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Original Research

Somatosensory changes at forearm donor sites following three different surgical flap techniques

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\textbf{A R T I C L E  I N F O}

\textbf{Keywords:}
Somatosensory recovery
Modified radial forearm flap
Donor site
Quantitative sensory testing

\textbf{A B S T R A C T}

\textbf{Background:} The aim of this study was to investigate the somatosensory changes at the forearm donor region after using different types of modified flap surgical techniques.

\textbf{Methods:} Thirty-one patients, who underwent oral and maxillofacial reconstructive surgery involving the use of a traditional radial forearm flap (TRFF) or two modified radial forearm flap techniques (MRFF-I; MRFF-II), participated in the study. Cold detection threshold (CDT), warm detection threshold (WDT), cold pain threshold (CPT), heat pain threshold (HPT), pressure pain threshold (PPT), mechanical detection threshold (MDT), and mechanical pain threshold (MPT) were assessed at four sites of the forearms corresponding to the middle of the vascular pedicle (VP) area, the middle of the forearm flap area, and the corresponding contralateral sites (cVP and cFF) at about 5.0 ± 1.9 months after the surgery. Data were analysed with one-way ANOVA, and post-hoc tests were performed using Tukey's Honest Significant Difference test.

\textbf{Results:} Significant differences between the VP and cVP sites were detected for WDT (P < 0.001) in TRFF and for WDT (P < 0.001) and MDT (P = 0.006) in MRFF-I. Significant differences among TRFF, MRFF-I, and MRFF-II at the VP site were detected for CDT (P = 0.022), WDT (P < 0.001), and MDT (P = 0.015). MRFF-II was associated with significantly higher sensitivity compared to that of TRFF for WDT (P = 0.017) and higher sensitivity compared to that of MRFF-I for CDT (P = 0.017), WDT (P < 0.001), and MDT (P = 0.013).

\textbf{Conclusions:} Significant sensory loss was detected for all types of surgical procedures with free forearm flaps. However, the MRFF-II was associated with a better sensory recovery at short follow-up after surgery. These results suggest that a longer follow-up period and larger sample size should be included in future studies.

\begin{enumerate}
\item \textbf{Introduction}

With the rapid progress of microsurgical technology since the 1980s, free-tissue transfer has become an important technique for head and neck reconstruction after oncologic resections [1–4]. Since the first fasciocutaneous radial forearm flap (RFF) was introduced [5], RFF has been used extensively because of its superiority in plasticity, flexible texture, and adequate blood supply [6–8]. It has gradually become the main flap for reconstructive surgery in the head and neck, with a high success rate (approximately 94%–96%) [2,9]. In addition to the traditional methods of RFF (TRFF) (Fig. 1AD), which usually require an auxiliary longitudinal incision on the pedicle of the free vessel and repair with free skin grafting from another region, two modified methods have been frequently used in clinical practice. The first type of modified radial forearm flap (MRFF-I) (Fig. 1BE) is harvested with a proximal isosceles triangle full thickness skin, which has some elasticity and can be pulled distally to cover the surgical area of the forearm, and does not require an extra operative site from other regions [10].

The second type (MRFF-II) (Fig. 1CF) is prepared without the longitudinal incision of the traditional flap, owing to the use of ultrasoically activated shears (e.g. Harmonic Scalpel, HS; Ethicon Endo-Surgery, Cincinnati, OH, USA), which can maintain skin integrity and efficiently

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As this page does not contain a question, the response will focus on summarizing the main points from the text provided:

**2. Materials and methods**

### 2.1. Study participants

Thirty-one patients (19 male, 12 female, age: 45–70 years) participated in the study. Among them, 12 (7 male), 10 (6 male), and 9 (6 male) underwent different types of flap surgery: TRFF, MRFF-I, and MRFF-II, respectively, for oral and maxillofacial reconstruction. The results in terms of changes in somatosensory function of the tongue following the reconstructive procedures have previously been published [18]. The follow-up schedule of the patients is shown in Table 1.

### Table 1
**Patient information.** TRFF, traditional radial forearm flap; MRFF-I, modified radial forearm flap I; MRFF II, modified radial forearm flap II.

