



Letters to the Editor

Bilateral heel pad hypertrophy

Sir,

The heel pad acts as a cushion in standing and walking. However, the heel pad is considered abnormal if the thickness exceeds 23 mm in male and 21.5 mm in females (Jackson, 1986). The thickened heel pad bulges out on weight bearing. The shearing force between the heel pad and shoes results in frequent trauma which can lead to problems. Idiopathic heel pad thickening has not been reported.



Fig. An elliptical incision was made and a portion of skin and fat was excised.

We have met a 22-year-old woman who had suffered from bilateral heel pad hypertrophy since early childhood. She had difficulties in wearing shoes as the heel pad was prominent upon weight bearing. The pad measured 25 mm, 3.5 mm thicker than the normal site. There was no drug history of Phenytoin or signs of acromegaly or obesity. Under general anaesthesia, an elliptical incision was made and a portion of skin and fat was excised (see Figure). The postoperative course was uneventful. The patient was followed up for 9 years.

The most well-known disease manifesting thick heel pad is acromegaly (Kho, 1970) in which case collagen tissue demonstrates a marked response to excessive amounts of growth hormone. Other conditions having a similar manifestation may include obesity (Jackson, 1986), infection, myxoedema, peripheral oedema and long-term use of Phenytoin (Kuttan, 1975). Idiopathic heel pad thickening has not been reported before. There are many disadvantages to a thick heel pad. Shearing forces between the heel pad and the shoes result in frequent trauma. Consequently, chronic irritation leads to hyperkeratosis as a pathological report showed. Therefore, surgical intervention of the type we have made is necessary. The case was followed up for 9 years postoperatively and no other systemic disease was found. We therefore named it "idiopathic heel pad hypertrophy" and presented it.

Yours faithfully,

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References

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Kho, K. M. (1970). Heel pad thickness in acromegaly. *British Journal of Radiology*, **43**, 119.
Kuttan, K. R. (1975). Thickening of the heel-pad associated with long-term dilantin therapy *American Journal of Roentgenology*, 1975; **124**, 52.

Keloids and hypertrophic scars

Sir,

In their excellent paper from Kashmir "Evaluation of various methods of treating keloids and hypertrophic scars: a ten year follow-up study", (*British Journal of Plastic Surgery*, **45**, 374) Darzi *et al.* make the important point that any series with less than two years of follow-up is missing a significant number of recurrences. As most of the patients were studied between August 1979 and July 1980 a much longer follow-up is really necessary. They go on to state that to date, beta radiation has been free from any oncogenic effect and suggest it can be used safely in children.

I ask whether it is a safe recommendation to use a known carcinogen to treat benign disease in children without at least a further ten years of follow-up?

Yours faithfully,

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Reverse digital artery flaps: a note of caution regarding cold intolerance

Sir,

The recent article by Lai *et al.* (*British Journal of Plastic Surgery*, **45**, 443-453) concerning the reverse digital artery flaps describes an elegant and sophisticated refinement of this flap and highlights six significant advantages that these flaps have over conventional ones.

Since the non-innervated flaps were first described I have

been using them to reconstruct certain fingertip pulp losses and defects overlying flexor tendons and can confirm the beautiful reconstructions that are possible. However, some of my patients have experienced very significant cold intolerance following this procedure, despite the precaution of not dividing the digital artery at the proximal margin of the flap – only ligating it – until after release of the tourniquet had confirmed rapid finger vascularisation through the opposite digital artery. I now regard this flap as relatively contraindicated in outdoor manual workers.

Lai *et al.* describe in detail the advantages of this flap but

do not mention the disadvantages. It may well be that below the 26th Latitude cold intolerance is not a problem, but in cold damp climates the sacrifice of a digital artery must be made with full understanding on the part of surgeon and patient of the possible consequences.

Yours faithfully,

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