<table>
<thead>
<tr>
<th>Product/Technology</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALLOGENIC ABSORBABLE SKIN SUBSTITUTE</td>
<td>Lacto-Capromer terpolymer Intelligent wound care</td>
</tr>
<tr>
<td>Sorbact</td>
<td>A Natural Method for Wound Management Instant &amp; Selective Binding of Hydrophobic Microorganism</td>
</tr>
<tr>
<td>ALHYDRAN</td>
<td>Medical after care for the Skin The new standard in the after care of Burns, Scars and fragile Skin</td>
</tr>
<tr>
<td>BapScarCare</td>
<td>New Generation SILICON SCAR TREATMENT</td>
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<td>Algicon</td>
<td>Alginate dressing impregnated with 100% Manuka honey</td>
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<tr>
<td>Actilite</td>
<td>Non-adherent viscoso net dressing coated with 99% Manuka honey &amp; 1% Manuka oil</td>
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<tr>
<td>Advazorb</td>
<td>Hydrophilic foam dressing range</td>
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<tr>
<td>Eclype</td>
<td>Super absorbent dressing Absorbs fluids, not your budget</td>
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<td>CORDLESS BATTERY OPERATED DERMATOMES</td>
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<td>SOBER HAND DERMATOME</td>
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<td>MESHER</td>
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<tr>
<td>Davies</td>
<td>Electric Dermatome</td>
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<tr>
<td>FDA APPROVED BREAST &amp; GLUTEAL IMPLANTS (BELLAGEL)</td>
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Ms. Jasmine Yao-Mei Tang

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Surgical Management of Pressure Ulcers Around Pelvis in Department of Plastic and Reconstructive Surgery, Bahawal Victoria Hospital, Bahawalpur.

Dr. Muhammad Mughese Amin, Dr. UzmaNazeer, Dr. AmmarAkhtar Dr. Akasha Amber Awan, Dr. Marina Maryem Khan, Dr. Leena Hafeez

ABSTRACT

Introduction: Pressure ulcers around pelvis is one of the major complication in paralyzed patients leading to hospitalization. To manage a pressure ulcer is a difficult task as there is high recurrence rate.

Objective: We conducted a study to know what is the role of surgery in the management of pressure ulcer and whether surgery is the substitute for the proper nursing care.

Study Design: This was a retrospective cross-sectional study conducted in six years from June 2007 to June 2013 in the department of plastic and reconstructive study, Bahawal Victoria Hospital, Bahawalpur.

Data Collection: After making a proper inclusion and exclusion criteria patients were admitted. Their serum chemistry sent. Patients with uncontrolled diabetes, anaemia and improper care were excluded, Highly motivated patients were included. Patients and their attendants were educated and sent to home for a month. After one month they were called for follow-up and patients who followed directions were selected for surgery.

Results: Fifty-five patients were selected for surgical management. Most common pressure ulcers were sacral followed by ischial and trochanteric ulcers. Ischial Ulcers were most difficult one to treat. Pressure ulcers have high recurrence rate of 21.8%. Different types of musculocutaneous flaps were used. Selection of flap depend on the muscle condition and type of ulcer.

Conclusion: Surgery is not the substitute of proper care rather care is a pre-requisite for surgery. All types of flaps used for reconstruction have comparable results.

Key words: Pressure ulcer, sacral, trochanteric, ischial, flaps

Introduction:
Pressure ulcer, also known as decubitus ulcer or bed sore, is a localized injury to skin or underlying tissue over a bony prominence due to pressure or pressure in combination with shear. Despite of improvement in management of paraplegic patients, bed sores remain a major complication causing a high rate of hospitalization. 85% of patients with spinal cord injury have at least one pressure ulcer during their life time and 70% suffer from multiple ulcers. Bed sores have very expensive treatment. Prevention is cheaper than cure. People who are immobile are at highest risk of developing pressure ulcer. Major causes of bed sores are pressure, shearing, unwanted moisture, and wrinkled sheets or hard objects left in bed. The most common site of pressure ulcers are around pelvis as up to 75% of all pressure ulcers are around pelvis. Other common sites are back of head, shoulders and heel.

In managing a bed sore, caring for the patient involves more than addressing the wound.
There are no clear criteria for selecting patients with pressure ulcers for surgery (3). Superficial stage I and II ulcers should be treated conservatively by eliminating conditions that interfere with healing (3). Deep ulcers of stage III and IV are candidates for surgery (3). However, they usually have other co-morbid illnesses which make the management of whole patient extremely important. Pre-operatively nutritional condition of patient must be evaluated. There should be no infection. Avoid any further progression of sore by relieving the source of pressure. Diabetes must be controlled. Proper counseling of patient and attendants must be done regarding care of patient and merits and demerits of procedure. The closure of pressure ulcer sore can be done by primary closure or flaps and then proper nursing care should be provided post-operatively as careful nursing care is critical to post-operative success. Post-operative bacteremia and infection must be controlled by broad-spectrum antibiotics. No pressure should be allowed at surgical site for 2 to 3 weeks. After 3 weeks most patients progressed enough to allow weight-bearing starting for 15 to 30 minutes interval and progress to two hours after six weeks (3,5).

Patients with paraplegia have greater tendency to develop bed sores around pelvis. We decided to conduct a study regarding our experience for management of pressure ulcer around pelvis in our department so that later we can set a proper protocol for managing bed sores.

**Materials and Methods:**

**Study Design:**

This was a retrospective cross-sectional study carried out in six years from June 2007 to June 2013 in the Department of Plastic and Reconstructive Surgery, Bahawal Victoria Hospital, Bahawalpur.

**Inclusion Criteria:**

A strict criteria is made to include the patients in our study. Following points were kept in mind for this purpose:

1. Young patients (age 25 years to 52 years)
2. No co morbidity
3. Good nutritional status
4. Serum profile normal
5. Motivated patients
6. Motivated attendants/caregivers

**Exclusion Criteria:**

Following patients were not included in our study:

1. Elderly patient (age more than 52 years)
2. Poor nutritional status
3. Neglected patient
4. Recurrence likely to occur

**Data Collection:**

After admitting patient of bed sore his complete history was taken and examination was done. All blood chemistry sent and any metabolic derangement was corrected if present. His nutritional evaluation was done. Wound was examined and if any infection present culture and sensitivity was sent and patient is started on antibiotics. Patient and attendants were counseled about care of the patient and their motivation for surgery was assessed. They were discharged and called for follow-up after one month. When patient came back after one month it was checked first that the instructions were followed or not. Patient was re-admitted if instruction followed. Planning for reconstruction was done. Wound was debrided if needed and prepared for surgery. Patient and attendants were counseled about merits and demerits of procedure. After proper education and informed consent surgery was done. In post-operative period posture of patient was maintained in such way that there should be no pressure on surgical site, infection was...
controlled by broad-spectrum antibiotics and proper nursing care was provided. Weight bearing was started after 3 weeks for 15 to 20 minutes interval and then patient was discharged. Patient is called for follow-up every week for two months and then after every fifteen days for six months and then every month for another six months.

