

Decline in facial trauma exposure for plastic surgical trainees? A survey of referrals of facial trauma in the UK[☆]



Dear Sir,

Facial trauma forms an important component of the Plastic Surgery Intercollegiate Surgical Curriculum Programme (ISCP). Moreover, plastic surgeons have traditionally played an integral role in managing traumatic facial injuries and their expertise in reconstruction make them optimally placed to do so. Opportunities for trainees to learn and practice fundamental techniques rely heavily on referral of such cases from the Emergency Department (ED). However, anecdotal evidence suggests referrals of patients with facial trauma to allied specialities such as Otolaryngology (ENT) and Oral and Maxillofacial surgery (OMFS) have increased, potentially leading to a lack of exposure for plastics trainees. This study presents the referral patterns of facial trauma from EDs to identify a link with decline in facial trauma exposure for UK plastic surgical trainees.

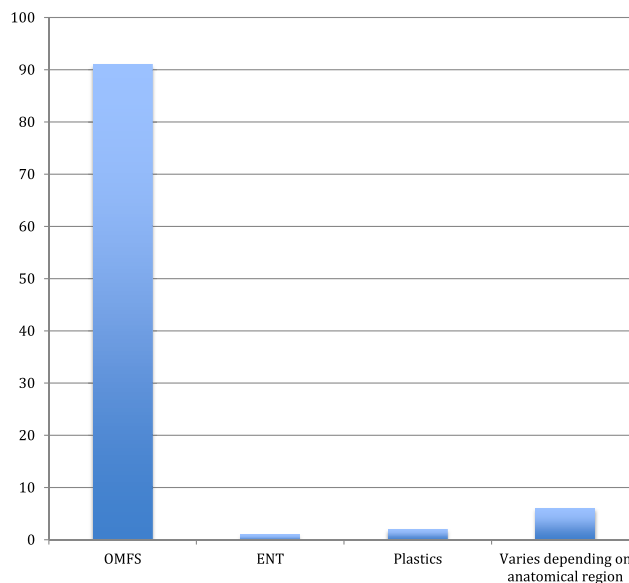
The objective of this study was to assess referral patterns from EDs for the management of facial trauma. We aimed to determine if this correlated with the perceived lack of exposure to facial trauma for UK plastics trainees.

A questionnaire regarding referral pathways was sent to all "level 1" trauma facilities in the UK. A total of 232 centres were contacted. Only centres with Plastics, OMFS and ENT within the same trust were included. A further survey was sent to GPs to assess their referral patterns and also sent to patients and medical students to gain insight into their perceptions of who should manage facial trauma. One hundred people from each group (GPs, patients, medical students) were surveyed.

70% ($n = 162$) of EDs responded. **Graph 1** shows the overall referral patterns. 91% of responding EDs refer all facial traumas to OMFS, and 23% had systems in place for nasal injuries to be referred directly to ENT clinics. A small number of respondents (6%) refer to all three specialities depending on the specific anatomical area of facial injury.

With one exception, all respondents referred bony facial injuries (excluding the nose) to OMFS.

Graph 2 shows the results of the survey of GPs, patients and medical students. 100% of respondents felt that lip lacerations, general facial lacerations, and also nasal injuries should be managed by plastics. Very few respondents (4% of GPs, 1% of patients and 3% of medical students) thought bony facial or orbital injury should be managed by plastics, with most suggesting OMFS or ophthalmology as the appropriate specialities. The majority felt that facial nerve injury (95% of GPs, 59% of patients and 56% of medical students) and ear



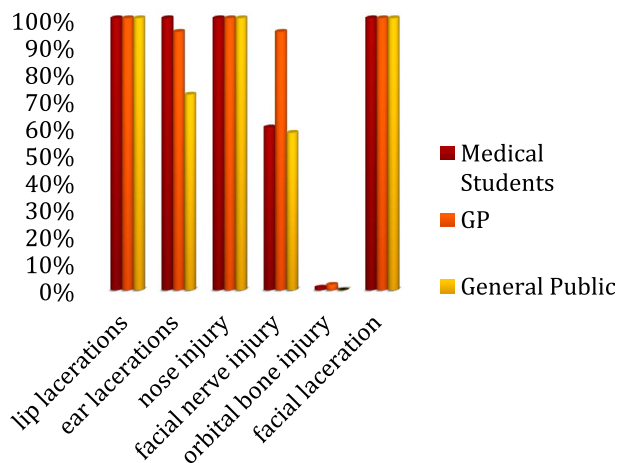
Graph 1 Referral patterns in EDs for patients presenting with facial trauma (showing percentage of responding EDs referring to each speciality). Most departments who responded to the study (91%) refer all facial trauma to OMFS, with a small number (6%) varying the speciality referred to based on anatomical region. The remaining 3% of EDs refer between ENT and Plastics for facial trauma.

lacerations (94% of GPs, 98% of patients and 70% of medical students) should be managed by plastics.

