



Fig 1. Clinical appearance of the patient's nose. (A) site of the basal cell carcinoma; (B) scar from biopsy at the wrong site.

reducing anxiety and assists in teaching wound care. Before and during laser or cosmetic procedures the patient's expectation can be aligned with those of the surgeon.

Other steps may be undertaken to avoid any uncertainty regarding the lesion in question, e.g. taking a photograph of the lesion at the time of the initial consultation. Additionally, routinely following the steps of the World Health Organization Surgical Checklist (one component of which refers to confirming with the patient the surgical site) should ensure that the correct area is operated on.

The hand-held mirror is inexpensive and has innumerable benefits. We recommend that it should be available in every consulting room and theatre. It confirms the lesion in question and almost totally eliminates any potential misunderstanding.

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Optimizing adherence of full-thickness skin grafts to the wound bed of the nasal ala with the 'sandwich suture'

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MADAM, Skin cancers on the nose are common.¹ Following surgical excision of a lesion on the nasal ala, many reconstructive surgeons will utilize a full-thickness skin graft (FTSG), harvested from a number of potential donor sites, to repair such a defect.² In order to maximize adherence of the graft to the wound bed, minimize movement and reduce shearing forces, the use of a tie-over bolster dressing is common practice when performing FTSGs.^{3,4}

The 'nasal ala FTSG' is challenging for the reconstructive surgeon in that any form of external pressure, such as a bolster, collapses the nasal vestibule. Not only is this uncomfortable for the patient but also does not maximize the adherence of the undersurface of the graft to the wound bed. The use of Meroceol® (Medtronic Xomed Inc., Jacksonville, FL, U.S.A.) nasal packing with airway⁵ or a 'D.I.Y. nasal plug'⁶ has previously been proposed to provide a form of rigid support inside the nasal vestibule and thus maximize the potential for graft uptake, while not impeding airflow into the nostril. With both the aforementioned nasal plugs, however, the pressure within the nostril is uniform including the medial nostril where it is essentially not required. Furthermore, both these devices are secured in place only by virtue of their 'tight fit' and sterile adhesive tapes. Thus the potential for them to be simply pulled out either intentionally or inadvertently remains.

Herein, we describe the 'sandwich suture' (SS) for securing a FTSG bolster dressing to the nasal ala while simultaneously enabling focal pressure to be applied to the undersurface of the graft.

Figure 1a illustrates a FTSG harvested from the right conchal bowl, sutured in place on the right nasal ala. A 4/0 polypropylene suture is passed through the graft into the nasal vestibule (Fig. 1b, c). A loop is created and the suture is passed back through the graft as shown (Fig. 1d). A standard nasal plug in this example (although Meroceol® or a D.I.Y. nasal plug could also be used), wrapped in paraffin-impregnated gauze, is passed through the loop (Fig. 1e) and initially directed medially inside the nose (Fig. 1f). The manoeuvre of 'tightening' the loop pulls the nasal bolster directly up against the undersurface of the wound bed upon which the FTSG is placed (Fig. 1g). The portion of the plug outside the nasal passage is then trimmed (Fig. 1h) and placed as a direct bolster over the FTSG and secured in place (Fig. 1i). As a result, the FTSG is 'sandwiched' between the internal and external pressure dressings as shown (Fig. 1j), providing focused pressure and thus maximizing the chances of full graft uptake.

The use of bolster dressings in FTSGs is a surgical dogma where opinion is divided. Indeed there is evidence for not

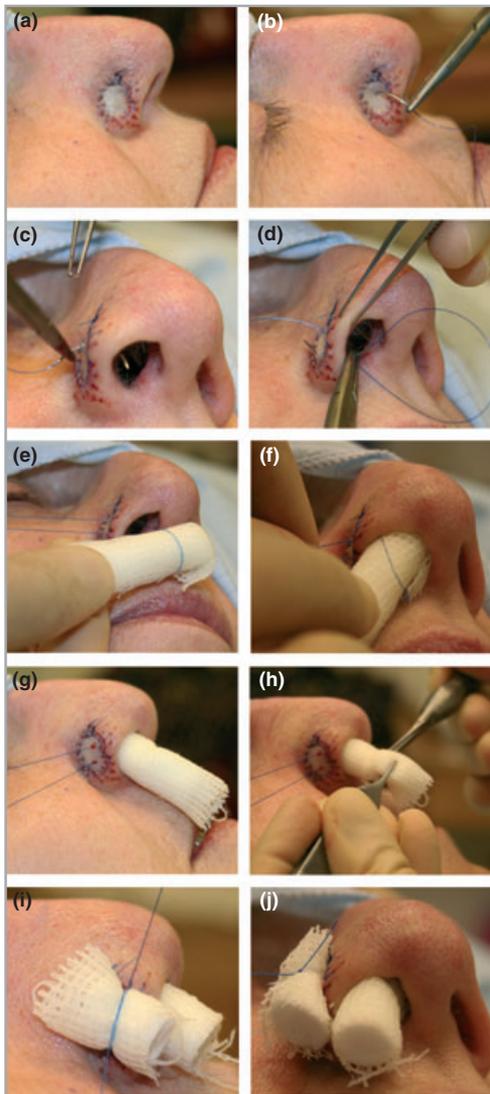


Fig 1. (a) A full-thickness skin graft on the right nasal ala. (b, c) A suture is passed through the graft into the nasal passage. (d) The suture is then passed back through the graft. (e) A nasal plug coated with a paraffin-impregnated gauze is passed through the created suture loop. (f, g) The plug is initially directed medially into the nostril. Tightening the suture then pulls the plug firmly up against the wound bed of the ala. (h) The excess length of the nasal plug is removed. (i) This is then secured as a bolster on the graft as shown. (j) The aforementioned technique 'sandwiches' the graft securely between the two plugs as shown. Note how the internal nasal bolster focuses the pressure within the nostril exactly where it is required on the lateral undersurface of the ala. According to its size, therefore, a degree of airflow may still occur within that nostril.

using a bolster dressing at all for small FTSGs.⁷ This practice, however, will vary according to the surgeon's surgical influences and experience.

In conclusion, we describe the SS, which in essence is a quilting suture in a unique location. As illustrated, it secures the bolster dressing in place and maximizes adherence of a FTSG to the wound bed of defects on the nasal ala. It has, in

our opinion, a number of advantages over bolster dressings previously described for this site, not least the comfort for the patient in having a degree of patency of their nasal airway. It is effective and simple to perform and provides the reconstructive surgeon with another technique for optimizing outcomes in FTSG repair of the distal nose.

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Differing patterns of methotrexate use for psoriatic disease among dermatologists and rheumatologists

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MADAM, Methotrexate (MTX) is the most frequent systemic immunomodulatory drug used by dermatologists for the treatment of psoriasis (PsO) and the most common disease-modifying antirheumatic drug used by rheumatologists for the management of psoriatic arthritis (PsA) and rheumatoid arthritis (RA).^{1,2} Disease treatment guidelines have been published in both specialties; however, limited data exist regarding current MTX use.

We compared practice preferences of MTX use among currently practising Canadian dermatologists and rheumatologists using a 56-question survey. The survey was distributed to 414