



Short reports and correspondence

Replantation of the great toe in a woman

Sir,

Unlike replantation of digits and the increasing number of toe-to-hand transplantations, the replantation of toes does not seem to be frequently performed.^{1–6} Moreover, the success rate of toe replantation is low,^{1,5} because the vessels are small in calibre, the interdigital space is small for arterial anastomosis and the reduced mobility of the vessel stumps makes anastomosis tedious.²

I successfully replanted the great toe in a 25-year-old woman (Fig. 1). In the first web space of the stump, the first lateral plantar digital artery (FLPDA) was chosen for arterial supply. To place the end of this artery in the most superficial location, the anterior perforating artery was ligated and divided. In the medial stump, the first medial plantar digital artery (FMPDA) and the medial plantar artery (MPA) were exposed as distally and proxi-



Figure 1—A 25-year-old woman with a crush injury to the dorsum of the right foot and a complete amputation of the right great toe.

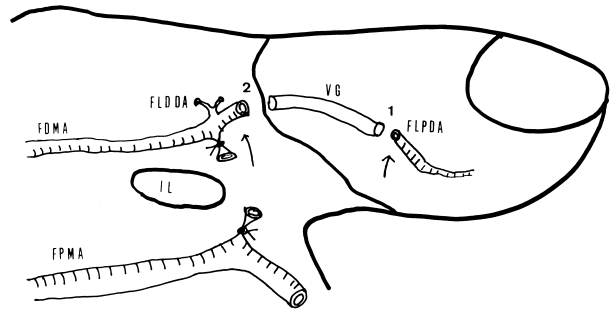


Figure 2—Schema of the arterial procedures in the web space. FDMA, first dorsal metatarsal artery; FPMA, first plantar metatarsal artery; FLDDA, first lateral dorsal digital artery; FLPDA, first lateral plantar digital artery; IL, intermetatarsal ligament; VG, interpositional vein graft. Numbers indicate the order in which the vessels were anastomosed.

mally as possible so that the stump of the artery could be anastomosed in the superficial plane. Two subcutaneous veins were isolated for venous drainage. In the amputated toe, the FLPDA and the FMPDA were exposed distally into the fatty tissue until they could be mobilised and placed superficially. Two subcutaneous veins were detected at the base of the nail matrix. The amputated toe was transfixed to the proximal stump through the metatarsophalangeal joint with a Kirschner wire, allowing a slight flexion of the interphalangeal joint. The ends of the flexor hallucis longus tendon were attached, and the extensor hallucis longus tendon of the amputated part was tied to the intact extensor hallucis brevis tendon in the proximal stump. While maintaining the widest possible interdigital space using a retractor, the lateral digital nerve was repaired. The FLPDA of the amputated toe was anastomosed to the FLPDA of the stump using an interpositional vein graft (1 and 2 in Fig. 2). For venous drainage, one of the subcutaneous veins of the amputated toe was anastomosed to one of the ends of the net-like vein graft. One of the ends of the net-like vein graft on the other side was sutured to one of the subcutaneous veins in the proximal stump. The flow of blood into the replanted great toe was confirmed and then the medial digital nerve in the medial portion of the great toe was repaired. The FMPDA and the MPA were anastomosed using an interpositional vein graft. Finally, on the dorsum of the great toe, the remaining subcutaneous veins were anastomosed.

The replanted toe healed well. The interphalangeal joint regained only 20° of flexion owing to adhesions; however, the active metatarsophalangeal joint motion was 40°. The static two-point discrimination on each side of the toe pulp was 15 mm, and the moving two-point discrimination was 13 mm. The patient was very satisfied with the appearance and function of the replanted great toe (Fig. 3).



Figure 3—Postoperative appearance at 16 months.

Yours faithfully,

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'Trapdoor' suture for facelift incision closure

Sir,
We read the short report of Ahmed and Ahmed's success with

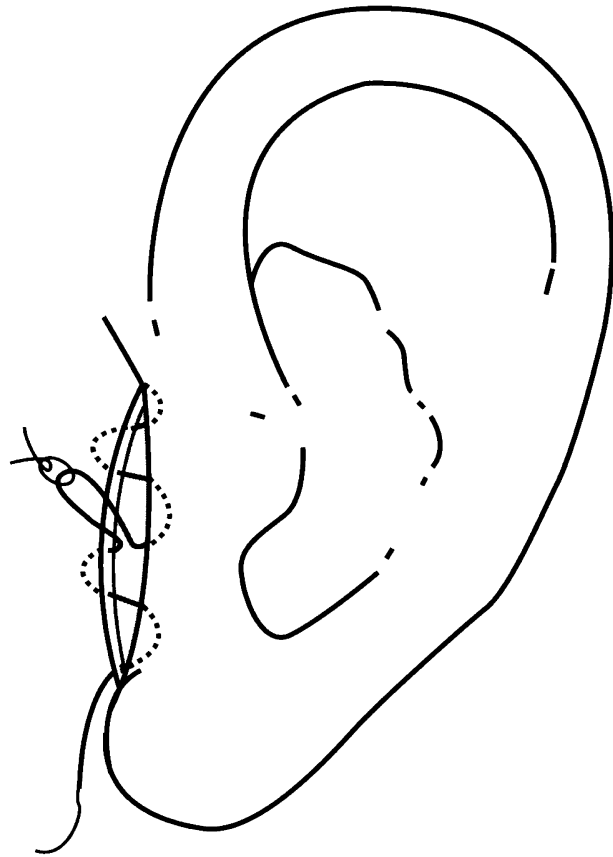


Figure 1—Schematic of the secondary 'trapdoor' suture's application around a standard subcuticular closure in preauricular closure of the facelift incision.

the 'recovery suture', which seems to have been beneficial in subcuticular closure of abdominal wounds, with great interest.¹ Coincidentally, we were in the process of preparing a report of a similar technique, which has been used successfully for a number of years in closure of the preauricular incision following a facelift. As the schematic (**Fig. 1**) shows a subcuticular closure is performed with 5/0 Prolene and the ends left long, but before being tightened, a loop of a smaller calibre suture, e.g. 6/0 Ethilon, is placed around the initial stitch and tied with the ends left slightly long. On tightening, the secondary suture is pulled into the wound leaving its ends protruding through the centre of the wound (**Fig. 2**). The purpose of this manoeuvre is evident in the presence of post-operative haematoma when traction of the smaller stitch delivers the subcuticular one allowing it to be loosened sufficient to allow egress of blood, and the ingress of a suction cannula, without having to return the patient to theatre for more formal evacuation and

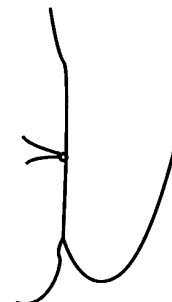


Figure 2—Final appearance of the two sutures demonstrating the readily available ends of the 'trapdoor' suture at wound closure.