'A close shave' – use of a disposable razor blade in the management of rhinophyma

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BACKGROUND

Rhinophyma is a common clinical problem, generally affecting older males. The treatment for rhinophyma is predominantly surgical. Conventional surgical methods utilise a scalpel, skin graft knife, carbon dioxide laser vaporisation,^{1,2} electrocautery, cryotherapy, or a combination of the above. We present a simple technique for the surgical management of rhinophyma using a disposable razor blade, an instrument readily available in every theatre suite. The technique is simple to perform, safe, effective and cost-effective.

Figure 1 Intra-operative photograph.

Figure 2 Appearance 2 weeks' postoperatively.

TECHNIQUE

It is the authors' own method and preference to use a cold excision technique, with a combination of scalpel dissection and a conventional disposable razor blade (Fig. 1). The disposable razor blade is an extremely useful adjunct to conventional techniques in creating a smooth finish and is convenient, readily available, quick and cost-effective. The disposable razor blades may be easily disinfected by soaking them first in aqueous betadine.

DISCUSSION

The disposable razor blade is excellent for refining the shape and re-contouring the nose. It is especially useful for areas that are difficult to mould and refine with the use of the scalpel, thereby achieving a better end aesthetic result (Fig. 2). It has the added advantage of conferring better depth judgement, allowing the rhinophymatous tissue to be excised in layers, thereby preventing inadvertent penetration into the underlying cartilage. The use of a scalpel and razor, in experienced hands and being extremely vigilant of the depth of tissue destruction can be very useful, cost effective, and convenient in the treatment of rhinophyma.

References

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Improved stone extractor in laparoscopic cholecystectomy

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BACKGROUND

Laparoscopic cholecystectomy is frequently complicated by stone spillage and retrieval of these stones is frequently complicated by injuries. Moreover, in laparoscopic choledocholithotomy, extracted stones from the bile duct are deliberately dropped inside the peritoneal cavity before removal. These stones have to be removed as they may lead to complications such as adhesions, obstruction, or intra-abdominal sepsis. Normally stones are removed individually either with a spoon forceps or collected in a retrieval bag through one of the wider ports. This is time-consuming and complicated by injury to omentum or gut. We have improvised a laparoscopic hand instrument which quickly and easily recovers scattered gall stones.

Figure 1 Materials required for preparing device.

Figure 2 The improvised device.

Figure 3 Line diagram of technique.

TECHNIQUE

The equipment (Fig. 1) consists of a 10-mm suction-irrigation pipe, Maelecot catheter (no. 30/32), and a small plastic container with air-tight cap. The stone picker (Fig. 2) is prepared as follows. With the help of the hot metal perforator, a small hole of ~3 mm (air vent) diameter is made in the cap of the plastic container. A second hole of ~10 mm diameter is made in the side wall. A small length of Maelecot catheter is used to connect the box to the 10-mm suction-irrigation pipe. The air vent is closed

with the right index finger and the system is inserted through the 10-mm (internal diameter) cannula (Fig. 3). Its tip should be placed near the stone to be extracted. The air vent is opened. As the intra-abdominal pressure (10–12 mmHg) is high, there is a gush of air through the cannula which takes the stone out. With this technique, stones less than 10 mm in diameter can be vented out. Larger stones are crushed and then they can be dealt with similarly. This whole set-up can be sterilised 2% glutaraldehyde or in a formalin chamber.

DISCUSSION

The instrument has been used in 50 cases from July 2002. Eleven cases had larger stones which had to be crushed before retrieval. Thus, the instrument and its application has proved to be simple, easy, economic and technically faster in recovery of intra-abdominal scattered gall stones.

'Mercedes' incision – another oncoplastic technique for the excision of breast tumours

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BACKGROUND

Oncologically safe treatment of selected neoplasms of the breast can be achieved with conservative surgery and radiotherapy. Peri-areolar tumours can be particularly cosmetically challenging, with the risk of nipple deviation and breast shape change.¹ The 'Mercedes' incision minimises these deformities.

TECHNIQUE

The incision is centred on the tumour as a concaved isosceles triangle, the base of which is formed along the circumferential border of the areola (Fig. 1), facilitating areolar elevation for dissection deep to the nipple. The tumour, with a margin of normal tissue, is excised in continuity with a triangular island of skin superficially. The skin is closed by apposing each side of the triangle and using a standard 'corner stitch' fixing all three sides of the defect centrally. The needle is passed through the skin edge from superficial to deep on one of the radial components of the wound. The areolar flap is then inverted, and a bite of sub-cuticular tissue incorporated from the underside of this flap. A third bite is made from deep to superficial through the remaining radial edge, and then a large bite is taken from side to side of the radial section,