<table>
<thead>
<tr>
<th></th>
<th>TRFF</th>
<th>MRFF-I</th>
<th>MRFF-II</th>
<th>Total patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up time (month)</td>
<td>5.0 ± 1.9 (2–8)</td>
<td>5.3 ± 1.6 (3–8)</td>
<td>4.8 ± 2.2 (2–9)</td>
<td>5.0 ± 1.9 (2–9)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>59.6 ± 5.2 (51–67)</td>
<td>61.0 ± 6.8 (45–70)</td>
<td>58.4 ± 5.8 (45–67)</td>
<td>59.7 ± 5.9 (45–70)</td>
</tr>
<tr>
<td>Sex (male)</td>
<td>(7/12)</td>
<td>(6/10)</td>
<td>(6/9)</td>
<td>(19/31)</td>
</tr>
</tbody>
</table>

The objective of this study was to evaluate somatosensory changes at the forearm donor site following different types of fasciocutaneous radial forearm flaps using a standardised QST protocol with the aim to identify the technique with the least interference and best recovery in terms of somatosensory functions of the patients.
in line with the STROCSS criteria [19].

2.2. Study protocol

The somatosensory function was tested in the innervated areas of the lateral antebrachial cutaneous nerve. Two sites at the donor forearm corresponding to the middle of the vascular pedicle (VP) area, and the middle of the forearm flap (FF) area were examined after 3 different types of procedures (Fig. 1DEF). QST were performed at the VP and FF sites at both forearms after surgery by the same trained examiner in a quiet room with a temperature of 25 °C.  

2.3. Quantitative sensory testing

Thermal detection thresholds for the perception of cold (CDT) and warm (WDT) stimuli as well as thermal pain thresholds for cold pain (CPT) and heat pain (HPT) stimuli were assessed with the use of a thermal stimulator (MEDOC TSA-2001 apparatus; Medoc Ltd, Ramat-Yishai, Israel). The test thermode had a contact area of 30 × 30 mm². The test sites, amongst different regions and surgical techniques. Post-hoc tests were performed using Tukey’s Honest Significant Difference test with corrections for multiple comparisons. The significance level was set at 0.05.

Z-scores were adopted to demonstrate the degree of differences between QST data from these types of surgeries and surgical sites [16,24]. The data from the right control forearm were used as the reference values. The data of WDT, HPT, MDT, MPT and PPT from the right side (VP and FF) were transformed using the following formula: Z-score \( = (\text{Value}_\text{control} - \text{Value}_\text{surgery}) / \text{SD}_\text{control} \), and Z-score \( = (\text{Value}_\text{surgery} - \text{Value}_\text{control}) / \text{SD}_\text{control} \) for CDT and CPT. A Z-score between \(-1.96\) and \(+1.96\) corresponds to the 95% confidence interval and can be considered normal, whereas a Z-score below \(-1.96\) indicates a loss of sensation to detect was at 20%. A total of 31 patients were recruited in the present study.

Descriptive statistics were used to summarise the data. The necessary logarithmic transformation was performed when the data was not normally distributed. The mean values and SD of the CDT, WDT, CPT, HPT, PPT, MDT and MPT at each region were calculated. A one-way analysis of variance (ANOVA) test was used to analyse the different outcome parameters of CDT, WDT, CPT, HPT, MDT and MPT at the test sites, amongst different regions and surgical techniques. Post-hoc tests were performed using Tukey’s Honest Significant Difference test with corrections for multiple comparisons. The significance level was set at 0.05.

The sample size was calculated with risk of type I and type II errors of 5% and 20%, respectively. An estimate of the inter-individual variation was set at 25% and a minimal relevant difference to detect was set at 20%. A total of 31 patients were recruited in the present study.

Descriptive statistics were used to summarise the data. The necessary logarithmic transformation was performed when the data was not normally distributed. The mean values and SD of the CDT, WDT, CPT, HPT, PPT, MDT and MPT at each region were calculated. A one-way analysis of variance (ANOVA) test was used to analyse the different outcome parameters of CDT, WDT, CPT, HPT, MDT and MPT at the test sites, amongst different regions and surgical techniques. Post-hoc tests were performed using Tukey’s Honest Significant Difference test with corrections for multiple comparisons. The significance level was set at 0.05.

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3. Results

The clinical information is shown in Table 1. Absolute values of all parameters are shown in Table 2, and summary statistics of CDT, WDT, CPT, HPT, PPT, MDT, and MPT are shown in Tables 3 and 4.

Significant differences between the VP site and contralateral site were shown for WDT (P < 0.001) in TRFF, and for WDT (P < 0.001) and MDT (P = 0.006) in MRFF-I. No significant difference was found for any parameter between the VP and cVP in patients who underwent MRFF-II. Significant differences between forearm flap regions and the contralateral sides were observed for all the parameters, except for PPT, for the three types of surgeries (Table 3). All data, except for PPT, were also significantly different between the forearm flap regions and the VP regions (Table 4).

