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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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M. M. Ghosh, FRCS, Senior House Officer,
A. R. Green, FRCS, Consultant Plastic Surgeon,
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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 Physicial 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

associated with mental delay and characteristic facial appearance and behaviour. It was first described in 1965 by Dr Harry Angelman, a paediatrician who noted several children with jerky ataxic gait who tended to laugh excessively and frequently protruded their tongues and who suffered microbrachycephaly. Many suffered from epileptic fits with severely abnormal EEG's.

There are approximately two hundred known cases in the United Kingdom, but there is probably a much larger number because the apparent clustering of this syndrome seems to be associated with awareness of the condition by certain paediatricians. The syndrome seems to be associated with a deletion on chromosome 15.

A large percentage of these children suffer from drooling. However, I believe it is important that surgeons who are requested to carry out anti-drool procedures should be aware of the fact that some of these children appear to grow out of their problem. At the support group meeting I took a straw poll on the percentage of cases who suffered from drooling and the number of those who drooled who seemed to grow out of it by the age of ten. It would appear that about two thirds of cases suffer from drooling and that of these about one third grow out of it. I therefore recommend that anti-drool procedures should not be undertaken at too young an age and probably not before the age of eight or nine.

The operation as described by Varma *et al.*[1] has been carried out in two cases and has been entirely successful.

Yours faithfully,

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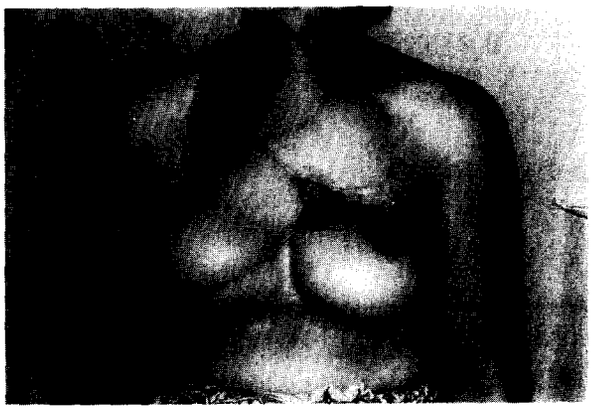
Reference

Varma S, Henderson H P, Cotton B R. Treatment of drooling by parotid duct ligation and submandibular duct diversion. *Brit J Plas Surg* 1991; **44**: 415–417.

Necrotising fasciitis in the head and neck region

Sir,

In their recent paper Maqbool *et al.* (*British Journal of Plastic Surgery*, **45**, 481) highlight the severe problems caused by this condition, although for their patient there appeared no obvious primary site of infection. However necrotising fasciitis of the neck has previously been recorded and the literature closely reviewed.[1] In our patient, a young woman, the infection originated in a tooth with sepsis spreading to cause severe systemic toxicity, and resulting in extensive necrosis of skin, fat and muscle of the neck and anterior chest wall. Several surgical excisions were required including a right mastectomy and partial left mastectomy.



Once the patient was over the acute illness, she underwent initial skin grafting to the neck and chest wall, and subsequently reconstruction with two pedicled latissimus dorsi myocutaneous flaps—one to release the neck contracture, and one to reconstruct the right breast (followed by tissue expansion of the flap and silicone gel breast prosthesis insertion) (Fig).

The need for appropriate antibiotic treatment and aggressive adequate debridement can be confirmed, but extensive reconstruction may, as in our patient, pose significant problems of staged surgery.

Yours faithfully,

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Reference

1. McAndrew P G, Davies S J, Griffiths R W. Necrotising fasciitis caused by dental infection. Br J Oral Maxillofac Surg 1987; 25, 314.