incidence of facial nerve palsy is relatively high following parotid surgery, with the rates of transient and permanent palsy being reported as high as 65% and 7% respectively. The initial branching arrangement we have shown may have implications for parotid surgery as the surgeon would need to be aware of the presence of six early branches. In particular, vigilance of the location of Branch I, occurring very proximally along the FNT, would be required when the FNT is being traced by anterograde dissection into the gland.

In conclusion, we present a novel variant of the branching pattern of the facial nerve trunk with six initial branches which emerge immediately within the parotid gland. This potential arrangement must be born in mind when performing surgery on the parotid gland in order to minimise risk of postoperative facial nerve palsy.

Conflict of interest/funding

None.

References


Oliver J. Smith
Gary L. Ross
Faculty of Life Sciences,
University of Manchester, UK
E-mail address: glross@gmail.com

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Demodex folliculorum: A parasite infection mimicking skin cancer

Dear Sir,

Demodex folliculorum is a parasite which lives on human skin around the hair follicles. We have found that it can cause lesions which can be mistaken for skin cancer. It has also been linked to rosacea, perioral dermatitis, blepharitis and pityriasis follicularum which may be due to the bacterium Bacillus oleronius found in the mites.1,2 Recently, four of our patients had suspected basal cell carcinomas surgically excised, which were found histologically to be infected with the mite, with no underlying of skin cancer.

In retrospect, the first patient presented with a history typical of a lesion infected with D. folliculorum. He had an 8 week history of a non-healing lesion on his nose which intermittently discharged a yellow exudate. The distracting factor was his significant history of sun exposure. Clinically he had a 5 mm lesion which appeared to have a pearly edge and a central ulcer. He underwent complete excision and local flap reconstruction (Figure 1).

Three further patients had clinically suspected basal cell carcinomas and again the histology report showed no skin cancer but an infection with the Demodex mite.

The D. folliculorum mite completes its whole life cycle of 18–24 days on a human. When the adult mites die, they decompose inside the hair follicles and produce a yellow

Figure 1 Suspected BCC confirmed to be Demodex folliculorum after excision and reconstruction with a local flap.
exudate. A third of children and young adults and two thirds of older adults are carriers of the mite. The mites are found in any hair-bearing area but in particular are found in areas of increased sebum production including the nose, the forehead and the chin.

*D. folliculorum* can be controlled by regular cleansing. Skin conditions attributed to the mite can be treated with topical insecticides or metronidazole gel. We feel that *D. folliculorum* should be considered as a differential diagnosis for basal cell carcinoma, especially when the history given is fitting. Although *D. folliculorum* doesn’t exclude basal cell carcinoma, we feel that if suspected and confirmed with a scraping, curettage or biopsy, a trial of topical therapy in conjunction with advice from a dermatologist should be considered. This could avoid formal excision with an acceptable margin of normal tissue as per basal cell carcinomas and the subsequent reconstruction required.

**Conflict of interest/funding**

None.

**References**


Dear Sir,

Generalised peritonitis can be caused by intestinal perforation after laparotomy and, in some severe cases, can be complicated by necrotising fasciitis of the abdominal wall, which requires debridement and subsequent long-term wound cleaning and care. An abdominal wall that has undergone secondary healing after conservative treatment or has epithelialised after skin grafting is prone to abdominal incisional hernia formation due to lack of mechanical strength. During reconstruction in a planned ventral hernia in such cases, a hernia sac is treated by either re-laparotomy, bowel adhesiolysis, and hernia sac resection or de-epithelialisation of the hernia sac without re-laparotomy.

A 67-year-old man underwent total cystectomy, total urethrectomy, and ileal conduit diversion for bladder/urethral cancer at the urology department of our hospital. After surgery, rectal perforation occurred and developed into generalised peritonitis and necrotising fasciitis. Necrotising fasciitis was treated by extensive peritoneal lavage, pelvic drainage and debridement of the abdominal wall, followed by wound preparation with daily wound cleaning under open abdomen conditions over a few months. After minimal debridement of abdominal granulation tissue covering the residual peritoneum and intestine, a split-thickness skin graft (0.014-inch thickness) harvested from the medial aspect of the left thigh was transplanted to the abdominal wall defect. After confirming engraftment of the skin graft and improvement in general condition, a second abdominal wall reconstruction surgery was performed. Epinephrine solution (1:200,000 dilution) was injected directly under the epithelium of the skin graft to perform hydro-dissection. The epidermal component of the graft only was removed (i.e. de-epithelialisation) with a scalpel (Figure 1A). During this procedure, the scar component of the graft that remained after de-epithelialisation was preserved as much as possible to avoid re-opening the abdominal cavity. Then, a 5-cm adhesiolysis was made over the residual anterior sheath of the rectus abdominis muscle around the hernia orifice as a margin for suturing to a fascia lata attached to the anterolateral thigh flap. Sufficient care was taken during this procedure not to damage the ileal conduit. A pedicled anterolateral thigh flap, to which the fascia lata of about 5 cm larger than the skin island was attached, was elevated and introduced to the abdominal wall through a tunnel created under the rectus femoris and sartorius muscles. The abdominal wall and the fascia lata attached to the flap were sutured as tightly as possible via horizontal mattress suture. Two years after reconstructive surgery, no hernia recurrence or complications such as ileus have occurred (Figure 1B).