

galactorrhoea associated with VP shunt and normal hormones¹³ (both without increase of the breast size). Of the other three cases, two were drained under US guidance and only one was published in journals related to our specialty. In that case the complication arose two years after the placement of the VP shunt and it was solved in a similar way.¹⁴ Another case exists in which the breast increase is subsequent to the VP.¹⁵

Our case is about a migration of the catheter which could perforate the periprosthetic capsule or could have been damaged during the tunnelisation or could have been in close contact with the capsule and subsequently with the prostheses, which could have produced the migration. The neurological symptomatology was very mild at the beginning because the gap capsule-prostheses was like a reservoir for the CSF, avoiding the hypertension due to hydrocephalus. Mammary surgery could be avoided, since it was a clear liquid collection, very similar to CSF, so that at that time it was not logical to consider the prostheses as septic or contaminated, which would have forced us to remove it. We chose a more conservative management waiting for the cultures and the patient evolution. The result, as is seen in Fig. 2 b–d, is very good aesthetically and we avoided surgery with its increased risk of capsular contraction.

Patients who have undergone augmentation mammoplasty who then need to have a ventriculoperitoneal shunt, it is important to note the possibility of shunt migration around the breast implant. In order to prevent this complication, it is recommended that the distance between the shunt and the implant is sufficiently more ample, or to avoid the implant zone in the passage of the shunt. It must also be stressed to the patient that cautious measures must be taken after subsequent surgery around the shunt site until the tissue has healed completely.

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doi:10.1016/j.bjps.2007.09.032

The six V-flap technique for preputial stenosis

Operations for preputial stenosis (phimosis) aim at achieving normal retractability of the prepuce so that it need not be removed.^{1,2} In Japan, the 'six V-flap technique' was developed by Iwakawa et al. and was initially used for buried penis.³ In this method, the penile skin and inner prepuce are cut in an equal way like peeling a banana and then sewn to each other, thus obtaining sufficient penile skin coverage without resection of any preputial tissue. We considered that this method might also be applicable to constriction at the orifice of the prepuce, where its inner and outer skin layers meet. Here we describe the use of this method for two cases of phimosis as well as a case of buried penis. To our knowledge, this is the first report of the six V-flap technique in the English literature.

Surgical technique

The first incision is made around the narrow ring at the margin between the inner and outer layers of the prepuce (Fig. 1A). Then three longitudinal incisions are made at 120° intervals, each approximately two-thirds of the length of the glans, in the outer preputial skin (Figs. 1B and 2B). After the incision releases tension, the outer preputial skin shrinks (Fig. 1C). If there are adhesions between the inner preputial skin and the glans, these should be released. Near the tip of the outer preputial skin flap, three longitudinal incisions are made in the inner preputial skin starting from the orifice with scissors (Figs. 1D and 2C, D). These incisions normalise the circumference, so that preputial