Significant differences amongst TRFF, MRFF-I, and MRFF-II at the
higher sensitivity than MRFF-I for CDT (P = 0.017), WDT (P < 0.001) between TRFF and MRFF-I. However, MRFF-II was associated with significant differences for multiple comparisons.

### 4. Discussion

The present study demonstrated for the first time the applicability and value of a standardised QST protocol to assess changes in somatosensory functions following RFF surgery. The somatosensory function at the donor site was impaired after all the types of surgeries. However, the recovery of somatosensory functions appeared to be the best after MRFF-II. These findings may have potential impact on quality of life for patients undergoing surgery and their recovery. Furthermore, QST data may help to better identify and monitor abnormalities in somatosensory function and development of neuropathic pain conditions.

#### 4.1. Somatosensory loss at the forearm

Abnormal sensations at the donor site in the radial nerve or the lateral and medial cutaneous nerve distribution, after forearm flap surgery, have previously been reported [25]. Since the preparation of flaps damages the superficial branch of the radial nerve in each surgical type, the numbness in the palm area, to some extent, did not correlate to different types of surgical procedures [25]. However, somatosensory loss in the proximal area of the forearm flap was significantly different among different areas and surgeries in the present study. The somatosensory function at the lateral area of the forearm is primarily innervated by the lateral antebrachial cutaneous nerve. It has been shown that the sensitivity at the test site reflects mostly the peripheral factors for the thermal and mechanical test items, such as peripheral nerve fibres and receptor density. Moreover, nerve fibres and receptor damage result in dysesthesia or numbness of the test area [16]. Therefore, the threshold changes assessed by QST can reflect the degree of damage to the lateral antebrachial cutaneous nerve.

In accordance with previous experimental results, impaired thermal and mechanical sensations occurred in the surgical side after nerve injury unilaterally [26]. As observed in the patient population in this study, almost all somatosensory modalities in the flap regions revealed a large impairment, indicating significant neurophysiological deficits at the FF sites. Additionally, a previous study has reported that the tissue injury and scar tissue formation lead to the difference in somatosensory function between the surgical and contralateral sides [26]. Therefore, reducing tissue trauma during the operation appears to be critical for recovery of somatosensory function.

#### 4.2. Differences in somatosensory function between types of surgeries and sides

All QST parameters in this study showed significant differences between the surgical flaps and contralateral regions except for PPT. Besides, WDT in TRFF, and WDT and MDT in MRFF-I at the VP regions, were significantly different. Our results indicated that there might have been a larger injury to the nerve fibres of the forearms undergoing MRFF-I in comparison to the contralateral sites. However, less significant differences were found in the VP regions of the MRFF-II, indicating less trauma in the forearm after MRFF-II surgery [27]. Further, we found that all QST parameters at the left forearm were less sensitive, except for lower PPT (more sensitive) at the surgical sides. PPT, mediated by both C-fibres and Aδ-fibres, is considered to evaluate the deep tissue pain sensitivity [16]. The forearm flap was generally prepared above the fascia without injury to the deep muscle tissues and nerve fibres. Therefore, only small differences in PPT values may have been detected at the donor sites.

In general, TRFF, MRFF-I, and MRFF-II are the surgical options for oral and maxillofacial reconstruction, and the flap areas are similar in all three procedures. However, the specific conditions and rationale for function for TRFF and MRFF-I, but not for MRFF-II, considering CDT and WDT. Also note the difference in recovery of somatosensory functions related to the time, after surgery for the individual patients.

### Table 3

Comparison between VP and FF in 3 different surgery types. TRFF, traditional radial forearm flap; MRFF-I, modified radial forearm flap I; MRFF-II, modified radial forearm flap II. VP, vascular pedicle; FF, forearm flap; cVP, contralateral side of VP; cFF, contralateral side of FF; CDT, cold detection threshold; WDT, warm detection threshold; CPT, cold pain threshold; HPT, heat pain threshold; PPT, pressure pain threshold; MDT, mechanical detection threshold; MPT, mechanical pain threshold. The parameters were tested with the one-way ANOVA. Post-hoc tests were performed with Tukey Honestly Significant Difference test with corrections for multiple comparisons.

