

Letters to the Editor

Apert's Syndrome

Sir,
The progressive shoulder joint deformities observed in Apert's Syndrome are not present at birth. We would like to postulate a mechanism of development. Previous descriptions have shown overgrowth of the greater tuberosity, a

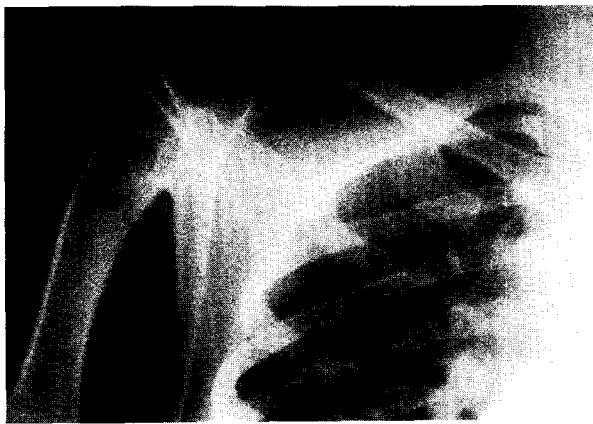


Fig. 1

Figure 1—Plain P-A X-ray of the right shoulder with anterosuperior subluxation and resultant lateral clavicular wearing.

relatively prominent acromion, and glenoid dysplasia. These features may combine to give a clinical picture of anterior subluxation.¹

Whilst on an Elective to Tygerberg Hospital, South Africa, M.E.J. observed a 12-year-old girl with the usual features of Acrocephalosyndactyly Type 1 and severe bilateral shoulder involvement resulting in both clinical and radiological anterosuperior subluxation (Fig. 1). We feel that this represents an extreme case with the joint nearing the end-stage of progressive functional loss. As a consequence of her severe uncorrected bilateral syndactyly, her hand abnormality prohibits pinch and single handed grip. In the western world greater function is obtained from early digital separation between 6 months and 3 years.² This young girl can only perform simple tasks such as lifting or grasping with both hands. In the normal subject this involves internal rotation of the humerus under the action of the anterior fibres of deltoid, subscapularis, pectoralis major, teres major and latissimus dorsi.³ When pressure is exerted on the object the net superior forces tend to displace the humeral head relative to the glenoid cavity (Fig. 2). The reader can confirm these force displacements by pressing his or her palms together in the prayer position. We feel this has greatly contributed to this clinical and radiological picture of anterosuperior subluxation, thus forming a strong argument for early digital separation to improve single hand function.

Yours faithfully,

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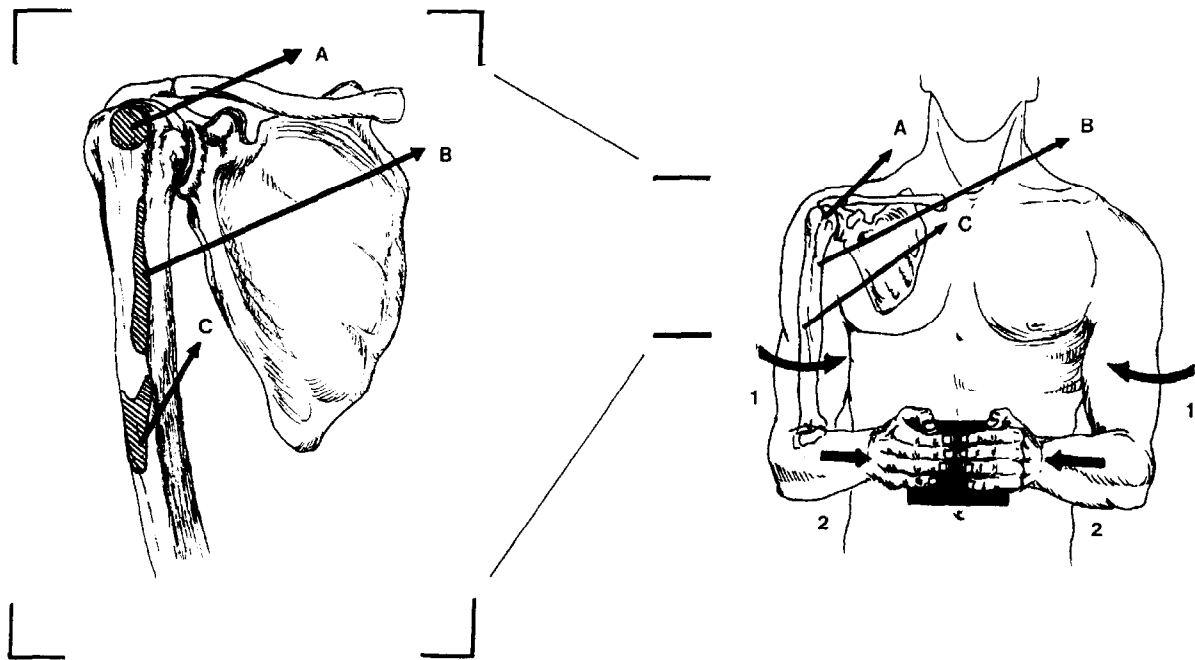


