Figure 1—Initial presentation of the burn following the application of a heating pad. Note the full-thickness necrosis of the abdominal skin.

Case report

A 53-year-old woman underwent abdominoplasty. She placed a heating pad over the abdominal wall 3 weeks after surgery in order to relieve lower abdominal pain. After she removed the heating pad, she noticed that the skin was erythematous. The following day, she noted blister formation and eventual full-thickness necrosis (Fig. 1). This second-degree burn healed with conservative treatment. The wound had completely re-epithelialised in 3 weeks.

Discussion

During abdominoplasty, neural connections are usually severed during the extensive undermining of the abdominal skin, resulting in a loss of sensation. Recovery of protective sensibility generally requires between 6 months and 3 years.[12] During this period, the insensate skin is susceptible to trauma, and a burn could easily be sustained following prolonged contact with hot objects or sun exposure. There is no report bringing this particular complication to the attention of plastic surgeons, who should include precautions against the use of a heating pad or other hot object in their instructions to patients following abdominoplasty.

References

1. Floros C, Davis PKB. Complications and long-term results following abdominoplasty: a retrospective study. Br J Plast Surg 1991; 44:190–4.
2. Uchelen JH, Werker PMN, Kon M. Complications of abdominoplasty in 86 patients. Plast Reconstr Surg 2001;107:1869–73.
3. Zecha PJ. Pseudocyst formation after abdominoplasty. Br J Plast Surg 1999;52:500–2.
4. Liszka TG, Dellon LA, Manson PN. Iliohypogastric nerve entrapment following abdominoplasty. Plast Reconstr Surg 1994;93: 181–4.
5. Girardeau JT, Young VL. Massive scrotal edema as a complication of abdominoplasty. Plast Reconstr Surg 1985;76:626–9.
6. Lejour M. Burn of a reconstructed breast. Plast Reconstr Surg 1996;97:1306–7.
7. Kay AR, McGeorge D. Susceptibility of the insensate reconstructed breast to burn injury. Plast Reconstr Surg 1997;99:927.
8. Alexandrides IJ, Shestak KC, Noone RB. Thermal injuries following TRAM flap breast reconstruction. Ann Plast Surg 1997;38: 335–41.
9. Maxwell GP, Tornambe R. Second and third-degree burns as a complication in breast reconstruction. Ann Plast Surg 1989;22: 386–90.
10. Nahabedian MY, McGibbon BM. Thermal injuries in autogenous tissue breast reconstruction. Br J Plast Surg 1998;51:599–602.
11. Stevenson TR, Hammond DC, Keip D, Argenta LC. Heating pad burns in anesthetic skin. Ann Plast Surg 1985;15:73–5.
12. Shaw WW, Orringer JS, Ko CY, Ratto LL, Mersmann CA. The spontaneous return of sensibility in breasts reconstructed with autologous tissues. Plast Reconstr Surg 1997;99:394–9.

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Bilateral upper and lower lid fatty herniation: an unusual presentation of non-Hodgkin's lymphoma

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SUMMARY. We report the case of a patient presenting with eyelid hernias who required bilateral upper and lower blepharoplasty; histological examination of the excised fat revealed B-cell non-Hodgkin's lymphoma. At diagnosis,

the disease was already systemically advanced, but the pa
detected in the preoperative tests. The bilateral orbital present
accompanied and revealed by exophthalmos, increased tear
knowledge, this is the first case in which lid hernias were th

Keywords: lid hernia, lymphoma, blepharoplasty, orbit.

Case report

In October 2001, a 48-year-old man presented to our department for treatment of bilateral upper and lower eyelid hernias. He complained about the senile appearance of his orbital region and the sense of effort required to open the lids, particularly in the evening. He had suffered from glaucoma and conjunctivitis for many years, and had undergone two ophthalmic examinations, which had ruled out any contraindication to surgery of the lids.

The patient was a heavy smoker but had no other relevant history.

Physical examination revealed asymmetry of the face and of the two orbital regions. The orbital fat was herniated, causing bilateral swelling of the upper and lower lids, especially on the right. The overlying skin was flaccid, particularly at the lateral canthus, decreasing the palpebral fissure. Mild redness of the conjunctiva was present (Fig. 1).

Preoperative laboratory tests showed a slight increase in white blood cells. Blood and urine analysis were normal. An electrocardiogram and chest radiograph were also normal.

Under sedation, we performed a standard upper and lower blepharoplasty, excising the redundant skin and the fat bulging through the orbital septum, which appeared to be attenuated. The excised fat was red and hard, very different from the common soft yellow orbital fat (Fig. 2).

Because of the unusual nature of the fat, it was examined histologically. This showed a neoplasm composed of monoclonal B lymphocytes. The high proliferative index and the uniform centrocytic-like morphology were suggestive of a mantle-cell lymphoma, and this diagnosis was confirmed by the cyclin D1 overexpression observed on immunohistochemistry. Bone-marrow biopsy showed a massive infiltration (>75%) of lymphomatous cells.

