

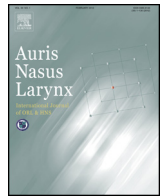


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Case report

A case grafted with polyglycolic acid sheets and fibrin glue for protection after temporary resection of a metastatic cervical skin tumor

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ABSTRACT

The aim of this case report was to evaluate the usefulness of a grafting with polyglycolic acid sheet and a fibrin glue spray (PGA sheet grafting) after resection of a cervical skin tumor. A 61-year-old woman presented with left cervical skin tumor resistance to chemo-radiotherapy. She had been undergoing multimodal therapy for ovarian serous papillary adenocarcinoma for the previous six years. Although she had a poor general condition and a cervical skin tumor of 9 cm in diameter, which was painful and easy bleeding, had offensive smell, she hoped to return to her job. Under local anesthesia, resection was performed, and PGA sheet grafting were used to shield the skin defect. After resection, she was relieved from pain, and could stay home without daily wound treatment. One and half months after resection, the wound was almost epithelialized. The PGA sheets consist of soft, elastic, nonwoven fabric made of PGA. In recent years, PGA sheet grafting has been widely used in the reconstruction and was chosen to shield the skin defect for this case. PGA sheet grafting after resection of cervical skin tumor can be an acceptable method for palliative care to relieve pain, bleeding, offensive smell, and ugly appearance.

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1. Introduction

The neck is usually not covered with clothes, and thick blood vessels run close to the skin. Due to these anatomical reasons, discussing the management of cervical skin tumors and reconstruction after resection with the patient is critical. In recent years, a treatment technique in which polyglycolic acid (PGA) sheets are applied with fibrin glue has been widely used in multiple surgical fields [1–5]. The aim of this case report was

to evaluate the usefulness of a grafting with PGA and a fibrin glue spray (PGA sheet grafting) for skin defects after temporary resection of a metastatic cervical skin tumor.

2. Case presentation

A 61-year-old woman was referred by our palliative care team to the department of otolaryngology in May, 2014. The patient visited the gynecology department of our hospital complaining of abdominal bloating in August 2006. Total hysterectomy with bilateral salpingo-oophorectomy was performed and she was pathologically diagnosed as having stage IIIc ovarian serous papillary adenocarcinoma. After three

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courses of chemotherapy with paclitaxel and carboplatin (TC), epiploectomy, pelvic node dissection, and appendectomy were performed in December, 2006. Stereotactic radiotherapy for brain metastasis and salvage operation for recurrence in the omentum were performed in 2010. Left supraclavicular lymphadenopathy and a left cervical skin tumor appeared in 2012, for which radiotherapy (total dose, 39 Gy) and chemotherapy with TC were performed but were unsuccessful in reducing these masses. In addition, metastasis to the duodenum was detected. Although temporary treatment with Mohs paste [6] for the cervical skin tumor was discussed, the tumor was too close to both the carotid artery and jugular vein to perform the treatment. Despite an increase in tumor size and the necessity of a gauze dressing to the discharge sites of pus and bleeding, the patient's wish was to return to work as a sales clerk, and she consulted the palliative care team.

When the patient visited our department, her general condition was poor; her performance status was grade two (ambulatory and capable of all self-care but unable to carry out any work activities), and blood examination revealed high C-reactive protein levels, anemia, hypoalbuminemia, hyponatremia, and heteropathy. The left cervical skin tumor was 9 × 8 cm in size, ulcerated, and protruded. CT revealed that the cervical tumor faced the sternocleidomastoid muscle without enclosure of major vessels. In contrast, the supraclavicular lymph node enclosed the subclavian artery and vein (Fig. 1).

In the treatment planning, she wished to have the cervical skin tumor removed even though the removal was not curative but temporary and palliative. In June, 2014, local anesthesia was used to reduce the surgical burden and the resection was performed. To prevent surgical site infection, 2 g of Cefazolin

was used only before the resection, and another antibiotics were not used preoperatively.

A skin incision was made on the narrowed part around the tumor. The extra jugular vein located close to the tumor was disposed, and the tumor was excised under the superficial fascia of the sternocleidomastoid muscle (Fig. 2a). After the skin was sutured to the sternocleidomastoid muscle to cover the deep neck structure (Fig. 2b), PGA sheet grafting was performed; PGA sheets and fibrin glue were used to shield the skin defect. Fibrinogen solution, a component of the fibrin glue kit (Bolheal; Kaketsuken, Kumamoto, Japan), was sprayed on the skin defect before application of the sheet [7]. The PGA sheet (Neoveil 015G; Gunze Ltd., Kyoto, Japan, Fig. 2c) was cut to fit the skin defect, making sure that the PGA sheet did not extend to the skin. The PGA sheet was applied to the defect and the sheet absorbed the fibrinogen solution that had been sprayed on the defect previously. Finally, thrombin solution was applied to cover the PGA sheet and the adhesion procedure was completed (Fig. 2d). The total duration of the procedure was 48 min, and total amount of blood lost was 10 ml.

One day after temporary resection, the patient did not experience any pain and the wound was slightly wet, but daily treatment of her wound was apparently not serous, no gauze dressing was required and she covered the wound with a scarf herself. Seventeen days postoperatively, the wound had reduced in size and had become a scar lesion (Fig. 3a). One and half months postoperatively, the wound had almost completely epithelialized (Fig. 3b). However, the patient died 70 days postoperatively due to primary ovarian cancer.

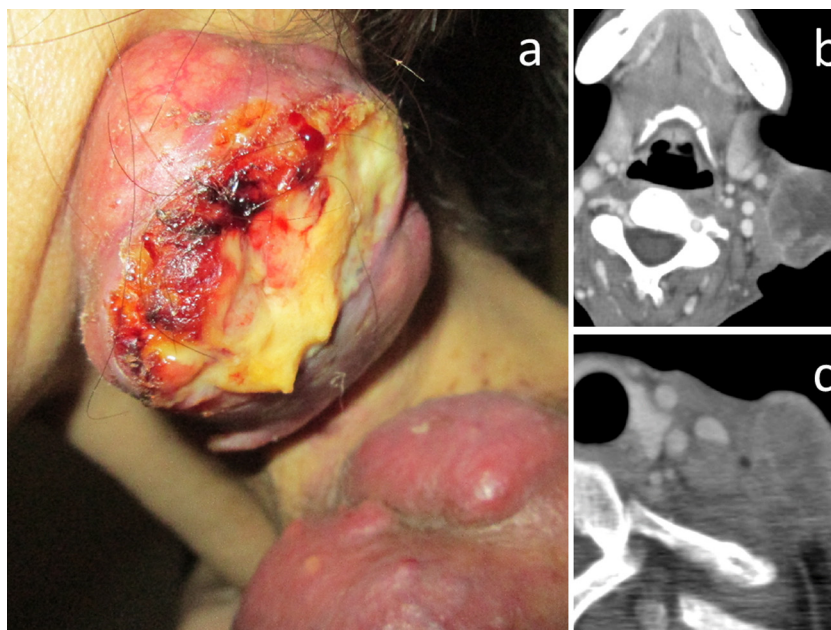


Fig. 1. Preoperative status of patient.

a: Left supraclavicular lymph node and left cervical skin tumor. The left cervical skin tumor was 9 × 8 cm, ulcerated, and protruding.

b: CT findings revealed that the cervical tumor faced the sternocleidomastoid muscle without enclosure of major vessels.

c: The supraclavicular lymph node enclosed the subclavian artery and vein.

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