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A giant acrochordon of the lower limb

Sir

Acrochordon, more commonly known as skin tag or Fibroepithelial polyp, is an extremely common, soft, round or oval, pendunculated skin papilloma [1] with a prevalence of 46% in the general population. It is usually constricted at the base and varies in size from 1 mm to 5 cm. Lesions tend to increase in size over a time [2]. Acrochorda have an irregular or smooth surface and most commonly located on neck (90-34%), axillae (54-38%), trunk (37%), eyelids (34-22%), face (7%), groin and on the lumbar area [3].

They may be associated with several diseases like diabetes mellitus, impaired glucose tolerance, obesity, increased cardiovascular (atherogenic lipid profile) risk, HPV 6 and 11 infections, ageing skin [1-3]. Furthermore, Basal cell carcinoma, squamous cell carcinoma and keratoacanthoma have been reported to occur on acrochorda [1-3].

The acrochorda occur in three types: (1) as multiple small, furrowed papules, generally only 1–2 mm long; (2) as single or multiple filiform, about 2 mm wide and 5 mm long; [3] as usually solitary pedunculated growths, generally 1 cm in diameter but occasionally much larger [4]. Because of their benign nature, treatment of these lesions is often unnecessary and only due to cosmetic reasons.

Fig. 1: Acrochordon before excision.

Fig. 2: Acrochordon after excision.

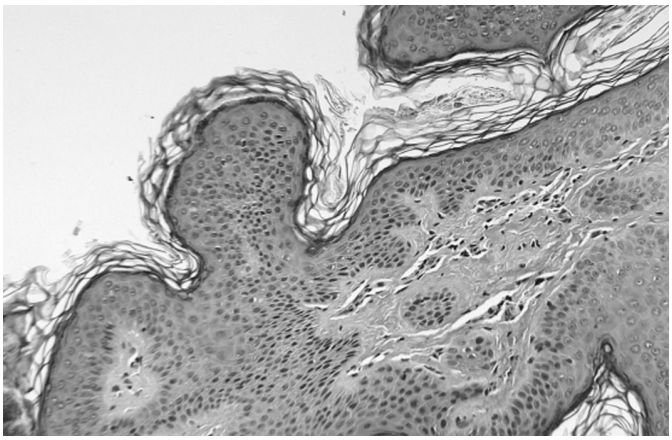

Fig. 3: Histology: hyperplastic epidermis with hyperkeratosis and acanthosis, hyaline degeneration of the collagen and dilated vessels, no malignant cells (10X).

The differential diagnosis of these lesions includes dermal nevus, neurofibroma, multiple small seborrheic keratoses, hamartoma (collagen nevus), and fibroepithelioma of Pinkus [5].

We present the case of a 50-year-old male who was admitted to our department. He presented with a soli-

tary, painless , pedunculated and bag-like skin mass over the upper part of right leg. The lesion starting as a small tag, growth had increased to the present size in the span of 13 years.
On physical examination, the lesion appeared as a mass soft, pedunculated and darker than the surrounding skin, measuring 10.5 cm in diameter.

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Laparoscopic treatment of pheochromocytomas

The study of Conzo et al.[1] deals with the topic, currently in evidence, of laparoscopic treatment of adrenal gland tumors and in particular of pheochromocytoma. Laparoscopic adrenalectomy (LA) with lateral transperitoneal approach can be currently considered the gold standard of surgery treatment of adrenal gland tumors. The first point in discussion concerns the kind of laparoscopic approach: retroperitoneal laparoscopic adrenalectomy [2,3] or lateral transabdominal approach [4]. I believe that the two procedures are essentially equivalent in relation to the skill, capacities and experience of the surgical team; in sum, the choice is strongly influenced by the background of the surgeons (urology or general surgery) and by school traditions. The issue consists in the size of the adrenal gland tumor. As it is possible to evince from other studies the limit dimensions for laparoscopic approach have gradually increased to values > 6 cm [5-7]. Thus the study provides an important contribution to this debate showing that the procedure is viable and safe also for lesions > 6 cm in size. Also in our experience which relates to more than 10 years of activity, the indications for LA in the treatment of adrenal gland tumors have gradually widened with respect to the size of the tumor (V. Neri "Laparoscopic adrenalectomy : ten years experience in a single institution" presentation to Asian American Multispeciality, Society of Laparoendoscopic Surgeons. Summit V Lap-Mininvasive Surgery. Honolulu (Hi) February 1-4, 2012. Unpublished data). A further issue is represented by the treatment of pheochromocytoma because of its cardiovascular implications. These require an appropriate preoperatory preparation, anesthesiological assistance and post-operative care. In this regard the study is exhaustive. Besides technical difficulties, the greater dimensions of the tumor raise the problem of potential malignancy (the reference is on the whole to all adrenal gland tumors, not only pheochromocytoma). Regarding this point there are in literature relevant data (Table I). However, this problem can be solved by referring to the imaging pre-operatory findings which show the integrity of the capsule. Thus, this allows the indication to laparoscopic approach. As shown in this study, it is essential that the integrity of the capsule be rigorously preserved during the surgical procedure. Finally, it is also important the formulation of this study which underlines the necessity of a multidisciplinary approach (endocrinological, surgical, anesthesiological, radiological) in the program of surgical treatment of adrenal gland tumors.

