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RFP Journal of Dermatology

Volume 6 Number 2
July – December 2021

Contents

Original Article

Journal of Dermatology
Volume 6 Number 2, July – December 2021

Innovative Use of Clip on Magnifying Lens in Plastic Surgery

[1]N V S Sai Kiran, [2]Ravi Kumar Chittoria, [3]Nishad K, [4]Padmalakshmi Bharathi Mohan, [5]Imran Pathan, [6]Shijina K, [7]Neljo Thomas

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Abstract

The application of magnification has revolutionized microvascular and reconstructive surgery. Tissue visualization is enhanced, suture placement will be easier. Magnification is achieved using binocularloupes, microscopes. Clip on magnifying lens is innovative method of achieving magnification using smart phone. It is cost effective, easy to use and easy to carry. It can be fitted to mobile phone which is readily available. Capturing of photos and video recording of the procedure can be done by using this method, which is not available with binocular loupe and microscope. Using this technique simple procedure like suture removal, identification of skin lesions can be done in a better way.

Keywords: Clip on Magnifying Lens; Plastic Surgery; Suture Removal; Skin Lesions.

Introduction

Plastic surgery commonly uses magnification to increased surgical refinement. With magnification tissue visualization is enhanced, precise anatomic details are appreciated, suture placement is precise and easier, microsurgical instruments can be positioned better, neurovascular structures are better appreciated. Loupes in general have a magnification of 2.5x to 5x, while microscopes provide a magnification of 6x to 40x. Loupes are preferably custom made and take into account corrected vision, interpupillary distance. Loupe is costly and difficult to carry always. Sometimes plastic surgeons get consutation about skin lesions. Clip on magnifying lens is a innovative method for achieving magnification. It is cost effective, easy to use. It is fitted to mobile which is commonly used and available with all. Difficulty encountered during suture removal and can be done by using this. It can also be used in better visualization and identification of skin lesions.

Materials and Methods

In this technique we will be using clip used for attaching lens to mobile phone, Portable and detachable, 0.45x wide angle convex lens. Android smartphone. Lens is attached to clip which is placed on smart phone.5 junior residents and 5 senior residents were instructed to use this technique in ward, casualty, OT for 3 days and feedback proforma was given to residents.

Proforma

Is it easy to use	**Yes**	**No**
Is it easy to carry		
Is it comfortable		
Is it convenient to perform procedure		
Visualisation of structure is easy		

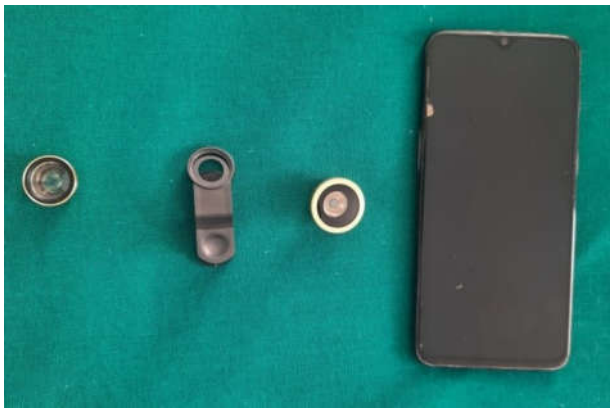
- Limitations in using:
- ***Overall experience:***

  Excellent
  Good

Fair
Poor
Bad

A replacement for loupe?

Advantage
Disadvantage



Materials required:

- Smart Phone
- Convex Lens
- Clip

Clip on lens has been used for the suture removal in this patient. Images showing:

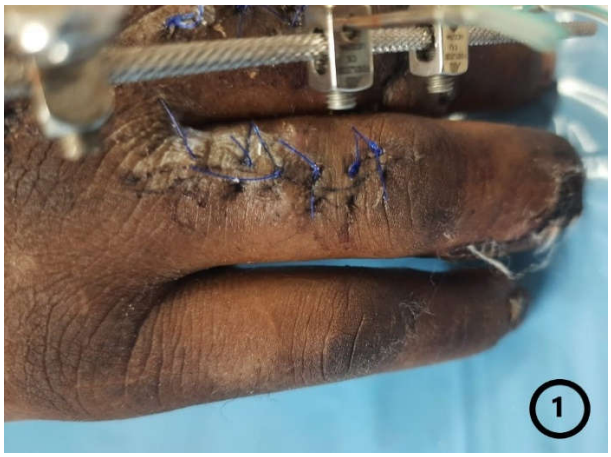


Fig. 1: Without magnification.