<table>
<thead>
<tr>
<th>TRFF (n = 12)</th>
<th>CDT &lt; 0.001 NS</th>
<th>&lt; 0.001 &lt; 0.001 NS</th>
<th>WDT &lt; 0.001 &lt; 0.001 NS</th>
<th>CPT &lt; 0.001 NS</th>
<th>&lt; 0.001 &lt; 0.001 NS</th>
<th>HPT &lt; 0.001 NS</th>
<th>&lt; 0.001 0.006 NS</th>
<th>PPT NS NS NS NS NS</th>
<th>MDT &lt; 0.001 NS</th>
<th>&lt; 0.001 &lt; 0.001 NS</th>
<th>MPT &lt; 0.001 NS</th>
<th>&lt; 0.001 &lt; 0.001 NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRFF-I (n = 10)</td>
<td>CDT 0.002 NS</td>
<td>0.005 0.015 NS</td>
<td>WDT &lt; 0.001 &lt; 0.001 NS</td>
<td>CPT &lt; 0.001 NS</td>
<td>&lt; 0.001 0.001 NS</td>
<td>HPT &lt; 0.001 NS</td>
<td>&lt; 0.001 0.003 NS</td>
<td>PPT NS NS NS NS NS</td>
<td>MDT &lt; 0.001 0.006</td>
<td>&lt; 0.001 0.001 NS</td>
<td>MPT 0.002 NS</td>
<td>0.005 0.033 NS</td>
</tr>
<tr>
<td>MRFF-II (n = 9)</td>
<td>CDT &lt; 0.001 NS</td>
<td>&lt; 0.001 &lt; 0.001 NS</td>
<td>WDT &lt; 0.001 &lt; 0.001 NS</td>
<td>CPT &lt; 0.001 NS</td>
<td>&lt; 0.001 &lt; 0.001 NS</td>
<td>HPT &lt; 0.001 NS</td>
<td>&lt; 0.001 &lt; 0.001 NS</td>
<td>PPT NS NS NS NS NS</td>
<td>MDT &lt; 0.001 NS</td>
<td>&lt; 0.001 &lt; 0.001 NS</td>
<td>MPT &lt; 0.001 NS</td>
<td>&lt; 0.001 &lt; 0.001 NS</td>
</tr>
</tbody>
</table>

### Table 4

Comparison of 3 different surgery types. TRFF, traditional radial forearm flap; MRFF-I, modified radial forearm flap I; MRFF-II, modified radial forearm flap II. VP, vascular pedicle; FF, forearm flap; cVP, contralateral side of VP; cFF, contralateral side of FF; CDT, cold detection threshold; WDT, warm detection threshold; CPT, cold pain threshold; HPT, heat pain threshold; PPT, pressure pain threshold; MDT, mechanical detection threshold; MPT, mechanical pain threshold. The parameters were tested with the one-way ANOVA. Post-hoc tests were performed with Tukey Honestly Significant Difference test with corrections for multiple comparisons.

<table>
<thead>
<tr>
<th>TRFF × MRFF-</th>
<th>VP 0.022 &lt; 0.001 NS</th>
<th>NS NS NS 0.015 NS</th>
<th>WDT</th>
<th>CPT</th>
<th>HPT</th>
<th>PPT</th>
<th>MDT</th>
<th>MPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRFF-I × MRFF-II (ANOVA)</td>
<td>cVP NS NS NS NS NS NS NS NS NS</td>
<td>cFF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
</tr>
<tr>
<td>TRFF × MRFF-II</td>
<td>cVP NS NS NS NS NS NS NS NS NS</td>
<td>cFF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
<td>FF NS NS NS NS NS NS NS NS NS</td>
</tr>
<tr>
<td>MRFF-I × MRFF-II</td>
<td>VP 0.017 &lt; 0.001 NS</td>
<td>NS NS NS 0.013 NS</td>
<td>WDT</td>
<td>CPT</td>
<td>HPT</td>
<td>PPT</td>
<td>MDT</td>
<td>MPT</td>
</tr>
</tbody>
</table>

