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Management of large cirsoid aneurysms of the scalp using tissue expanders, intravascular occlusion and en bloc resection

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The arteriovenous malformations of the scalp consist of abnormally connecting arterial feeding vessels and draining veins, devoid of a normal capillary bed within the subcutaneous fatty layer of the scalp. The name "Cirsoid" derived from the Greek word kirsos which means Varix. En bloc excision of scalp tissues affected by the aneurysm is better than selective ligation of feeding and draining vessels. Management of cirsoid aneurysm is an elective procedure and therefore using tissue expanders to create scalp flaps enough to reconstruct the site of the excised lesion is better performed in the 1st stage. Preoperative embolization greatly reduced blood loss during resection. The aim of this work is to present successful management of cirsoid aneurysms of the scalp using tissue expanders, endovascular occlusion and en bloc excision. Five patients presented by cirsoid aneurysms of the scalp (two temporoparietal, two frontal and one occipital). They were managed successfully using three stages intervention. The first is the application of one or two tissue expanders. Expanders were applied under the normal (non-affected) scalp in the sub-galeal plane. Expansion was performed weekly for 3-4 months. Second stage included endovascular occlusion through endovascular neuroradiology. Third stage was performed the day after occlusion and included en-bloc excision, delivery of tissue expanders and reconstruction of the site of excision using scalp flaps. The postoperative period was uneventful. Six months to three years follow up showed no recurrence. The conclusion is that the three stages management of large cirsoid aneurysms of the scalp (application of tissue expanders, endovascular occlusion then en-bloc excision and reconstruction) give excellent results.

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Frontocele: Experience from a resource challenged environment

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Background: Frontocele occur as a result of obstruction in the outflow tract of the frontal sinus and this may be due to both congenital and acquired factors. Management involves the use of open, endoscopic or combined approaches with varying success and complication rates. This retrospective study highlights our experience with the management of frontocele in a resource challenged environment.

Methods: A 17 year retrospective analysis of all patients managed in our department was undertaken. Information was sourced from patient's case notes and operating theatre records. Data was analysed using Statistical Package for Social Sciences (SPSS) version 16 (SPSS Inc., Chicago, IL, USA) and Microsoft Excel 2007 (Microsoft, Redmond, WA, USA).

Results: A total of 17 patients were managed within the years reviewed. Males accounted for 52.9% of the patients and ocular presentation was the commonest clinical presentation. Plain radiography alone was used in 76.5% of patients for assessment and bicoronal incision provided access to the frontal sinus in 88.2% of patients. Of the 17 patients managed, 1 (5.9%) patient died 24 hrs postoperative while 2 (11.8%) patients presented with recurrence 1 year and 3 years postoperatively respectively.

Conclusion: The tendency for patients in our environment to present with extensive disease and to default in their postoperative follow-up appointment may favor a more radical approach in the management of frontal sinus mucocele.

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