Fig. 2: With magnification using clip on lens.

Result

Junior residents felt that clip on lens was easy, cost effective and convenient to use in minor procedures such as suture removal. Senior residents were comfortable in using, but felt loupe provide better magnification and comfortable with it. Residents felt it better to take photos and record procedure using clip on magnifying lens, which was not possible with loupe. Drawback we got from residents was assistant has to constantly hold the mobile phone and difficulty in focusing the image for prolonged time.

Discussion

The application of magnification is needed in microvascular and reconstructive surgery.[1] Complex and specialized procedures have become possible in areas of neurosurgery, plastic surgery, urology, pediatric surgery, Otorhinolaryngology. With Magnification tissue visualization is enhanced, microsurgical instruments can be positioned and smaller neurovascular appreciated. Magnification may lead to substantial decrease in positive margins[2] and nerve injuries.[3] Magnification Magnification is used for wound care, skin closure in emergency room.[4] Manification is achieved using binocular loupes and microscopes. Loupes preferably be custom made, to take into account field of view, depth of vision. Disadvantages with loupes and microscopes is costly and difficult to carry. Clip on magnifying lens is cost affective in achieving magnification. It is fitted to a smart phone and easy to carry. Suture removal is not always easy, difficult suture removal requires magnification which can be achieved using this technique. Dermatological lesions sometimes require dermoscope which is very costly. In such sitations better visualization of skin lesions can be done using this method. Storage of the data can be done by capturing image or video which is not possible with lopue. This innovative technique can be considered as an alternative of loupe in low resource countries

Conclusion

Clip on magnifying lens is a innovative method to achieve magnification in a cost effective and easy way. It can be considered in situations where loupe is not available and difficulty to carry. Limitation of the study is, sample size is not adequate. Overall clip on magnifying lens can be considered can be considered in beginners who are not affordable for loupe and in situations where capturing of images is needed.

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Original Article

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Role of Keystone Designed Flap in Management of Venous Leg Ulcer

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Abstract

The purpose of this case report is introducing keystone design perforator based island flap (KDPIF) as a therapeutic method for management of venous leg ulcer (VLU).

Keywords: Venous leg ulcer (VLU); Keystone design perforator based island flap (KDPIF).

Introduction

Venous reflux arises due to failure of venous valves in the saphenous veins, which results in retrograde flow and stasis, or pooling of venous blood in the branches of the saphenous veins, that can translate into elevated ambulatory venous pressure and can produce associated symptoms, including dilated visible veins at the skin surface (varicose veins, reticular veins, and telangiectasias), swelling, aching, heaviness, skin discoloration, and potential ulcer formation. A poor calf pump mechanism may even worsen venous reflux.[1, 2]

VLU is a late indicator of chronic venous insufficiency and venous hypertension. In normal conditions, calf muscle contraction and intraluminal valves promote the prograde flow, preventing blood reflux. However, when retrograde flow, obstruction, or both exist, will result in chronic venous hypertension that is responsible for the dermatologic and vascular complications that result in the formation of a VLU.[3-5] The prevalence of VLU is between 0.18% and 1%.[6] Over the age of 65, the prevalence increases to 4%. On an average 33-60% of these ulcers persist for more than 6 weeks and are therefore referred to as chronic VLU. These ulcers represent most advanced form of chronic venous disorders like varicose veins and lipodermatosclerosis.

