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Letter to Editor

Composite grafts—the frustration continues

Dear Sir,

I had occasion to treat a columellar defect in a young woman. [Figure 1] Since she was not in favour of a procedure which would cause additional scars on her face; the option of a composite graft from her ear lobule was given to her, which she accepted despite being told that there were absolutely no guarantees as far as the successful 'take' was concerned.

She was admitted into an airconditioned room, and preoperatively she was started on Isoxuprine (vasodilator) 10 mg t.i.d. Intraoperatively it was also administered intramuscularly. The graft was taken first, and the terminal portions were deepithelialised, so as to be able to tuck it under the septal mucosa. The graft was sutured with the minimum effective number of interrupted sutures, using fine nylon. [Figure 2] Post operatively, Isoxuprine was continued for 4 days, when she complained of nausea and vomiting due to cerebral vasodilation. In addition she received 2 pints of low molecular weight dextran daily for 5 days. She also received enzymatic anti inflammatory drugs, and was in a controlled cool environment till her discharge.

The graft was pale for 3 to 4 days, and then it turned reddish for 2 to 3 days. It then showed the bluish colour of engorgement. All these are mentioned in literature as 'expected' colour changes[1]. The colour is supposed to return to normal if the 'flap is destined to survive'.

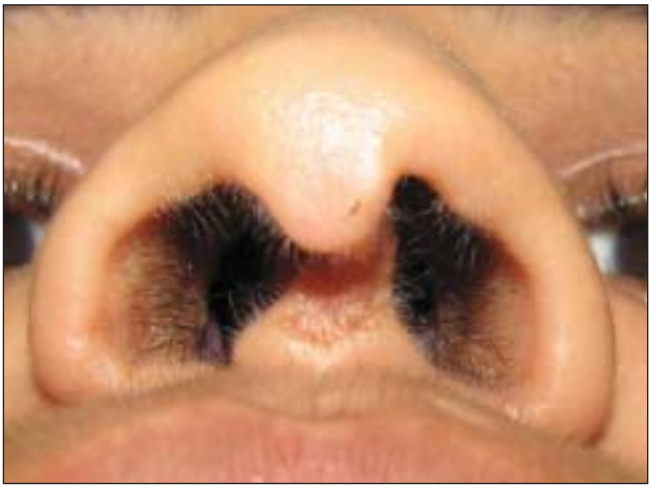

Figure 1: Preop defect

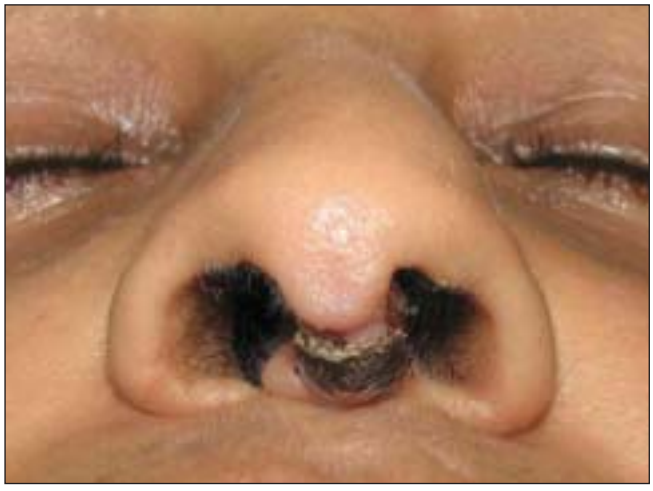

Figure 3: showing ischaemia

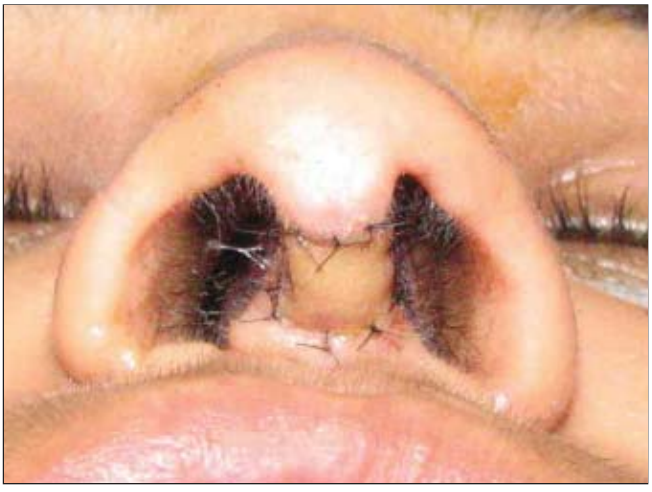

Figure 2: Immediate postop

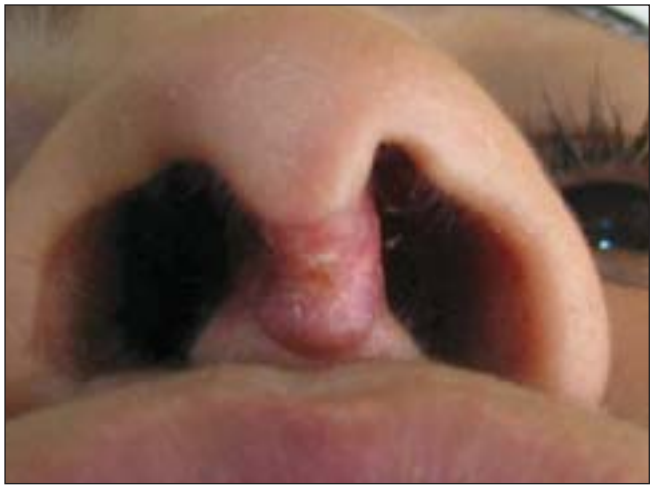

Figure 4: Late postop final appearance

The graft turned black after 8 to 9 days and formed an eschar. [Figure 3] The final survival can be made out from the 3 week postop photo. [Figure 4]

I have seen composite grafts done in Caucasian patients. Most surgeons are absolutely nonchalant with regards to such patients. The level of precautions taken by me would surely be classified as extreme.

How then can we ensure a reasonable success rate with respect to such procedures. I would like to know if there is any foolproof regime to be followed. If not, this is a procedure I would shudder to do in the future.

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REFERENCE

1. McLaughlin (1994) as quoted in McCarthy. J. G. Plastic Surgery W. B. Saunders; 1990. p. 1932.