**Statistical Analysis:**
The statistical analysis was done with the help of computer programme SPSS 10.0.

**Results:**
Seventy-two patients came to us for surgery. After proper screening and evaluation fifty-five patients were selected for surgery. Out of these 55, 26 patients have sacral sores (47.3%). Eighteen have ischial ulcers (32.7%) and eleven have trochanteric ulcers (20%). We used gluteus maximus perforator based V-Y advancement flap in seventeen patient (30.9%) but used it most commonly on sacral sores. Out of seventeen, two flaps develop wound dehiscence (11%) and in three patients there was recurrence (17%). Gluteus maximus rotational flap was used in seven patients (12.7%) and most commonly used for ischial sores. Out of seven there was no wound dehiscence but recurrence occur in two patients (28.5%) Pedicled island tensor fasciae latae flap was used in eight cases (14.5%) and most commonly used in trochanteric sores. One patient developed wound dehiscence (12.5%) and two have recurrence (25%). Six patients undergo pedicled island anterolateral thigh flap (10.9%). None of them have wound dehiscence and one patient has recurrence (16.67%). Ten cases undergo islanded V-Y thigh flap (18.1%). One patient develop wound dehiscence (10%) and two have recurrence (20%). Seven patients have posterior thigh flap (12.7%), out of which only one develop recurrence(14.2%) and none have wound dehiscence. In this way total four patients have wound dehiscence (7%) due to infection and poor healing for which grafting was done and wound was healed with secondary intention. 12 patients have recurrence(21.8%) due to negligence of directions, infection, uncontrolled diabetes and no proper nursing care. Our study also shows that ischial sores are most difficult one to treat as they highest recurrence rate of 33.33% followed by trochanteric (18.18%) and then sacral bed sores (15.4%). All results are shown in table and figures.

<table>
<thead>
<tr>
<th>Site of pressure ulcer</th>
<th>No. of patients</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Sacral area</td>
<td>26</td>
<td>47.3%</td>
</tr>
<tr>
<td>Ischial</td>
<td>18</td>
<td>32.7%</td>
</tr>
<tr>
<td>Trochanteric</td>
<td>11</td>
<td>20%</td>
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Table No. 1

<table>
<thead>
<tr>
<th>Method used</th>
<th>No. of cases</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>G.M. perforator based V-Y advancement flap</td>
<td>17</td>
<td>30.9%</td>
</tr>
<tr>
<td>G.M. rotational flap</td>
<td>7</td>
<td>12.7%</td>
</tr>
<tr>
<td>Pedicled island tensor fasciae latae flap</td>
<td>8</td>
<td>14.5%</td>
</tr>
<tr>
<td>Pedicled island anterolateral thigh flap</td>
<td>6</td>
<td>10.9%</td>
</tr>
<tr>
<td>Islanded V-Y thigh flap</td>
<td>10</td>
<td>18.1%</td>
</tr>
<tr>
<td>Posterior thigh flap</td>
<td>7</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

Table No. 2

<table>
<thead>
<tr>
<th>Site of ulcer</th>
<th>No. of patients with recurrence</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Sacral</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Ischial</td>
<td>6</td>
<td>33.33%</td>
</tr>
<tr>
<td>Trochanteric</td>
<td>2</td>
<td>18.18%</td>
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Table No. 3
Surgical Management of Pressure Ulcers Around Pelvis in Department of Plastic and Reconstructive Surgery, Bahawal Victoria Hospital, Bahawalpur.

Dr. Muhammad Mughese Amin, Dr. Uzma Nazeer, Dr. Ammar Akhtar, Dr. Akasha Amber Awan, Dr. Marina Maryem Khan, Dr. Leena Hafeez

Recurrence in pressure ulcers after surgery

Figure No.1 Comparison of results of different flaps

Figure No.2 Sacral bedsore….Gluteus maximus perforator based V-Y advancement flap.

Figure No.3 Ischial bed sore covered by gluteus maximus rotational flap

Figure No. 4 Trochanteric flap treated with pedicled island tensor fascia latae flap
Discussion:
Surgical management of patients with bed sores is difficult, justifying a therapeutic strategy involving multidisciplinary collaboration\(^{(2)}\). It is proved that surgery done as early as possible provides better results than secondary healing\(^{(6)}\). Direct closure is a simple, yet rarely indicated method in pressure ulcer surgery\(^{(3)}\). Skin grafting is effective but a split-thickness skin graft is thin and unpliable and therefore erodes easily when subjected to pressure and friction\(^{(3)}\). A full-thickness skin graft has better mechanical properties but it is more susceptible to mechanical strain than a flap, that's why a flap is often preferred to a graft\(^{(3)}\). Sacral bed sores are treated most commonly with musculocutaneous flaps based on gluteus maximus muscle which is usually a rotational flap\(^{(5)}\). For trochanteric defects tensor fasciae latae flaps are used\(^{(5)}\). In the surgery of ischial ulcers multiple types of flaps can be used but their recurrence rate is very high, 75% to 77%, regardless of the method used for them\(^{(5)}\).

In a study carried out in The Copenhagen Wound Healing Center it was concluded that in general, pressure ulcer patients should be treated locally. Debridement can be performed by the local surgeons. Only in cases where special interventions are required the patient will be examined by specialists. If surgical treatment is needed, the plastic surgeons who will perform the reconstructive procedures should also be involved\(^{(3)}\).

In a study conducted by Ichiko and et al it was shown that collagen matrix substitute dermis, or artificial dermis is desirable to achieve effective treatment with less invasion in sacral bed sores\(^{(7)}\). A study conducted at Department of Plastic Surgery of Rennes University Hospital it was shown that ischial sores are the most difficult one to treat with greater chances of recurrence and complication\(^{(2)}\).

A study conducted in Combined Military Hospital, Rawalpindi concluded that timely surgical intervention should be done for early and effective recovery. If the flaps are chosen carefully, they are very effective for rehabilitation of the paraplegic patients\(^{(9)}\).

We have selected only those patients for surgical management of pressure ulcers who are highly motivated, got good nursing care at home and highly vigilant and enthusiastic attendants/caregivers. Because management of pressure ulcer is not just the management of ulcer but management of whole patient himself. After admission of such a patient his metabolic derangements are corrected. Uncontrolled diabetes and anaemia are addressed. Infection was controlled. Wound was debrided and prepared for surgery. The site of the bedsore has a great impact on our selection of flaps. Sacral bed sores near the edges of the gluteus maximus make the gluteus maximus flaps our first choice. For ischial sores gluteus maximus rotational flap are our first choice but in some cases where gluteus maximus is atrophied we used posterior thigh flap and islanded V-Y thigh flap. In patients with trochanteric sores pedicled island tensor fasciae lata flap preferred but pedicled anterolateral thigh flap is also done in patients where fascia lata is damaged with bed sore. We have noticed that ischial sores are very difficult to treat and have high recurrence rate. We have observed that whatever the procedure we use for closure of bed sore, recurrence rate is high in bed-ridden patients. Success of flap depends solely on the care of patient. There should be no pressure on flap post-operatively. Patient should lie prone for the period of two to three weeks. If patient is diabetic, try to control his serum glucose level as close to normal as possible. Infection must be controlled with broad spectrum antibiotics. Recurrence rate of bed sores is high and the reason is negligence of directions or advice given to patient and attendants, uncontrolled diabetes, anaemia and infection.
Conclusion:
Surgery is not the substitute of care rather a proper care is a pre-requisite for reconstructive surgery of pressure sore. Recurrence rate of pressure ulcers is very high. Post-op treatment should be just like prevention of bed sore. All types of flaps used to reconstruct bed sore have comparable results.

References:
1. En.wikipedia.org/wiki/pressure_ulcer

* * * * *
Use of “Famm” Flap in Palatal Fistula

Dr. Muhammad Ashraf Ganatra, Dr. Asad Awan, Dr. Hyder Ali

ABSTRACT:
Objective: Palatal fistula is one of the commonest complications of the palate repair. Its accepted incidence is about 10%. Treatment is always surgical by using coverage of the fistula by flap. Flaps used are Tongue flap, Buccal flap and Free radial forearm. We have used Facial artery Musculo Mucosal (FAMM) flap because of its size, reliability, ease of use and less morbidity.

