downward pointing curved lines are drawn, with the superior curve crossing the breast just above the areola and the inferior line on the inframammary fold (Figs 1 and 2). The area between the curves will form a crescent containing the nipple–areola complex, with both tips pointing upwards. The mastectomy can be performed through this area. The shape of the scar with the direction change results in elimination of the excess skin.

DISCUSSION

Several techniques have been described to avoid dog ears, such as the ‘fish-tail’,¹ the ‘tear-drop’² and lateral-superior extension.³ These techniques are successful but produce unhelpful scars in immediate or delayed reconstruction (Fig 3). The curved long superior flap technique keeps the scar as low as possible while simultaneously removing excess skin. Although not novel, we believe that this technique is superior in terms of scar placement, reconstruction suitability and cosmesis.

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An alternative technique for optimal exposure of the pericardium in cardiac surgery

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Cardiac exposure with multiple heavy silk sutures passed through the edges of the opened pericardium can be cumbersome and time consuming, and sutures may cut through fragile pericardium. We apply Roberts forceps to four corners of the opened pericardium (Fig 1), remove the sternal retractor, and then retract the Roberts forceps upwards and outwards over the chest wall under tension. The sternal retractor is reinserted with the Roberts forceps still in situ and is progressively opened, ‘sandwiching’ the pericardium between the sternal edge and the retractor (Fig 2). The Roberts forceps are then removed. This provides excellent visualisation of the intrapericardial structures and is particularly suitable for trainees.

Figure 1 Roberts forceps (arrows) are applied to four corners of the pericardium.

Figure 2 The pericardial edges are elevated and ‘sandwiched’ between the sternal edge and retractor.