NMR showed extensive bilateral involvement of the orbits (Fig. 3). A total-body CT scan showed systemic disease involving the mediastinal and abdominal nodes. The postoperative course was normal, and the stitches were removed 7 days after surgery.

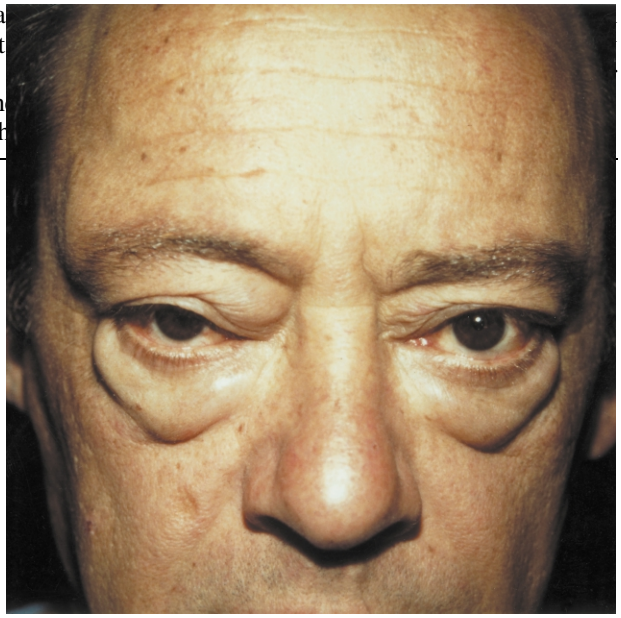

Figure 1—Preoperative appearance of the patient. The bilateral upper and lower lid hernias are evident. Exophthalmos is not present.

Discussion

The orbit is a rare site of secondary dissemination for systemic non-Hodgkin's lymphoma, being involved in only 5.3% (10/187) of cases, according to Bairey et al.[2] When affected, it is involved relatively late, at a mean of 30.5 months after diagnosis.[2] Bairey et al report only one patient (0.5%), 71 years old, with bilateral involvement, which became clinically evident about 46 months after the diagnosis of systemic lymphoma.

Lazzarino et al studied the characteristics of non-Hodgkin's lymphoma presenting in the orbit.[3] They report that the incidence of this clinical presentation is 2.5% (8/325 patients), and in their series 5/325 patients (1.5%) had clinically evident bilateral involvement, always accompanied by exophthalmos or conjunctival masses.[3] Other symptoms of orbital involvement are proptosis, increased tear formation, diplopia and decreased visual acuity.[1,3]

In our case, the patient was completely asymptomatic, and no exophthalmos, lymphadenopathy, cutaneous nodules or abdominal masses were detected during the preoperative physical examination. No haematological abnormalities were found in the preoperative tests. The appearance of the orbital regions caused by lid hernias

Figure 2—The fat herniated from the orbit was reddish and hard, very different from that commonly found during a blepharoplasty.

Figure 3—NMR shows lymphomatoid tissue invading the orbital fat, particularly on the left.

that both the patient and the surgeon attributed to facial aging and which were corrected by a blepharoplasty, was the first and only clinical sign of widespread B-cell lymphoma.

We found unusual histological features, compatible with mantle-cell lymphoma. The most frequent type of lymphoma with orbital involvement is the lymphoplasmocytoid subtype, as reported by Lazzarino et al.[3] Their eighth patient had an aggressive lymphoma with a diffuse centrocytic-like morphology, very similar to that in our case, which would probably, today, be classified as a mantle-cell lymphoma. It affected only the left orbit, while in our case the involvement was bilateral and synchronous.

References

1. Bairey O, Kremer I, Rakowsky E, Hadar H, Shaklai M. Orbital and adnexal involvement in non-Hodgkin's lymphoma. Cancer 1994; 73:2395–9.
2. Lazzarino M, Morra E, Rosso R, et al. Clinicopathologic and immunologic characteristics of non-Hodgkin's lymphomas presenting in the orbit. Cancer 1985;55:1907–12.
3. Shields CL, Shields JA, Carvalho C, Rundle P, Smith AF. Conjunctival lymphoid tumors. Clinical analysis of 117 cases and relationship to systemic lymphoma. Ophthalmology 2001;108:979–84.

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Mandatory bone scans for the assessment of extremity loss in meningococcal septicaemia?

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SUMMARY. Meningococcal septicaemia can cause progressive necrosis of skin, soft tissue and bone. Successful limb reconstruction following the disease depends on an accurate assessment of the viability of these tissues and on a multidisciplinary team approach to ensure optimal care. However, bone scanning is not commonly performed in these patients. We present a case of meningococcal septicaemia where bone scanning significantly altered the management by demonstrating an extensive area of bone necrosis proximal to the soft-tissue necrosis. In view of this finding, we propose that bone scanning should be considered in all cases of meningococcal septicaemia where there is tissue necrosis affecting a limb, and that the radiologist should be considered a vital member of the multidisciplinary team.

Keywords: meningococcal septicaemia, limb salvage, bone scan.