Plastic surgeons are often described as the "last generalists", competent to operate on almost any anatomical region. Traditionally a significant component of the plastic surgeon's workload is facial surgery, both elective and trauma, and this is reflected in the ISCP for Plastic surgery.

With the advent of European Working Time Directive (EWTD),¹ trainee working hours and subsequent surgical experience has diminished.² With respect to facial trauma, this lack of UK trainee experience has been compounded by an apparent preference of EDs in referring to alternative specialities.

Our preliminary survey confirms this, demonstrating an overall low rate of facial trauma referral to plastics.



Graph 2 Opinions of medical students, GPs and patients on which subtypes of facial injury should be managed by plastics.

[☆] This paper was presented at the The British Association of Plastic, Reconstructive and Aesthetic Surgeons Summer Scientific Meeting, Nottingham, U.K. 19–21st June 2013.

Pinder et al.³ showed that a significantly lower proportion of facial trauma was making up the plastic surgery caseload in 2007 (6%) compared to that in 1989 (23%). Our results may provide some part of the explanation for this. UK trainees entering junior registrar posts are already less experienced than their counterparts were 20 years ago,³ and they may now struggle to gain adequate exposure to facial trauma during their progression. Whilst Interface fellowships offer the chance to work with OMFS and ENT, helping build facial trauma experience, such opportunities aim to “fine-tune” senior registrars and assume an already confident grasp of fundamental principles in facial trauma since junior registrar level. Unfortunately if the low rate of referral to plastic surgery continues, then senior registrars may not have acquired the necessary knowledge and skills needed to benefit from such interface fellowships.

The British Association of Plastic, Reconstructive and Aesthetic Surgeons Undergraduate Courses have gone some way in demonstrating the positive educational impact of a one-day plastic surgery event and improving knowledge of the speciality.⁴ Such courses could be beneficial for GPs and ED and Minor injuries unit staff in providing insight into the scope of plastic surgery with respect to facial trauma.

This small study confirms how changes in referral pathways for facial trauma have contributed to a decline in opportunities for plastic surgery trainees in the UK and lends some evidence to previous studies as to why emergency operating in the early years of training has fallen dramatically. Ideally a higher response rate would be needed to confirm this, however from the 70% of EDs who responded it is evident that the majority refer to specialities other than plastics when dealing with facial trauma.

Plastic surgeons have much to offer in the area of facial trauma, and continuing with such low numbers of referrals may have detrimental effects on future UK trainees in plastics. We recommend increasing referrals for facial trauma, which could be done by agreeing cover protocols with allied specialities and improving insight into the scope of facial plastic surgery within primary care and EDs. The alternative option is to accept that facial (in particular bony) trauma has fallen into the remit of allied specialities and to remove it from the plastic surgery syllabus in the UK. However the authors feel that efforts should be made wherever possible to retain facial trauma in plastics as it provides fundamental learning and experience relevant to both reconstructive and aesthetic head and neck surgery.

Ethical approval

Not required.

Funding

None.

Conflict of interest

We declare no conflict of interest (personal or financial) in the publication of this paper.

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Rectus sparing approach to left ventricular assist device exchange and use of the omental flap for coverage



Dear Sir,

With a rising incidence of left ventricular assist device (LVAD) infections owing to their wide spread use in patients with end stage cardiac failure,¹ stable flap coverage after LVAD exchange has become crucial in minimising complications.^{2,3} Flap options in these patients are severely limited because firstly, the rectus muscle is cut or pierced (by the driveline) and secondly, free flaps entail long surgery with a risk of pump thrombosis if anti-coagulation is not resumed early.^{4,5}

We illustrate our reconstructive approach in two patients, highlighting the need to spare the rectus abdominis muscles and allowing their combined use with the omental flap.

A 45-year-old lady presented with pump pocket infection four years after LVAD (Heartmate II, Thoratec) implantation for herceptin induced cardiomyopathy. Drainage of the abscess was accomplished through a rooftop incision transecting both recti. After thorough washout, VAC therapy was applied for several weeks. However, instead of accomplishing wound closure, the