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Double capsule or capsule within a capsule: is there a difference?

Sir,
We were interested to read Pandya and Dickson's short report on a capsule within a capsule,[1] as we have recently published an article 'True double capsules in oil-based (Trilucent) breast implants'.[2] In both reports, cosmetic augmentation using textured implants was performed on young women with no immediate postoperative complications and, in each case, further surgery was performed within 2 years of the initial procedure. Pandya and Dickson suggest that the double capsules may be caused by the tightly adherent capsule-implant complex shearing from the breast tissue with vigorous movement, resulting in haematoma and subsequent organisation, and that 'irritation' causes seroma. We have suggested that implant bleed[3] (histology revealed that foreign material was present in both capsules) causes excessive irritation,[4] creating an inner capsule. Bleed through this capsule or irritation by the foreign material within it leads to the formation of an outer capsule adherent to the chest-wall cavity. There were only small amounts of seroma in both our cases and no organised haematoma. We do not think that the outer capsule splits from the inner one, and believe that the strands found connecting the capsules in one of our cases are adhesions rather than the vestiges of separation.

Yours faithfully,

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Metastatic malignant melanoma presenting with a bruise

Sir,
In May 2002, a 50-year-old female with known metastatic malignant melanoma presented to our plastic surgery outpatients clinic with a 5 cm × 3 cm bruise to the anterior chest (Fig. 1), centred under which was a subcutaneous nodule. A previous similar presentation had been attributed to unsuspected trauma.

The bruise and subcutaneous nodule were excised under local anaesthetic and examined histologically, revealing an extravasated pool of red blood cells and a haemorrhagic deposit of malignant melanoma, respectively. Her coagulation screen was normal and her medication was non-contributory.

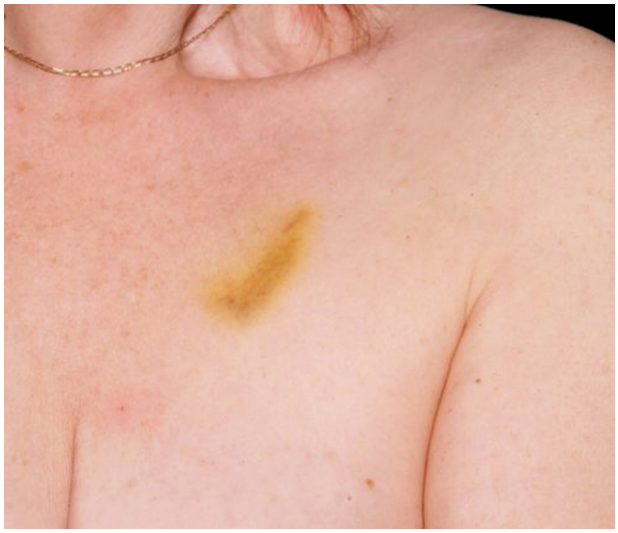

Figure 1—Chest-wall bruising.

Her primary tumour was a malignant melanoma of Breslow depth 5.1 mm, excised from the left cheek in 1998. A left cervical lymphadenectomy was performed in June 1999, and three of the nine biopsied nodes were positive. Her subsequent clinical course has been one of diffuse and rapidly recurring metastatic melanoma, with more than 17 documented positive excisional biopsies of metastatic disease to the cheek, eyelid, neck, breast, arm, thigh, chest wall, buttock and axilla. She has recently received radiotherapy for bony foot metastases. Her history also includes fibromyalgia and duodenitus.

Unlike haematological malignancies, which are associated with coagulopathy,[1] there are few reports of solid tumours or their metastases presenting with localised bruising. This is surprising given the need for all growing tumours to obtain a blood supply by angiogenesis or local-vessel co-option.[2] Bruising has been described in parathyroid adenomas,[3] orbital neuroblastoma[4] and neurofibromatosis,[5] but not in association with malignant melanoma.

Yours faithfully,

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