

REFERENCES

1. Eren, S., Ghofrani, A., and Reifenrath, M. The distally pedicled peroneus brevis muscle flap: A new flap for the lower leg. *Plast. Reconstr. Surg.* 107: 1443, 2001.
2. Tobin, G. R. Hemisoleus and reversed hemisoleus flaps. *Plast. Reconstr. Surg.* 76: 87, 1985.
3. Fayman, M. S., Orak, F., Hugo, B., and Berson, S. D. The distally based split soleus muscle flap. *Br. J. Plast. Surg.* 40: 20, 1987.
4. Yoshimura, M., Shimada, T., Matsuda, M., Hosokawa, M., and Imura, S. Treatment of chronic osteomyelitis of the leg by peroneal myocutaneous island flap transfer. *J. Bone Joint Surg. [Br.]* 71: 593, 1989.
5. McCraw, J. B., and Arnold, P. G. *McCraw and Arnold's Atlas of Muscle and Musculocutaneous Flaps* (Foreword). Norfolk, Va.: Hampton Press Publishing, 1986.
6. Anthony, J. P., and Mathes, S. J. Update on chronic osteomyelitis. *Clin. Plast. Surg.* 18: 515, 1991.
7. Mathes, S. J., and Nahai, F. *Reconstructive Surgery: Principles, Anatomy, and Technique*. New York: Churchill Livingstone, 1997. Pp. 6, 1437.
8. Hughes, L. A., and Mahoney, J. L. Anatomic basis of local muscle flaps in the distal third of the leg. *Plast. Reconstr. Surg.* 92: 1144, 1993.

GIANT ANCIENT SCHWANNOMA OF THE AURICULARIS MAJOR NERVE

Sir:

At the Department of Maxillofacial Surgery of "Federico II" University of Naples (Naples, Italy), we recently treated an interesting case of schwannoma of the auricularis major nerve.

A 28-year-old, white, female patient complained of a painful mass in the right side of the neck that had appeared 3 months earlier. A firm, oval mass was identified, measuring 3 cm in diameter at the largest point, covered by normal skin and mobile in the deep planes (Fig. 1). Ultrasonography was unhelpful; computed tomography with iodide medium showed a large, noninfiltrating mass displacing the neurovascular bundle.

Fine-needle aspiration biopsy revealed mesenchymal cells with a round or spindle nucleus in a metachromatic pattern, suggesting a neurogenic neoplasm of mesenchymal origin. The patient underwent surgical excision of the mass, which appeared tightly related to the auricularis major nerve (Fig. 2). Histologic examination showed spindle cells, loosely arranged, and focally hypercellular and degenerating phenomena; focally nuclear irregularities were present though mitotic activity was not increased; immunohistochemical assays revealed positivity to S100 (DAKO, Carpinteria, Calif.). The final diagnosis was ancient schwannoma.

In the differential diagnosis of lateral neck masses, many disorders may be involved, such as disembryogenic cysts and fistulas, enlarged lymph nodes, parotid neoplasms, inflammatory diseases, and benign or malignant tumors. Schwannomas are benign, slow-growing neoplasms that develop from the neural sheath of peripheral and cranial nerves, except in the optic and olfactory nerves, which lack Schwann's cell sheath. Schwannomas of the head and neck area are not uncommon and more frequently involve the nerves of the brachial and cervical plexus, the vagus, and the facial and the second and third branch of the trigeminus, but no case involving the auricularis major nerve has ever been encoun-



FIG. 1. Computed tomographic scan showing a large non-infiltrating mass displacing the neurovascular bundle in the right side of the neck.

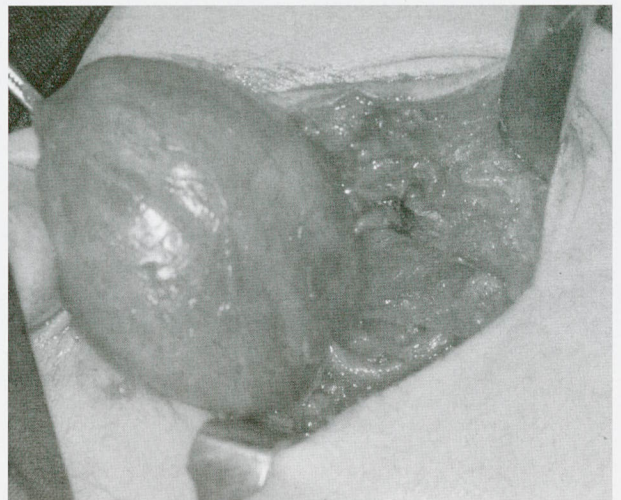


FIG. 2. Surgical excision of the mass.