Materials and Methods

This study was conducted in Plastic surgery department in a tertiary care center in the month of August-September-October 2021. Written informed consent was taken from the patient. The study subject was a 54 years gentleman, tea stall worker by profession, known case of bilateral varicose veins and chronic liver disease, and chronic alcoholic and chronic smoking with 30 pack year history, presented with complaints of swelling over the left foot and leg on prolonged standing with dull aching pain and swelling associated with non-healing ulcer over the dorsum of left foot. He had no complaints of trauma resulting in present complaints, pain on walking or exertion, similar illness in the past, or past surgeries for similar complaints.

On evaluation of left lower limb, inspecting in both lying down and standing position, raw area of size 7 X 4cm was present over the dorsum of left foot extending from the tarso-metatarsal joint level to metatarso-phalangeal joint overlying the third and fourth toes and surrounding skin was scaly and hyper pigmented (figure 1). Pitting pedal edema was present, with hyperpigmentation of left front and lower leg with

atrophy of the distal leg. Dilated tortuous veins were present over the great saphenous vein territory. Saphenofemoral junction was competent, but multiple incompetent perforators were present. Palpation was done for confirmation of the inspected findings. Tenderness was present over the foot with local raise of temperature. Base of both the ulcers were formed by bone. Digital sensations and distal pulses were intact. He had no restrictions in joint movement and all lower limb muscles were having normal power.

Wound bed preparation was done with wound debridement and dressing. The raw area was covered by type I Keystone Flap (Figure 2a and 2b). Incompetent perforators were located in left lower limb which were ligated (figure 3.1 and 3.2). Flap was healthy. Wounds healed well (figure 4).

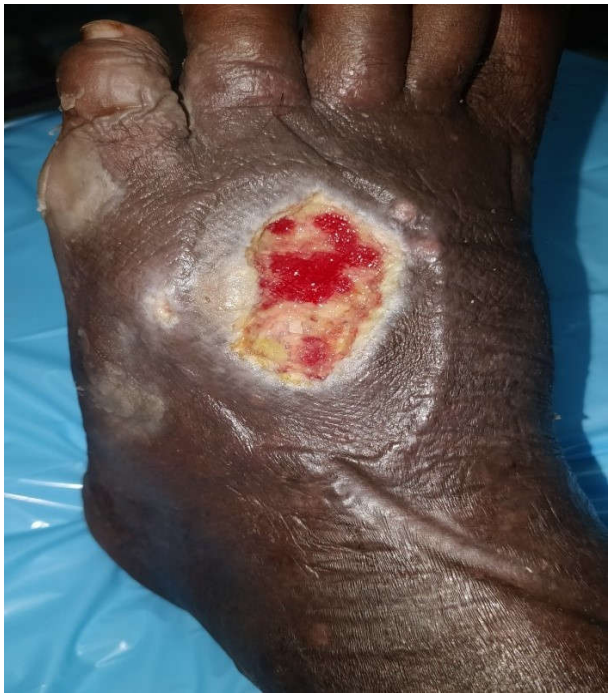

Fig. 1: Wound on the dorsum of left foot.

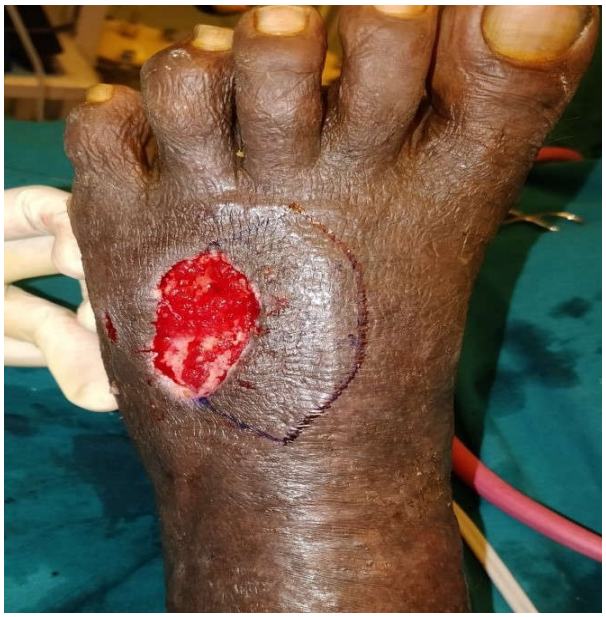

Fig. 2a: Keystone Flap marking.

