The Lazy 'S' Incision

The 'Z' plasty, while obviously valuable, does require expertise in its execution, handling and resuturing, and can be time-consuming. A simpler method for the average case was then sought, providing no previous scar was present. By replacing the original straight-limbed 'J' incision with a very sharply waved serpentine or lazy 'S' type, an easily executed way of gaining skin was found. This incision is best started with a downwardly convex cut situated between the medial malleolus and the point of the heel. From here the long vertical and short horizontal limbs of the exposure are broken up with sharp 'S' inflections, as far in either direction as is required (Fig. 3a).

The shape of the skin incision alone, however, achieves but a small skin gain. The essential feature is to undermine the superior flap sufficiently so that in effect a very wide-based triangle of skin may be induced to slide downwards and backwards to a considerable extent. In the thin patient this flap of skin lifts off the deep layer of superficial fascia with no difficulty, and the thickness of the flap is thus more or less predetermined. In the fat child, however, it has been our policy to leave the edge of this flap thin and deepen the incision progressively until by the time the medial malleolus is reached, there is a tapering layer of fat attached to the skin flap. Undermining of this flap must be ruthless and carried out to well beyond the medial malleolus—or a gain in skin will not be achieved.

Resutting of this flap is perfectly straightforward, and it is interesting to note that an incision that commenced as a very wavy 'S' indeed, closes in the form of a 'J'—an indication of skin gain (Fig. 3b).

If additional length is required in the vertical limb over the tendo achillis, or should this close in a straight line that would be better broken, a small 'Z' plasty may be carried out at the upper end of the incision.

Skin healing with the lazy 'S' incision initially followed the same pattern as with the 'Z' plasty. Where full correction of the foot was forced and maintained at the time of operation, some edge sloughing of this incision always occurred, whereas if full correction was delayed until the first plaster change at 2 weeks, healing by first intention was the usual result.

Haematoma formation has been observed under the large anterior flap in 2 recent cases. Since then we have taken the added precaution of removing the tourniquet and compressing the wound until haemostasis is complete, before applying the plaster-of-paris cast.

EVALUATION OF THE SKIN INCISIONS

The management of skin closure in the Dwyer osteotomy falls into 2 distinct categories:

1. Where the heel is unscarred by previous surgery.
2. When a previous soft tissue release or tendo achillis lengthening has left a contracted scar.

In the case with no previous operation, it is now our policy to use the lazy 'S' incision, because it is easier to plan and quicker to close. Even when considerable corrections have been achieved, skin closure is relatively easy by this method, and as long as full correction is not held at the time of operation, healing is seldom a problem.

Where, however, previous scars exist on the medial side of the ankle, the 'Z' plasty comes into its own. The usually encountered scar is either 'J'-shaped or vertical along the medial aspect of the tendo achillis; and either may be easily excised and incorporated into the 'Z' plasty. Particularly where a 'J'-shaped scar is present, the 'Z' plasty is the only incision we know that will give an adequate exposure, allow excision of the old scar, and still permit skin closure over a lengthened and everted heel.

CONCLUSION

The use of Kiel deproteinated calf bone in place of autogenous graft in Dwyer opening medial os calcis osteotomy is simple and entirely satisfactory.

Following previous surgery, a 'Z' plasty; and in the unscarred foot, a lazy 'S' incision, have given the most satisfactory results in this operation.

REFERENCE


SPOROTRICHOSIS IN CHILDREN

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Sporotrichosis is a fungus disease well known in the Witwatersrand area of the Transvaal. It occurs predominantly in adults and the great majority of cases have occurred in underground mine workers. Over the years large outbreaks of sporotrichosis, in certain mines of the Witwatersrand, have practically assumed epidemic form.

Only cutaneous and lymphangitic sporotrichosis have been encountered, and visceral and systemic sporotrichosis must be very rare indeed in the Transvaal.

The clinical features of sporotrichosis in adults are, in the majority of cases, so clear and well defined that the diagnosis does not present any great difficulty. The primary ulcerating granuloma is followed by a marked linear thickening of the lymphatic channels draining the area and by the development of subcutaneous nodules, which may ulcerate, along the thickened lymphatic cord.

In doubtful cases the presence, detected by direct microscopic examination, of Sporotrichum schenckii in the secretions of the primary granuloma or a positive culture from the secretion or from a scraping or biopsy of the primary lesion, or from the aspiration of one of the lymphangitic nodules, would conclusively establish the diagnosis.

Sporotrichosis in children is rare. The possibility of sporotrichosis in these cases is not even considered and it may, therefore, remain undiagnosed and untreated for long periods of time. The clinical features of the disease to be described in 3 children seen during the past 4 years,
moreover, show certain deviations from the characteristic clinical features in the adult, which would add to the difficulty of diagnosis.

Case 1
A boy aged 6 years injured his knee on the ground while playing. According to his mother, a progressively enlarging heaped-up 'sore' developed over the area of the trauma. The diagnosis made was that of a post-traumatic granuloma pyogenicum. The lesion had been treated for 4 months by antibacterial, antiseptic and antibiotic topical and internal therapy without result.