TABLE I - *Adrenal neoplasia. Malignancy and tumor size*

Adrenal Neoplasia - Malignancy and tumor size
The risk of malignant neoplasia is very high for greater size lesions
The tumor threshold of 4 cm has:
Sensitivy of 96%
Specificity of 52%
The tumor threshold of 6 cm has:
Sensitivy of 90%
Specificity of 80%

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Bifid median nerve and carpal tunnel syndrome: an uncommon anatomical variation

Dear sir,

one of the most common entrapment neuropathy syndromes in clinical practice is "Entrapment of median nerve in carpal tunnel" also called "Carpal tunnel syndrome (CTS)" (Aydin et al., 2007; Huisstede et al., 2010). This syndrome is caused by entrapment of the median nerve in the wrist (Preston and Shapiro, 2005) when the pressure increases in the carpal tunnel.

A high division of the median nerve proximal to the carpal tunnel, also known as a bifid median nerve, is a rare anatomic variation that may be associated with CTS and with persistent median vessels (Lanz, 1977). This anatomic variation has an incidence of 0,8% to 2,3% in patients with CTS.

Lanz (1977) has characterized this anatomic condition of the median nerve in the carpal tunnel. These anatomic variants have been classified into four groups:

Group 0: extraligamentous thenar branch (standard anatomy)

Group 1: variations of the course of the thenar branch

Group 2: accessory branches at the distal portion of the carpal tunnel

Group 3: divided or duplicated median nerve inside the carpal tunnel

Group 4: accessory branches proximal to the carpal tunnel During dissection of the wrist performed for the treatment of a CTS under local anesthesia, we found an anatomical variation of the median nerve that was divided in two branches inside the carpal tunnel (Group 3 of Lanz Classification) and in which its radial branch passed through its own compartment. The two parts of the nerve seems to be unequal in size (Fig. 1).

Moreover the nerve passed in carpal tunnel associated with a median artery, so we classified this variation in the group 3b of Lanz Classification (Fig. 2). The persistence of median artery coexisting with a bifid median nerve has been widely reported in surgical literature (Lanz, 1977; Barbe et al., 2005). Before surgical intervention clinical evaluation of patient and electrophysiological examination showed no differences compared to a non bifid median nerve entrapment syndrome.

In conclusion the bifid median nerve may facilitate compression of median nerve in the carpal tunnel because of its increased cross sectional area even if it has no electrophysiological or clinical differential diagnosis in case of CTS. The aim of this letter is aware the physicians in order to borne in mind the possible presence of a median nerve variation during dissection of carpal tunnel in order to avoid the damage of this non common anatomical structures.

KEY WORDS: bifid median, carpal tunnel syndrome, anatomical variation.

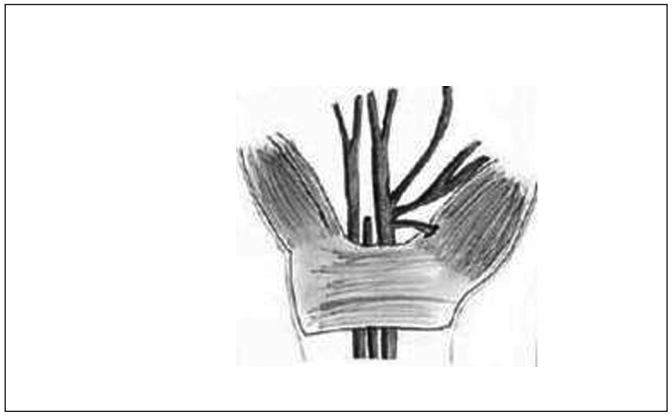

Fig. 1.

