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BREAST IMPLANTS

Sir:

I thought that a recent case would provoke some thought and maybe some comments from other readers concerning breast implants.

Recently, a patient was brought to the operating room with a predetermined desire for implant removal. The implants were the old style thick-walled Dow Corning implants with a highly coherent gel and fixation patches on the back. Being aware of the irregular reflection which is seen on the surface of a ruptured implant by virtue of the presence of free silicone, I have been in the habit of observing the surfaces of the implants carefully before making a large opening in the capsule. On one side the implant was obviously ruptured, and the implant was removed along with the patches. On the other side, there was no evidence at all of a rupture, but when the implant was removed, there was a fracture of the implant along the upper edge of the uppermost patch, and even after all of the surgical manipulation in dissecting the implant free and delivering it, the highly coherent gel of the old style implant was confined to an area no larger than 3 cm in diameter, even at reinspection following realization of rupture.

On the basis of this finding, I would no longer consider the light reflection criterion as 100 percent reliable for the detection of rupture through a small incision or an endoscopic procedure.

Another concern which I have had is one about the term *gel bleed.* Just as we have created problems for ourselves with use of the word *cosmetic* when we really meant *aesthetic,* we have accepted the term *gel bleed,* which particularly for the lay public, including those in the media, has a certain emotionally laden connotation when one thinks about it. When one thinks about it, when a structure bleeds, it is through unnatural openings such as are caused by a rupture or laceration or incision, but when a substance diffuses through an intact membrane, the process is more analogous to sweating.

Therefore, I would propose that the term *gel sweating* is a preferable term not only because it has an inherently less sensational connotation but especially because it more accurately reflects the actual physical event. We would not want to use the term *gel leak* unless there were actually a hole in the shell of an implant, but that is exactly what blood does when it leaks out of a ruptured or lacerated blood vessel.

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TWO CASES OF APPARENT SILICONE ALLERGY

Sir:

I have seen two patients with apparent silicone allergy and can find no reports of a similar case in the literature. A 45-year-old woman presented with a scar contracture of the hand. She had had a prior augmentation mammaplasty in 1983. A first-stage reconstruction of the scar contracture with insertion of a tissue expander was performed on September 27, 1990. She had an incidental mammogram on November 1, 1990 and noted pain in the breasts afterward. The implants were intact on radiologic examination. She had a rash in the cervical region after the mammogram and was treated on December 7 and 22 for a rash over the tissue expander. The expander was removed on December 19. The cervical rash continued. Both breast implants were replaced with gel implants on July 8, 1991. Both were ruptured. The cervical rash resolved in the immediate postoperative period and recurred on July 31. She last saw me in November of 1993 following TRAM flap reconstruction of both breasts and reported resolution of the rash since removal of the implants.

A second patient, a 30-year-old woman, had bilateral augmentation mammaplasty with gel implants on April 25, 1991. About 48 hours after surgery she had a fever of 100°F that resolved after another 48 hours. She was asymptomatic until September 23, 1991, when she had tenderness and a rash of the right breast (Fig. 1, *left*). She was taken to the operating room the next day. At that time she had a bilateral rash involving both breasts and axillae (Fig. 1, *left* and *center*). The right implant was noted to be intact. A partial capsulectomy was performed, and the implant was replaced. The left breast implant was untouched.

The patient continued with a rash of the breast and torso (Fig. 1, *right*) with episodes of angioneurotic edema and anaphylactic shock. She had removal of both implants on February 21, 1992, with complete resolution of symptoms. Both implants were intact at the time of removal. A silicone port-a-cath was placed for an unrelated problem on June 24, 1992. Her rash recurred, requiring removal of the catheter.

Both patients had giant-cell foreign-body reaction in the breast capsules. Neither had eosinophilia. Some authors have speculated that rupture or bleed of silicone gel can contribute to a connective-tissue disease process.[1–4] There are no previous studies of silicone allergy to breast implants in humans, and previous in vivo studies in animals are inconclusive.[5–8]

The first patient noted a localized rash of the hand overlying a soft-tissue expander. She had a cervical rash after apparent rupture of breast implants after mammography. It is hypothesized that rupture of the implant and leakage of gel initiated an allergic reaction. Replacement of leaking implants with intact silicone gel implants did not resolve her symptoms. When the implants were removed, her symptoms ceased.

The second patient was asymptomatic after breast augmentation until 5 months after surgery. The rash and other allergic manifestations eventually resolved after removal of the still-intact implants. Both patients are presented as cases of apparent silicone allergy to silicone implants.