Methodology: In all patients with palatal fistula size of the fistula was measured with calipers and pattern of defect was made. Superiorly based flap was marked for anterior fistulas with alveolar clefts and inferiorly based flap was marked for fistulas present in the posterior part or in slightly older children in order to avoid bite. Circumferential incision was given around the fistula and turn in flaps were raised and sutured to each other to provide the base for the FAMM flap. Over this FAMM flap was applied. Donor area was closed primarily.

Results: We have used this flap in seven cases. In five cases fistulas were anterior and were large. In four patients FAMM flap survived. In one case there was necrosis of flap. In case of two posterior fistulas both flap survived but there was super added fungal infection in one case which responded to local antifungal treatment. There was no morbidity as far as food intake and speech is concerned.

Conclusion: FAMM flap is one of the useful tools in the armamentarium of Plastic surgeon dealing with palatal fistulas.

Key words: Palatal Fistula, Facial art Flap.

Introduction:
Palatal fistula is one of the commonest complications of the palate repair. The occurrence of fistula formation after surgical repair of cleft palate varies widely. The range can be none to thirty, forty, or even sixty⁴. Many literatures found the rate is related to the method of repair cleft palate, the experiences of surgeon, and the type of cleft ². The bilateral complete cleft of primary and secondary palate had the highest rate of cleft palate fistula after palatoplasty³. Most of the patients who had cleft palate fistula would develop VPI later.

Fistulas Can be classified as small (when 1 to 2 mm), medium (when between 2 and 5 mm) and large (when >5 mm)⁴. Palatal fistulas have significant functional consequences. Fistulas leak fluid and air; leaking air can cause a speech impediment because of nasal air escaping⁵. Leakage of fluids from the nose can be embarrassing. Food particles that become lodged in these fistulas produce fetor oris. Treatment depends upon size of the fistula. Small ones can close by re-do surgery. Medium and larger ones may need coverage by flap. Flaps used are Tongue flap⁶, Buccal flap⁷ and Free radial forearm⁸. We have used Facial artery Musculo Mucosal (FAMM) flap because of its size, reliability, ease of use and less morbidity.
Methodology:
In all patients with palatal fistula size of the fistula was measured with calipers and pattern of defect was made. Superiorly based flap was marked for anterior fistulas with alveolar clefts and inferiorly based flap was marked for fistulas present in the posterior part or in slightly older children in order to avoid bite. Circumferential incision was given around the fistula and turn in flaps were raised and sutured to each other to provide the base for the FAMM flap. Over this FAMM flap was applied. FAMM flap was marked in such a way that Facial artery was always in the center of the flap, extending from retormolar trigone to ipsilateral labial sulcus. The width of the flap was 1.5 to 2cm and length varies fro9 to 11cm. Care was taken to avoid Parotid duct. Raising the flap begins at the distal end, with an incision through the mucosa and buccinator. The facial artery was identified and ligated. The flap included a minimum overlying buccinator muscle and orbicularis oris. The arc of rotation has its pivot point at retormolar area for inferiorly based flaps and at gingival labial sulcus for superiorly based flap. The donor-site defect was closed in two layers.

In cases of intact dentition, an inferiorly based flap was used, coming from behind the maxillary arch. In these cases, bite blocks were used to avoid biting of pedicle and second surgery of division and insetting of the flap was done.

Results:
We have used this flap in seven cases. In five case fistulas were anterior and were large. In these cases superiorly based FAMM flap was used (Fig.1 and 2). In four patients FAMM flap survived. In one case there was necrosis of flap.

In case of two posterior fistulas, where inferiorly based flaps were utilized, (Fig.3) both flap survived but there was super added fungal infection in one case which responded to local antifungal treatment. There was no morbidity as far as food intake and speech was concerned. In both cases bite blocks were applied for two weeks .flaps were detached in second stage after two weeks.

Discussion:
The occurrence of fistula formation after surgical repair of cleft palate varies widely. It represents a technical failure resulting from poor wound healing, tension, or absent multilayer repair. The incidence can range from none to thirty, forty, or even sixty percent. Many literatures found the rate is related to the method of repair cleft palate, the experiences of surgeon, and the type of cleft. The bilateral complete cleft of primary and secondary palate had the highest rate of cleft palate fistula after palatoplasty. Most of the patients who had cleft palate fistula would develop Velopharangeal incompetency (VPI) later.

Palatal fistulas result from failure of healing or breakdown of original repair. They must not be confused or equalled with alveolar clefts or intentionally left anterior cleft palate by the surgeon.

Palatal fistulas have significant functional consequences. Fistulas leak fluid and air; leaking air can cause a speech impediment because of nasal air escaping. Leakage of fluids from the nose can be embarrassing. Food particles that become lodged in these fistulas produce fetor oris. Avoidance of palatal fistulas in the treatment of cleft palates is critical, because nearly 50 percent of children with fistulas require re-operation. Furthermore, the treatment of palatal fistulas has proved challenging; conventional methods of surgical closure have reported success in only 35 percent of cases. Mostly studies cite junction of soft and hard palate to be most frequent site of the fistula formation, but they can occur at any site. The Pittsburgh classification System includes seven fistula types:

1. Fistulas at the uvula,
2. Fistulas at the hard palate,
3. Fistulas at the soft palate,
4. Fistulas at the alveolar ridge,
5. Fistulas at the maxillary sinus,
6. Fistulas at the nasal septum,
7. Fistulas at the floor of the mouth.
bifid uvulae (type I); within the soft palate (type II); at the junction of the soft and hard palates (type III); within the hard palate (type IV); at the incisive foramen, or junction of the primary and secondary palates (type V (this designation is reserved for use with Veau type IV clefts); lingual-alveolar (type VI); and labial-alveolar (type VII). This system provides clear nomenclature that serves as a prerequisite for meaningful discussion, ongoing research, and evolving new treatment strategies. The palatal fistula's clinical significance is magnified by its propensity for recurrence. Myriad surgical approaches to fistula repair span the reconstructive ladder. Cauterization was described by Obermeyer in 1967. Berkman designed a vinyl appliance to guide local healing. Local flap options for fistula repair are numerous, but two flaps were quite popularized. One was tongue flap described by Guerrero-Santos and Altamirano in the 1960s and 1970s; The advantage of tongue flap is that large area can be harvested from tongue, flap is robust as it has rich blood supply. Can withstand infection, donor site can be closed primarily with little or no morbidity. Dis-advantages include two stages of surgery, restriction of diet to children and more morbidity.

In order to cover few of the dis advantages of tongue flap we opted for FAMM flap. It's a good flap and provides larger area to cover but the problem is in patients with dentition. One has to provide bite blocks and have to do second stage also. Second disadvantage is the learning curve for this flap which is slightly higher as compare to tongue flap. Facial artery should be in the center part of the flap otherwise its chances of fuller partial necrosis would be there. Pre-operative Doppler marking of facial artery is essential and reduces the chances of complication. In our population of Pakistan, where beetle nut chewing is quite common, sub mucous fibrosis is prevalent and harvesting a FAMM flap sometimes is difficult in adults. However, FAMM flap is one of the many options available out of local flaps available for palatal fistula repair.

**Conclusion:**
FAMM flap is one of the useful tools in the armamentarium of Plastic surgeon dealing with palatal fistulas.
Fig. 2: Pre-operative (L) and post-operative (R) result of a Inferiorly based FAMM flap.

Fig. 3 (a)

Fig. 3 (b)

Fig. 3 (c)

Fig. 3: Pre-operative (a) , immediate post op.(b) and delayed post-operative (c) result of a Inferiorly based FAMM flap.