VP site was observed for CDT (P = 0.022), WDT (P < 0.001), and MDT (P = 0.015) (Table 4). There were no significant differences between TRFF and MRFF-I. However, MRFF-II was associated with significantly higher sensitivity than TRFF for WDT (P = 0.017); and higher sensitivity than MRFF-I for CDT (P = 0.017), WDT (P < 0.001) and MDT (P = 0.013) (Table 4). The Z-score profiles of the patients are shown in Fig. 2 and clearly demonstrate the loss of somatosensory function at the FF sites for CDT and WDT. Moreover, the Z-score profiles show loss of somatosensory function for TRFF and MRFF-I, but not for MRFF-II, considering CDT and WDT. Also note the difference in recovery of somatosensory functions related to the time, after surgery for the individual patients.
Flap selection have not been elaborated so far. Indeed, the three methods have their own advantages and disadvantages. First, both TRFF and MRFF-II require extra grafting, whereas MRFF-I eliminates this step, causing a greater damage in the operated forearm. Second, a longitudinal incision in TRFF and a triangular incision in MRFF-I are made to secure the best field of vision for the surgeons and may better protect the lateral antebrachial cutaneous nerve. The longitudinal incision is not performed in MRFF-II, but this technique requires better surgical instruments and sufficient proficiency of the surgeons. In this study, a direct comparison of the somatosensory function, as assessed by QST, was made among these flap techniques, and it appears that MRFF-II is better owing to fewer changes in somatosensory function.

The present study also proposed the use of Z-score profiles to evaluate the results in individual patients. In accordance with the group analyses, the Z-score profiles in MRFF-II indicated a better recovery for CDT, WDT and MDT with less impairment at the longer follow-up period (Fig. 2). Interestingly, almost all QST parameters were within the normal range even after a short postoperative time in MRFF-II.

Free flap tissue dissection was generally harvested with the use of electrocautery dissection and surgical clip appliers. The new ultrasonic anatomical surgical technique has been developed to convert high frequency ultrasound (55000 Hz) into mechanical energy by using a harmonic scalpel [28]. This new technique is widely used in many surgical specialties; many studies have reported a reduction in haematoma formation after using harmonic blades in plastic and reconstructive surgeries [29,30]. Owing to the ideal haemostatic function of the harmonic scalpel, the procedure of surgical knot is omitted [31]. Importantly, the mean surgical time has significantly shortened by

![Figure 2. The Z-score profile of all QST parameters at the vascular pedicle regions from 31 patients. The grey zone indicates a Z-score between −1.96 and +1.96, representing the normal range as determined from the contralateral side, and the Z-score below-1.96 indicates a loss of somatosensory function. The different follow-up times are marked with different colors. CDT, cold detection threshold; WDT, warmth detection threshold; CPT, cold pain threshold; HPT, heat pain threshold; PPT, pressure pain threshold; MDT, mechanical detection threshold; MPT, mechanical pain threshold. TRFF, traditional radial forearm flap. (For interpretation of the references to color in this figure legend, the reader is referred to the Web version of this article.)](image-url)
applying the ultrasonically activated shears compared to electrocautery in a previous study [32]. This was significant in reducing the time of application of the tourniquet, which is usually used for forearm flap preparation. Therefore, the risks of neural injury were reduced [32]. Further, maintaining the integrity of the epidermis at the VP site can reduce the damage of the superficial nerve fibres, which might be the reason why somatosensory recovery in MRFF-II appeared to be better than that with TRFF and MRFF-I techniques.

4.3. Limitations of the study

Primarily, the study was a cross-sectional study with only around 2–9 months of follow-up. Therefore, the relationship between somatosensory changes at the VP site and long-term follow-up requires further exploration. Besides, the results of this study should be interpreted with caution. First, all QST assessments in this study were based on the patient’s subjective judgments that could lead to response bias. Electrophysiological studies, in other aspect, e.g., using nerve conduction velocity and cortical evoked potentials, could further investigate objectively the somatosensory deficits in response to the flap procedures. Additionally, the total sample size and the sample size of each group were relatively small, which may affect the strength of the conclusion. A larger sample size should be used in future studies.

5. Conclusions

The present study tested the somatosensory changes at the forearm donor site after three different types of flap surgeries. Significant disturbances in somatosensory functions were detected after all types of surgical procedures. However, the MRFF-II was associated with a better sensory recovery. These results might contribute to decision-making in specific types of radial free flap procedures.

Ethical approval

The study was approved by the Nanjing Medical University Ethics Committee (PJ2017-035-001) and all patients signed informed consent forms.

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Author contribution

Fang Wang: Study design, concept, writing; Xu Ding: Data collection, data analysis; Xiaomeng Song, Yunong Wu: Corresponding author; Jinglu Zhang: Review the data organization; Peter Svensson, Kelun Wang: Review the data management.

Conflicts of interest

There are no conflicts of interest to declare.

Guarantor

Xiaomeng Song.

Research registration Unique Identifying Number (UIN) 3684.


