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Gluteal Thigh Flap Coverage In Pressure Sores

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KEY WORDS

Pressure Sores, Flaps.

ABSTRACT

Single stage successful and easy closure of Ischial and trochantric pressure sores is now possible with use of a gluteal thigh flap. Experience of six cases, so treated is presented.

INTRODUCTION

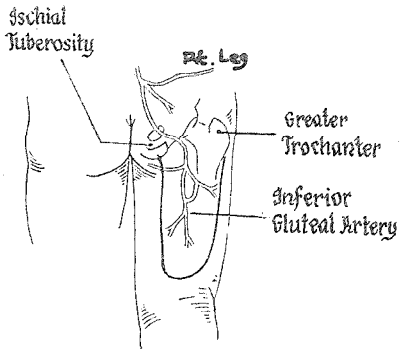
Treatment of pressure sores is one of the most difficult challenges in reconstructive plastic surgery. (Dansereau and Conway, 1964).In recent years superb myocutaneous flaps have been designed and offer a wide range of choices for coverage . A flap is *labeled good if it fulfills* the purpose of cover as well as filling material at one operation.

The present study was conducted in six cases in which ten ischial and trochantric pressure sores were covered with gluteal thigh flap.

FLAP DESIGN

The flap is raised from posterior aspect of thigh and buttock as described by Hurwitz et al (1981). The pivotal point is 5 centimeters above the ischial tuberosity. Central axis of the flap is midway between greater trochanter and ischial tuberosity, perpendicular to gluteal Crease. The width is variable according to the size of the defect. Lower border extends to within 8 centimeters of the popliteal fossa.

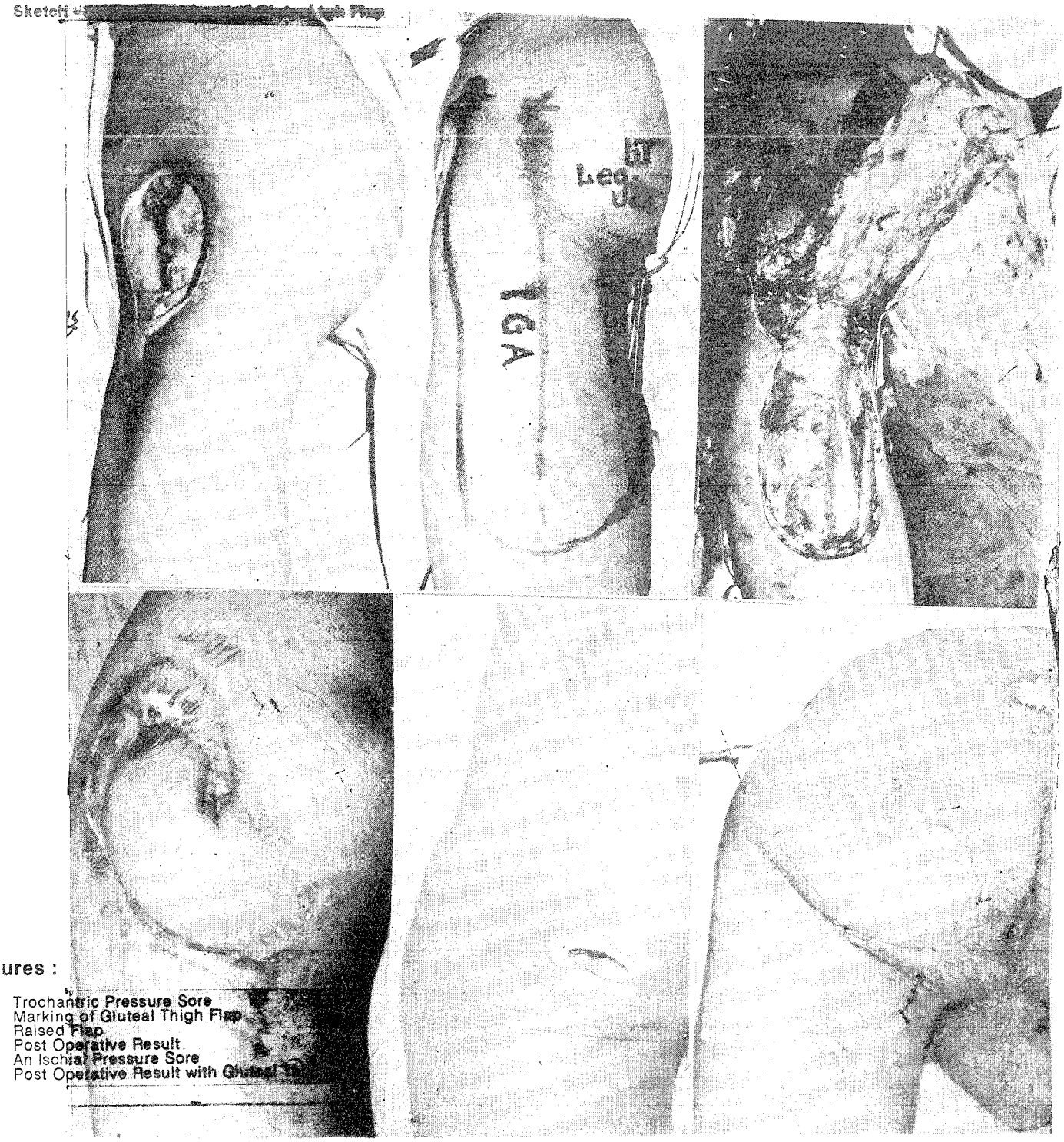
Photographs. 1-6



Flap was raised along with subcutaneous tissue and fascia lata, from distal to proximal end by sharp dissection over hamstrings. The flap was rotated and inset into the defect and the donor defect was directly closed after wide undermining.

OBSERVATIONS

All the flaps raised proved successful. Almost all donor area could be closed directly after undermining. One year follow up did not show any breakdown.



Figures :

1. Trochantric Pressure Sore
2. Marking of Gluteal Thigh Flap
3. Raised Flap
4. Post Operative Result.
5. An Ischial Pressure Sore
6. Post Operative Result with Gluteal

TABLE - I

S. No.	Type of Pressure Sore		Result	Recurrence
	Ischial	Trochantric		
1.	2	-	Good	Nil
2.	1	-	Good	Nil
3.	-	2	Good	Nil
4.	-	2	Good	Nil
5.	1	-	Good	Nil
6.	-	2	Good	Nil

Wound Healing Properties Of Hone

DISCUSSION

Though Davis (1938) came out with the idea of using flap replacement, Lamon and Alexander (1945) reported the first surgical closure. Ger (1971) introduced the muscle flap with split thickness skin graft to cover the defects of lower extremity. Tensor fascia lata myocutaneous flap has been found to be very useful to cover ischial and trochantric pressure sores (Nahai et al, 1978, Krupp et al, 1983). Minami et al (1977) used Vastus Lateralis myocutaneous flap to cover trochantric defects. Hurwitz et al (1981) introduced gluteal thigh flap for coverage of perineal and buttock wounds. They presented a series of 21 cases out of which 18 were successful. Distal necrosis in three cases was reported. Grotting et al (1986) also advocated the use of gluteal thigh flap for coverage of perineal wounds.

In our series of 10 sores treated with gluteal thigh flap, we have found it to be a reliable, low morbidity and versatile flap for coverage of ischial and trochantric pressure sores. To conclude it is a single stage procedure and the donor defect can be directly closed.

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