References:


CASE REPORT

Simultaneous Nose Lip Revision and Alveolar Bone Grafting for Correction of Secondary Unilateral Cleft Lip and Palate Deformity

Dr. Suresh Vyloppilli

ABSTRACT:

Introduction: The secondary unilateral cleft lip deformity is highly variable. The lip and the nose may present with scars and/or anatomic abnormalities that require correction. The simultaneous lip nose correction does not affect the surgical correction of the alveolus or the anterior maxillary reconstruction. Post-surgical orthodontic treatment also can be carried out without interference. Patient problems like unaesthetic scar, residual nasal deformities and bony arch problems can be best treated with alveolar anterior maxillary reconstruction and simultaneous lip & nose revision. Here we present a patient who underwent nose & lip revision and alveolar bone grafting as simultaneous procedures for secondary deformity correction.

Key words: cleft rhinoplasty, cleft lip and palate, secondary alveolar bone grafting

Key Messages:
Patient problems like unaesthetic scar, residual nasal deformities and bony arch problems can be best treated with alveolar anterior maxillary reconstruction and simultaneous lip & nose revision.

Case History:
A twenty year old female patient reported to the cleft unit with a complaint of unsightly scarring and notching in the upper lip. She gave history of having been operated upon previously. On examination of the patient, she was found to have scarring and notching of the upper lip vermillion, flattening of alar rim on the affected side, deviation of the columella and flat down turned tip. Intra oral examination revealed the presence of an alveolar cleft and a buccal fistula.

Figure 1. Pre-operative Photograph

Figure 2. Pre-operative Photograph
Radiographic examination revealed a defect in the alveolus which would require bone grafting. In the context of the clinical and radiographic findings, it was decided to do a simultaneous lip nose revision and unilateral alveolar cleft reconstruction using the modified lateral and medial vestibular incision.¹¹

**Figure 3. Pre-op occlusal view**

The patient was taken up for surgery under general anesthesia. Lip scar and alar correction of the nose were carried out. Defect in the alveolus was grafted using cancellous bone harvested from the iliac crest by creating a trap door. Closure of the alveolus was done using 3-0 vicryl, and closure of the nose & lip revision using 6-0 prolene. The soft tissue healing in the post operative period was satisfactory except for minor hypertrophic scarring in the region which was managed by topical steroid application and massage. There was satisfactory nose and lip architecture and good bone formation in the alveolar region after a three month clinical and radiographic evaluation.

**Surgical Technique**

A through and through excision of the existing unaesthetic lip scar was done incorporating a Millard pattern. The rest of the incision was a combination of Millard, multiple z of Noordoff and reconstruction of the lip musculature of Veau and Delaire

**Figure 4. Incision marking**

This procedure was designed to remove the existing lip scar, better stimulation of the normal philtral ridge, correction of the vermilion – cutaneous mismatch, redefinition of the white roll, narrow the wide alar base and to straighten the columella. The incision into the nasal floor and vestibule was deferred till the alveolar repair was complete. Intraoral incisions are placed leaving 3 to 4 mm of attached gingiva. Incisions on the non cleft side end with a back cut. On the cleft side, in the region of the molar, this incision is carried superiorly into the free mucosa and sulcus to permit relaxation for the advancement flap. Lateral and vestibular incisions are now extended from the cleft alveolus to the alar base on the cleft side and to the base of the columella.

**Figure 5. Incision**
The medial soft tissue dissection along the cleft margin is extended into the nasal septum and correction and fixations are done. Then the nasal floor and the palatal mucosa are closed using a slowly resorbing inverting suture. The cancellous bone is packed along with a corticocancellous strut wedged at the level of the inferior piriform rim to provide a more stable surface to pack the cancellous bone and better support of the alar base.

**Figure 6. Alveolar Bone Grafting**

The soft tissue is closed over the bone graft taking great care to ensure a water tight tension free closure which was possible with this extended medial and lateral incision. Then the lip was closed in layers with 5-0 chromic and 6-0 prolene. When there is abnormal positioning or hypoplasia of the alar cartilage on the cleft side, an open Tip Rhinoplasty incision is generally used for the correction of the defects.

**Discussion:**
Primary surgery for the cleft deformity aims for an acceptable aesthetic reconstruction and correction of functional elements of the lip and the soft tissue sphincters and separate the oral and nasal cavities. Despite meticulous surgical techniques and well timed surgery secondary deformities will inevitably occur. Scarring which occurs in the nasomaxillary complex following primary surgery results in restrictive forces on the normal growth and developmental processes in this region. Once the patients are old enough to be aware of this situation their psychological reaction enters into their own assessment of the cosmetic result. These results, in turn, may have an impact on the physiological consequences of the deformity, which can be vastly different from one case to another. Secondary cleft deformities are therefore the result of surgeon's attempts to correct the initial cleft deformity with inherent tissue deficit. Although Millard's “rotational advancement” operation is universally accepted and preferred approach for unilateral clefts, many steps to fine tune the results, carrying the relaxing incision past the midline under the columella and small z plasties just above the vermilion and white line has been incorporated. This surgical approach gives excellent access when the lip was retracted superiorly for bone grafting. Reconstruction of the nasal floor was carried out with palatal and labial mucosa holding the graft. Preservation of attached gingiva permitted the advancement of gingiva into the area of future tooth eruption. Carrying the incision superiorly into the free mucosa in the molar region allows adequate relaxation for the advancement flap. Thus a three staged procedure can be fine-tuned into a single surgery for correction of these secondary deformities.

**Figure 7. Closure**
Conclusion
Management of secondary cleft deformities is commonly accomplished by multiple surgeries since it often needs to be customized to fit the individual needs of the patients. But this technique which is reported in the literature by Epker et al may be incorporated more increasingly for the management of these secondary deformities so that a single step correction is possible, avoiding multiple surgical episodes.

References:

* ★ ★ ★ ★
Management of Rhiophyma by Shaving Technique

Dr. Asad Ullah Awan, Dr. Muhammad Ashraf Ganatra, Dr. Hyder Ali

ABSTRACT:
Introduction: Rhiophyma is the benign swelling of the nose because of hypertrophy of the sebaceous glands of the nose causing mainly cosmetic problem. Among the multiple treatment modalities, Simple shaving is one of them which we have used because of simplicity and less morbidity.

Methodology: All patients coming to the outpatient clinic of Plastic Surgery Service at Dow University & Civil Hospital, Karachi with the diagnosis of Rhiophyma were included in the study. After complete work up patients were operated under anaesthesia. Whole lesion was shaved and dressed.

Results: 12 patients were operated by this technique. Epithelisation was complete in two week's time. There was no recurrence and morbidity was minimal.

Conclusion: In conclusion one can say that the Shaving technique for excision of Rhiophyma is superior to others because it is simple, easy to perform and carries very less morbidity.

Key words: Rhiophyma, Shave Technologies, Co.Laser.

Introduction:
Rhiophyma is the benign swelling of the nose because of hyper trophy of the sebaceous glands of the nose. Rhiophyma is a slow-growing and possibly disfiguring tumour of the nose that primarily affects men in their fifth to seventh decade. It is characterized by the progressive enlargement of the nose.\(^1\)

The precursor lesion is Acne Rosacea. Rhiophyma is currently classified as stage IV rosacea.\(^2\) In the past, Rhiophyma has often been associated with heavy alcohol consumption, but new studies have shown that there is no significant correlation.

There are many treatment modalities for Rhiophyma, both conservative and surgical. Surgical treatment gives durable and reliable results. Among the surgical modalities, Simple shaving is one of them. We are sharing our experience of this modality with 1 patients treated by us.

