Camphor burns over the forehead: Socially relevant non-homicidal injury in a child

Sir,
We reported camphor burns over the palm, seen mainly in Indian population due to religious practices.[1] We would like to share another interesting case of same aetiology, which is not been reported.

Child abuse and homicidal attack are not an unknown event. Homicidal injury may be associated with psychiatric illness;[2] sometimes, children may become a victim of non-homicidal injury induced by their relatives because of illiteracy or false beliefs. Here, we would like
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to share a non-homicidal injury inflicted by parents over the forehead of a 1-year-old child in an attempt to treat a seizure disorder, the child was suffering with. We also want to highlight the need of psychosocial therapeutic effort for such victims. Camphor burns of the hand has been described in literature as a self-inflicted non-suicidal injury.[3]

A 6-year-old, female child was brought to us by parents with complaints of a large unsightly scar over the forehead. The child was a known case of seizure disorder since 8 months of age. Detailed history revealed that, according to the religious belief of their society, burning camphor over forehead can cure mental illness.

On examination, a 3.5 cm × 3.5 cm well-defined, circular and healed, hypo-plastic scar over the centre of forehead with hypopigmented patches [Figure 1] was noticed. The surgery was challenging as the scar was located in the centre of forehead with the potential risk of distortion of other subunits. Informed consent was taken, and she was planned for serial excision of the scar. Parents were given psychosocial counselling. The patient had undergone serial excision and significant reduction of scar was noticed after the 1st and 2nd excisions [Figures 2 and 3].

We would like to report this case as no such case report is found on internet search. Such injury has caused a great impact on the child socially, emotionally and cosmetically. Social awareness of such conditions is must to prevent long-term morbidity and possible mortality.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest
There are no conflicts of interest.

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Sir,

We wish to present a unique case of total oesophageal reconstruction using tubed skin and myocutaneous flaps, performed in 1989 by the senior authors. The patient was symptom-free, feeding satisfactorily and socially well rehabilitated for the past 25 years. This case was brought to our attention while he presented with a small fistula below the original pharyngostomy site following active pulmonary tuberculosis.

Twenty-five years back, this patient had sustained extensive corrosive stricture of the oesophagus [Figure 1]. A colon transfer had failed and he was being managed with a pharyngostomy and feeding gastrostomy. Once the general condition of the patient was stabilised, he was subjected to a multistage segmental neo-oesophageal reconstruction that took a year to complete. Upper third of the neo-oesophagus was reconstructed with a reversed, tubed deltopectoral flap which was tunnelled subcutaneously into the cervical region and anastomosed to the pharyngostoma. Flap donor site was skin grafted. The middle third of neo-oesophagus was constructed with a reversed, tubed pectoralis major myocutaneous flap. Subsequently, skin of the lower chest wall was fashioned into a Gillies tube pedicle flap and connected to the remnant of transferred colon [Figure 2]. An average interval of 3 months was maintained between each stage of the reconstruction.

The flaps were meticulously planned to give the widest possible lumen, and precautions were taken to avoid strictures at the anastomotic sites. Following the release of a minor synechia at the proximal anastomosis, the patient started feeding adequately. The patient was then followed up with barium swallows and the conduit appeared smooth and strictureless [Figure 3]. Since the neo-oesophagus lacked peristalsis, the patient was propelling the swallowed food forwards with a gentle massage, aided by gravity. Except for a minimal redundancy of the tubed conduit, he was symptom-free and feeding adequately till the development of the fistula. He has completed antituberculous drug therapy and undergone an oesophagoscopy with dilatation of a minor inflammatory stricture around the fistulous tract. However, the fistulous tract persisted and a subsequent biopsy revealed a well-differentiated squamous cell carcinoma. The patient has now undergone a resection of the involved segment followed by chemoradiation [Figure 4].

A literature search from 1980s to 1990s showed that four types of pharyngo-oesophageal reconstructions were employed at that time, namely, (1) subcutaneous or intrathoracic interposition or migration of alimentary tract, either stomach or colon, (2) free flaps of jejunum or colon, (3) local or regional skin flaps and (4) free skin grafts. [1]

Wherever facilities for microvascular surgery exists, a free jejunal interposition flap is considered to be the best reconstructive option. [1-4] However, salvage reconstruction of neo-oesophagus with skin and myocutaneous flap still