Sutureless circumcision: Comments

Sir,
It was interesting to read the article by Sharma in October 2004 issue of the journal.[1] Circumcision, in spite of being one of the oldest and extensively performed surgical procedures, seems to be a technique not yet perfected, having a considerable complication rate.[2] The procedure can be conveniently performed under local anaesthesia, infiltrating the preputial skin circumferentially one cm proximal to the coronal rim. The glans can be anaesthetized by lignocaine jelly instilled into the preputial sac. This avoids a nerve block, which requires deeper injections.

The authors have used stay sutures at times and I feel instead of three, six can be used. Use of gauze dressings on top of the cyanoacrylate does not save much. The average healing period in their series was between 13 to 28 days (mean 21 days) and frenular junction took longer to heal. In the last paragraph of the discussion they have given the disadvantages of the glue in terms of shelf life and cost. Nothing has been mentioned about the time taken in performing circumcision with glue and with sutures at least in “normal” situations. Unfortunately a claim to this effect has been made in the abstract. Careful approximation of the edges appears to be an essential step and it takes more time.

I feel that there is no alternative to a good frenular stitch, properly applied biodegradable sutures (absorbable sutures other than catgut) and good haemostasis for cosmetically good results. The tension built up during erections can dislodge the glue in adults.

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Sutureless circumcision: Author's reply

Sir,
I was glad to have comments from our colleagues and I wish to add my clarifications.

1. I agree that the procedure can be performed under local anaesthesia, in fact I have performed the procedure under the same in the older age group. I feel that penile block is better as there is no distortion of the prepuce which can occur with infiltration of the prepuce. The cuts would be smooth and regular if they are taken in normal uninfiltrated tissues and so would be the final scar.
2. Stay sutures were taken 90 degrees apart so that makes it 4 sutures at 3, 6, 9 and 12 o’clock position. I found that one rarely requires more than 4 stay sutures. Of course one can take any number of sutures to make the approximation easier.
3. The dressing was placed so that the hardened glue should not catch the undergarments and come off.
4. The frenulum is the last area to heal. This is due to its peculiar anatomy of being a tongue-shaped delicate tissue. The traditional U stitch (irrespective of whether it is catgut or polyglycolic acid) strangulates the tissue and hence the healing is invariably delayed. Haemostasis is the key point in this technique hence I use bipolar cautery. Even the frenular artery is cauterised with the bipolar cautery.
5. The glue took comparatively less time (average 5 min) compared to suture (varies between 8 to 15 min depending on whether it is interrupted or continuous suture. The literature also highlights the same.[3] Accurate approximation is a must.

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Sir,
1. We read with interest the article by Garg et al. [1]
2. We tried the technique described by the author in a series of 10 cases of Lichtenstein's Mesh Hernia repair and compared it with the standard technique with prolene sutures. Our experience is as follows:
   a. It is extremely difficult, if not impossible, to staple the mesh to pubic tubercle as there is virtually no ‘give’ in the periosteum for the staple to hold.
   b. As there is no space to manoeuvre the broad head of the stapler when we try to staple the inferior edge of the mesh to the upturned portion of the inguinal ligament, it is very cumbersome trying to align the inferior edge of the mesh to the inguinal ligament.
   c. In both the above situations we had to resort to applying prolene sutures additionally to secure the mesh as we were not convinced of the integrity of the mesh repair with stapler application only.
   d. The mean operative time was noted from insertion of the mesh to placement of the last staple / prolene suture. The mean time in 10 cases of staples was 14 min (09-17 min) while in 10 cases of prolene sutures it was 11 min (09-14 min).
3. Hence we do not agree with the authors’ conclusion in ibid article that using skin staplers is as effective as conventional repair or that there is significant reduction in operative time.

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Use of skin stapler in Lichtensteins mesh repair

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A logical approach to trauma - Damage control surgery: Comments

Sir,
I would like to congratulate the authors for their excellent review article on Damage Control Surgery. [1]

I would also like to emphasize a few points regarding Abdominal Compartment Syndrome (ACS), the clinical diagnosis of which is difficult and prognosis