Methodology:
All patients coming to the outpatient clinic of Plastic Surgery Service at Dow University & Civil Hospital, Karachi with the diagnosis of Rhiophyma were included in the study. A proper history was sought with special emphasis on alcohol consumption. Clinical examination includes of noting the extent of Rhinophymatos lesion especially on the lateral ala. All patients were investigated for Blood sugar, Lipid profile and cardiac status.

All the surgeries were done under general anaesthesia. After cleansing and draping, the Rhinophymatos lesion was marked. Ten millilitre of Inj. Lidocaine 2% with 1:100,000 adrenaline was injected under the lesion. After seven minutes of wait by clock the lesion was excised with ten number surgical blade.

Care was taken to leave behind the reticular dermis layer intact as re-epithelisation of the wound takes place from this layer.
Care was taken not to injure perichondrium of the cartilaginous skeleton of the nose; Bleeding was controlled by adrenaline soaked gauze pieces kept on the nose with slight pressure. Dressing was done by applying tulle gras followed by dry gauze pieces and pressure tape. Dressing was removed on second or third day depending upon the soakage. After the fifth day wound was left open. Patient was advised to wash it with mild soap and water and apply very thin layer of Polymyxin-Bacitracin ointment. Patient was called on 7th day and then on 10th day. Patient was also advised to avoid direct sun light.

Results:
From February 2007 to February 2013, 12 patients presented to us. All patients were male. Age varied from 40 to 67 years. In all patients the lesion involved the nose except one, in which lesion on the chin was also present. None of them were found to be alcoholic. Two patients were diabetic and two were hypertensive.

All the patients were treated by shaving technique. Healing was achieved in all cases by day 10 with resolution of edema by day 15. Hospital stay was 1 to 3 days. No complication was seen in all cases till one month post operatively. The follow up of seven patients was up to three months and there was no recurrence up to this time. None of the patient has reported after three months post operatively.

Discussion:
Rhinophyma though is a benign condition, carries a weight of social stigmata because of deformity it produced and also because of misconception that is usually seen in alcoholics. Over time as the Rhinophyma enlarges the excess weight of the phymatous tissue on the alar can lead to collapse of the internal and external nasal valves with resulting functional nasal obstruction.

There are few lesions which are quite rare but they can present as Rhinophyma. They are sebaceous carcinomas, angiosarcomas, Basal cell carcinomas and Squamous cell carcinomas. The gold standard treatment is the removal of lesion. Different methods had been used for excision of the lesion. The removal of excessive tissue can be achieved by dermabrasion, excisional surgery by cold steel, cryosurgery, electrocautery, decortication and/or CO2 laser ablation. Regardless of the method employed, it is important to respect the delicate anatomy of the nose.

Many authors have advocated excision and coverage either by split thickness skin graft or full thickness skin graft. Couple of authors recommended coverage by local flaps. We used the shaving method. shaving off the Rhinophyma with preservation of the fundi of the sebaceous glands as foci for re-epithelialization, a technique later termed decortication. Advantages of the Shaving technique are that it is straightforward to perform under local or general anaesthesia, dressing are simple and hospital stay is short, from a day case to a few days. Opponents of the technique report that there is a risk of recurrent disease, and that a cosmetically unacceptable, red, shiny scar, which may be unstable when subjected to climatic extremes, can persist for many years. While these disadvantages undoubtedly can occur, they are not generally a problem and the results are usually satisfactory to all concerned.

There are two problems with Shaving technique. One is danger of excising the nasal cartilage. For this one must care not to shave beyond the depth of the sebaceous glands or to expose cartilage. Second problem is bleeding, which can be troublesome. It is reduced by injection of local anaesthetic with adrenaline before starting, and by applying...
adrenaline soaked gauze. The use of diathermy to excise the Rhinophyma has the sole benefit of reducing bleeding during the procedure. However, many feel that this is more than outweighed by the difficulty in controlling the depth of tissue destruction, as burning occurs deep to the resection level, with delayed healing, cartilage destruction and nasal distortion being the possible squeal.\textsuperscript{13}

It was in attempts to overcome the potential problems of the re-epithelialization technique that skin grafting and local flaps were advocated; but both of these have drawbacks. Skin grafting is more difficult to perform, the graft may fail to take or its colour and texture match may be less than ideal and there is the additional wound of the donor area with its possible morbidity. The majority of authors feel that these disadvantages exceed the claimed advantages of a more stable and more natural looking skin cover, both of which have been frequently disputed. The use of local flaps is almost universally criticized as it must inevitably employ diseased skin, except in the most localized of cases. The technique is now effectively obsolete.\textsuperscript{14}
CONCLUSION:
In conclusion one can say that the Shaving technique for excision of Rhinophyma is superior to others because it is simple, easy to perform and carries very less morbidity.

REFERENCES:


How to Attempt Plastic Surgery Fcps II Theory

Dr. Prof. Muhammad Ashraf Ganatra

ABSTRACT:
Introduction: Generally, exams produce anxiety and fear in the minds of students all over the world. Charles Caleb Colton (1780-1832) said that examinations are formidable even to the best prepared, for the even the greatest fool may ask more than the wisest man can answer. Albert Einstein once said “I never try to teach my students anything. I only try to create an environment where they can learn”.

Objectives: Examination are held to assess three things. We assess Knowledge (Cognitive aspect), Skills (Psychomotor) and Attitudes (Affective or behaviour)

Theory paper is one mode of examination and it is one of the oldest methods to assess student. The advantage of theory paper is that we can assess acquisition by the candidate the broad knowledge of the subject. We can also assess the proficiency of application of this knowledge to solve clinical problems.

Advantages: Nowadays theory papers in FCPS II Plastic Surgery consist of Short Answer Questions (SEQ). Short Essay Questions are used to assess the students’ ability to integrate facts and problem solving skills, which are fundamental to good practice. Question requiring consolidation of facts and critical thinking are asked.

Advantages of theory papers are twofold. One we can assess acquisition by the candidate the broad knowledge of the subject and two we can assess the proficiency of application of this knowledge to solve clinical problems.

Disadvantage: There are certain disadvantages also. Number one, the performance on written examinations does not always predict success in the application of the knowledge in real clinical setting.

Theory papers do not assess important clinical skills such as the technical and performance aspects of physical diagnosis, communication, humanism and professionalism.

However since theory paper is in practice, I will concentrate on how to attempt it amicably.

Key words: Theory papers, Plastic Surgery, Pakistan.

Paper setting:
The first thing is paper setting in exams .When the exam paper is set, the question paper setter is asked by the CPSP to write a key for the answer, so that there is uniformity in correction. All the theory assessors are given this key of points that they need to look for in an answer. If these points are there in the answer sheet, the assessor would give marks for content, which can be passing. Content part would be heavily benefitted and candidate would get more marks, if it is presented in the answer sheet in clean and tidy way with appropriate diagram, tables and charts.

What Candidate Do First Ten Minutes After Receiving Question Paper: The candidate should read the paper quickly. S/He should divide the questions in three types: Easy, Moderately difficult and Difficult. First candidate should attempt easy one. It should be noted by the candidate that S/He has about 15 to 18 minutes to answer each question (180 minutes/10 questions).
Candidate will be given answer sheet for each single question. Candidate should note that each answer book will contain four pages which are considered enough of answering the question. The question has to be answered in these four pages. CPSP will neither provide any sheets or continuation pages nor are they allowed. The candidate will be supposed to answer each question on a separate answer book writing only on the ruled sides of the sheets. The candidate must ensure that the Roll number and question no. is written on each answer sheet. The roll no. should be on the designated place in the answer sheet. Writing roll no. at places other then the designated place might lead to a disciplinary action by the CPSP.