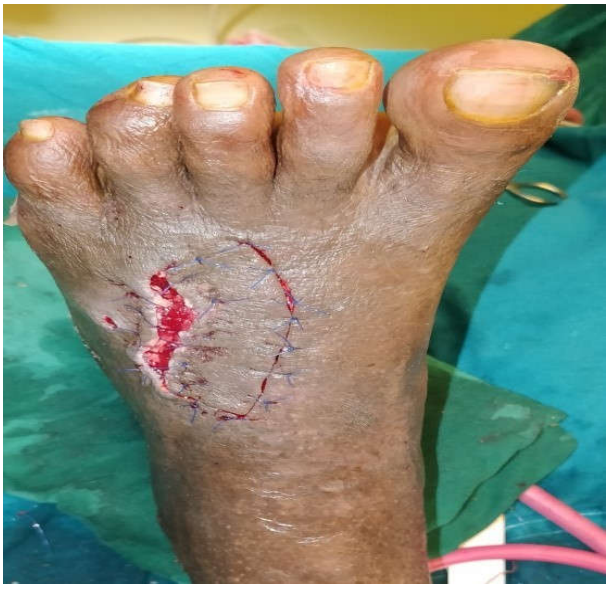

Fig.2b: Keystone Flap done for the raw area.

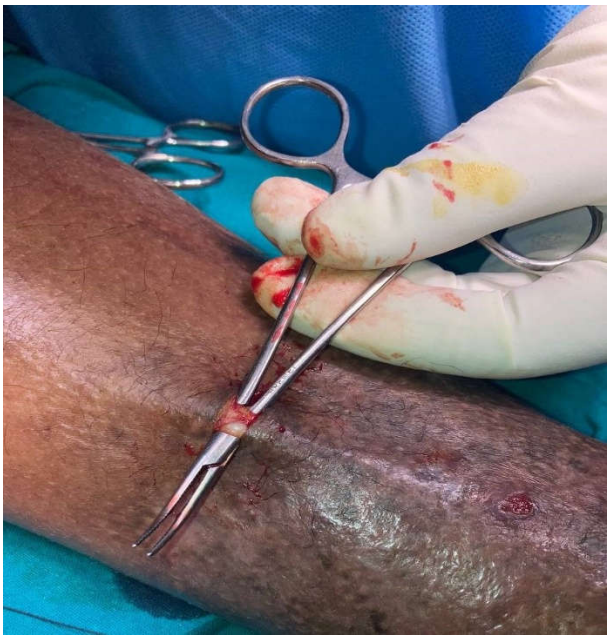

Fig. 3.1: Incompetent perforator ligation.

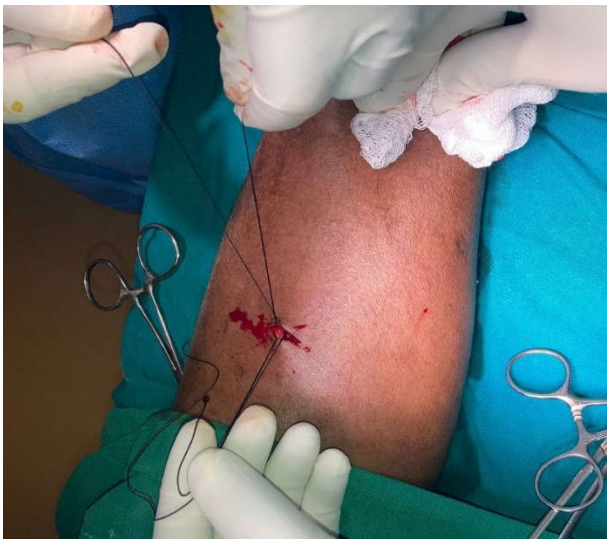

Fig. 3.1: Incompetent perforator ligation.

