Re: A novel method to insert drain atraumatically after liposuction in gynecomastia

Sir,

We read with great interest the article titled, ‘A novel method to insert drain atraumatically after liposuction in gynaecomastia’ by Sunil Gaba, and we congratulate the authors.[1]

We agree with the authors that, also liposuction, even when combined with glandular resection, has an important role in the surgical treatment of gynaecomastia, for flattening the thorax, eliminating fat residuals and creating a controlled shrinking of the cutaneous flat to recontour the male chest area. Seromas is one of the most common complications when liposuction is included in gynaecomastia surgical correction.[2]

In our practice, with more than 600 patients undergoing gynaecomastia surgical correction and long-term evaluation for complications and recurrences, mainly based on direct excision of the gland, the inferior emi-periareolar access, allowing a direct view of the surgical field, ensures a valid control of haemostasis, reducing the incidence of haematomas significantly.[3]

Furthermore, we retain that quilting stitches, firmly connecting the adipo-cutaneous thoracic flap to the fascial plane, with a compressive medical dressing, effectively contributes in reducing seromas and haematomas. Moreover, the compression is maintained, for at least 1 month postoperatively, using a compressive jersey.[4,5]

The use of drains should be suggested only in patients with the removal of large amount of breast gland or with a personal history of coagulation disorder, although the final choice for their insertions should be made directly in the operation room and last for not longer than 48 h. In fact, we do not retain the use of drains mandatorily for this type of surgery, even because the use of suction drains themselves could be responsible for complications such as surgical-site infections and pathological scarring which might be the cause of patients’ complaints, especially in aesthetic surgery.

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There are no conflicts of interest.

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REFERENCES


Nerve trimming device

One of the prerequisites for an appropriate nerve repair in case of peripheral nerve injury is to have well prepared and viable cut ends of the nerve to be repaired. The conventional method of holding the cut ends of the nerve with forceps and using an 11 number blade or a micro scissors supporting the nerve with the spatula covered with a moist gauge, have objections and needs relook. Equipment like Laser and Nerve Miter box are expensive and are not readily available.

We the authors are describing a simple and effective way of atraumatically trimming the lacerated nerves before repair.

The nerve trimming device that is being described in this original work is very simple in its design which consists of a curved (70 degree) smooth forceps with a tapered long and narrow tip made up of stainless steel. It consist of 4 cms long forceps with a tapered smooth end of 1mm. The prongs of the forceps themselves are proximally curved at an angle of 70 degrees to be used as a handle. This curved handle is sufficiently long enough (4 cms) for the ease of handling [Figure 1]. At a sufficient distance from the tip of the forceps, there are 3 co‑linear perforations (big enough to accept 23/25 gauge needles) on both the shafts of the prongs of the forceps allowing the surgeon to transfix the full thickness of the structure which is to be trimmed (including both the anterior and the posterior walls). Depending on the size of the structure to be trimmed one or two needles can be used for the same purpose. This provides the surgeon a reasonable control over the structure to be trimmed in all planes with a gentle "vice" like grip which is fully adjustable by his nondominant hand while trimming. A gentle longitudinal...