



Figure 1 Patient with perforated earlobe after prolonged use of topical corticosteroid.

restrictive OTC marketing authorisation.³ Clinicians should be aware of the increased potential for adverse effects as a result of patients self-medicating with hydrocortisone for an extended period.

Summary

We present a case in which the prolonged application of topical corticosteroid resulted in an earlobe perforation. This is the first time, to our knowledge this complication has been reported in the literature. The patient applied the topical steroid for a period of 24 months to treat an area of contact dermatitis, without continued medical supervision. This highlights the importance of clinicians being aware of the increased potential for adverse side effects as a result of patients self-medicating with steroid creams.

References

1. Boo-Chai K. The cleft earlobe. *Plast Reconstr Surg* 1961;28:681–8.
2. McLaren LR. Cleft earlobes: a hazard of wearing earrings. *Br J Plast Surg* 1954;7:162.
3. Rogers PJ, Wood SM, Garret EL, et al. Use of non-prescription topical steroids: patients' experiences. *Br J Dermatol* 2005; 152:1103–98.

F.J. Rogge
M.D. Pacifico
A.O. Grobbelaar,
Mount Vernon Hospital,
Department of Plastic and Reconstructive Surgery,
Northwood, Middlesex, UK
E-mail address: fabrice.rogge@skynet.be

© 2006 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.

doi:10.1016/j.bjps.2006.05.016

Microvascular anastomosis: is there a role for robotic surgery?

Surgical robots have been used in several clinical applications, especially in laparoscopic surgery. Recently the first experimental microvascular surgery was performed in a pig using the da Vinci Surgical System (Intuitive Surgical, Inc, Sunnyvale, US).¹ This system consists of a three-dimensional stereoscopic vision system with three robotic slave arms. The instruments have 3 degrees of freedom and are controlled by the surgeon from a console (Fig. 1). We would like to share our first clinical experience with the robot in microvascular surgery.



Figure 1 Surgeon operating behind console.

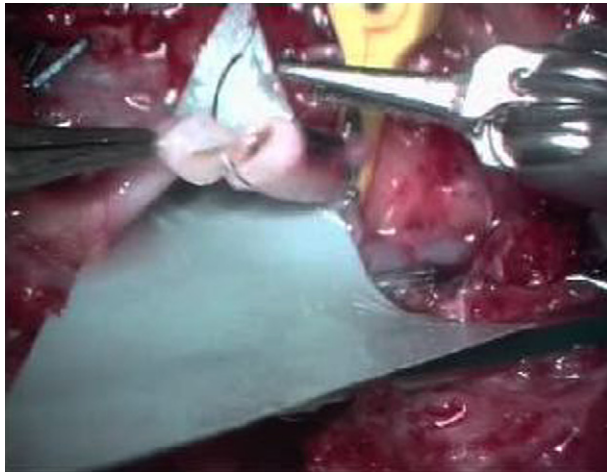


Figure 2 Intraoperative view of microvascular anastomosis performed using the robotic system.

A 58-year-old woman underwent a breast reconstruction with a muscle sparing free TRAM-flap. The deep inferior epigastric vein was connected to the mammary vein using standard microsurgical techniques. After performing the venous anastomosis the robot was installed and the primary surgeon took place at the console. An assisting surgeon stayed, together with the nurse next to the patient. Subsequently the arterial adventectomy and anastomosis was performed using 9/0 nylon sutures (Fig. 2). The time to perform this anastomosis was about 40 min and significantly longer than the standard technique (around 15 min). To put a sterile draping around the robot took 20 min, but was performed during dissection of the flap.

The theoretical advantages of performing robotic surgery, minimalization of tremor and scaling of movement, were not yet translated into a clear advantage e.g. decreased operating time. However, learning microvascular robotic surgery appears to go very fast and we have the impression that standard times can be achieved with more experience. Applications could be found in microsurgery in areas difficult to assess, or with limited space. In addition, developments in optics, mechanics and software may have important impact on the future development of supermicrosurgery.

Reference

1. Katz RD, Rosson GD, Taylor JA, et al. Robotics in microsurgery: use of a surgical robot to perform a free flap in a pig. *Microsurgery* 2005;25:566.

Rene van der Hulst
John Sawor
Nicolle Bouvy

University Hospital Maastricht, P. Debeyelaan 25,
6229 HX Maastricht, The Netherlands
E-mail address: rene2002@home.nl

© 2006 The British Association of Plastic Surgeons. Published by Elsevier Ltd. All rights reserved.

doi:10.1016/j.bjps.2006.05.011

An alternative device for illuminated retraction in augmentation mammoplasty

A standard disposable sterile laryngoscope blade may be attached to a handle covered by a sterile glove which is secured using steristrips. As such it may act as a useful alternative to a lit retractor for illumination in breast augmentation surgery (Fig. 1). It proves more lightweight and less cumbersome than the lit retractor connected to fibre optic cabling; in addition,

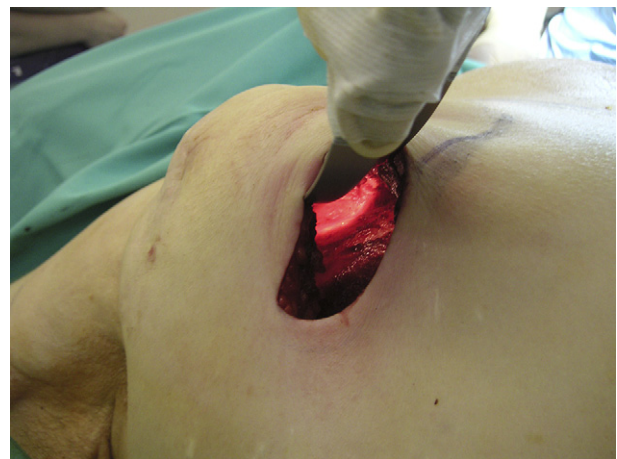


Figure 1 The assembled device as an illuminating retractor to aid in breast pocket dissection and haemostasis.

it provides a useful readily available option in the case of equipment malfunction or accidental perioperative decontamination. We have found that the handling of this device superior to the lit retractor, and its lighting capability as good. The equipment may be prepared rapidly and without difficulty.

Nadim Gulamhuseinwala
Victoria Rose
Department of Plastic Surgery,
St Thomas' Hospital, London, UK

© 2006 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.

doi:10.1016/j.bjps.2006.04.022