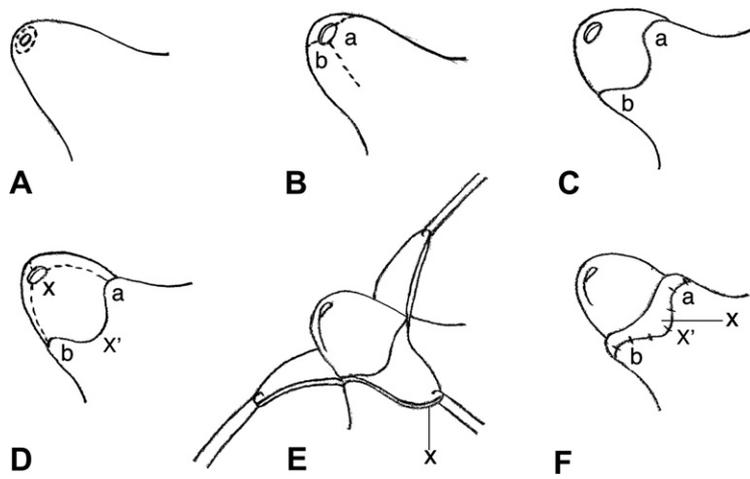


Figure 1 Surgical procedures. (A) The first incision is made along the dotted line around the site of phimosis. (B) The outer preputial skin is incised along the dotted lines. (C) The outer preputial skin shrinks back. (D) The inner prepuce is cut along the dotted lines. (E) The inner prepuce is reversed and the glans emerges. (F) The V-flaps are sutured in place. a, b: Tip of the outer preputial skin flap. X: Tip of the inner preputial skin flap. X': Base of the outer preputial skin flap.

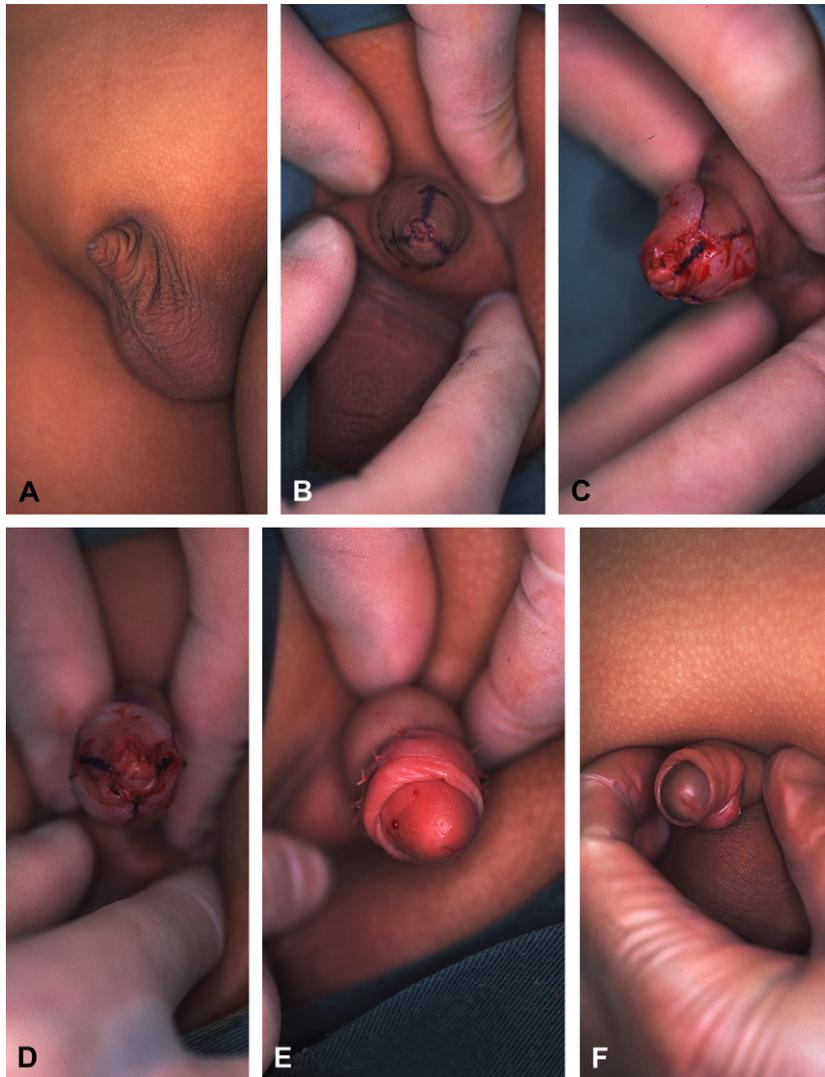


Figure 2 The patient with a buried penis. (A) Buried penis trapped by a phimotic ring. (B) Marking of three V-flaps on the outer preputial skin. (C, D) Near the tip of the shrunken outer preputial skin flap, three longitudinal incisions are designed on the inner preputial skin. (E) The penis is visualised by displacing the prepubic fat. (F) The prepuce is fully retracted.

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