



(Fig -3) Stumps closed, proximal phalangeal fracture of left ring finger fixed with an injection needle and the flap inset completed.

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.¹

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

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GRACILIS MUSCLE FLAP FOR FAECAL 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 Pickerell¹. All the 5 patients had already had an initial