

Surgical treatment of grade III gynaecomastia

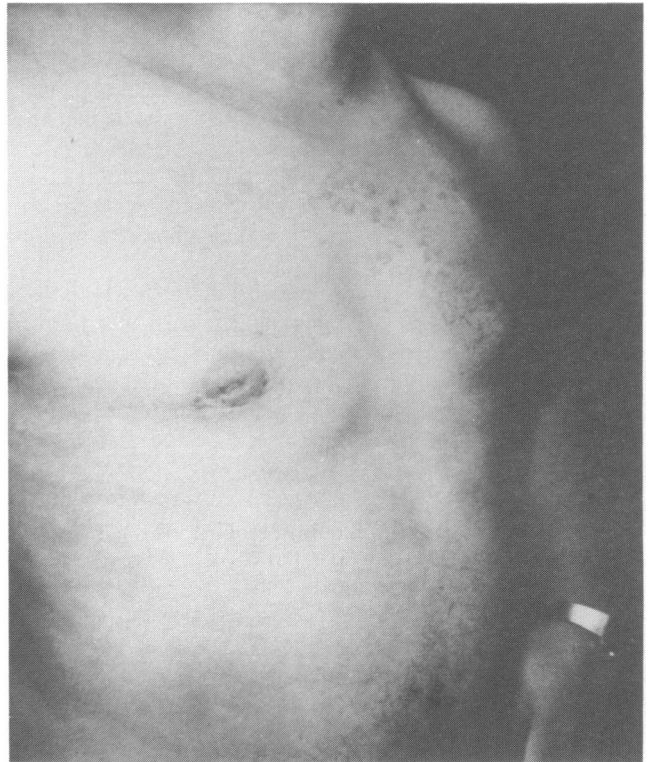
The authors (*Annals*, July 1989, vol 71, p227) are to be congratulated on presenting a technique based on the McKissock breast reduction vertical pedicle (1). The technique presented does, however, have one major drawback in that the scar is visible. While this may be acceptable in males with hairy chests, it is unfortunately not acceptable in those less endowed.

Benelli (2) has presented a wonderful technique for internal mastopexy either with nipple-areolar reduction and elevation alone, or with internal lifting. His technique was directed only towards females. The key to the success of his technique is the 'Round Block' method of suturing, where a subcuticular clear, non-absorbable suture is used as a 'pursestring' to draw in the wide excess of the resected area (Fig. 1). Initially, when sutured, the disparity in the skin edges leaves a wrinkled areolar-skin margin. With time this smoothes out to leave an almost invisible scar.

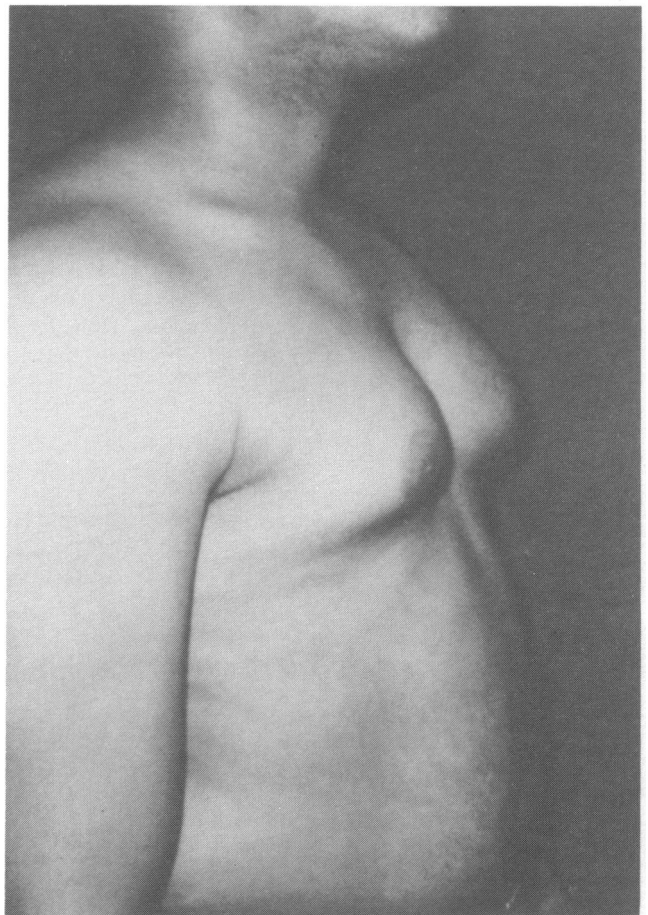
Figure 2 shows the result in a male with Grade III gynaecomastia in which this technique was used. Vascularity is maintained by doing the subcuticular mastectomy through a hemicircumferential areolar approach, leaving the nipple attached by a single pedicle. Suturing was done with a single 'Round Block' 5/0 Prolene® and 6/0 Surgilene® to the nipple skin edges.

