Breast reconstruction following mastectomy

Sir,
I read with interest your article “Post mastectomy immediate breast reconstruction experience in a high volume center in India” I congratulate authors for such excellent results. General surgical tradition has dismissed breast reconstruction following mastectomy as frivolous, unnecessary and not in the patient’s best interest. But development of successful and reliable techniques of breast reconstruction in carefully selected group of patients has resulted in the most positive, rewarding and dramatic improvement in self-esteem and self-confidence among patients. Among the pedicle flaps TRAM flap is a gold standard for breast reconstruction and have been used extensively with low complication rate. Initially breast reconstruction was offered only to patients with stage II and I but now indications are extended to even those with limited life expectancy, who may benefit from the improved quality of life. Regarding your article I have following queries.

1. I have also used TRAM flap for post mastectomy breast reconstruction. In my experience I have seen many patients who have midline infraumbilical post caesarian scar mark. In these cases the random area of flap usually gives problem in terms of its vascularity. Have you encountered any such patients in your series, if so, than what was the result in these cases?
2. It is unconceivable that with such high volume work and regular follow-up, authors have not shown any pre and postoperative photographs.
3. You have offered immediate breast reconstruction in stage III carcinoma breast; it is locally advanced cancer with high chances of local recurrence. Would it not be better to offer delayed breast reconstruction in these patients? In your study what was the local recurrence rate beneath the flap and how did you detect it.

I again appreciate your effort and hope that this article will stimulate other centers for reconstruction of breast following mastectomy.

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REFERENCE


Laparoscopic surgery of inguinal hernia in children- experience with 110 repairs

Sir,
This has reference to the article “Laparoscopic surgery of inguinal hernia in children- experience with 110 repairs” by Sanjay Oak et al IJS 2004;66:70-4.

The authors have concluded that laparoscopic surgery is

1. Cost effective (detailing the cost of supplies, operative time, length of study (Or should it be “length of stay”?)), early return to unrestricted activity, reduction in the period of absence for the parents)
2. Cosmetically superior
3. Safe
4. Feasible for bilateral repair in the same sitting

BUT COMPARED TO WHAT?

Authors have not mentioned the main disadvantage that it makes the surgery transperitoneal which could well be done without entering the abdomen in open surgery.
Letter to Editor

COST EFFECTIVE

In the main article author have not given any data on the cost-effectiveness or analysis of the cost of surgery. Neither have they compared laparoscopic repair with open surgery (herniotomy) to show that it is superior to herniotomy.

To my knowledge many centers are doing herniotomy as day care procedures. I’ve seen our pediatric herniotomy patients start playing normally within 36 to 48 hours (early return to unrestricted activity referred to above).

Operative time – conventional surgery is also done as fast as, probably faster than, laparoscopic repair.

Reduction in the period of absence for the parents- Most of our patients are from rural area. Mothers are housewives. So this factor is not significant. Even in the case of both parents employed, they plan it on Saturday so that next day will be holiday. From Monday they can go to their duty normally. Hence, herniotomy can be done with one-day leave or even without a leave.

Without referring to any of these things in the main article, it is wrong to conclude “it is cost effective”.

COSMETICALLY SUPERIOR

Inguinal skin crease incision used in the herniotomy is one of best incisions as far as cosmesis is concerned. It is hardly visible after a few months. Also, it covered in the underwear. Compared to this three stab incisions, however small, are in the visible area (if the patient’s habit of dress is so). So, is it appropriate call laparoscopic surgery is cosmetically superior?

SAFE

In the article itself authors have mentioned 4 recurrences and one hydrocoele. In my 11 years of experience I am yet to see a recurrence or hydrocoele after herniotomy (Either done by me or any other surgeon). Reason may be inexperience. But herniotomy gives good results in the hands of relatively inexperienced surgeons. This implies risk of another surgery (And anesthesia). To say safe it should not only comparable in mortality but also in morbidity.

FEASIBILITY IN BILATERAL CASES

The only conclusion addressed in the main article. Even here, herniotomy is also feasible. Of course, with two incisions.

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The case report: Like birds tossed over a stormy ocean: Only a few gain a foothold in the rigging of passing ships – for the rest, oblivion

Sir,

It was quite interesting to read the special article on ‘The case report’ by Dr. Pujari.1 Case report are “like birds tossed over a stormy ocean: only a few gain a foothold in the rigging of passing ships – for the rest, oblivion”.2

Though most of the reputed journals with high impact factor do not encourage publication of case reports, there is also an apathy amongst surgeon to report such cases due to lack of recognition of their uniqueness, a misdiagnosis or lack of thought or desire to disseminate the information. Case report should be written to inform rather than to impress, and in doing so using clear and purposeful prose that is accurate and concise.3

Case report are an ideal ground for novice / ‘debutant’ authors to produce scholarly work during their postgraduate training. In general, the completion of case report is easier and less time consuming and paradoxically, leads to a temptation to write up anything that is remotely interesting in the hope to see one’s name in print. Therefore, there is always an antagonism between evidence – based medicine and case reporting. New Zealand Medical Journal has ‘Case note’ instead of ‘Case report’.

Finally, Sorinola et al reviewed 249 journals and concurred that ‘Instruction to authors’ pages provided