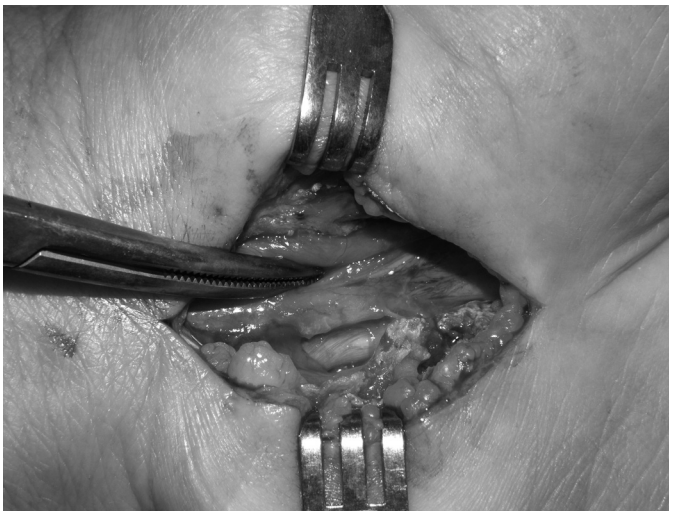

Fig. 2.

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SICUT
Vita della Società

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Dal 23 al 27 settembre scorso si è celebrato a Roma,nella maestosa cornice dell'Auditorium della Musica, il primo Congresso Nazionale della Chirurgia Italiana Unita con la partecipazione di ben 20 Società. In questo contesto straordinario, inaugurato dal Presidente della Repubblica, si è svolta la quarantesima edizione del Congresso SICUT. L'impegno organizzativo e scientifico è stato gravoso ma ricco di soddisfazioni. Le sedute sono state organizzate dalle varie Società in modo congiunto e anche le nostre sessioni hanno visto la partecipazione di vari ospiti mentre molti nostri rappresentanti sono intervenuti a loro volta nei lavori di altre Società gemelle.

In particolare le sessioni SICUT si sono tenute nei giorni 26 e 27 riscuotendo un grande successo di pubblico che ha dimostrato estremo interesse per gli argomenti trattati e per la qualità dei contributi.

Nel corso del giorno 26 si sono svolte, come già a suo tempo previsto, le votazioni per il rinnovo delle cariche sociali. Tutti i soci in regola sono stati chiamati ad eleggere il Next President e il nuovo Consiglio Direttivo per il periodo 2013-2014.

Hanno votato 84 soci in regola con la quota sociale. Alla fine dello spoglio è risultato eletto Next President il Prof. Franco Stagnitti con 80 voti a favore, due schede nulle e due bianche. Per quanto riguarda il nuovo Consiglio Direttivo la maggior parte dei voti sono stati appannaggio di 19 candidati che hanno distanziato abbondantemente tutti gli altri. Pertanto alla fine l'Assemblea dei Soci ha deciso, a norma di Statuto, di cooptarli tutti e 19. Sono quindi risultati eletti i seguenti Consiglieri: Donato Antonellis, Franco Baldoni, Guido Basile, Vincenzo Blandamura, Corradino Campisi, Gianfranco Cocorullo, Giovanni De Manzoni, Giuseppe Di Grezia, Mauro Frego, Bartolo Fusco, Stefano M. Giulini, Michele Greco, Antonio Martino, Aldo Marzaioli, Andrea Mingoli, Stefano Miniello, Antonino Mirabella, Giuseppe Salamone, Mauro Zago.

Il Prof. Gulotta si complimenta con tutti gli eletti, rinnova la propria stima ai Consiglieri confermati e augura il benvenuto ai nuovi arrivati, in particolare esprime viva soddisfazione per l'elezione del prof. Stagnitti a nuovo Presidente 2015-16 ricordando quanto egli ha fatto negli anni per la Società come Segretario Generale e lo prega a nome di tutti di continuare ad occuparsi della Segreteria SICUT fino al momento in cui la nuova carica non diventi effettiva.

L'Assemblea approva poi all'unanimità la proposta del Presidente di aumentare la quota annuale da sessanta a ottanta Euro per i soci seniores lasciando ferma a trenta quella per gli juniores.

Come ultimo atto infine l'Assemblea dei Soci approva come da Statuto all'unanimità il bilancio Consuntivo del 2011 e quello Preventivo dell'anno in corso presentati dal Segretario Generale.