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(a)



(b)

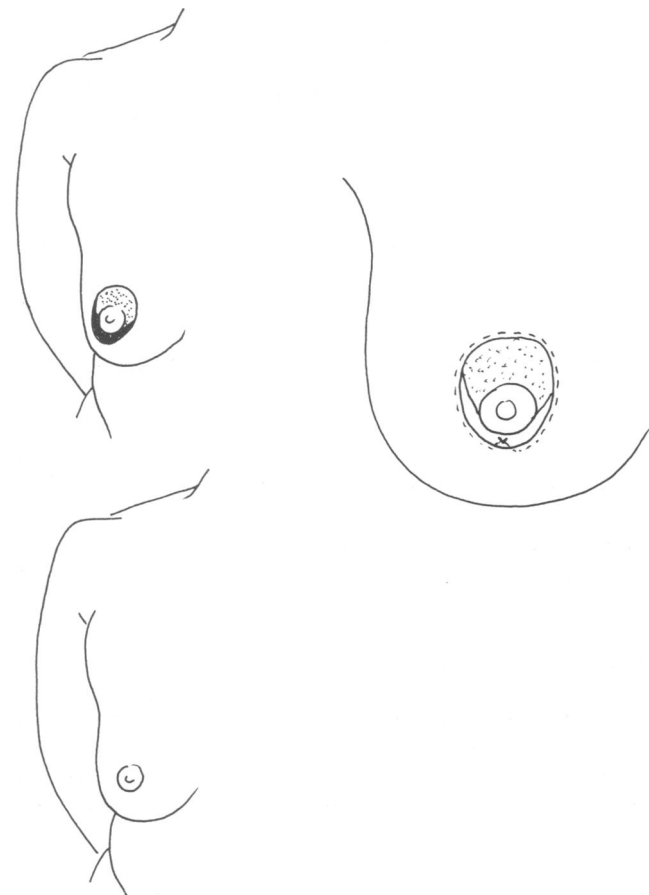


Figure 1. Nipple vascularity supported by vertical pedicle. All breast and glandular tissue is resected through lower portion of the incision. Dotted line indicates position of subcuticular clear 4/0 Prolene suture to reduce the outer skin circumference using the 'Round Block' technique.

Figure 2. (a), Initial result with wrinkled areolar-skin margin. (b) Later, with almost invisible scar.

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Surgery for gastro-oesophageal reflux: the Angelchik prosthesis compared to the floppy Nissen fundoplication. Two-year follow-up study and a five-year evaluation of the Angelchik prosthesis

Deakin *et al.*'s thoughtful paper (*Annals*, July 1989, vol 71, p249) highlights the difficult technical problems inherent in performing the Nissen fundoplication. The tightness of the wrap is critical, for if it is too loose the symptoms of gastro-oesophageal reflux persist, while if it is too tight gastro-oesophageal reflux is abolished at the expense of producing gas bloat and dysphagia.

The main injurious agent in reflux oesophagitis is gastric acid (1). If a loose wrap is to be constructed, allowing some degree of gastro-oesophageal reflux to occur, perhaps a highly selective vagotomy (HSV) should be included in the operative procedure (2). Thus, any reflux that does occur postoperatively is less likely to produce symptomatic heartburn. The authors aimed to achieve the ideal degree of looseness/tightness by using an intraoesophageal stent of a total 60G. The addition of an HSV might have reduced the 28% incidence of symptomatic reflux observed (Visick 2-4), although the need for further surgery was uncommon.

Kennedy *et al.* (3) reported a 9% incidence of lesser curve necrosis following combined HSV and fundoplication, but in a series of over 125 patients in whom this combined procedure has been undertaken there has not been one such complication (GG Jamieson, personal communication), which agrees with our experience in the much smaller number of patients. The time may be right for a formal comparative study of Nissen fundoplication with and without a concomitant HSV.

The simplicity of the Angelchik prosthesis and the short postoperative stay are attractive. The effectiveness of the procedure in Deakin *et al.*'s series may have been substantially enhanced by the coincident surgical procedures in a quarter of the patients (three cholecystectomies, two HSVs). The high risk of reoperation observed by the authors and reported by others (4) may have been abolished by a change in design of the prosthesis and crucial plication, but the authors do not come off the fence and say which of the two procedures reported is their current first choice.

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An operation for rectal strictures following Ripstein rectopexy

We were interested to read McCue and Thompson's solution for rectal strictures following Ripstein rectopexy (*Annals*, July 1989, vol 71, p260). This complication is very rarely seen when the sling is placed posteriorly as described by Wells. It is interesting to note that the innovator of this former procedure now advocates a posterior sling specifically to avoid this particular complication (1). As the long-term results from both types of rectopexy are comparable the message is clear. If more surgeons took note of this, then the procedure described by McCue and Thompson should become obsolete.

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Reference

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Plasma lignocaine levels during transurethral prostatectomy

I read the above article (*Annals*, September 1989, vol 71, p278) with interest. The term 'bladder mucosa' is widely used and yet, of course, it is a misnomer, since the lining of the bladder does not produce mucus. Neither, furthermore, does the urethra, so the phrase 'mucosal damage within the urethra' in the authors' summary is surely wrong.

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Lower oesophageal contractility monitoring during anaesthesia for cardiac surgery: preliminary observations

After ensuring that no harm befalls them, the prime duty anaesthetists owe their patients during general anaesthesia is to render them insensible to surgery. For this reason, and because there appears to be an increased risk of awareness associated with anaesthesia for cardiac surgery than for most other types of surgery, I was immediately attracted by the title of Thomas and Evan's paper (*Annals*, September 1989, vol 71, p311). Any means of monitoring depth of anaesthesia during cardiac surgery must be investigated and lower oesophageal sphincter contractility may be that means. However, I read the paper with mounting concern.

Surely any systematic enquiry into awareness under general anaesthesia must first control the essential variable that is the anaesthetic technique? Thomas and Evans did not do so nor did they provide an adequate description of the anaesthetic techniques used, far less dosages of drugs given. However, all other grievances regarding the paper pall into insignificance when they state that "no additional anaesthetic or analgesic agents were given during bypass". Recently, Dr Rona Patey and I have conducted a survey of anaesthetic practice during cardiopulmonary bypass (CPB) (1) and the data is in the early stages