In conclusion, the Rieger flap, which is an appropriate repair technique for defects of the caudal nasal region, can be used with good effect for MCC at the same anatomic site.

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References


Discussion

We describe a patient who underwent excision of a caudal nasal MCC with reconstruction utilizing the Rieger flap. This technique was first reported in 1967 and was described as a flap appropriate for the nasal base when the diameter of the defect is less than 2 centimeters. In 1970, Marchat et al. altered the original design to an axial pattern dorsonal nasal flap, based on an axial vessel. The Rieger flap is a surgical technique designed as a temporally based, rotation-advancement flap. The pedicle is superolateral to the surgical defect and the cutaneous line is made from the defect laterally to the nasofacial sulcus to the superior aspect of the glabella. For maximum tissue movement, the pedicle must be completely mobilized down to the epicantal ligament and the contralateral nasodorsal sulcus. Advancement and rotation of the myocutaneous flap into the primary surgical defect complete the closure.

The use of the Rieger flap, which is used for non-MCC skin cancers of the caudal nose, has not been described in the literature for use in MCC. Several limitations of this repair technique in general is that it cannot be used to treat surgical defects larger than 2-3 centimeters. It also may generate asymmetry or deviation of the nasal form, as with any repair. An alternative surgical option would have been a midline frontal flap; however, this repair requires repeat operation. Therefore, based on our experience, we believe the Rieger flap is an effective option for MCC of the caudal nose. Future studies could compile all published nasal repairs for MCC to compare their cosmetic and functional outcomes. Additional surgical and reconstructive techniques used for non-MCC skin cancer of the nose may also be effective for anatomic/analogs of cases of MCC. In conclusion, the Rieger flap, which is an appropriate repair technique for defects of the caudal nose less than 2 centimeters in size, can be used with good effect for MCC at the same anatomic site.

In a world where the divorce rate continues to rise, a smartly executed prenuptial agreement is more than just a tedious and legalease document—it is an insurance contract for your marriage and financial future. As professionals with high-paying careers, doctors are understandably very concerned about protecting their assets. After all, doctors have worked extremely hard throughout medical school and residency, and their income is well deserved, hard earned, and should be protected. Doctors are forced to learn the skill of frugality very early in their career and are rightfully protective of their hard earned money.

Many high income earning individuals such as doctors start their career on the opposite end of the spectrum. In the start of your career, it is natural to think that you will never need a prenuptial agreement because doctors earn a meager income during residency. Instead of viewing it as a current need, perhaps frame your mind to view it as a future, potential need in case your marriage falls apart. In my practice, many of my clients have been doctors who wished they had entered into a prenuptial agreement at the start of their marriage. While we all wish to think our marriages will work out forever, unfortunately, this is often not the case.

When it comes to a prenuptial agreement, you get what you pay for. While it may seem tempting to download a form off the internet, it is imperative that you invest in the quality of your prenuptial agreement. For starters, you must ensure that your prenuptial agreement is drafted by a practitioner who specializes in the fields of family law and drafting prenuptial agreements. Your prenuptial agreement signing should be videotaped and you must go through extensive financial disclosure. There are many formalities to a prenuptial agreement that an internet form cannot cover and a Google search cannot properly explain. As a doctor you would not use substandard equipment for your patient, so why use a substandard prenuptial agreement?

Prenuptial agreements are understandably not an easy topic to discuss with your wife or husband to be, but a few awkward conversations could potentially save you years from financial hardship. Generally, prenuptial agreements:

- Must be in writing and signed by both parties,
- Allow the parties to address all substantive rights in the agreement.

In Florida, the Uniform Prenuptial Agreement Act (UPAA) governs any prenuptial agreement executed on or after October 1, 2007 in Florida and is located at Florida Statutes § 61.079. You may read the statute on the Florida Legislature’s website. On December 2, 2010, the Florida Supreme Court in Pareles v. Pareles, 199 So. 3d 810, held that the Uniform Prenuptial Agreement Act is constitutional.

If you are a doctor who is heading to the altar soon, consider entering into a prenuptial agreement to protect your assets and control the method and manner as how they are distributed in the event of a divorce, by incorporating the following suggestions tailored to your profession:

- Provide for your Spouse While Wearing Alimony. Create an equitable distribution schedule payout for your spouse and waive alimony. Since Florida is an equitable distribution state, in the event you and your spouse divorce, the marital estate must be divided in an equitable manner. Alimony is based on income and as you progress in your career, your income increases; thus, your alimony obligation increases. You can still provide for your spouse in an equitable distribution payout, meaning a payout of the value of the marital estate (usually 50%, but could be more or less depending on the circumstances at hand), and base the payout schedule on the number of years you were married, as the length of the marriage increases and you invest more time in your spouse.

