



Letters to the Editor

Thromboembolic prophylaxis in plastic surgery

Sir,

We were interested to read the paper by Dujon *et al.*, surveying, by questionnaire, the use of DVT prophylaxis by consultant plastic surgeons in the U.K. (*British Journal of Plastic Surgery*, 45, 418). We conducted a similar appraisal by telephoning the junior surgeon on call at 25 plastic surgery units in June, 1992, as part of the formulation of our own DVT prophylaxis policy.

Dujon *et al.* reported 23 consultant plastic surgeons having a fixed personal policy for DVT prophylaxis with 10 belonging to units with a fixed policy. However, of 25 units telephoned, our survey revealed only one unit operating a fixed prophylaxis policy. The means employed were low dose Heparin in 24 units, graduated compression stockings in 17 units, intermittent calf compression in 10 units and electrical calf stimulators in 2 units.

Dujon *et al.* omit to mention the electrical calf stimulator (Biomedical Engineering Services, Australia) which is easily applied, unobtrusive and enables perioperative prophylaxis in frequent situations in plastic surgery where access to the lower limbs is necessary to harvest skin grafts or undertake other procedures.

Whilst the questionnaire method suffers from the inaccuracy of a poor response rate (44%) our telephone appraisal is necessarily less complex but represents what is actually happening on the "shop floor". It provides additional evidence for the need for DVT prophylaxis policies to be effectively instituted.

We wholeheartedly concur with Dujon *et al.*, that serious consideration be given to preparing adequate guidelines for thromboembolic prophylaxis in Plastic Surgery.

Yours faithfully,

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Registrar in Plastic Surgery,

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Thromboembolic prophylaxis in plastic surgery—reply

Sir,

We were interested to read the comments made by Messrs. Carver, Ghosh and Green with regard to our recent publication. We would like to clarify the points raised.

We felt that information on thromboembolic prophylaxis

policy would be more reliably obtained by a consultant questionnaire rather than by telephoning junior staff.

Our survey was done in anonymity. This would have to be taken into consideration when interpreting the results, i.e. one or more consultant with a personal policy could be from the same unit which may also have a fixed unit protocol for D.V.T. prophylaxis.

As pointed out by Carver *et al.*, a questionnaire survey is limited by response rate. None of the respondents to our survey quoted electrical calf stimulation as a method of D.V.T. prophylaxis currently being used. Whilst we agree that electrical calf stimulation may be unobtrusive and suitable for certain lower limb procedures, we could find no statistical evidence to prove that electrical stimulation reduces the incidence of thrombo-embolism in surgical patients. A literature search revealed only one paper showing that a combination of subcutaneous heparin and electrical calf stimulation reduced the incidence of D.V.T.'s in the acute spinal cord injured patient (Merli *et al.*, 1988). This technique was therefore intentionally omitted from our discussion.

Carver *et al.* may also be interested in reading the recommendation of the Thrombo-Embolic Risk Factors (THRIFT) Consensus Group (BMJ September 1992). This review provides an excellent over-view on the subject and suggests sensible guide-lines for D.V.T. prophylaxis.

Yours faithfully,

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References

Merli G J, Herbison G J, Ditunno J F, Weitz H H, Henzes J H, Park C H, Jaweed M M. Deep Vein Thrombosis: prophylaxis in acute spinal cord injured patients. *Archives of Physical Medicine and Rehabilitation* 1988; 69: 661-664.

Thrombo-Embolic Risk Factor (THRIFT) Consensus Group. Risk of and prophylaxis for venous thrombo-embolism in hospital patients. *British Medical Journal* 1992; 305: 567-574.

Angelman syndrome

Sir,

I was recently invited to deliver a paper about the surgical control of drooling to a support group involved with the Angelman Syndrome.

The Angelman Syndrome is a neurological disorder