An examination showed a large fungating granulomatous tumour, well raised above the surface of the normal skin and exuding a viscos sero-pus, on the anterior aspect of the left knee. There was an absence of any thickening of the draining lymphatics. The general health remained very good.

An examination of the secretion was negative for sporotrichosis. A biopsy of the granulomatous tumour, on culture, showed the presence of Sporotrichum schenckii. Potassium iodide, slowly increasing in dosage to 30 grains per day, caused resolution within 6 weeks.

Case 2
A young girl aged 3 years presented with a large infiltrated nodular granulomatous plaque on the flexor aspect of the left lower leg. There was no thickening of the regional lymphatic vessels.

There was no history of trauma. The lesion had been treated as a 'veld-sore' for a period of 6 months by various topical and internal remedies.

Direct microscopic examination of the secretion was negative for sporotrichosis. A biopsy scraping of the ulcer was positive for the sporotrichum on culture.

An uneventful recovery followed potassium iodide therapy after a period of 8 weeks.

Case 3
A young girl aged 6 years presented with a persistent ulcer of the right forearm of 4 months' duration. Various therapeutic measures had been adopted during this period on the presumed diagnosis of a chronic pyococcal ulceration of the skin.

An examination revealed a serpiginous nodular granulomatous ulcer, with some degree of healing and fibrosis, on the flexor aspect of the right forearm about 5 cm. above the ulnar aspect of the wrist. There was no lymphangitic spread from the initial ulcer.

Sero logical tests for tertiary syphilis were negative. A direct smear failed to reveal the sporotrichum. A culture was also negative, which could well be explained by the scarring and fibrosis which had occurred.

The immediate favourable response to potassium iodide therapy, the exclusion of syphilis serologically, of tuberculosis of the skin on histological examination and of other mycotic granulomata bacteriologically, strongly pointed to the diagnosis of sporotrichosis.

SUMMARY
Three cases of sporotrichosis in children were briefly described. The only clinical sign present was that of a chronic non-healing granulomatous ulcer, exuding sero-pus, on the lower limb in 2 cases and on the upper limb in one case.

The characteristic thickened lymphatic cord draining the area of the primary granuloma, with subcutaneous nodules along its course, as frequently encountered in adults, was absent in all the cases. Garrett and Robbins,1 in a series of 8 cases of sporotrichosis, found the lymphangitic form in one case only.

Direct microscopic examination of the secretion for the sporotrichum was negative in the 3 cases. It was positive on culture in 2 cases, and the diagnosis in the third case was made by a process of exclusion of other possible aetiological causes, and by the therapeutic response to potassium iodide therapy.

Paul D. Ellner,2 in 8 cases of sporotrichosis, failed to find the sporotrichum by direct microscopic examination of the smears in any one case, but by culture a positive result was obtained in 5 cases.

The clinical features and the response to therapy established the diagnosis in the remaining 3 cases.

A similar difficulty in finding the sporotrichum by direct microscopic examination from the secretions has been mentioned by Robinson.3

The 3 cases in these children were treated for periods of many months as pyogenic skin infections and the possible diagnosis of sporotrichosis was not considered.

A history of trauma was obtained in one case only. Minor unobserved injuries from wood splinters or from plants may have occurred in the other two cases.

It is advisable that the diagnosis of sporotrichosis should be considered in a chronic granulomatous ulcer of the upper or lower limbs in children in whom antibacterial and antibiotic therapy has been ineffective after thorough trial.

A culture for the sporotrichum will be positive in the majority of cases.

The therapeutic test by the administration of potassium iodide will assist considerably in the final attempt at a correct diagnosis.

The sporotrichin skin test and the serum agglutination test for sporotrichosis are not employed in this country in the diagnosis of sporotrichosis. They have been stated to have been of value in America.4

REFERENCES

DEVELOPMENT OF THE PSYCHIATRIC UNIT OF THE JOHANNESBURG HOSPITAL AND THE ROLE OF THE CLINICAL PSYCHOLOGIST
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DEVELOPMENT OF THE PSYCHIATRIC UNIT
A psychiatric outpatient clinic was started at the Johannesburg Hospital in 1932 attended by part-time psychiatrists. A full-time consultant psychiatrist was appointed to the staff in November 1950 to ensure that psychiatric consultation was available at all times, but there were no psychiatric beds as yet. In January 1959 a Chair of Psychological Medicine was established at the University of the Witwatersrand and Prof. L. A. Hurst was appointed to it. He was at the same time appointed Chief Psychiatrist of the Johannesburg Hospital.

It was then decided to establish an inpatient psychiatric unit at the Johannesburg Hospital which is the teaching hospital of the University. Conferences took place with the Medical Superintendent of the hospital and twelve medical beds were converted to psychiatric ones in one of the wards. A senior houseman was appointed in February 1959.

However, the attitudes of the staff to psychiatric services were varied, and, particularly on the part of the nursing staff, much resistance had to be overcome. Conferences were held to orientate the nursing staff towards...