Spongostan Used as a Carrier for Diced Cartilages in Rhinoplasties

To the Editor:

Diced cartilages are used for the contour restoration of nasal dorsum in rhinoplasties. They are wrapped with oxidized cellulose (Surgicel) or fascia to hold them together and to shape them. Decomposition of diced cartilages while placing them onto the nose is the essential problem. Hardening of cartilage is a very important point in the process to place it straight onto the nose. Venous blood or fibrin glue may be used to achieve this purpose. Venous blood is added drop by drop to the wrapped diced cartilages. Diced cartilages are attached together by clotted fibrins. But this is not enough to harden them. Using manufactured fibrin glue can shape diced cartilages irreversibly, and the surgeon may not approve of the shape.

In 30 nasoplasty cases practiced in our clinic in 2003–2005, Spongostan (hemostatic sponge) was used to mold diced cartilages instead of Surgicel. It was carved easily in desired sizes by using a blade no. 12 (Fig. 1). The carved area was filled with diced cartilages (Fig. 2). The open side of the carrier was closed with a chip of Spongostan. Just before the insertion, the material was reduced to the desired size by pressing with fingers. Spongostan has many advantages over Surgicel:

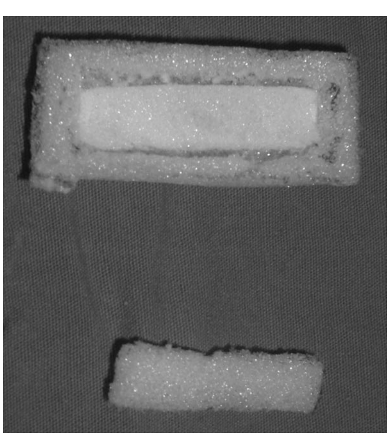

FIGURE 1. Carved spongostan and a chip of spongostan.

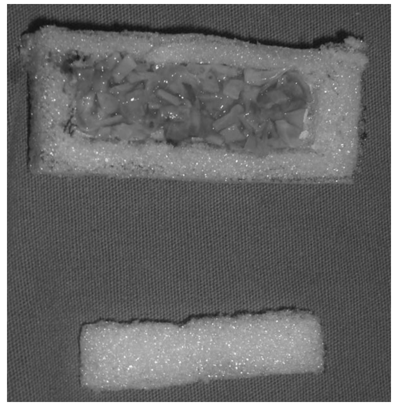

FIGURE 2. Filling of the carved area with diced cartilages.

1. It is approximately 7 times cheaper than Surgicel.
2. It does not need venous blood or other glue for stabilization.
3. Desired amounts can be adjusted more successfully.
4. Diced cartilages do not spread when they are carried in Spongostan.
5. Its stability time is longer than Surgicel. Surgicel is fully absorbed in 7–14 days, while Spongostan is absorbed in 3–5 weeks.
6. Spongostan's stability is enough to support wrapped diced cartilages.

Any kind of infection, volume loss, allergic or foreign body reaction, and deformity was not seen after operation during at least 1 year of follow-up. Spongostan is a cheap and more stable carrier for diced cartilages.

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Vascular Anatomy of the Lateral Pterygoid Muscle

To the Editor:

Lateral pterygoid muscle is among the muscles of mastication. It has got 2 heads that originate from the lateral lamina of the pterygoid process of the sphenoid bone and greater wing of the sphenoid bone subsequently. Both of these parts insert into the fovea pterygoidea on the coronoid process of the mandible and temporomandibular disc.[1] It is innervated by lateral and medial pterygoid nerves.[2] It protrudes the mandible anteriorly when contracted. Although this information could be found in any textbook of anatomy, there is little known about the vascular supply of lateral pterygoid muscle. In a cadaver study that we have carried out for a different purpose, we have noticed the vascular branches from the maxillary artery to the lateral pterygoid muscle during dissection. The maxillary artery was filled with red latex before dissection and branches to the lateral pterygoid muscle were dissected in 5 of the cadavers. There were 2 or 3 branches to the lateral pterygoid muscle from the maxillary artery. These branches were entering the muscle at the middle of the muscle belly. The greatest of these branches arise just behind the subcondyle of the mandible (Fig. 1). In this position, the branch is prone to injury during the internal fixation of the subcondylar fractures. Although we did not carry out a more detailed and systematical study of the vascular anatomy of the lateral pterygoid muscle, we hope that this short paper will add initial information to the literature about the vascular anatomy of the lateral pterygoid muscle and promote more detailed studies.

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FIGURE 1. Vascular supply of the lateral pterygoid muscle. Black arrowhead and periosteal elevator indicate the branch from the maxillary artery. Subcondylar region of the mandible has been removed.

Postobese Patients and Inherent Surgical Complications

To the Editor:

Sanger and David[1] recently outlined an important issue in their article. Obese patients often undergo significant complications following surgery, mainly wound and respiratory infections. The elevated insulin resistance, the direct suppressive effect on the immune system exerted by their peculiar metabolism, the reduced wound repair activity derived by hypercortisolism, and many other factors are involved in this process. The devastating effects of these alterations are typically seen in all types of surgery. In our burn center, for example, we observed that obese patients had an increased percentage of grafts loss and a rate of inconsistent direct wound closures higher than normal (Fig. 1).

FIGURE 1. Fifty-four-year-old burned female with body mass index 31.2 kg/m^2 and 20% total burn surface area (all deep partial-thickness burns). Left breast, 12 days after primary wound closure attempt. Presence of secretions.

Postobese patients are increasing in number either because the incidence of morbid obesity in modern western societies is growing or because bariatric surgery is becoming less invasive and with less complications than in the past. Some authors demonstrated that metabolic derangements, such as insulin requirements or cholesterol blood values, often set back following bariatric surgery and weight loss stabilization.[2] However, what is new and interesting in the article of Sanger and David[1] is that the adverse condition predisposing to postoperative complications seems not to reverse. Their study in fact outlines that postobese patients undergoing body contouring surgery have a persistent increased postoperative risk if compared with the normal population. We also noticed it in our departments during body-contouring operations following bariatric surgery. All patients required more than 2 operations to achieve a final esthetic acceptable appearance; many of them had wound infections in at least 1 operation, even with the best local wound care.

This raises few questions. If this condition is not reversible, what are the causes? And most important, how can it be dealt with? We believe that pathophysiology of obesity, and in particular of marked weight loss in a short period of time, should be better investigated and would provide some answers. This is in fact a relatively new condition that derived during the last years from the massive development and employment of bariatric surgery. A better understanding of its metabolic modifications could give new insights and open the way to more rational approaches for these patients.

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