Reply: Bioengineered Breast: Concept, Technique, and Preliminary Results

Sir:

We appreciate the comments and the refinements to the upper pole placement of the acellular dermal matrix using the bioengineered breast. Minimizing contamination within the implant pocket by using techniques that will achieve this is always welcome.

The principle of bioengineered breasts includes using cells, regenerative matrices, and highly cohesive gel implants. These principles are used both in a prepectoral and a dual-plane position in reconstructive surgery. This principle also extends to aesthetic revision procedures when similar reinforcements and additions are needed to create an aesthetically pleasing form. Upper pole acellular dermal matrix is sometimes placed posterior to the pectoralis major and sometimes anterior to it. In either case in which the upper pole acellular dermal matrix is being placed, we appreciate the comments by Drs. Zhang and Blanchet with their suggested refinement to this technique.

DOI: 10.1097/PRS.0000000000002793

Allen Gabriel, M.D.
G. Patrick Maxwell, M.D.
Department of Plastic Surgery
Loma Linda University Medical Center
Loma Linda, Calif.

Correspondence to Dr. Gabriel
Department of Plastic Surgery
Loma Linda University Medical Center
11234 Anderson Street
Loma Linda, Calif. 92354
gabrielallen@yahoo.com

DISCLOSURE
The authors are consultants for Allergan and LifeCell.

Lipofilling of the Breast Does Not Increase the Risk of Recurrence of Breast Cancer: A Matched Controlled Study

Sir:

We read with great interest the article by Kronowitz et al. in the February issue of Plastic and Reconstructive Surgery.1 As enthusiasts of lipofilling of reconstructed breasts, we congratulate the authors on the effort to prove that this is indeed not only an extremely valuable technique, but also safe for post–breast cancer patients. It is, to our knowledge, the largest observational study to date on one of the most important questions in our field. It will have a significant impact on the plastic surgery community and will be largely discussed by our colleagues.

However, some issues with the reporting of the findings limit the extent to which readers can understand the findings and may ultimately jeopardize the conclusions. The most relevant measure of disease occurrence reported in the Results section are the average incidence rate (0.25 case per 100 person-years in cases versus 0.65 case per 100 person-years in controls) and cumulative recurrence risk (1.6 percent versus 4.1 percent at 5 years). These results show a risk of recurrence approximately 2.5 times higher in the control group and, if directly compared, could suggest that lipofilling might be protective for locoregional recurrence. Even if not statistically significant, this is not a negligible difference. However, recurrence-free survival time was defined as the interval from the date of mastectomy to the date of first locoregional recurrence or the date of last follow-up, biasing the estimated risk in the lipofilled group, a form of bias in survival analysis known as immortal time bias,2 as subjects at a higher risk of recurrence after mastectomy probably had a lower chance of receiving a posterior lipofilling procedure. This could single-handedly explain the observed difference between the groups. As stated in the article, one of the possible approaches to this issue is the use of the time-dependent Cox proportional hazard regression model. However, in Table 3, where the results for this analysis are presented, the hazard ratios and their confidence interval are omitted, and the conclusions are based solely on the calculated $p$ values. Assuming that a value of $p > 0.05$ means that there is no difference between groups is a common misconception of the meaning of the $p$ value ($p$-value fallacy).3 Adequate reporting of the results of the statistical model should include the measures of disease association and their confidence interval, allowing readers to adequately evaluate the difference in risk observed between the groups.

DOI: 10.1097/PRS.0000000000002794

Bernardo N. Batista, M.D.
Murillo F. P. Fraga, M.D., Ph.D.
Marcelo M. C. Sampaio, M.D.
Alfredo C. S. D. Barros, M.D., Ph.D.
Breast Unit
Hospital Sírio-Libanés
São Paulo, Brazil

Correspondence to Dr. Batista
Rua Prof. Atílio Innocenti, 683
04538-001 São Paulo, Brazil
bernardonb@uol.com.br

DISCLOSURE
The authors have no financial interest to declare in relation to the content of this communication.
REFERENCES


Avulsion Thighplasty: What about the Consent for Loss of Reconstructive Options for Microsurgical Breast Reconstruction?

Sir:

We read the article by Hunstad et al. on avulsion thighplasty with great interest. We congratulate them for their innovative technique to address a difficult problem such as thigh contouring with reduced complications. A recent literature review on medial thigh lift emphasized the need to fully inform patients about the high risk of complications, especially seroma, as these appear to be commonly associated with thigh lift, particularly with the vertical technique.

The inner thigh represents an important donor site for two of the most used second-choice flaps for autologous breast reconstruction: transverse upper gracilis and profunda artery perforator flaps. Al-Benna et al. pointed out the need to inform female patients undergoing abdominoplasty about the loss of an autologous breast reconstruction option and the importance to add this content in the abdominoplasty consent form.

Information particularly relevant to medial thigh lift does not seem to include the loss of a breast reconstruction option. We believe this needs to be taken into account, especially in postbariatric patients that often undergo a thigh lift after a previous or simultaneous abdominoplasty. From the conventional thigh lift to the latest, the vertical medial thigh lift, all the techniques involving the excision en bloc of skin and fat excess seem to violate the Scarpa fascia, whereas with the avulsion thighplasty these two components are addressed separately.

Evaluating the medial thigh as the transverse upper gracilis donor site, the majority of the flap volume and subcutaneous tissue harvest is located over the gracilis muscle and part of it posteriorly. The profunda artery perforator flap donor site lies more posteriorly, and the vascular pedicle is located approximately 3 cm posterior to the gracilis muscle, depending on the position of the best suitable perforator. To our knowledge, no patients undergoing either transverse upper gracilis or profunda artery perforator flap breast reconstruction after a thigh lift have been reported in the literature. However, we believe that neither flap would be compromised using the technique described by the authors. In fact, in terms of free flap donor-site morbidity, the avulsion thighplasty drawings are limited to the medial area of the thigh and lie over the territory of the transverse upper gracilis (the insertion of the gracilis muscle is one of the markings). Neither the liposuction nor the skin resection seems to violate the profunda artery perforator donor-site area or the perforator itself as described by the authors. For these reasons, we would like to suggest the need to mention in the thigh lift consent form this potential future consequence, specifying which flap option is lost according to the technique proposed.

DOI: 10.1097/PRS.0000000000002795

Sergio Razzano, M.D.(Hons.)

Department of Orthopaedic, Traumatologic, Rehabilitative, and Plastic-Reconstructive Sciences

Second University of Naples

Fabrizio Schonauer, M.D., Ph.D.

Francesco D’Andrea, M.D.

Unit of Plastic, Reconstructive, and Aesthetic Surgery

Federico II University

Giovanni Francesco Nicoletti, M.D.

Giuseppe Andrea Ferraro, M.D., Ph.D.

Department of Orthopaedic, Traumatologic, Rehabilitative, and Plastic-Reconstructive Sciences

Second University of Naples

Naples, Italy

Andrea Figus, M.D., Ph.D.

Department of Medical Education

Norwich Medical School

University of East Anglia, and

Department of Plastic and Reconstructive Surgery

Norfolk and Norwich University Hospital NHS Foundation Trust

Norwich, United Kingdom

Correspondence to Dr. Razzano

Department of Orthopaedic, Traumatologic, Rehabilitative, and Plastic-Reconstructive Sciences

Second University of Naples

Piazza Miraglia

80138 Naples, Italy

razzanosergio@gmail.com

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

REFERENCES


1069e