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Abstracts

1. Gorney, M., Falces, E., Jones H., and Manis J. R. : One stage reconstruction of substantial lower eyelid margin defects. Plast. & Reconstr. Surg., 44 : 592—596, 1969.

The authors have reviewed the various procedures used for eyelid reconstruction and have discussed their merits and demerits. A new method of reconstruction of lower eyelid margin defects, using a composite upper eyelid flap, containing conjuntiva, tarsus and skin has been described. The authors have used the method in twenty two patients with malignant and benign neoplasms of the lower eye lids and have reported good results. Not every case is suited to this method of repair and the choice of operation should be decided on the merits of the case.

N. N. K.

2. Chase, R. A. : An alternate to pollicization in subtotal thumb reconstruction. Plast. & Reconstr. Surg., 44 : 421—430, 1969

The author has described two cases of thumb reconstruction, one by the tubed flap, bone graft and island pedicle flap technique and the other by pollicization of the index finger. The addition of the neurovascular pedicle flap to the tubed pedicle bone graft technique enhances the sensibility, increases its blood supply, sudomotor function is obtained and hand skin characteristics are preserved. The author has suggested some refinements in the technique and states that the cortical bone graft as the sole skeletal support is enough to maintain the architectural strength in the reconstructed thumb. He however admits that where phalangeal joint function is important, as in total thumb reconstruction, the method of digital pollicization is still the best.

N. N. K.

3. Khoo Boo-Chai : The transverse facial cleft : its repair. Brit. J. Plast. Surg., 22 : 119—124, 1969

The author has presented four cases of transverse clefts and the ratio of these to clefts of the lip and palate was 1:120 in his series. Attention has been drawn to certain useful landmarks in the mouth which make the sitting of the new commissure relatively easy. The author has stressed the importance of suturing the muscle as close to the new commissure as possible and the use of a Z-plasty in the skin closure. The article is well illustrated by suitable photographs.

N. N. K.

4. Kaplan I. : Neurovascular island flap in the treatment of trophic ulceration of the heel. Brit. J. Plast. Surg., 22 : 143—148, 1969

In a majority of cases with trophicul-ceration on the heel the whole foot is anaesthetic and conventional methods of treat-

ment have to be relied upon. In an occasional case there is good sensation in certain areas of the foot and in these cases the use of island flap technique can be considered. The authors have described the anatomical and surgical considerations in planning out such a flap, and has described report in which a neurovascular island flap was successfully transferred from the great toe to the heal with satisfactory results.

N. N. K.

5. Converse, J. M. and Rapaport F.T. : The development of tissue typing. Plast. & Reconstr. Surg., 44 : 9—19, 1969

The possibility of matching donor and recepient by means of tissue typing techniques offers an approach to the alteration of the reaction of the host against the transplant. In 958 Dansset first discovered the leucocyte groups and Amos suggested that leucocyte antigens were a part of the complete genetic system. The methods used to test such antigens consist of leucoagglutination tests, lymphocytotoxicity tests and complement fixation methods. The authors have discussed the response of tissue groups to transplantation, the sharing of antigens between unrelated individuals, the preimmunisation with group specific leucocyte antigens and erythrocyte antigens. The five readily detectable major blood group antigens consists of the two erythrocyte antigens A and B and the three major leucocyte group mosaics of the HL—A system 1, 3 and 7. The authors state that living donor organs are usually not available and in a significant number of patients the cadaver must necessity, be the main source of new tissue. The establishment of regional transplantation centres is proposed, where anephric patients could undergo complete tissue typing, while waiting for suitable and histocompatible donor organs. These cadaver donors could also be the source of other needed tissues, such as skin, cartilage, bone and cornea. The authors have discussed at depth the development of tissue typing and described its value in clinical organ transplantation.

N. N. K.

6. Kendall, T.E., Robinson, D. W. and Masters, F.W. : Primary malignant tumours of the hand. Plast. & Reconstr. Surg., 44 : 37—40, 1969

The authors have reviewed their findings in 73 patients with 78 primary malignant tumours of the hand seen at the University of Kansas Medical Centre from 1947 to 1967. This consisted of 61 squamous cell carcinomas, 8 basal cell carcinomas, 2 basisquamous carcinomas. The remaining malignancies consisted of melanomas, fibrosarcomas and chondrosarcomas. Among the etiological factors the role of hereditary, disturbance of metabolism, radiation and trauma are mentioned. For superficial epidermoid carcinomas, excision and skin grafting is recommended, and for deeper lesions an amputation is the treatment of choice. Nodal dissection is indicated only when the nodes are enlarged. X-ray treatment is seldom required.