Meaning Of Different Terms:
Candidate should read the question carefully and should concentrate what examiner is asking. Is he asking “Describe”, is he is asking “Discuss” or he is asking “define”. Following are the meaning of common terms which are being asked in the exam paper:
- Enumerate OR List – do the listing.
- Define - try to give definition in simple words.
- Discuss –try to give different perspectives of a thing that is asked e.g. Discuss Euthanasia. Then you have to give views, those in favour and those against.
- Describe – try to give a detailed description.
- Clinical features - Symptoms and physical signs
- Diagnosis - Clinical signs and investigations
- Treatment - conservative, medical, surgical & preventive.
- Management - Diagnosis and treatment.
- Summarize –Sum up all aspects concisely.

Content:
Candidate should always plan what they want to write. They can use the last page of the Answer Booklet to write their “thought blocks”. Generally candidates write more than what is asked, in the hope that they will get more marks. On the other hand it irks the assessor and sometime they might not give proper marks, so more writing should be avoided at all costs. Candidates must try to write in numbered points or in the form of bullets. All the sentences should be as short as possible.

Hand Writing:
Hand writing should be eligible and readable. Don’t write in stylish way. Also don’t use continuous Capital letters as it amount to shouting in writing? There should be ample space between the words and also between lines.

Diagramitic Representation:
Diagrams, line drawings, tables and graphs add weight to the answers and should be incorporated in each and every answer.

Important Don'ts To Remember
1. Don't write concepts about which you are not clear.
2. Don't make too many underlines.
3. Don't use more than two colours in a page
4. Don't write abbreviations.
5. Don't write the words and phrases used for texting in mobile phones.

Important Tips:
- In a Paragraph always write one concept.
- A paragraph should be of not more than five to six sentences.
- In the answer always try to reply what is being asked.
Examples:

**September 2004**
- Write a short essay on skin grafting and after care.

**Aug. 2006**
- Write a short essay on “Vacuum Assisted wound closure” enumerating its definition, mechanism, method of application, advantages, and disadvantages. Also enumerate the indications.

**Feb 2007**
- What are the commonly used sites for harvesting non vascularised bone grafts
  a) how does bone graft heals?
  b) Give advantages and disadvantages of any three donor sites.

**Jan 2008**
- A) How can you differentiate between hypertrophic scar and keloids?
- b) How can you prevent this?
- C) How would you propose to treat a large pre sternal keloid in a 40 years old male?

**March 2009**
- A 26 year old male presents with recurrent purulent infection of the axillae, groins and perineum, on and off for the last two years.
  a) What is the most likely diagnosis?
  b) What is the underlying pathology?
  c) What are the principles of treatment?

**Sept. 2010**
- Patients with major burns are more susceptible to infection:
  a) Explain the factors which render these patients more susceptible to infection
  b) What specific steps in the management can help to prevent sepsis

**March 2011**
In current cleft surgery:
- a) Name the three commonly used incisions for cleft lip surgery.
- b) Describe the most commonly used primary rhinoplasty incision?
- c) What other surgical procedures are considered mandatory before or with complete cleft lip repair?
- d) What are the advantages of pre surgical orthodontics?

**March 2012**
- An 18 years old girl gets married. After one month her husband brings her to you as he is unable to consume marriage. She has never menstruated. On examination she is a normal looking girl with normal external genitalia. However there is no opening under the urethra:
  a) What is the possible anatomy of her internal sexual organs?
  b) What is the embryological basis of this defect and what is her genotype?
  c) Enumerate methods to produce a normally functioning vagina.

**Last Advice:**
The key to a question paper is a good, well planned preparation well in advance. Always anticipate a difficult paper. Do have a disciplined scheduled for a few months before the exam. Always sleep well. And do little exercise & some entertainment. but most importantly don't catch up bad habits (smoking, tobacco chewing, etc.) to handle stress. Best luck!

**References:**
Learning knows no boundaries: 
My experience as part of a foreign surgical aide team to Gujrat, Pakistan

Ms. Jasmine Yao-Mei Tang

Abstract:
People often look to the Western world for good education and training, particularly in medicine and surgery. However, even the best training in the top university hospitals can only give a surgeon the fundamental skills to which he or she can build their practice. One can be too comfortable and complacent working in this environment. It is only when we step out into the world to broaden our horizons, when we realise how little we know and how humbling the experience can be; as I did when I joined a local charity, Overseas Plastic Surgery Appeal, on their charitable missions trip to Gujrat, Pakistan.

Key words: Cleft Camp, Gujrat, Pakistan.

Article
It has now been two years since I returned from my trip to Pakistan as part of the Overseas Plastic Surgery Appeal (OPSA) team and yet I remember it fondly as though it was yesterday. One short week that flew by; working from daylight into the late hours of the night, under the most basic circumstances – but yet it was the one week that reminded me most of why I pursued the path of becoming a surgeon.

I read medicine in the United Kingdom and have continued my training there under the National Health Service; which provides free healthcare for all. However, at the heart of every great system and ideal, are the people who make it so – both patients and healthcare workers alike. The National Health Service is a system developed over many decades of planning, restructuring and remodelling – to provide the best possible healthcare for the nation. Surgical training follows a systematic path with structured objectives. Does this all equate to the making of great surgeons?

For me, the path has only just begun. Training in a great system only gives us a solid foundation to which we build our future. In this day and age, with minimal restrictions to travel and sharing of knowledge, it is foolish pride to think that there is nothing to be learnt from impoverished areas as there are from well-equipped university hospitals in the Western world. The difference in Plastic Surgery which sets it apart from other specialties should be the surgeons' ability to adapt fundamentals of reconstruction in any circumstances; for the restoration of function and form.

In my week in Gujrat, I came across people with conditions rarely seen in the United Kingdom; in addition to varying severities of cleft lip and palate babies. Treatment plans and operations have to be modified to reflect the facilities available and the fact that people were travelling great distances in hopes of improving their lives but may not be able to afford another trip back.
The constant questions that ran through my head were, 'What is this?'; 'This is what will be done in the UK, can we do it here?'; 'We can't offer this treatment here. What now?'. Every day was a new experience, as the scope of work was great but the need of the people greater still. What was most humbling is in the way the families use up their life savings to come from afar, in the hopes that their children may have a chance at integrating with society, following surgery for their congenital deformities. There are no criticisms, no aggressive behaviour and unrealistic demands from the patients, but a lot of healthy respect and patience for all the healthcare workers at the Cleft Centre. This sort of deference most certainly deserves equal measure of respect in return. There is a sense of vulnerability in these people that can be easily exploited by foreign doctors offering surgical aide, but this was not observed during my time in Gujrat. I admire the fact that the surgeons apply the same standards of practice as what is acceptable in the United Kingdom; and never taking on what was beyond their abilities. I can see how difficult it can be to turn some of these people away, seeing their hopes dashed, mirrored vividly in their facial expressions – but how important it is to have a sense of ethical and moral responsibility towards these people.

OPSA first started providing surgical aide in the model of a cleft camp as many cleft charities do. Under the guidance of Mr Nick Hart, Mr Mohammed Riaz and Dr Rafique, this has evolved dramatically. Sixteen years of strong collaborative work with a local charity in Pakistan (Pakistan Cleft Lip and Palate Association (PCLAPA)), and a vision towards independent sustainability, the charities are now moving towards a model of teaching and training local staff, and bringing together all the elements of multidisciplinary care that is required to optimise the results from cleft surgery. This will no doubt be a slow process as with all non-profit enterprises but what is most heart-warming is the sincerity and earnestness of all those involved to do the little they can to improve the health standards of those who cannot afford healthcare.

