal.

Patients are often upset when their rings have to be removed with cutters due to the sentimental and market

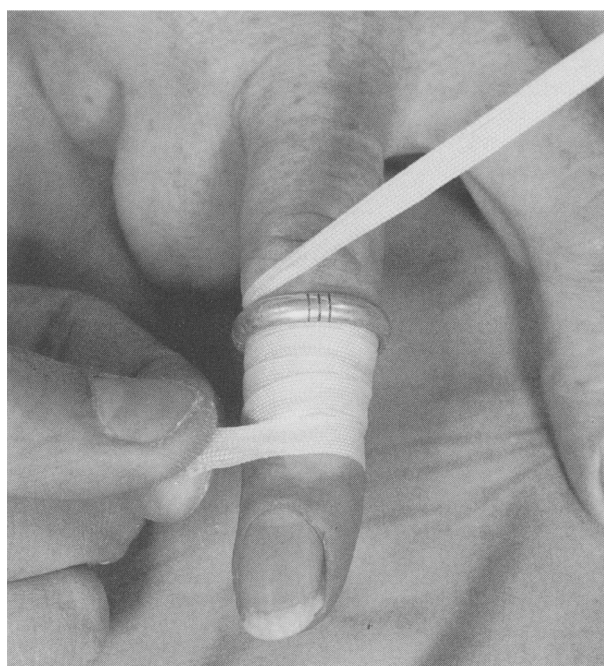


Figure 2—Tape is unwound and the ring advances distally.

value of the ring concerned. In order to minimise this, we wish to recommend this technique, as it is safe and effective in uninjured digits.

Yours faithfully,

L. Y. Hiew FRCS, Senior House Officer in Plastic Surgery
A. Juma FRCS, Specialist Registrar in Plastic Surgery
Department of Plastic Surgery,
Withington Hospital,
Nell Lane,
Manchester M20 2LR, UK.