A simple trick to excise the carpal bones during proximal row carpectomy

Sir,

Proximal row carpectomy (PRC) is a common surgery done in the hand surgery practice. It involves excising the scaphoid, lunate and triquetrum bones. It is a common motion preserving operation done in conditions such as scapholunate advanced collapse (wrist), instability of the wrist, scaphoid non-union advanced collapse (wrist), Kienbock’s disease and as a part of total wrist fusion in conditions such as rheumatoid arthritis.

It remains one of the time-tested surgeries, which is quick, simple and effective with early return to activities for the patient. Its effectiveness has been proven in many long-term studies.[1] However, Green quoted, “PRC is not an elegant operation.”[2] Truly so, as the piecemeal excision of the carpal bones which is commonly practiced is not elegant. It is time-consuming, there is chance of leaving some bone chips behind and the removal of the most volar part of the lunate and scaphoid can be very difficult.

Having faced these difficulties, we started using “Schanz pin” as a joystick to manipulate the carpal bones and help in easy excision of the carpal bones. Schanz pin is easily available instrument in all the operation theatres; therefore, no special instruments are required.

Operative technique – The wrist joint is opened by a standard dorsal approach. The capitate and the lunate articular surface of the radius are inspected to confirm the possibility of PRC. The scapholunate and lunotriquetral ligaments are excised. The dorsal cortex of the lunate is first nibbled to expose cancellous bone, and then a 3 mm Schanz pin is passed into the lunate. The pin should be directed toward the body of the lunate to avoid damage to the articular surface of the capitate. The Schanz pin is used to manipulate the lunate and release all its soft-tissue attachments allowing it to be excised as a single piece [Figure 1a]. Similarly, the Schanz pin is put in the triquetrum and scaphoid and both the bones are excised in a single piece making the surgery elegant, easy and fast [Figure 1b]. We observed a reduction in operative time of 10–15 min when using this technique as opposed to the piecemeal excision.

PRC is a commonly performed and time tested surgical technique for various wrist pathologies. The simple technical tip described here not only makes the surgery easy and quick but also makes it look elegant!

Hence, we report this small technical tip for wider use.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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Figure 1: (a) Schanz pin in place in the carpal bone which is being manipulated to cut all the soft-tissue attachments around it. (b) The whole scaphoid has been excised as a single piece
Sir,

Gynaecomastia is a complex benign condition characterised by enlargement of male breasts affecting mainly the young population. It can be caused by hypertrophy of the ductal tissue, stroma and/or fat. Surgery remains the mainstay of the management. It can be managed by direct excision, liposuction, combination of direct excision and liposuction. According to the literature, the overall complication rate for gynaecomastia surgery is 15.5% with the highest rate in Grade 1 patients. The reported complications are seroma, minor bleeding, skin dehiscence, wound infection and haematoma necessitating evacuation in operation theatre. Drain placement is routine after liposuction of severe gynaecomastia. This is achieved blindly and forcefully with the help of an artery forceps. This may cause injury to the skin or underlying muscle. The famous surgeon, Illouz, published his ten commandments for liposuction in 1989. The pertinent points were (1) surgeon should use only small blunt cannulas and (2) the technique demands blind surgery which reiterates the experience surgeon should have. Inspired from these principles we developed an atraumatic method to insert the drain after the liposuction. The steps are as follows:

• Step 1 [Figure 1] – Take a fine blunt infiltration cannula and the drain going to be inserted
• Step 2 [Figure 1] – Make a hole on the surface of drain tube with the help of No. 11 blade
• Step 3 [Figure 2] – Insert the infiltrating cannula into the drain tube

How to cite this article: Altaf W, Bhardwaj P, Sabapathy SR, Haseeb BA. A simple trick to excise the carpal bones during proximal row carpectomy. Indian J Plast Surg 2018;51:101-2.

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