simple and cost effective method that can be considered in any situation where protruding metalwork is present.

Minimally invasive open thyroid surgery combined with facelift approach for the surgical management of metastatic papillary thyroid carcinoma

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BACKGROUND

The surgical management of metastatic papillary thyroid carcinoma involving total thyroidectomy and neck dissection can be achieved with two distinct techniques: the conventional approach requiring a longitudinal neck incision (collar incision) extending between the posterior borders of the two sternocleidomastoids and minimally invasive video assisted thyroid surgery (either robotic or endoscopically assisted), which requires appropriately equipped units.¹ We report a new strategy for the surgical management of thyroid cancer with neck metastasis that involves a combination of the minimally invasive open thyroid surgery (MIOTS) technique and a facelift approach. To our knowledge, this technique has not been published by any other unit.

TECHNIQUE

Through the facelift approach (Fig 1), levels II, III and V (ipsilateral) are accessed while through the MIOTS approach (Fig 2), level IV (left and right), level VI and the thyroid are accessed. Depending on the levels requiring clearance, a second facelift approach can be developed on the

Figure 2 Minimally invasive open thyroid surgical approach

opposite side. The operative time is approximately 180 minutes and the patient is usually discharged after 72 hours. The 2014–2015 reference cost to the trust for total thyroidectomy and bilateral neck dissection was £8,006.²

DISCUSSION

The combined surgical approach described does not require expensive surgical equipment, has a good cosmetic result, provides the maximum surgical outcome required for an oncological procedure and benefits the trust financially. We believe that it is a good alternative to the rapidly developing robotic/endoscopically assisted thyroid surgery, which is much more expensive (£21,117 in 2014–2015),² requires more time and training, and has a longer recovery time.^{3–5}

References

1. Dordea M, Aspinall SR. Short and long-term cosmesis of cervical thyroidectomy scars. *Ann R Coll Surg Engl* 2016; **98**: 11–17.
2. NHS Reference Costs 2014 to 2015. GOV.UK. <http://www.gov.uk/government/publications/nhs-reference-costs-2014-to-2015> (cited April 2016).
3. Henry JF, Thakur A. Minimal access surgery – thyroid and parathyroid. *Indian J Surg Oncol* 2010; **1**: 200–206.
4. Kang SW, Chung WY. Transaxillary single-incision robotic neck dissection for metastatic thyroid cancer. *Gland Surg* 2015; **4**: 388–396.
5. Cabot JC, Lee CR, Brunaud L *et al*. Robotic and endoscopic transaxillary thyroidectomies may be cost prohibitive when compared to standard cervical thyroidectomy: a cost analysis. *Surgery* 2012; **152**: 1,016–1,024.

Figure 1 Left facelift approach (preauricular and postauricular)

A novel and bespoke absorbable cement restrictor

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BACKGROUND

Cement restrictors are used for maintaining good filling and pressurisation of bone cement during hip and knee arthroplasty. We describe a technique using Surgicel® (Ethicon, Somerville, NJ, US) and