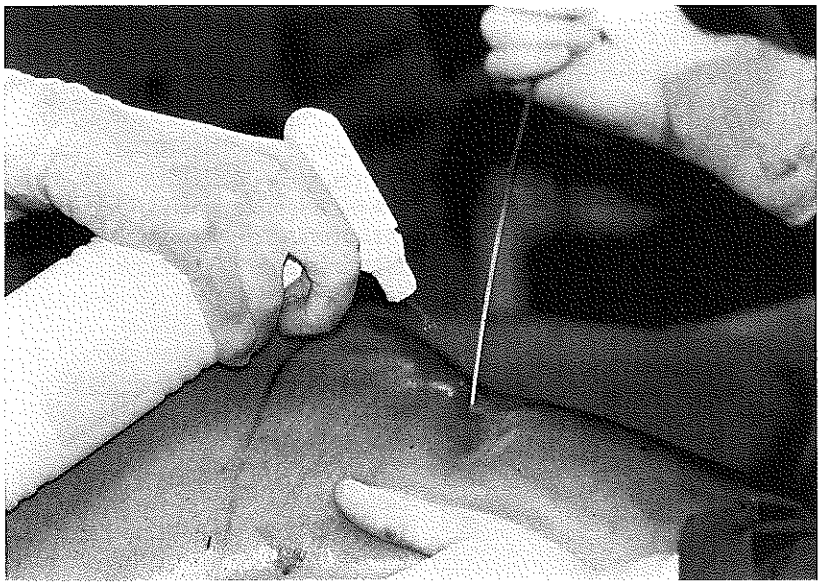

The cannula is sprinkled with cold saline using the spray bottle many times throughout the liposuction procedure.

tipped Mercedes cannulas with diameters that range from 1.8 to 2 mm. The cannula is first introduced to the superficial areolar layer and is then moved deeper to break up and aspirate the deep lamellar fat.[3,4] Lastly, a 2.5-mm cannula is used to suction the fat that has been crushed but yet not aspirated. The gauge of the cannula is increased progressively to remove the fat more quickly. When we face major fat deposits, such as those encountered in the abdomen, we increase the gauge of the cannula to 3.5 to 4 mm.

The incisions resulting from the insertion of these thin cannulas are usually very small and do not need to be sutured. Nevertheless, the liposuction scars are often pigmented, and the surrounding skin may show a pigmented halo of a few millimeters, and is evident for a long time. In many cases hyperpigmented scars are the only permanent signs of liposuction.

The use of such thin cannulas implies hundreds of to-and-fro movements through tiny stab incisions that damage the tissues surrounding the stab incisions. In fact, the passage of the cannula produces erythema and bruises the skin surrounding the incisions. In addition, the heat generated by the friction of the cannula on the skin margins eventually burns them. In our opinion, trauma and heat cause inflammation during the healing phase of the wound, resulting in hyperpigmentation of the scars and surrounding skin.

We use a spray bottle to sprinkle cold saline on the cannulas to reduce the trauma that results from the passage of the cannula (Fig). The spray is applied by an assistant or the scrub nurse. The saline is sprayed throughout the length of the cannula and on the stab incision many times during the procedure. The cannula is kept cold by the cold saline, which reduces the heat generated and, because it acts as a lubricant, prevents friction lesions.

We compared the skin excised around sprayed and nonsprayed incisions. The specimens were taken 1 and 3 hours after liposuction and were examined microscopically. The sprayed skin specimens showed less neutrophils in the vessels and in the connective tissue surrounding the vessels compared with the nonsprayed skin specimens, suggesting that the inflammation was less in the sprayed skin. We think that less inflammation implies less postinflammatory changes in the wound, and thus fewer pigmentary changes in the corresponding scars.

Also, observation of postliposuction scars at 1 week, 1 month, and 6 months in more than 200 patients revealed that the scars from sprayed areas were less evident than those from nonsprayed areas. In fact, the liposuction scars of the sprayed side of the body were clearer than the contralateral scars. Moreover, in 3 patients the skin surrounding the scars in the unsprayed areas showed a pigmented halo, which was absent in sprayed skin.