The whole week in Gujrat was not only about the patients, but about fostering friendship and a close working relationship with the local staff, who will provide the continuity of care. The team from United Kingdom was a small during this particular trip, consisting of 2 surgeons and 1 anaesthetist. Two other anaesthetists joined our efforts from different cities in Pakistan and one local surgeon who is trained by Dr Rifat Hussain (a cleft surgeon from the United States of America who joins the team annually).

As a foreign observer, it is equally important to walk away, learning and understanding the local culture; for without cultural tolerance, there can only be dissidence. Hence, the most important things I've gained from this trip are skills that cannot be taught in my training, but gained through experience and broadening my horizons; embracing all learning opportunities available. It was truly a humbling experience.

I have much respect for both OPSA and PCLAPA for their vision and continual efforts. Quoting an old Chinese proverb 'Give a man a fish and you feed him for a day; teach a man to fish and you feed him for a lifetime'; the collaboration between foreign and local charities; working towards a sustainable goal, is a model that is commendable with both parties gaining as much as they receive in their own different ways.

* * * *
INSTRUCTION TO AUTHORS

All material submitted for publication should be sent exclusively to the Pakistan Journal of Plastic Surgery. Work that has already been reported in a published paper or is described in a paper sent or accepted elsewhere for publication should not be submitted. Multiple or duplicate submission of the same work to other journal should be avoided as this fall into the category of publication fraud and are liable for disciplinary consequences, including reporting to Pakistan Medical & Dental Council and Higher Education Commission. A complete report following publication of a preliminary report, usually in the form of an abstract, or a paper that has been presented at a scientific meeting, if not published in full in a proceedings or similar publication, may be submitted. Press reports of meetings will not be considered as breach of this rule, but additional data or copies of tables and illustrations should not amplify such reports. In case of doubt, a copy of the published material should be included with a manuscript to help the editors decide, how to deal with the matter.

Authors can submit their articles by post or by E-mail: mughese@yahoo.com to the Managing Editor, Pakistan Journal of Plastic Surgery. Article can also be submitted by post or by hand on a Compact Disc (CD) with three hard copies (laser copies or inkjet, photocopies are not accepted). Articles submitted by E-mail do not require any hard copy or CD.

General archival and linguistic instructions.
The author should submit the manuscript typed in MS Word. Manuscripts should be written in English in British or American style/format (same style should be followed throughout the whole text), in past tense and third person form of address. Sentences should not start with a number or figure. Any illustrations or photographs should also be sent in duplicate. Components of manuscript should be in the following sequence: a title page (containing names of authors, their postal and Email addresses, fax and phone numbers, including mobile phone number of the corresponding author), abstract, key words, text, references, tables (each table, complete with title and footnotes) and legends for illustrations and photographs. Each component should begin on a new page. The manuscript should be typed in double spacing as a single column on A4 (8-1/2” x 11” or 21.5 cm x 28.0 cm), white bond paper with one inch (2.5 cm) margin on one side.

Material for Publication.
The material submitted for publication may be in the form of an Original research (Randomized controlled trial - RCT, Metaanalysis of RCT, Quasi experimental study, Case Control study, Cohort study, Observational Study with statistical support etc), a Review Article, Commentary, a Case Report, Recent Advances, New techniques, Debates, Adverse Drug Reports, Current Practices, Clinical Practice Article, Short Article, KAP (Knowledge, Attitudes, Practices) study, An Audit Report, Evidence Based Report, Short Communication or a Letter to the Editor. Ideas and Innovations can be reported as changes made by the authors to an existing technique or development of a new technique or instrument. A mere description of a technique without any practical experience or innovation will be considered as an update and not an original article. Any study ending four years prior to date of submission is judged by Editorial Board for its suitability as many changes take place over the period of time, subject to area of the study. Studies more than four years old are not entertained. JCPCP also does not accept multiple studies/multiple end publications gathered/derived from a single research project or data (wholly or in part) known as 'salami slices'. Original articles should normally report original research of relevance to clinical medicine. The original paper should be of about 2000-2500 words excluding abstract and references. It should contain a structured abstract of about 250 words. Three to 10 keywords should be given for an original article as per MeSH (Medical Subject Headings). There should be no
more than three tables or illustrations. The data should be supported with 20 to 25 references, which should include local as well as international references. Most of the references should be from last five years from the date of submission.

Clinical Practice Article is a category under which all simple observational case series are entertained. The length of such article should be around 1500 - 1600 words with 15 - 20 references. The rest of the format should be that of an original article. KAP studies, Audit reports, Current Practices, Survey reports and Short Articles are also written on the format of Clinical Practice Article. Evidence based reports must have at least 10 cases and word count of 1000-1200 words with 10 - 12 references and not more than 2 tables or illustrations. It should contain a non-structured abstract of about 150 words. Short communications should be of about 1000 words, having a nonstructured abstract of about 150 words with one table or illustration and not more than five references. Clinical case reports must be of academic and educational value and provide relevance of the disease being reported as unusual. Brief or negative research findings may appear in this section. The word count of case report should be 1200-1500 words with a minimum of 3 key words. It should have a non-structured abstract of about 100-150 words (case specific) with maximum of 10 references.

Review article should consist of critical overview/analysis of some relatively narrow topic providing background and the recent development with the reference of original literature. It should incorporate author's original work on the same subject. The length of the review article should be of 2500 to 3000 words with minimum of 40 and maximum of 60 references. It should have non-structured abstract of 150 words with minimum 3 key words. An author can write a review article only if he/she has written a minimum of three original research articles and some case reports on the same topic. Letters should normally not exceed 400 words, with not more than 5 references and be signed by all the authors-maximum 3 are allowed. Preference is given to those that take up points made in contributions published recently in the journal. Letters may be published with a response from the author of the article being discussed. Discussions beyond the initial letter and response will not be entertained for publication. Letters to the editor may be sent for peer review if they report a scientific data. Editorials are written by invitation.

Between 3 to 10 key words should be given for all the category of manuscripts under the abstracts as per mesh [medical subject heading].

**Dissertation /Thesis Based Article.**
An article, based on dissertation, approved by REU, submitted as part of the requirement for a Fellowship examination of the PJPS, can be sent for publication provided the data is not more than four years old. Approval of REU is not required for an article submitted for second fellowship examination in lieu of dissertation. The main difference between an article and a dissertation is the length of the manuscript, word count, illustrations and reference numbers. Dissertation based article should be re-written in accordance with the journal's instructions to the author guidelines. Such articles, if approved, will be published under the category of Dissertation based article.

**Ethical Considerations.**
If tables, illustrations or photographs, which have already been published, are included, a letter of permission for re-publication should be obtained from author (s) as well as the editor of the journal where it was previously published. Written permission to reproduce photographs of patients, whose identity is not disguised, should be sent with the manuscript; otherwise the eyes will be blackened out. If a medicine is used, generic name should be used. The commercial name may, however, be mentioned only within brackets, only if necessary. In case of medicine or device or any material indicated in text, a declaration by author/s should be submitted that no monetary benefit has been taken from manufacturer/importer of that product by any author. In case of experimental interventions, permission from ethical committee of the hospital
should be taken beforehand. Any other conflict of interest must be disclosed. All interventional studies submitted for publication should carry Institutional Ethical & Research Committee approval letter. Ethical consideration regarding the intervention, added cost of test, and particularly the management of control in casecontrol comparisons of trials should be addressed: multicentric authors' affiliation may be asked to be authenticated by provision of permission letters from ethical boards or the heads of involved institutes.