Fig. 2

Figure 2—A: Supraspinatus, B: Pectoralis Major, C: Deltoid (anterior fibres) 1: Internal rotation is the net effect of the above muscle action, 2: direction of force on an object whilst lifting. The net effect is superior displacement of the humerus relative to the glenoid cavity.

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First use of tongue flap

Sir,

I have read with interest the paper on "The tongue flap in the primary treatment of cleft palate: a report of 19 cases" by R. Thatte, P. Govilkar and J. Patel (*British Journal of Plastic Surgery*, 45, 150).

This publication has the merit of reporting a new approach to the use of the lingual flap in primary repair of the cleft palate, as most previous reports have referred to its use in secondary repair of cleft palate and for closing nasopalatal fistulas.

In our clinic at the Jalisco Institute for Reconstructive Plastic Surgery at the University of Guadalajara, Mexico, we have used the tongue flap since 1961 (Guerrerosantos *et al.*, 1964), using it initially for lip reconstruction but subsequently in 1963 for secondary repair of palatal fistula (Guerrerosantos and Altamirano, 1966). This was the first report of the use of the tongue flap in reconstruction of the cleft palate. Klopp and Schurter (1956) were the first to report tongue flaps for the reconstruction of the palate in cancer patients. Subsequently we have used the tongue flap in primary repair of cleft palate (Guerrerosantos and Fernandez, 1973) for the alveolus and anterior hard palate reconstruction.

These references were not mentioned in Thatte *et al.*'s article. I hope they may be kept in mind for future publications about this interesting material, and I look forward to seeing the further report regarding growth of the middle third of the face of these patients.

Yours faithfully,

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The case of the disappearing leech

Sir,

A 49-year-old woman, who had bilateral silicone gel breast implants inserted in 1978, presented with pain and a change in shape of her left breast following exercise. On examination, she had a Baker's grade IV capsular contracture on the left, but a soft-non-tender right breast.

An ultrasound scan of her breasts suggested that the right implant was ruptured and that the left one was intact.

After lengthy discussion, it was felt that we should remove both implants and perform bilateral mastopexy.

At operation, the findings of the ultrasound were confirmed and both implants were removed. She had a mastopexy as planned, but postoperatively the left areola complex became engorged and cyanotic. She was started on Dextran 40 and a leech was applied to the areola. However, as soon as the leech was applied, it disappeared between the sutures around the areola and into the wound. In order to retrieve it, three sutures were removed from the wound and the leech was just visible beneath the nipple. However, despite attempts at pulling it out, the leech would not let go and sterile saline was therefore injected into the wound around the leech. This caused it to release its grip and it was then easily removed from the wound.

I would be interested to know if any other surgeons have been faced with this problem and how they managed to retrieve the leech.

Covering the wound with steristrips or with paraffin gauze *etc.* would have prevented this happening. However, the injection of saline around the leech seems to be an excellent method of discouraging them from further feeding, causing them to loosen their grip and allowing them to be removed with relative ease.

Yours faithfully,

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