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Re: RHINOPLASTY AND OMFS

Sir,

As a Specialist Registrar, one always keeps an eye out for interesting and relevant courses. Following the Specialist Registrar conference on facial aesthetic surgery in Bristol and the President's newsletter on the theme for 2003 as being and on the same topic I felt compelled to scrutinize the journals and ask the consultant's their advice on courses. Interestingly, both my senior colleagues had been on and recommended Mr Nasser Nasser's Rhinoplasty Course in India. The courses are held in Dharwad, Goa and Cochin in February, October and November. The courses are intended mainly for Maxillofacial Surgeons (Consultants and Specialist Registrars).

The 4-day course I attended was in Cochin, Kerala. With the undoubted advantage of being set in the most beautiful state in India. The venue being The Specialist Hospital (Fig. 1). This is a well run ethical establishment which treats many of the poor of the region. The main specialities include plastics and microvascular surgery, oral and maxillofacial, orthopaedics, urology as well as general surgery.

Fig. 1 The Specialist Hospital, Cochin, Kerala.

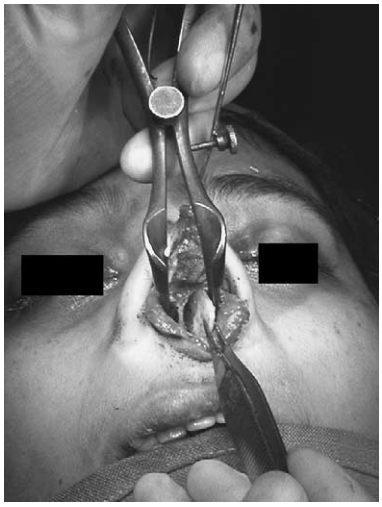

Fig. 2 Open rhinoplasty.

The organisers were very hospitable and had arranged an inauguration ceremony on the first day followed by an evening event.

The programme of the course started with 8.00 a.m. lectures followed by theatre from 9.00 a.m. to 5.00 p.m. The day was rounded of with another 1 hour lecture. The Specialist Hospital is a regional referral centre for cleft lip and palate surgery and traumatic amputations. The patients that Mr Nasser was referred were mainly cleft rhinoplasty cases. The techniques that were shown included open and closed rhinoplasty with harvesting of conchal and costochondral grafts (Fig. 2).

This programme was for the first 3 days. The final day was spent in theatre with the Plastic Surgeon who was trained in microvascular surgery under Professor Fu Chan Wei at the world renowned Chang Gung Memorial Hospital, Taiwan. We observed a reconstruction of a soft tissue defect of the elbow using a anterolateral thigh perforator flap.

All maxillofacial units have strengths and weaknesses, as trainees we are exposed varying amounts of facial aesthetic surgery in our rotations. It is, therefore, useful to travel to other units and courses abroad as well as attend the core courses such as the Microvascular Course and Head and Neck Surgical Anatomy Course.

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Re: Wales CJ, Matthews NS. Use of stoma bags to cover extraoral sites for incision and drainage. Br J Oral Maxillofac Surg 2002; 40: 339–340

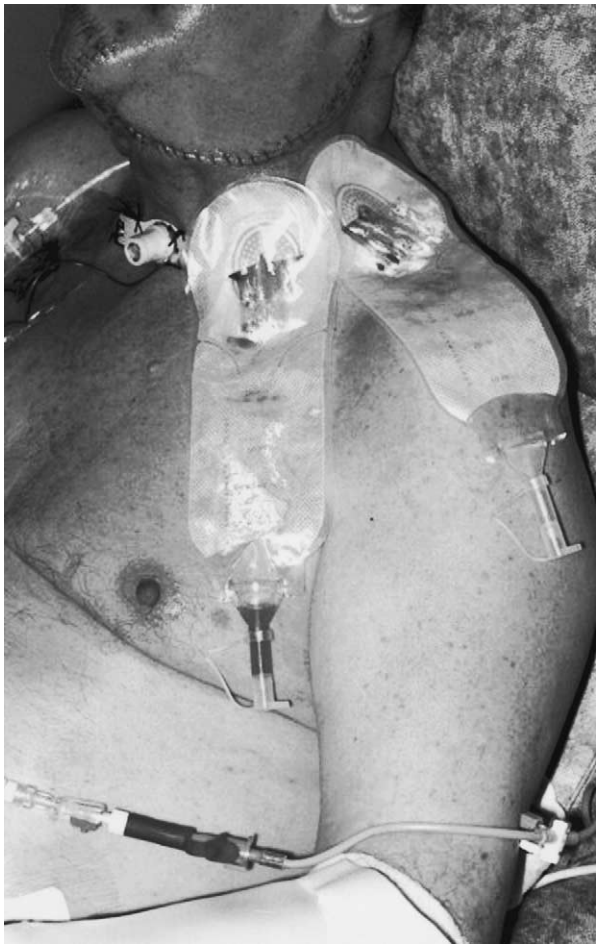

Fig. 1 Neck incision with paediatric stoma bags covering corrugated drains.

Sir,

We read with interest the above article and would like to highlight both a modification and additional use for stoma bags in maxillofacial surgery. We routinely use corrugated drains following microvascular free flap reconstruction and collect the drained fluid in paediatric stoma bags.

The use of corrugated drains has been advocated to reduce both haematoma formation and microvascular compromise.[1] Using stoma bags to collect drained fluid ensures a closed collection system and allows accurate measurement of drained volume. We advocate the use of paediatric stoma bags rather than conventional adult stoma bags as they occupy less surface area and so can be used without encroaching upon wound margins and the tracheostomy site (Fig. 1). Both staff and patients find this technique acceptable.

Yours faithfully,

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