For basal cell carcinomas local excision and skin grafting is usually adequate.

Melanomas, should be managed by early biopsy and a radical amputation and simultaneous block resection. For fibrosarcoma

a radical amputation and for chondrosarcoma a limited radical excision is the treatment of choice.

N. N. K.

7. Kriby N.G. : Nobecutane in the exposure treament of burn wounds. Brit. J. Surg., 56 : 583 585, 1969

The author has discussed the use of Nobecutane in the exposure treatment of burn wounds particularly in hot dusty climates. After cleaning the burn wound with Hibitane under a general anaesthetic, it is sprayed first with Polybactrin and then with Nobecutane. Two further layers of Polybactrin and Nobecutane are applied in the theatre and thereafter Nobecutane is sprayed every 4 hours for 24 to 48 hours. After 10 days the edges of the pellicle start to separate and underneath, the pink healed wound is exposed. Partial skin loss burns heal satisfactorily under it, and whole skin loss burns are in good condition for excising and grafting.

N. N. K.

8. Maisels, D. O. and Sasd, M. N. : Early surgery in the treatment of burns Brit. J. Surg., 56 : 466—471, 1969

The authors have summarised the indications for early surgery in burn as (a) Tracheostomy to save life, (b) Release incisions to save a part (c) Early excision of eyelid burns to save sight, (d) Early excision of hand burns to save function and (e) Early excision of full thickness localised burns to save time. These have been adequately discussed and are well illustrated by photographs. Although the cases with clear indications are relatively few, yet a proper and timely use of surgery might make all the differences between success and failure of treatment in a particular case.

N. N. K.

9. Stell P.M. : Transverse incisions for radical neck dissection. Brit. J. Surg., 56 : 286—288, 1969

The author says that the standard Y incision described by Crile (1906) allows a good access and in the non irradiated patient heals well. In the irradiated patient however there is a high incidence of flap necrosis endangering the major blood vessels of the neck. The author recommends two transverse incisions as descibed previously by Mac Fee (1960) and Grillo and Edmunds (1965) in irradiated patients are compared to the Criles incision. The double horizontal incision conforms to both the principles applicable to operations on the irradiated neck namely avoidance of three point junction and omission of the verticle limb, as is given in a standard incision for radical neck dissection.

N. N. K.

10. Pugh, R. C. B. and Hanby, H. G. : Spontaneous recanalisation of the divided vas deferens. Brit. J Urol., 41 : 340—347, 1969

The authors report a series of seven cases in whom the vasa recanalised after complete surgical section. Recanalisation might be expected to occur if, at the conclusion of the operation the epithelial cells of the two cut ends of the vas deferens are allowed to come in contect with each other.

The vas being a thick walled, muscular, semirigid tube does not usually completely collapse by simple ligation. The mechanism that leads to recanalisation is not clearly understood, but probably the leakage of seminal fluid leads to the formation of a sperm ganuloma lnto which vas epithelium grows as sheets of cells until continuity is reestablished. The authors recommend the Rolnick's technique of folding back the cut ends, or the Hanleys technique of over lapping the cut ends to avoid recanalisation.

N. N. K.

11. Brallier, F. and Horner, R. L. : Sensory cross finger pedicle graft. J. Bone & Joint Surg., 51A : 1264—1268, 1969

The authors have described a new technique by which a sensory pedicle flap from the dorsum of the index finger was used to resurface and provide sensation to defects of the thumb. The authors series consists of 14 cases in which the procedure gave successful results in 9 cases (64%). The article is well illustrated by suitable diagrams.

N. N. K.

12. Schneider L. H. : Opponensplasty using the extensor digiti minimi. J. Bone & Joint Surg. 15A : 1297—1302, 1969

Loss of ability to oppose the thumb to the finger tips is a severe impairment to function of the hand. The author has described a technique of using the extensor digiti minimi for providing opponens action to the thumb. The advantages claimed are (i) the construction of pulley mechanism is unnecessary, (ii) Length of tendon is adequate and tendon graft is not required; (iii) the delicate flexor mechanism of the superficialis is not violated. The authors used the method in 10 cases and claimed good results in 8 and fair results in 2 cases.

N. N. K.