PREOPERATIVE DIAGNOSIS: , Left upper extremity amputation.,POSTOPERATIVE DIAGNOSIS: , Left upper extremity amputation.,PROCEDURES:,1. Left abdominal flap 5 x 5 cm to left forearm.,2. Debridement of skin, subcutaneous tissue, muscle, and bone.,3. Closure of wounds, simple closure approximately 8 cm.,4. Placement of VAC negative pressure wound dressing.,INDICATIONS: , This 3-year-old male suffered amputation of his left upper extremity with complications of injury. He presents at this time for further attempts at closure.,OPERATIVE FINDINGS: , A clean wound to left upper extremity with partial dehiscence of previously closed wounds and also the closure was satisfactory.,DESCRIPTION OF PROCEDURE: , Under inhalational anesthesia, he was prepped and draped in usual fashion exposing left upper extremity and also exposing continuity of the left abdomen, chest, and groin. He underwent systematic evaluation of his wound of his left upper extremity and we excised first the whole wound prior to doing some additional closure. Some areas were dehisced and appeared to be because it was approximation of granulation tissue and as a result the edges were freshened up prior to approximating them. In this fashion, simple closure was accomplished and its total length was approximately 8 cm. It should be noted that prior to doing any procedure that appropriate timeout was performed and he received prophylactic antibiotics as indicated and did not require DVT prophylaxis. At this time, once we accomplished debridement and simple closure removing skin, subcutaneous tissue,

muscle and bone as well as closing the arm, we could design our flap for the abdomen. The flap was designed as a slightly greater than 1:1 ellipse of skin from just below the costal margin. This was elevated at the level of the external oblique and then laid on the left forearm. The donor's site was closed using interrupted 4-0 Vicryl in the deep dermis and running subcuticular 4-0 Monocryl on the skin. Steri-Strips were applied. At this time, the flap was inset using again 4-0 Monocryl sutures and then ultimately the VAC negative pressure wound dressing was applied to help hold this in place and optimize the vascularization of the flap. The patient tolerated the procedure well and he returned to the recovery room in satisfactory condition.