

Letters to the Editor

Considerations on the corseting' or strangling' technique to treat large venous malformations

We read with interest the paper entitled “Corseting: a new technique for the management of diffuse venous malformations in the head and neck region” published in the *International Journal of Oral & Maxillofacial Surgery*¹, and found that it deals with a relevant topic.

We agree that this can be an advantageous approach, as we have previously published an almost identical technique (“Strangling technique to treat large cervicofacial venous malformations: a preliminary report”, Colletti et al.²) and we have further described its role in the management of venous malformations (“Understanding venous malformations of the head and neck: a comprehensive insight”, Colletti and Ierardi³). However, we feel that the principles and the realization behind our technique and this one are far too similar to surmise that the technique of Nair et al. is a new one. Moreover we believe that there are some critical points in the paper that are worth discussing:

- There are no preoperative CT or MRI images of the reported cases, so it is difficult for the reader to perceive the extent of the malformations and, hence, the indications for surgical treatment, given that the accepted first approach to venous malformations was, and still is, sclerotherapy.
- We find it difficult to justify such extensive use of CT over MRI, which is considered the gold standard examination to diagnose and stage soft tissue venous malformations, not to mention exposure to radiation.
- This paper reportedly deals with venous malformations, but in the table

“Indications, advantages and limitations of corset suturing” the authors invoke the term ‘haemangioma’, which is another disease.

- The authors describe “the occlusion of all arterial and venous connections”. With the exception of (utterly rare) arterialized ones, arterial afferents are never an issue during surgical management of venous malformations.
- We employed the strangling technique on our patients and not a single one of them experienced transient facial palsy or swallowing sequelae. The key here is to pass the stitches parallel to, and not onto or crossing, the facial nerve fibres that are usually easily visible on the surface of the malformation.
- It is our opinion that non-resorbable stitches are best suited for the purpose of long-lasting results. Resorbable stitches, as preferred by the authors of this paper, will leave the way for subsequent recanalization, which will hinder what is achieved in the first place.

All in all, we believe that the authors should be congratulated for their efforts, but the readers should be informed that this is not a new technique and there is (already described) room for conceptual and technical improvement.

We are available for further explanations.

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Competing interests

None.

Ethical approval

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Patient consent

Not required.

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