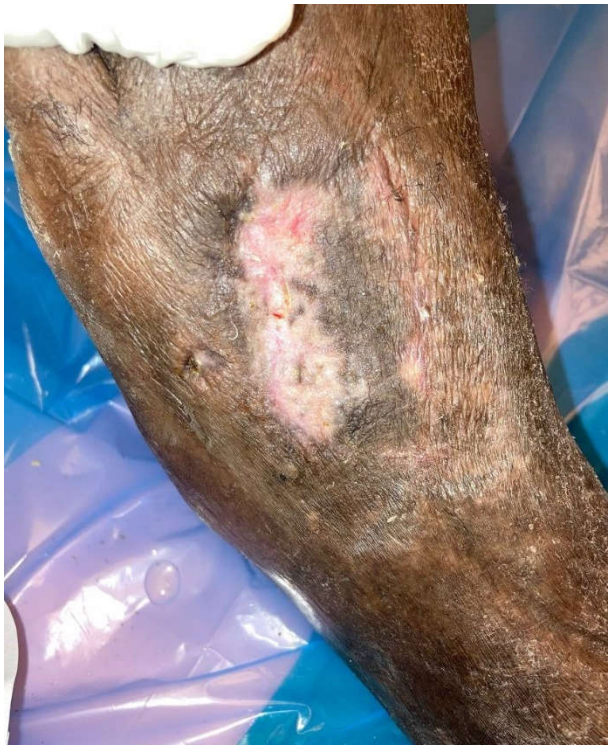

Fig. 4: Healed wound.

Results

Postoperative period was uneventful and patient was discharged with the varicose stockings.

Discussion

KDPIF is widely used for loco-regional reconstruction and is simple with better aesthetic results with stable coverage. It was initially described for lower extremity defects.

Four subtypes are:

Type I: The standard flap design and closure is used for defects of different shapes over most areas of body up to 2 cm in width.

Type IIA: Used for larger areas of reconstruction, mostly located over the muscular compartments, the deep fascia over the muscular compartment is divided along the outer curvature of the KF for its further mobilization.

Type IIB: With split skin graft to secondary defect
Where excess tension exists, the secondary defect may be skin grafted

Type III: Double KF Used for larger defects (5-10 cm), a double keystone design can be done to exploit maximum laxity of the surrounding tissues.

Type IV: Rotational KF Occasionally to facilitate rotation across a joint contractures or compound fractures with exposed bone, the KF is raised with undermining up to 50% of the flap subfascial and the perforator support is derived from the attached part of the flap.

Type 1 KF was used in our study The limitation of the study includes that it is a case report with a single centre study with no statistical analysis. Further randomised controlled studies are required to validate the efficacy, physiology of intake and complications of KF.

Conclusions

In our study we found that KDPIF was useful in management of venous ulcer and can be added to armamentarium of plastic surgeons for management of venous ulcer.

Authors' contributions: All authors made contributions to the article.

Financial support and sponsorship: None.

Conflicts of interest: None.

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Case Report

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Favre: Racouchot Disease

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Abstract

Favre-Racouchot disease is characterized by diffuse yellowish hue with presence of large, open, black comedones, nodules and cysts associated with the clinical signs of actinically damaged and atrophic skin. Sun exposure, smoking, and therapeutic radiation are considered important risk factors. Pathogenesis of the disease includes loss of functional elastic tissue network and reduction of tensile strength, distension of the infundibular canal of the seba-ceous follicles and retention of sebum with consequent comedones formation. Dermatoscopy showed yellowish lobular like structures with rare peripheral telangiectasia. Combining medical and surgical therapy is the best approach.

Keywords: Favre-Racouchot Disease; Comedones; Dermatoscopy.