Tables and Illustrations.
Legends to illustrations should be typed on the same sheet. Tables should be simple, and should supplement rather than duplicate information in the text; tables repeating information will be omitted. Each table should have a title and be typed in double space without horizontal and vertical lines on an 8-1/2" x 11" (21.5 x 28.0 centimeters) paper. Tables should be numbered consecutively with Roman numerals in the order they are mentioned in the text. Page number should be in the upper right corner. If abbreviations are used, they should be explained in footnotes. When Graphs, scatter grams, or histograms are submitted, the numerical data on which they are based should be supplied. All graphs should be made with MS Excel and other Windows/Macintosh compatible software such as SAS and be sent as a separate Excel file, even if merged in the manuscript.

S.I. Units.
System International (S.I) Unit measurement should be used. Imperial measurement units like inches, feet etc are not acceptable.

Figures and Photographs.
Photographs, X-rays, CT scans, MRI and photomicro-graphs should be sent in digital format with a minimum resolution of 3.2 mega pixels in JPEG compression. Photographs must be sharply focused. Most photographs taken with a mobile phone camera do not fulfill the necessary requirements and, therefore, not acceptable for printing. The background of photographs must be neutral and preferably white. The photographs submitted must be those originally taken as such by a camera without manipulating them digitally. The hard copy of the photographs if sent, must be unmounted, glossy prints, 5" x 7" (12.7 x 17.3 centimeters) in size. They may be in black and white or in color. Negatives, transparencies, and X-ray films should not be submitted. Numerical number of the figure and the name of the article should be written on the back of each figure/photograph. Scanned photographs must have 300 or more dpi resolution. The author must identify the top of the figure. These figures and photographs must be cited in the text in consecutive order. Legends for photomicrographs should indicate the magnification, internal scale and the method of staining. Photographs of published articles will not be returned. If photographs of patients are used, either they should not be identifiable or the photographs should be accompanied by written permission to use them.

References:
References should be numbered in the order in which they are cited in the text. At the end of the article, the full list of references should give the names and initials of all authors (if there are more than six, only the first six should be given followed by et al). The authors' names are followed by the title of the article; title of the journal, abbreviated according to the style of the Index Medicus (see "List of Journals Indexed," printed yearly in the January issue of Index Medicus); year, volume and page number; e.g.: Hall RR. The healing of tissues by C02 laser. Br J Surg 1971; 58:222-225 (Vancouver style). Reference to books should give the names of editors, place of publication, publisher, year and page numbers. The author must verify the references against the original documents before submitting the article. The Editorial Board may ask authors to submit either soft or hard copy (full length) of all the articles cited in the reference part of the manuscript.
Abstract
Abstract of an original article should be in structured format with the following subheadings:

i. Objective.
ii. Design.
iii. Place & duration of study.
iv. Patients & Methods.
v. Results.
vi. Conclusion.

Four elements should be addressed: why was the study started, what was done, what was found, and what did it mean? Why was the study started is the objective. What was done constitutes the methodology and should include patients or other participants, interventions, and outcome measures. What was found is the results, and what did it mean constitutes the conclusion. Label each section clearly with the appropriate subheadings. Background is not needed in an abstract. The total word count of abstract should be about 250 words. A minimum of 3 Key words as per MeSH (Medical Subject Headings) should be written at the end of abstract. A non structured abstract should be written as case specific statement for case reports with a minimum of three key words.

Introduction.
This section should include the purpose of the article after giving brief literature review strictly related to objective of the study. The rationale for the study or observation should be summarized. Only strictly pertinent references should be cited and the subject should not be extensively reviewed. It is preferable not to cite more than 10 references in this segment. Pertinent use of reference to augment support from literature is warranted which means, not more than 2 to 3 references be used for an observation. Data, methodology or conclusion from the work being reported should not be presented in this section. It should end with a statement of the study objective.

Methods.
Study design and sampling methods should be mentioned. Obsolete terms such as retrospective studies should not be used. The selection of the observational or experimental subjects (patients or experimental animals, including controls) should be described clearly. The methods and the apparatus used should be identified (with the manufacturer's name and address in parentheses), and procedures be described in sufficient detail to allow other workers to reproduce the results. References to established methods should be given, including statistical methods. References and brief descriptions for methods that have been published but are not well-known should be provided; only new or substantially modified methods should be described in detail, giving reasons for using them, and evaluating their limitations. All drugs and chemicals used should be identified precisely, including generic name(s), dose(s), and route(s) of administration.

For statistical analysis, the specific test used should be named, preferably with reference for an uncommon test. Exact p-values and 95% confidence interval (CI) limits must be mentioned instead of only stating greater or less than level of significance. All percentages must be accompanied with actual numbers. SPSS output sheet must be attached with manuscript to clarify results (p-values).

Results.
These should be presented in a logical sequence in the text, tables, and illustrations. All the data in the tables or illustrations should not be repeated in the text; only important observations should be emphasized or summarized with due statement of demographic details. No opinion should be given in this part of the text.

Discussion.
This section should include author’s comment on the results, supported with contemporary references, including arguments and analysis of identical work done by other workers. Study limitations should also be mentioned. A summary is not required. PJPS does not publish any acknowledgement to the work done. Any conflict of interest, however, must be mentioned at the end of discussion in a separate heading.
**Conclusion.**

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Silver sulphadiazine has been responsible for an increase in the efficiency of topical burn therapy. The low incidence of positive wound cultures, reduced mortality rate from sepsis, in addition to its convenience of use as well as an almost total absence of side effects, has made it widely acceptable as a topical agent for the control of burn wound sepsis.


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Composition: 10g of cream contains 1g of micronized silver sulphadiazine U.S.P. in a hydrophilic base. Indications: Treatment and prevention of burn wound infections and infected dermal defects, including bed sores and deep neglected wounds. Contraindications: The use of DERMAZIN is contraindicated in premature infants and neonates because of possible kernicterus. DERMAZIN should not be used in pregnancy except in cases when the potentially life-saving benefits of the medication outweigh possible hazard to the fetus. Precautions: Caution is required in the presence of hypersensitivity to sulphonamides because of possible allergic reactions, in patients with inherited glucose-6-phosphate dehydrogenase deficiency, and if there is a history of aminopenicillin allergy. When treatment with DERMAZIN cream involves prolonged administration or large burn surfaces, the white blood cell count should be monitored, as leucopenia may occur. Side effects: In prolonged treatment of burn wounds involving extensive areas of the body, the serum sulphadiazine concentrations may approach the levels equal to those in systemic treatment. Dosage and administration: An appropriate treatment regimen is promptly instituted after evaluating the extent and depth of the burn wound. After the burn area is cleansed and debrided, DERMAZIN cream is applied to a thickness of 5-10 mm to the burn area or preference, the cream is applied to sterile gauze which is placed over the burn wound. The cream is applied by a sterile spatula or gloved hand. The burned areas are usually covered with the cream once daily, in severe burn wounds the cream can be reapplied. Duration of superficial burn treatment depends on the injury ranging from several days to one month of the most. Surgery is required only if no healing occurs after one month of treatment with DERMAZIN. To each application of the cream, the burn should be washed with soapy water or with an antiseptic solution to remove remnants of cream and wound exudate which are abundant after DERMAZIN application, resembling pus in colour but actually acellular. DERMAZIN cream in jars are intended for repeated application in one patient only. The application of the cream is painless. It does not stain clothes and bed linen. Price: 25g = Rs. 78.99, 50g = Rs. 102.99, 125g = Rs. 439.39. Full prescribing information is available on request.