

THE ABDOMINAL SKIN-FLAP IN RADICAL AMPUTATION OF THE BREAST

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VARIOUS plastic operations have been recommended for covering in the defect remaining after a radical amputation of breast with extensive skin removal. In a number of patients skin grafting is necessary.

The surgeon should never be influenced in the amount of skin he will sacrifice by considerations relating to the later closure of the wound. By extensive undermining of the skin it is often possible to close a wound whose edges it had seemed impossible to approximate. The same can be accomplished by plastic operations using flaps of neighboring skin.

During the past two years I have operated upon several patients with malignant disease of the breast, who had metastases in the skin of the chest wall below the breast, so that the radical removal of the disease required a widespread excision of skin and subcutaneous tissue. The large defect that remained could not have been closed by any of the plastic methods ordinarily used and skin grafting would have been necessary. By means of a large flap of skin from the abdominal wall the raw surface was easily covered over. The steps of the procedure are shown in Figs. 1-4 and can be understood without further explanation.

The skin of the abdominal wall is generally very lax and receives abundant blood supply from branches of the arteries which run through the wall of the abdomen from behind forward. If the base of the skin flap is not too small the tissues will be well nourished with blood, and there is no danger of sloughing or of marginal skin necrosis. After flap has been raised from fascia and slid upward into new position, there is no difficulty in closing the defect in the abdominal wall with interrupted sutures. It is surprising how much skin can be used for the flap and sufficient remain to close up the defect in the abdominal parietes without much tension. Size and shape of the abdominal skin flap will depend upon size and form of the raw surface on the chest wall.

The abdominal skin flap is necessary only in those cases in which the defect left after radical amputation of the breast cannot be closed by any of the methods ordinarily in vogue; it is useful after extensive removal of skin and makes skin grafting unnecessary. Nothing especially original is claimed for this plastic operation, but I believe that it should be considered the typical procedure in many cases.

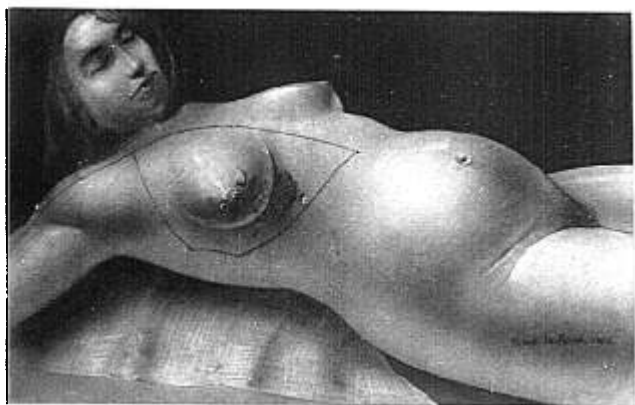


FIG. 1.—The skin incision for the removal of the breast and the diseased skin.

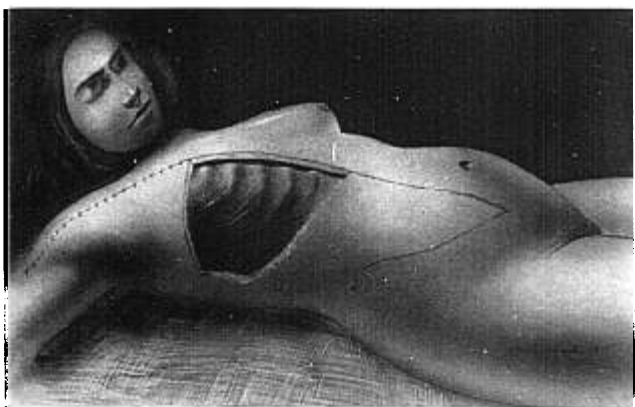


FIG. 2.—Part of the wound has been sutured. The abdominal flap is shown in outline.

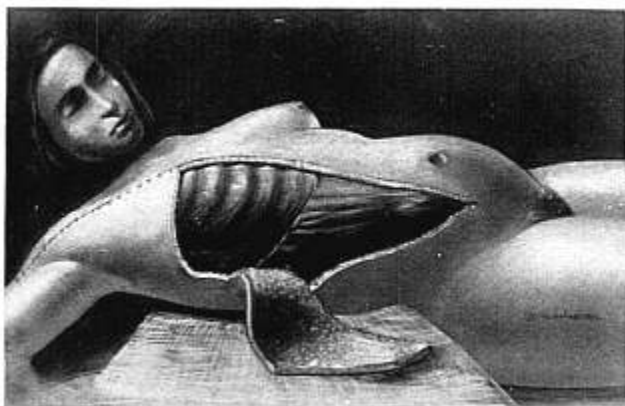


FIG. 3.—The abdominal flap of skin and fat has been raised.



FIG. 4.—The abdominal flap in its new position and the entire wound closed by suture.