Introduction

Favre-Racouchotdisease (FRD) is also referred as senile comedones, solar comedones, and nodular elastosis with cysts and comedones. It was originally described in 1932 by Favre and later reviewed in detail by Favre and Racouchot in 1951.[1] It is characterized by diffuse yellowish hue with presence of large, open, black comedones, nodules and cysts associated with the clinical signs of actinically damaged and atrophic skin.

It is more common in Caucasian males in up to 6% of patients aged from 40 to 60 years. Diagnosis is primarily clinical and histopathology is rarely required. Dermatoscopy can be used as an non invasive tool for the diagnosis. Medical and surgical mode of therapy can be combined for its effective treatment. We hereby present a case diagnosed on clinicodermatoscopic basis as FRD.

Case report

A 70 year old male presented with asymptomatic lesions over his face since 1 year, which were gradually progressive. By occupation he was vendor. He was chronic smoker since almost 40 years (20 bidis per day) and was hypertensive on beta blockers since 10 years. No other comorbidities present. Cutaneous examination showed yellowish hue of the skin with multiple comedones and yellow colored cysts, ranging from 0.5 to 5 mm in diameter over bilateral upper part of cheeks and at outer canthus of both eyes. (Zygomatic area)(Fig. 1)

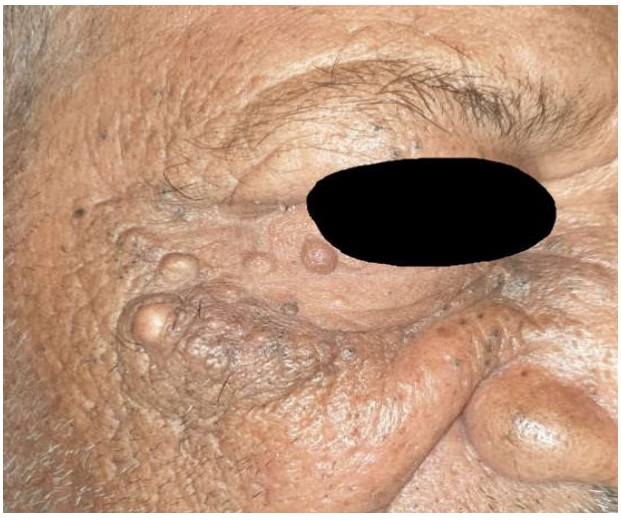

Fig. 1: Multiple comedones and yellow colored cysts, ranging from 0.5 to 5 mm in diameter over right zygomatic area.

Deep wrinkles and furrows were also seen more on left side of face. (Fig. 2)

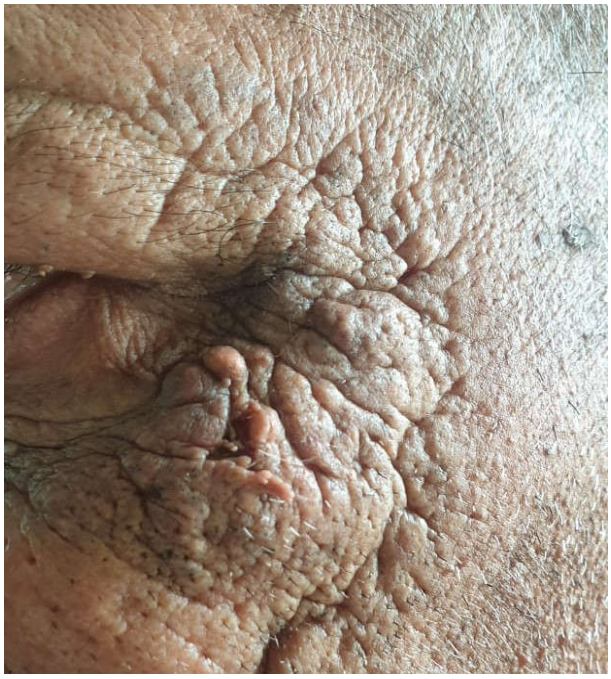

Fig. 2: Multiple comedones and yellow colored cysts with deep forrows and wrinkles over left zygomatic area.

