WPRS
Warrnambool Plastic & Reconstructive Surgery

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this issue

Let us answer some questions you may have

- **Carpal tunnel release: Is endoscopies better than open release?**
- **What is the best way to manage recurrent lower lip crusting?**

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Recurrent lower lip crusting: what is the best way to manage this?

Recurrent crusting of the lower lip is a common problem often affecting men with high levels of sun exposure over the years. The important thing is to differentiate between benign crusting and squamous cell carcinoma (SCC).

Solar chelitis is the most common cause of lower lip crusting. It reflects chronic sun damage and often presents with recurrent crusting worse in the summer months. Clinically, there is often a lack of symptoms and no evidence of ulceration. I recommend to my patients to wear regular clear zinc cream on their lower lip. If the crusting is recurrent and the patient is finding it difficult to manage, I will offer them a vermillionectomy.

SCC in situ often present in a similar fashion to solar chelitis, however the crusting does not usually resolve and they may occasionally bleed. Often this is diagnosed on biopsy. Recommendation for SCC in situ of the lower lip is a vermillionectomy. Occasionally due to the position or size of the lesion, a wedge resection may be required.

SCC of the lower lip is extremely common. If often present with a non- healing ulcer, often bleeds and is painful. There is a higher rate in smokers. As metastatic spread is possible (4% of lower lip SCC's metastasise) examination of their parotid and cervical nodes is essential. A biopsy proven SCC of the lower lip requires a wedge resection to excise.

The most important rule in management of lower lip lesion is: if in doubt punch biopsy the lesion.

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Carpal tunnel release: Is endoscopic better than open release?

As with all things in surgery we are always trying to improve techniques and minimise morbidity to patients. The laproscope has revolutionised many areas of diagnostic and therapeutic work in surgery such as cholecystectomy. As a result, minimal access surgery has been adapted to other areas in an attempt to improve patient outcome. One such development has been the endoscopic carpal tunnel release (CTR).

There is a lot of confusion surrounding endoscopic CTR. This technique involves insertion through a single 1cm incision of an endoscope and under direct vision, the carpal ligament is divided. This is as opposed to other minimally invasive techniques, where an instrument is inserted blind and the carpal ligament is divided blind. This blind technique is not recommended and can be dangerous.

So what are the proposed benefits of endoscopic CTR? Smaller scar (1cm vs. 3cm for open), decreased scar tenderness, better grip strength at 3 months and earlier return to work. So if there are all these benefits , then why do all hand surgeons not perform endoscopic carpal tunnel release?

There have been three prospective randomised controlled trials into open vs. endoscopic release, with a meta-analysis of these studies published in 2004. Endoscopic CTR does in fact increase grip strength and decrease scar tenderness at 3 months. However, endoscopic CTR does not decrease return to work time or improve functional status. More concerning for endoscopic release is that there is a 4% increase in median nerve injury, an increased rate of incomplete release and significantly longer operative time. It is for these reasons that I elect to perform open CTR.

It is my opinion that the patient's outcome following CTR is directly related to their compliance with hand therapy, not whether the procedure is performed open or endoscopic. At WPRS, we have 3 hand therapists working 5 days per week to ensure that patients achieve their best outcome.

Annual Leave Notification

Please note that Mr Toma will be on Annual Leave from -

Friday 18th April until Sunday 27th April 2014 inclusive.

WPRS will remain open as usual from 8.00am to 5.30pm
with the exception of Public Holidays.