Technical Section [TECHNICAL NOTES AND TIPS

The inferior dermal flap technique for trans male chest contouring

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BACKGROUND

Published research shows masculinising chest contouring surgery to be associated with improved body image and symptoms of gender dysphoria in trans male individuals.^{1,2} Periareolar and free nipple grafts are the more commonly performed surgical techniques. A less common albeit established technique is the inferior dermal flap (the 'buttonhole' technique).

Figure 1 Patient marking and positioning

Figure 2 De-epithelialisation of inferior dermal flap

Figure 3 Dissection of dermal flap from breast parenchyma

Figure 4 Nipple delivered via 'buttonhole'

Figure 5 Early postoperative results

TECHNIQUE

The required skin excision is marked preoperatively in the standing position. For the procedure, the patient is positioned supine. The arms are abducted and secured so the patient can be sat up intraoperatively (Fig 1).

The areola is reduced, the inferior dermal flap de-epithelialised (Fig 2) and the mastectomy performed, at the level of the gland. The dermal flap is dissected from the parenchyma, retaining a thin layer of subdermal fat including the deep dermal vascular plexus (Fig 3).

The wounds are closed in the dermal and subcuticular planes using 2/0 Vicryl® (Ethicon, Somerville, NJ, US) and 3/0 Monocryl® (Ethicon). The patient is sat up and the new nipple position selected. A ‘button-hole’ is created for the nipple (Fig 4) and this is sutured with a subcuticular, continuous, periareolar suture (4/0 Monocryl®).

DISCUSSION

The utility of a periareolar approach is limited by the required amount of skin and tissue to be resected. At many institutions, the alternative for moderate to large breasts is mastectomy with a free nipple graft. This renders the nipple insensate and liable to depigmentation.

The technique described above is suitable for excisions up to 700g. It maintains nipple sensation and erectile function in >70% of cases (unit data) while still resulting in a masculine chest (Fig 5).

References

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2. McNeil J, Bailey L, Ellis S *et al.* *Trans Mental Health Study 2012*. Edinburgh: Scottish Transgender Alliance; 2012.

Real time ultrasound guided insertion of Veress needle in obese patients

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BACKGROUND

Creation of pneumoperitoneum is the first step in laparoscopy and is often done blindly using a Veress needle. Although generally safe, this technique may be associated with life threatening complications such as injury to bowel and intra-abdominal vessels, especially in obese patients.^{1–3} We describe a simple technique of ultrasound guided visual insertion of a Veress needle.

TECHNIQUE

The stomach is decompressed by an orogastric tube. The ultrasonography probe is tilted, rotated or both to improve visualisation of the three layers of the abdominal wall (Fig 1). With an oblique orientation on the abdominal wall, the muscle planes are identified and the Veress needle is inserted. (We use Palmer’s point for insertion (Fig 2).) The progression of the needle is assessed by

Figure 1 The layers of the abdominal wall are well visualised even in morbid obese patients using real time ultrasonography

Figure 2 Palmer’s point is our preferred site for Veress needle insertion, lying two fingerbreadths below the left subcostal margin in the midclavicular line

Figure 3 The path of the Veress needle (arrow) is visualised using real time ultrasonography