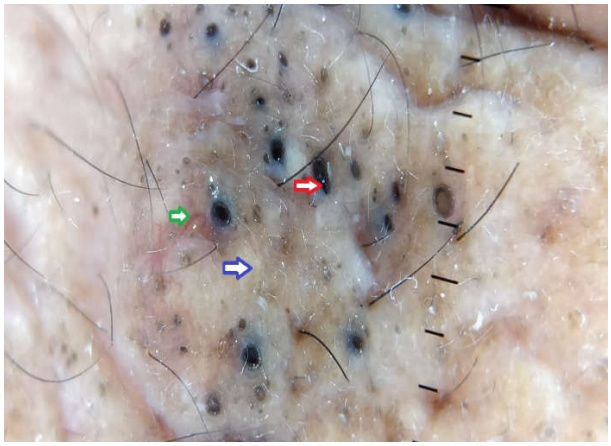

Fig. 3: Dermatoscopy (polarized LED ILLUCO dermoscope IDS-1100 having 10x magnification) showed yellowish lobular-like structures (Blue arrow), comedone like openings (Red arrow) and peripheral telangiectasia. (Green arrow)

Dermatoscopy done with handheld polarized LED ILLUCO dermoscope IDS-1100 having 10x magnification showed yellowish lobular-like structures, comedone like openings and peripheral telangiectasia. (Fig. 3) Histopathology was not done as patient denied for biopsy. On the basis of clinical and dermatoscopic examination diagnosis of Favre Racouchot disease (FRD) was made. Patient took 2 sittings of co2 laser, but then was lost in follow up.

Discussion

FRD is characterized by nodules and cysts associated with the clinical signs of actinic-related skin damage and solar elastosis of the face with deep wrinkles and furrows. In 1888 Thin et al. described grouped comedones occurring in solar-damaged skin of elderly individuals for the first time. Cases in dark skinned people including Indians have been reported.[2] Sun exposure, smoking, and therapeutic radiation are considered important risk factors.

Pathogenesis of the disease includes loss of functional elastic tissue network and reduction of tensile strength, distension of the infundibular canal of the sebaceous follicles and retention of sebum with consequent comedones formation.[1]

Clinically it is characterized by slowly progressive waxy and soft plaques with open or closed comedones. The surrounding skin may be thickened and shows deep furrows, isolated papules, nodules, cystic lesions and rough and waxy plaques from 2 to 6 cm in diameter especially involving the periocular region, nose, malar regions, temples, cheeks or neck. Uncommonly, the lateral neck, retroauricular areas, earlobes, and forearms may also be involved. Lesions are symmetrically distributed, but rarely can be unilaterally.[3] It has to be differentiated from chloracne, sebaceous adenoma, syringoma, acne, comedones, milia, colloid milium, trichoepitheliomas, and sebaceoushyperplasia.[2]

Dermatoscopy showed yellowish lobular like structures with rare peripheral telangiectasia.[4] Our case showed yellowish lobular like structures, peripheral telangiectasia and also comedone like openings not reported previously. Histopathology of FRS are very characteristic with presence of dilated pilosebaceous openings, atrophic sebaceous glands and large, round cross-out like spaces lined by a flattened epithelium and filled with layered horny material. Solar elastosis could be pronounced or absent also.[1]

Conditions closely linked to FRS include cutis rhomboidalisnuchae, considered to be its variant.[2] Other conditions associated with FRS include cutaneous myxoma, actinic keratosis, basal and squamous cell carcinoma, trichostasis spinulosa, keratoacanthoma, and eyelid papilloma.[5]

Sunscreen and cessation of smoking can arrest the progression of the disease. Combining medical and surgical treatments is the best approach. Regular use topical retinoids results in expulsion of small comedones and improvement in photo damaged skin along with oral Isotretinoin. Surgical techniques include comedone extraction, curettage, simple or multiple stage excision, dermabrasion, and laser resurfacing.[5]

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