Consider this simplified example: Spouse A and Spouse B divorce after a 10 year marriage. Spouse A earns $500,000 of net income per year at time of divorce and Spouse B is a nonworking spouse that earns no income. The marital estate is worth $1,000,000. If the parties do not have a prenuptial agreement at the time of divorce, Spouse B would likely be entitled to ½ of the marital estate, $500,000. In addition to alimony which is up to 40% of Spouse A’s net income, Spouse A’s maximum alimony exposure is $16,666 monthly, or $200,000 annually to Spouse B. If the parties have a prenuptial agreement according to the above terms, Spouse A can provide for Spouse B in an equitable distribution payout. For example, the parties can contract in a way that Spouse A pays Spouse B $100,000 annually for a period of five years. Importantly, Spouse B would not be obligated to pay Spouse B alimony if the agreement waives it. This could save Spouse A up to one million dollars depending on the length of the alimony obligation.

1 The Uniform Prenuptial Agreement Act (UPAA) governs any prenuptial agreement executed on or after October 1, 2007 in Florida and is located at Florida Statutes § 61.079. You may read the statute on the Florida Legislature’s website. On December 2, 2010, the Florida Supreme Court in Pareles v. Pareles, 199 So. 3d 810, held that the Uniform Prenuptial Agreement Act is constitutional.

4 Florida Statute § 61.079(1).
5 Florida Statute § 61.079(2).
6 Florida Statute § 61.079(3).
Appendicitis in the Older Adult: A Diagnostic Conundrum and Serious Issue

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Abstract

Florida’s population of people aged 65 years and older (the older adult) rose 37% in the last decade. The older adult is set to be the largest proportion of the Florida population by the year 2050. As this change occurs, physicians will increasingly face illnesses in the older adult that previously predominated in younger age groups. One such disease is appendicitis. Appendicitis in the older adult may present differently, and is associated with an increase in death, perforation, abscess, sepsis, and wound dehiscence which is not seen as commonly in younger patients. This editorial provides for more robust considerations and dialogue among physicians regarding this new paradigm in the hope of earlier diagnosis and reduction in morbidity and mortality. Older adults themselves and their caregivers and nurses also benefit from education regarding the potential for appendicitis and encouragement to seek early medical evaluation.

Introduction

In a 2010 census, HUD’s population consisted of 3,659,602 people who were 65 years and older (the older adult), which correlates to 17.9% of the state’s population.7 In the 2010 to 2020 decade, this age bracket of older adults increased by 37%, which is the greatest rate of change among any age group within the state.8,9 older adults may hold the highest percentage of the population at 25.3%, or 6,642,622 people.10 With a growing older adult population, Florida physicians need to recognize that the demographic may be changing for certain medical conditions. One such condition is appendicitis.

Approximately 7% of the general population in the United States has had appendicitis, most of whom are in their 2nd and 3rd decades of life.11 In this patient population, morbidity and mortality is low with minimal lengths of stay, continued care, and complications.12 In the older adult however, all of these parameters are increased. Spangler et al stated that the mortality rate is four to eight times higher in the elderly population and 50% of appendicitis-caused deaths are in the elderly.13 Physicians in states with dominating older adult populations need to recognize abnormal presentations of appendicitis to ensure early diagnosis and care for over 50% may be misdiagnosed according to Spangler et al.14 The present literature on appendicitis in the older adult discusses multiple topics including abnormal presentation, complications, and cost of care. This editorial aims to emphasize this information and the need for further research in this topic and recommend education of physicians, the older adults themselves and their caregivers in regards to this illness to ensure optimal care for this patient population.

Presentation

Appendicitis can be a clinical diagnosis. An excellent history and physical are the tools a physician needs to have a strong suspicion of appendicitis. Abdominal pain that is acute, sharp, and continuous dominates as the typical presentation for appendicitis.15 Periappendicular pain migrates to the right lower quadrant as the inflammation worsens.16 Anorexia, nausea, and vomiting may also occur, and fever may be present.17 Several physical exam maneuvers exist to localize the abdominal pain. Elicit a list of symptoms following McBurney’s point suggests appendicitis at the suspected anatomic location of the appendix.18 Reproducing pain when the patient raises the right knee to the physician’s hand as pressure is applied in the right thigh or extending the right leg at the hip while the patient is lying supine, may point toward appendicitis of the pelvic appendix.19 Finally, replacing pain in the right lower quadrant (RLQ) while pressing on the left side is the Rovsing sign which raises suspicion for appendicitis of the retrocecal appendix.20 The obturator sign, which involves rotating the right hip internally while the patient is lying supine, may point toward appendicitis of the pelvic appendix.21 Finally, replacing pain in the right lower quadrant (RLQ) while pressing on the left side is the Rovsing sign which raises suspicion for appendicitis of the retrocecal appendix.

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References

10. Florida courts read the statutory provision in tandem with the language of Citizens.
16. You must consult with an attorney who specializes in prenuptial agreements when drafting your specific prenuptial agreement. This article in no way guarantees results or a particular outcome of any kind.