WPRS
Warrnambool Plastic & Reconstructive Surgery

Issue
30
February 2015

this issue

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In situ melanoma: what does it mean?

Great confusion surrounds melanoma in situ. This is predominantly due to the different names given to the condition including lentigo maligna, Hutchinson's melanotic freckle, level 1 disease and in situ superficial spreading melanoma.

It is simply better to consider all of these as Melanoma in situ (disease confined to the epidermis). Melanoma in situ often presents on the face and neck in people aged 60 and above. It has no metastatic potential, however approximately 20% will over 10 years progress to invasive disease.

NHMRC guidelines suggest excision of melanoma in situ with a 5mm clinical margin. Occasionally,this is difficult due to the location of the lesion and lesser margins maybe accepted if further excision will cause functional or cosmetic deformity.

The relative risk of developing melanoma once you have had one in situ melanoma will increase slightly. Hence yearly skin checks would be recommended.

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Carpal tunnel release: what are the dangers to avoid

Carpal tunnel release (CTR) is one of the most common surgical procedures performed on the hand. However, not only are there a number of techniques by which the release can be performed (open, endoscopic, closed single port techniques) there are a number of pitfalls that need to be avoided in order for patients to achieve the best results.

The most common patient concerns post operatively are:

1. Pain in the scar: This can last up to 3 months. Patients are often warned of this and at WPRS we have our hand therapist work regularly with patients to speed up recover.
2. Finger stiffness: unless a hand therapist works on tendon gliding, the flexor tendons get caught in the carpal tunnel resulting in finger stiffness.
3. Ongoing numbness in fingers: the more severe and prolonged the compression of the median nerve the slower finger numbness recovers post- surgery. Symptoms of intermittent paresthesia and nocturnal symptoms should however resolve within 48-74 hours.
4. Wrist pain: "pillar pain syndrome" can occur in 5-8% of people undergoing CTR. It is important that this is identified and managed early. Good outcomes can be achieved with hand therapy and conservative measure.
5. Chronic regional pain syndrome (CRPS): 2% of patients undergoing CTR develop some form of CRPS. It is very important that this is identified early. Early management involves hand therapy.

Operative complications should be rare; however it is important to understand the anatomy to avoid

1. Nerve injury. Median nerve injury is rare. However, injury to the motor branch is more common and it is important to appreciate the anatomical variation of this branch to avoid injury
2. Incomplete release. It is often under appreciated how far proximally and distally the carpal ligament extends. If symptoms of paresthesia and nocturnal do not improve by 6 month post surgery an MRI is required to assess adequate release.

It is important for patients considering CTR that they are aware of these potential pitfalls and the need for hand therapy post operatively. At WPRS we employ a full hand therapist to ensure optimum results for our patients and quickest recover.

How to directly refer to hand therapy at WPRS (Monday - Friday 9 - 5pm)

1. GP clinic or client to call reception to book appointment time.
2. Written GP referral required if WorkCover, TAC or Enhanced Primary Care Plan and Fax to 5562 5360
3. Hand therapy will send written correspondence to GP after first visit and at discharge to update progress.
4. GP to write separate referral to Mr Toma if you would like his surgical opinion at any stage.

Please call us on 5562 5330 for all hand therapy appointments and enquires.