tered in the English medical literature. Schwannomas can be subdivided into two histologic patterns: Antoni A, composed of compact cellular regions, and Antoni B, with loosely arranged hypocellular areas.¹ Occasional schwannomas may present hyperchromatic areas and bizarre nuclei. These cellular changes reflecting degeneration are typical of the so-called ancient schwannoma and may be misinterpreted, leading to a diagnosis of malignant tumor.² The presence of a mass in the neck can represent a diagnostic dilemma, although current imaging techniques generally resolve most cases. In other cases, as in our case discussed here, though often criticized, fine-needle aspiration biopsy may be helpful

in the preoperative diagnosis of masses of the neck, but the final histologic and immunohistochemical assay is always necessary for a precise diagnosis.

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REFERENCES

1. Williams, H. K., Cannell, H., Silvester, K., and Williams, D. M. Neurilemmoma of the head and neck. *Br. J. Oral Maxillofac. Surg.* 31: 32, 1993.
2. Zachariades, N., Skoura, C., Papageorgiou, G., and Chrisomali, E. Giant ancient neurilemmoma of the cervical region: Report of case. *J. Oral Maxillofac. Surg.* 59: 68, 2001.

DEGLOVING INJURY OF THE ANTERIOR ABDOMINAL WALL

Sir:

Degloving injuries result from a sudden shearing force that avulses the skin and subcutaneous tissue. The perforating vessels underneath are disrupted; as a consequence, vascularity of the skin is compromised.¹ To produce a shear, a parallel and counterreactive force must be generated against



FIG. 1. (Above) Total degloving injury of the anterior abdominal wall; the rectus fascia underneath was intact. (Below) Six months after the debridement and split-thickness skin graft.

the external force. This counterreactive force seems to be produced by the underlying solid tissue framework. As a result, most degloving injuries are seen at areas supported by the underlying skeletal framework, mostly the extremities.²⁻⁴ On the contrary, degloving injuries of the abdominal wall seem to be extremely rare,⁵ because the area lacks a bony framework to counteract the reactive force.

We report a degloving injury of the abdominal wall that, to our knowledge, has not been described in the literature previously. The abdominal skin of a 23-year-old man was caught by a roller machine while he was bending over it. The abdominal skin between the costal arches and suprapubic area up to the iliac crests at the sides was torn off as a degloving injury from the abdominal wall. The rectus fascia underneath was intact (Fig. 1, above). Simultaneously, he had a degloving injury in his right arm and forearm. After adequate debridement and split-skin grafting, the patient recovered uneventfully (Fig. 1, below).

Degloving injuries are seen in areas with underlying skeletal framework that generates a counterforce. However, in this case the counterforce was generated by the abdominal musculature and fascia without reflecting the force into the abdominal contents. The presented case demonstrates that degloving injuries typical for the extremities may also occur in other body areas, depending on the strength and the stability of the underlying musculature and fascia.

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REFERENCES

1. Slack, C. C. Friction injuries following road accidents. *Br. Med. J.* 2: 262, 1952.
2. Letts, R. M. Degloving injuries in children. *J. Pediatr. Orthop.* 6: 193, 1986.
3. Kudsk, K. A., Sheldon, G. F., and Walton, R. L. Degloving injuries of the extremities and torso. *J. Trauma* 21: 835, 1981.
4. Lehr, H. B., and Fitts, W. T. The management of avulsion injuries of soft tissue. *J. Trauma* 9: 302, 1975.
5. Cohen, S. R., LaRossa, D., Ross, A. J., Christofersen, M., and Lau, H. T. A trilaminar skin coverage technique for treatment of severe degloving injuries of the extremities and torso. *Plast. Reconstr. Surg.* 86: 780, 1990.

THROMBOSPONDIN-1 MAY MODULATE KELOID FORMATION THROUGH UP-REGULATION OF THE MATRIX-ASSOCIATED PLASMINOGEN/PLASMIN SYSTEM

Sir:

Thrombospondin-1 is a multifunctional extracellular matrix glycoprotein that has been demonstrated to play a sig-