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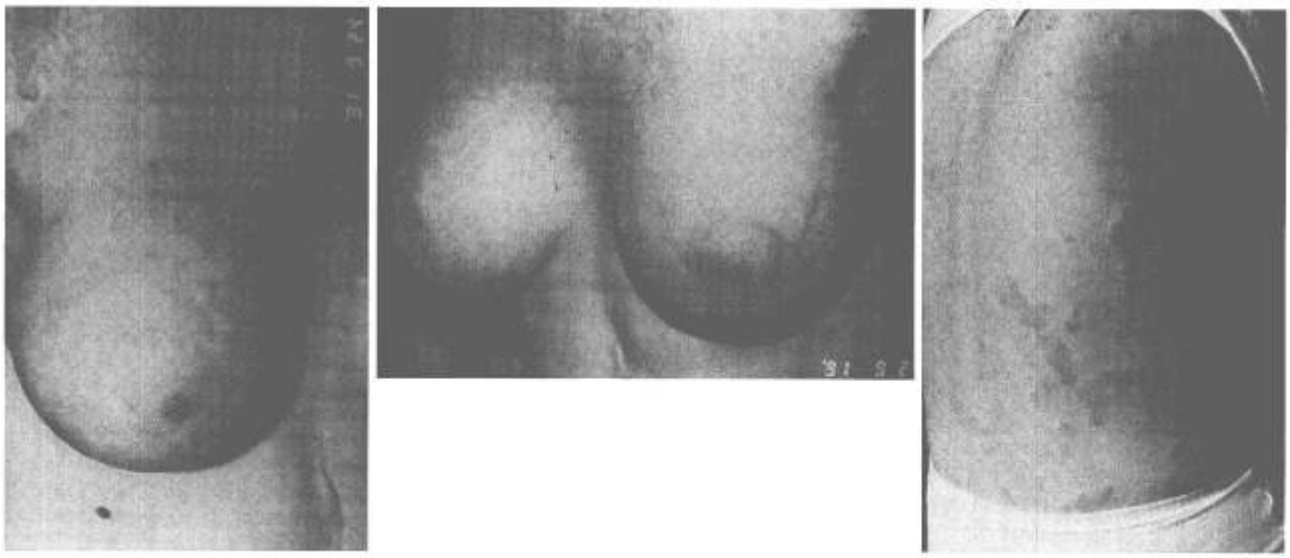

FIG. 1. *Case 2.* (*Left*) Rash of periareolar region of right breast and axilla shown on day of second surgery. (*Center*) Rash of periareolar region of left breast and axilla shown on day of second surgery. (*Right*) Postoperative view of generalized rash involving the back.

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AGGRESSIVE SURGICAL MANAGEMENT FOR MERKEL CELL CARCINOMA

Sir:

The recent article by Shack et al. on aggressive surgical management in the treatment of Merkel cell carcinoma (*Plast. Reconstr. Surg.* 94: 970, 1994) is justified. I wish to share my experience with another patient with an even more aggressive approach that may have led to a better outcome.

Approximately 4½ years ago a 68-year-old white woman presented to my office with a lesion in her left cheek. Biopsy revealed this to be a Merkel cell tumor. A metastatic workup was negative, and there were no palpable lymph nodes. A wide excision with 2-cm margins was performed, and due to the proximity, a superficial parotidectomy also was performed. At that time, one lymph node was positive for metastasis. The patient was seen 2 months ago in good health. Rather than waiting for nodes to become clinically palpable, regional node dissection may be indicated. Perhaps early aggressive intervention may result in improved survival.

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ENDOSCOPIC MEDIAN NERVE DECOMPRESSION

Sir:

I wish to comment on the article written by Dr. Hillel Skoff and Robin Sklar, entitled Endoscopic Median Nerve Decompression (*Plast. Reconstr. Surg.* 94: 691, 1994). In their article, Drs. Skoff and Sklar mention that their open-palm technique has an operative time averaging 28 minutes. In addition, intravenous regional anesthesia was utilized for all procedures.

I wish to report that in our last 20 patients on whom open palmar carpal tunnel was performed, the average operating time was 16 minutes, and all operations were done using local infiltrative anesthesia of 0.25% marcaine. These were all done in a freestanding ambulatory surgery setting without an anesthesiologist or nurse anesthetist providing any type of sedation.

I mention this not to tell the world "how fast and slick a surgeon I am," but rather that open palm technique can be done faster and more safely than endoscopic carpal tunnel release. All of this can be done at much less expense for anesthesia, anesthesiologists, preadmission testing, and any other steps that are involved in doing this procedure. Whether the patient's time of return to work is improved significantly with the endoscopic technique and whether the