A pure dermal sling for implant reconstruction after mastectomy in the generous breast

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BACKGROUND

Skin reducing mastectomy is a useful technique in immediate implant-based reconstruction. The implant is usually covered by muscle and a dermal flap.[1] We describe a modification to this technique for generous breasts involving the creation of a pure dermal sling.

Figure 1 Pre-operative marking for Wise pattern incisions

TECHNIQUE

A skin reducing mastectomy is performed via Wise pattern incisions, retaining an extensive inferior dermal sling of de-epithelialised tissue. A sizer is used to ensure the skin envelope meets the inframammary fold before an anatomical implant is placed on the pectoralis major. Complete coverage is achieved with the inferior dermal sling, which is sutured to the pectoralis superiorly. The superior skin can then be draped to the inframammary fold and sutured in the usual manner.

DISCUSSION

The benefits of a pure dermal sling include complete coverage of the implant and the preservation of an intact pectoralis major. This technique has been trialled successfully in two patients with generous ptotic breasts.

Figure 2 Pure dermal sling

Figure 3 After reconstruction using pure dermal sling

Figure 4 Results at four-month follow-up appointment

Reference

1. Nair A, Jaleel S, Abbott N *et al*. Skin-reducing mastectomy with immediate implant reconstruction as an indispensible tool in the provision of oncoplastic breast services. *Ann Surg Oncol* 2010; **17**: 2,480–2,485.

A technique to aid the insertion of distal locking screws

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BACKGROUND

The insertion of distal locking screws on an intramedullary nail can be problematic as there is no hardware such as a jig to aid insertion. Newly developed computer aided techniques are available but the cost can be prohibitive. Insertion of distal screws usually relies wholly on image intensifier guided positioning. This can be time consuming and requires many x-rays to be taken in order to create the 'perfect circles' on the image intensifier that demonstrate satisfactory alignment. We propose a technique that decreases insertion time and requires fewer image intensifier images to be taken while inserting a distal locking screw.

TECHNIQUE

Pass a drill guide through the jig used for inserting proximal screws. Leave the drill guide in position against the limb. This can now be used to align the C-arm. Position the C-arm distally and adjust its position until it is parallel to the drill guide in its orbital and swivel axis. This will give near perfect alignment to the distal locking holes. Finer adjustments may be needed under image intensifier guidance to gain the final position. Once satisfactory alignment is achieved, insert the distal screws as usual.

DISCUSSION

This simple technique is effective, saves time and reduces radiation exposure to both the patient and surgeon. This technique is free as it uses standard equipment that comes with the nail.

Explantation of aortic infrarenal stent graft

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This technique has helped us to achieve proximal control during stent graft explantation. A large Foley catheter is inserted through a disconnected limb of stent graft and placed in the suprarenal aorta. Inflation of the balloon provides proximal control (Fig 1). The proximal

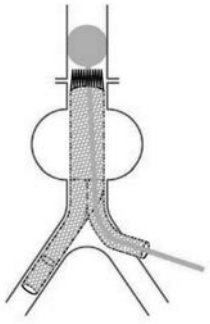

Figure 1 A Foley catheter is inserted through the stent graft and placed in the suprarenal aorta, after which the balloon is inflated.

end of the stent graft is extracted from the aorta. If another graft is used, proximal anastomosis is carried out with the balloon inflated. To complete the anastomosis a second Foley catheter is passed through a limb of the new graft (Fig 2). While the original catheter is deflated and removed, the second balloon is inflated in the suprarenal aorta (Fig 3) and the anastomosis completed.

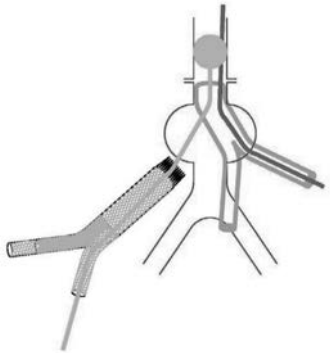

Figure 2 A second Foley catheter is passed through a limb of the new graft.

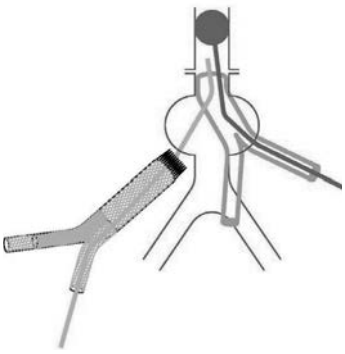

Figure 3 The original catheter is deflated and removed, and the second balloon is inflated in the suprarenal aorta.

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A technique for optimal manipulation of rotation of the flexible ureterorenoscope

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BACKGROUND

Three different types of movement are required to perform flexible ureterorenoscopy: insertion/retraction, rotation and deflection of the tip. Many trainee urologists struggle to manipulate the rotation of the scope. We describe a technique for optimally controlling this rotation.

TECHNIQUE

When performing ureterorenoscopy, the scope is extended in a straight line (Fig 1) rather than held in a curved position (Fig 2). By applying