A simple and cost-effective protocol for the management of anterolateral thigh free-flap donor site

Sir,

The perforator-based anterolateral thigh flap was first described by Song et al. Minimal donor site morbidity and functional impairment has led various authors to use this flap for a wide variety of defects. The management of the donor site poses a unique problem as a large area of skin (upto 800 cm²) can be harvested. Primary closure of the donor site with mobilization of surrounding skin is possible only in a few cases when the size of the defect is less than 8 x 8 cm².

The anterolateral thigh flap is invariably used for reconstructing large defects, where a split skin graft is needed in a majority of the cases for closure of the donor site. Although the harvesting of the split skin graft is routine for a plastic surgeon, it still has its own complications such as pain and infection of the donor site in the early postoperative period with a probability of later hypertrophic scarring. For resurfacing of the flap donor site, a split skin graft is usually harvested from another anatomical region which leads to two wounds at different sites.

In our series of 15 consecutive cases of anterolateral thigh flap we harvested split skin grafts from the medial or posterior aspect of the same thigh. The skin graft donor site was dressed with antibiotic-impregnated tulle dressing and absorbent sponge. The flap donor site was resurfaced with the split skin graft and fixed using a tie-over dressing. The tie-over dressing was removed on the 5th postoperative day without disturbing the split skin donor site tulle dressing. All the cases had total (n = 13) or near total (n = 2) graft take. The skin graft donor sites healed over 14 to 17 days (mean = 15.8 days). Thus, all the patients had dressing limited to one limb and there was no additional donor site morbidity in any of the cases. Late management included the use of a single compression garment, both for the skin graft as well as for the grafted flap donor sites.

To conclude, we suggest that in the management of the donor site of an anterolateral thigh flap, split skin grafts can be harvested from the same thigh without any additional complications. This helps to limit the use of dressing material and time. Postoperative management of the skin graft and flap donor sites becomes simple and cost-effective as both donor and recipient sites can be managed with the same compression garment. In addition, this method helps to restrict the scarring to the same thigh.

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A simple method to make a reusable volar splint

Sir,

Application of a Plaster of Paris (POP) volar splint for the immobilization and/or patient comfort is a common procedure in Plastic Surgery Units either after the initial assessment of a trauma patient or postoperatively in theater. In our unit, the on-call plastic surgery trainee may assess up to 30 new referrals in a day. Most of these are hand trauma referrals, often requiring a volar resting slab to be applied by the trainee. However, patients often need senior review/reassessment within 24 h, necessitating the removal and reapplication of this cast. The standard plaster technique requires wrapping wool around the limb, placing the wet plaster on this, and securing it with a circumferential crepe bandage. When removed, this is not easily reusable.

We describe here a simple method to make a reusable cast using standard plaster trolley materials. This method utilizes a stockinette to confine the POP, preventing it from sticking to the wool.

1. Cut the required length of plaster as usual.
2. Cut a length of stockinette approximately 2 inches longer than the plaster. Pull this piece of stockinette over your own dominant forearm.
3. The plaster is soaked in warm water and wrung out. While holding the plaster with your dominant hand, pull the stockinette over the plaster [Figure 1].
4. Even out the plaster inside the stockinette by laying it on a flat surface.
5. Fold the edges of the stockinette inwards to neaten the ends.
6. Lay wool padding over the top and apply to the volar aspect as required. Secure to arm with bandage and tape [Figure 2].
7. Mould into required position as it sets.

The standard POP cast is not easy to reuse. The method described above allows the patient to have a removable cast that can be reapplied after reassessment simply by using a new piece of wool and crepe.

• Saves time during on-call periods.
• Can be reused postoperatively, saving time in the theater.
• Cost-saving, with single rather than multiple POPs required.
• More aesthetically pleasing as the POP is confined within the stockinette, giving it a neater appearance.

References