

through the induction of angiogenesis.⁵ Clinical use of the omentum to perform a two-stage orchiopexy has not previously been described.

In summary, a two-stage transposition to the scrotum of a high intra-abdominal testicle was performed successfully via an omental pedicle flap. The omental pedicle flap for orchiopexy has several advantages, including the ease of lengthening the flap, so that the testicle can be transferred into the scrotum, and neovascularization of the testicle, decreasing its probability of atrophy. This procedure should be performed in two stages, to allow angiogenesis and neovascularization of the testicle to occur. Due to the high rate of atrophy associated with the standard orchiopexy of intra-abdominal testes, we propose that our procedure be added as a surgical option to increase the likelihood of preserving testicular viability and function. This is especially important in patients who have only a single functional testicle, to prevent their need for life-long treatment with exogenous testosterone.

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Periumbilical Full-Thickness Skin Graft Donor Site for Pretibial Skin Cancer Excisions

Sir:

Skin grafts have long been a mainstay in the reconstruction of skin cancer excision defects. Sun-exposed

areas such as the head and neck, as well as the upper and lower extremities, are common sites for skin cancer and, therefore, postexcision reconstruction. In particular, the anterior tibial area can present difficulties in reconstruction given the paucity and inelasticity of skin anterior to the tibia. As a result, full-thickness skin grafts have been a useful tool in reconstructing skin cancer excision defects in the pretibial area. Historically, the groin has served as a common donor site. Although it is still a good option, the donor-site scar can be long and unsightly, given that skin cancer excision defects are frequently circular (especially melanoma) and the donor site is designed elliptically to achieve a linear closure.

We propose the use of a periumbilical donor site for reconstruction of pretibial skin cancer excision defects. The advantages of such a donor site are as follows: (1) the periumbilical donor site supplies skin in a circular pattern ideal for filling the circular pretibial defect; (2) there is a good color match between the pretibial and periumbilical skin; and (3) the resultant periumbilical scar is well hidden.

A doughnut-shaped area around the umbilicus is marked out, leaving a small, superiorly based skin bridge intact (Fig. 1). The skin is excised full thickness and thinned appropriately. The skin is then sutured into the defect with primary closure of the central hole, with very little trimming or tailoring necessary (Fig. 2). The donor site is closed in a purse-string fashion using a permanent suture to avoid widening of the scar, much like a Benelli blocking suture.¹

The periumbilical donor site has proven to be a useful tool in the full-thickness skin grafting of pretibial skin cancer excision defects (Fig. 2), particularly in patients concerned with cosmesis. The graft allows for easy in-setting into the defect because of its circular nature, it provides a color match similar to that of pretibial skin (Fig. 2), and it leaves the patient with a well-camouflaged donor scar (Fig. 1). It provides yet another weapon in the armamentarium available to plastic surgeons who often deal with full-thickness, circular pretibial defects.

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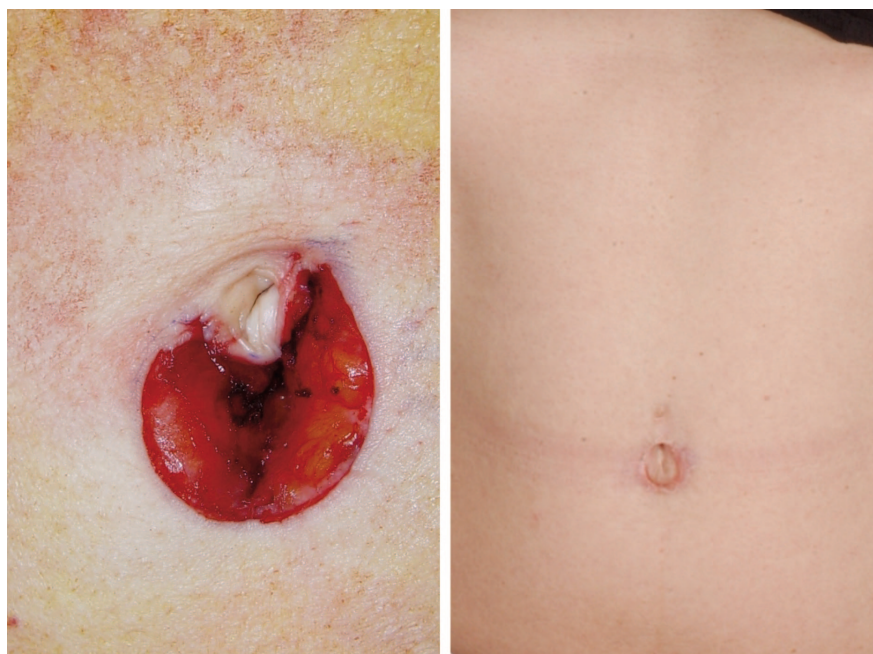


Fig. 1. (Left) Umbilicus donor defect after skin graft harvest. (Right) Umbilicus healed at 6 months.



Fig. 2. (Left) The tibial defect after excision of melanoma. (Center) The tibial defect after skin graft placement. (Right) The tibial defect healed at 6 months.