These observations suggest that the use of the spray reduces the tissue damage at the incision sites, and reduces the occurrence of hyperpigmentation of the scar.

Because the use of the spray is an easily incorporated maneuver and is not expensive, time-consuming, or harmful, our liposuction armamentarium now sports a new "surgical tool" to reduce the incidence of hyperpigmentation in postliposuction scars.

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Pediatric Plastic Surgery in a Day Hospital: Use of Propofol and a Laryngeal Mask

The increasing demand for health care, and above all for surgical care,

made it mandatory to arrange health services with a higher rate of turnover of patients, especially through widespread application of the "day surgery model."

The increasing amount of plastic surgery procedures in children contributed further to the spread of this method that, thanks to a short hospital stay, reduces risks related to a prolonged stay in the hospital (e.g., infection, upsetting of feeding habits, psychological trauma resulting from separation from one's family and environment).[1]

In close cooperation with our anesthesiology team, we developed an anesthesiological approach to applying the day surgery model to pediatric plastic surgery patients. During the last 20 months we performed 38 pediatric plastic surgery procedures (e.g., congenital eyelid ptosis, bat ears, distal hypospadias, minor cleft lips, syndactylys, giant nevus, scar revisions) on patients ranging in age from 6 months to 12 years and with a range in body weight of 5.8 to 50 kg. All patients belonged to the American Society of Anesthesiology I class. Careful selection of patients was carried out by preoperative anesthesiological examination, and parents were given an information booklet that explains the behavior to adopt before and after surgery. Written informed consent was obtained regarding the operation, the anesthesia, the postoperative period, and potential complications.[2]

All patients were monitored by systolic blood pressure, diastolic blood pressure, mean blood pressure, heart rate, electrocardiogram, oxygen saturation, end tidal, and carbon dioxide saturation. Forty-five to 60 minutes before the operation, all the patients received an occlusive topical bandage containing EMLA anesthetic cream (eutectic mixtures of local anesthetics containing lidocaine and prilocaine), to create venous access.

The anesthesia-inducing method was selected depending on the patient's age. In patients younger than 2 years we used a facial mask with air–oxygen (1:1) and 3% to 5% sevofluorane. For patients older than 2 years we preferred intravenous propofol induction in a boolus, with a ratio of 2.5 mg per kilogram of body weight, administered over 30 seconds. After positioning the laryngeal mask, anesthesia was maintained using a mixture of oxygen and air, and continuous infusion of propofol (using a pump syringe) with a ratio of 5 to 8 mg per kilogram body weight/hour, suspended approximately 5 minutes before the end of the operation, and fentanyl with a ratio of 1 to 2 γ per kilogram body weight.

The average operative duration was 42.5 minutes. The method used provided satisfactory results in all patients in terms of surgical anesthesia level, stability of cardiocirculatory parameters, and side effects.[3,4] Cough was reported in 3 patients, vomiting in 3 patients,and pharyngodynia in 1 patient. All these adverse events cleared up several hours after awakening. No patient was compelled to stay longer in the hospital because of additional complications. Awakening was satisfactory in all patients, allowing their discharge after a 4-hour period of observation, according to the criteria recommended by Societa Italiana Anesthesisti Rianimatori E Terapia Intensiva (SIARTI) for day hospital anesthesia:

1. Recovery of consciousness that allows liquid feeding
2. Cardiocirculatory stability
3. Recovery of urinary function
4. Body temperature more than 38°C
5. Absence of respiratory distress
6. Absence of bleeding
7. Absence of orthostatic hypotension
8. Pain and/or nausea that can be managed at home

In our experience, our anesthesiological procedure proved to be very effective in terms of patient and surgeon safety. Propofol proved to be an easily manageable, effective drug, capable of ensuring high tolerability of the laryngeal mask, which turned out to be a fundamental feature in preserving airways and maintaining satisfactory oxygenation during spontaneous breathing even during long-lasting operations.[5–8]

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A Giant Recurrent Pyogenic Granuloma of the Thumb

Pyogenic granuloma is a common, benign vascular tumor of mucous membranes and skin. Previously it