
To the Editor:

We read Noaman’s article with interest. We agree that degloving of digits remains a challenge in reconstructive surgery. When replantation is not possible, alternative techniques have been advocated for soft tissue coverage. Distal pedicle flaps taken from the groin or the abdomen have been used in the past, with poor results both aesthetically and functionally.

In 1995, we published, as did others, articles on the use of a distally based radial forearm flap to treat degloved fingers. Despite the use of a radial forearm flap with its cutaneous nerve supply, there was little recovery of sensibility in the reconstructed finger, and the aesthetic results were always unsatisfactory. In Noaman’s Figures 2 and 3, the reconstructed ring finger appears bulky. Moreover, the mature donor site is highly visible. This is the frequent outcome when the forearm skin cannot be closed directly.

We are impressed to hear of the recovery the sensibility obtained in 16 of the 26 patients to less than 10 mm of static 2-point discrimination. We believe that a radial fascial flap provides thin, pliable, and vascularized tissue that allows for free gliding of tendons and easy mobilization of joints, with acceptable aesthetic results and, above all, a pleasing donor site result.

We wonder why the author decided to salvage the nail during the operation, yet the final result shows the ring finger without the distal phalanx. We contend that the best treatment for ring degloving injuries (when replantation is impossible) is ray amputation, but to satisfy insistent requests to salvage the ring finger, the best solution is to use fascial flaps.

Contrarily, a degloved thumb must always be salvaged. Today, the standardized procedure is to harvest the wrap-around flap from the great toe to provide a pleasing cosmetic result.

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The authors of the article were invited to reply but did not respond.

REFERENCES


To the Editor:

I read with great interest the article by Sato et al. This work addressed that platelet-rich plasma (PRP) improved tendon healing strength. I would like to complete the discussion of Lee and colleagues by introducing a major complementary route by which platelet-rich plasma could reduce tendon re-rupture.
One of the most important complications in flexor tendon repair is tendon re-rupture, with a frequency of 6%. Several studies have been done to reduce this obstacle. Recent studies have shown the essential role of angiogenesis-related cytokine in flexor tendon repair. These studies have shown that the level of interleukin 1 is correlated with tendon degeneration and rupture. High concentration of interleukin 1 significantly associated with increased tendon tear. In contrast, transforming growth factor beta can enhance tendon strength.

Platelet-rich plasma, which is also known as platelet gel, can not only reduce inflammatory effects of interleukins but also upregulate production of transforming growth factor beta. Therefore, these important mechanisms should be borne in mind as the major complementary mechanisms for platelet-rich plasma–reduced tendon re-rupture.

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Palmaris Profundus Tendon as Possible Cause for Median Nerve Compression

To the Editor:
We have read the report of McClelland and Means with great interest and want to contribute our opinion and another case report.

Our patient experienced tingling sensation in the median-supplied fingers for the past 3 years. The complaints predominated nocturnally and were aggravated by exercise. The Hoffmann-Tinel sign was positive, and further clinical examination was normal. Median motor latency at the wrist was 5.4 ms, and sensory nerve conduction velocity was 40 m/sec.

An open carpal tunnel release revealed a palmaris profundus tendon passing through the carpal tunnel, crossing over the median nerve, and inserting into the palmar aponeurosis (Fig. 1). The tendon and nerve were enveloped in the same epineurial connective tissue sheet. The median nerve showed distinct compression where the tendon crossed over. The remaining local anatomy, including the palmaris longus tendon, was normal. The accessory tendon was dissected from the epineurial sheet and resected. The median nerve received an external epineurolysis. After surgery, the patient was absolutely free of complaints. We feel that the anatomic variant was at least an aggravating factor for the pathogenesis of the median nerve compression. Magnetic resonance and sonographic imaging excluded any anatomic variant on the opposite side.

Although a palmaris profundus tendon is rare, the carpal canal is a highly variable region. Lindley et al found 31 anomalies within 526 carpal tunnel releases. This means that a variant can be found in 1 of 17 hands. This should also influence the selection of the surgical approach. The open approach features a far more comprehensive view, whereas the benefits

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