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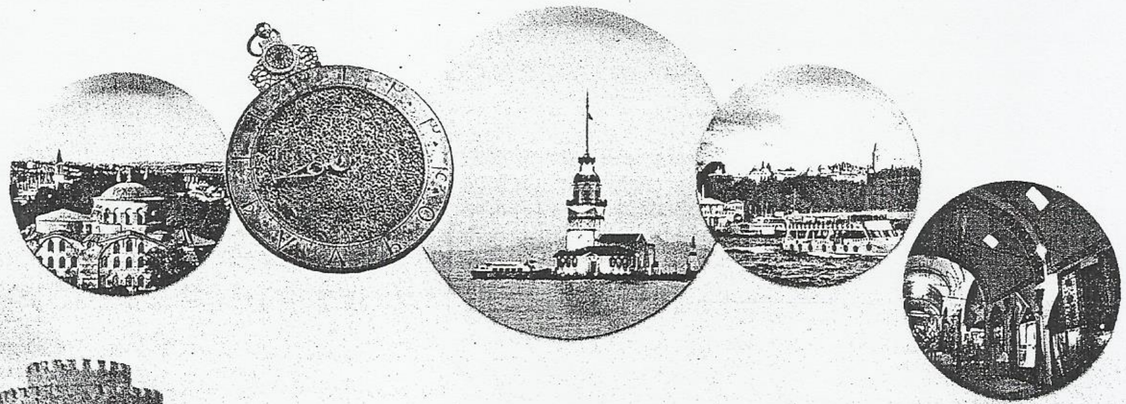

Program & Abstract Book

pressure and silicone are needed to manage hypertrophic scars on challenging and contracture prone anatomic locations.

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OUR APPROACHES FOR PRESERVING COSMETIC AND FUNCTIONAL RESULTS OF GENITAL DEFECT REPAIR

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Introduction: Skin loss is one of the most common problems that can cause anatomic and functional problems. Genital defects usually occur subsequent to flame, hot water or chemical burn, trauma or tumor resections. There are a variety of repair methods using primary suture, skin grafting, flaps in genital skin defects. In this paper, we present anatomical and functional results of alternative repair methods that we performed due to genital defects.

Material and Method: In this study 38 cases (21 males, 17 females, mean age 17.8 years; range 2 to 64 years) with genital defects were evaluated who applied to the burn unit of the Department of Plastic Reconstructive and Esthetic Surgery of Dicle University between March 2007 and December 2009. There were scrotal defect in 6 cases, medial thigh defect in 14 cases, gluteal defect in 10 cases, perineal defect in 6 cases, and penile defect in 2 cases.

Results: Thigh and gluteal defects were repaired with partial-thickness skin grafts, scrotal defects with full-thickness skin grafts, local flaps and Singapore flap, proximal penile defect was repaired with full-thickness skin graft, and distal corpus of the penile defect with preputial flap. In the areas that move full-thickness skin grafts or local flap alternatives were preferred. Satisfactory results were seen in the short- and long-term follow-ups.

Conclusion: Genital regions are among the affected areas especially in cases such as large burn. Skin or soft tissue loss in genital region is one of the conditions resulting in both functional and anatomic problems in patients. Another issue is that, since this region is close to the anal channel, it is exposed to contamination. The most common late complications of genital defects are perineal and genital contractures. Although full-thickness skin grafts are preferred in order to minimize the complications, this alternative also carries the risk of contraction. Ideally, flaps that have less chance of contraction or full-thickness skin grafts should be preferred among surgical alternatives.

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LIMITATIONS OF RUNNING Y-V PLASTY IN RELEASING BURN SCAR CONTRACTURE

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Background: Many approaches to the release of burn contracture have been described, every of which offers some advantages for the treatment of burn contractures, but they have some limitations in surgery affecting their indications and outcomes. In this study, difficulties with running y-v plasty are tried to describe after the experience of 21 patients treated by using this technique.

Methods: This study included 21 patients who had burn scar contracture placed either one anatomical area such as neck, shoulder, axilla, antecubital area, wrist, forearm, leg, ankle and popliteal area; or more than one anatomical area such as cervicopectoral area, axillodeltoid area, upper extremity from wrist to arm, and lower extremity from ankle to poplitea. Preoperatively, for marking the flaps, a zig-zag line of which angles were kept in the range of 60-90° was drawn over the contracture line. In the operation, incision was firstly made only into the skin to avoid retraction of the flaps which might deform the skin marking, and then deepen through the fascia, making advancement of the V flap in the way of sliding easy. V flap was advanced as possible as along the long limb of the Y on the base of subcutaneous pedicle. After meticulous hemostasis, all incisions were sutured.

Results: In most of the patients, successful release of the contracture was achieved without any complication and recurrence in the follow up period. However; in a few cases some challenging problems developed either in the operation or early or late postoperative period, suggesting possible limitations of the running Y-V plasty procedure. In two cases, V's tip necrosis was occurred, but healed uneventfully within 1 month after debridement of the dry eschar. In another patient, V flaps were insufficient to cover the antecubital defect area after releasing the contracture, then skin grafting required. One cervical contracture relapsed at about one year later the surgery, and needed reoperation. Also in two patients, for three joints, wrist, elbow and ankle, undermining of the distal V flap was necessary to advent sufficiently the V flap into the Y incision. Significant skin wrinkles were also observed at the dorsal surface of the hand in one patient who had severe upper extremity scar contracture.

Conclusions: When considering running Y-V plasty for the release of contracture, knowing of its difficulties will help and facilitate selection of the cases suitable for the procedure to achieve successful results and avoid possible complications.