

Reply: Titanium Exposure Outcome in Facial Plastic and Reconstructive Surgery

Sir:

We thank the authors for their report.¹ We agree that the safety of titanium is not 100 percent. In our two studies,^{2,3} we removed titanium implants because of infection in two cases and allergy in one. Higher sensitivity in terms of antigen levels in white blood cells cannot be expected, as all cases initially manifest with the onset of allergic symptoms. We remain fully confident in the safety of titanium, compared with other metals, but we do monitor our patients closely for any indication of allergy.

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DISCLOSURE

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

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Superior Pedicle Mastopexy with the Three Fat-Glandular Flap Support

Sir:

We read with great interest the article from van Deventer and Graewe entitled “The Blood Supply of the Breast Revisited.”¹ The analyzed and compared research studies showed that the main sources of blood supply to the breast are the internal

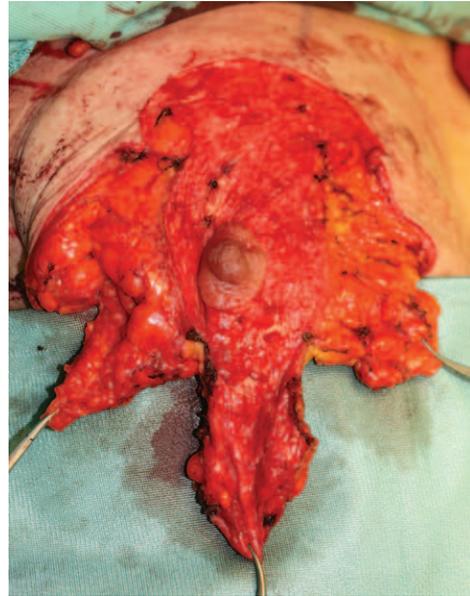


Fig. 1. The lower pole of breast parenchyma is divided into three portions.

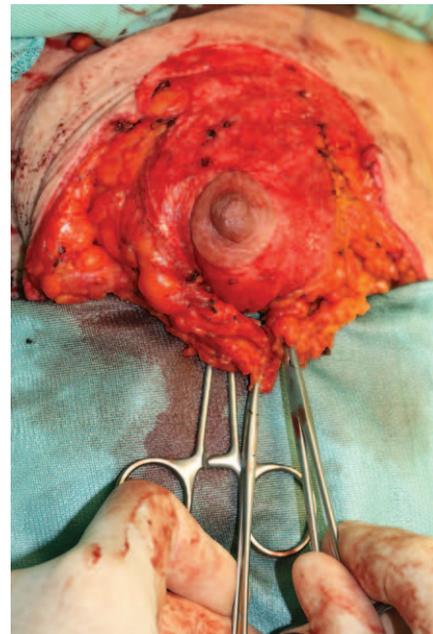


Fig. 2. The lateral flaps are folded onto the central one.

thoracic, lateral thoracic, anterior intercostal, and acromiothoracic arteries. These come almost entirely from the upper arterial circulation. Based on these findings, the superior pedicle techniques appear to be the safest and the most reliable surgical mastopexy procedure.

Mastopexy is an established procedure performed to correct breast ptosis. Numerous techniques have been developed over the years, with several refinements to restore upper pole fullness and harmonious breast shape.²⁻⁴ Based on our

experience, the three fat-glandular flap technique is proposed to achieve a safe and aesthetically pleasing breast lifting through the surgical concept of autoaugmentation.

Preoperative drawings follow an owl-incision pattern.⁵ After the deepithelialization and removal of excess skin, incision of the inframammary fold and complete dissection of the gland from the pectoralis muscle fascia are performed. The lower pole of breast parenchyma is divided into three portions (Fig. 1). The central flap is rolled back onto itself, suspended to the back, and fixed to the upper pole edge. The remaining lateral flaps are then folded onto the breast midline (Fig. 2). Therefore, skin synthesis is carried out.

This type of autoaugmentation-mastopexy is in our opinion very reproducible, especially in those cases where enough glandular tissue is available. The dense network of arteries of the upper pole secures the preservation of perfusion of the flap. With this Letter, we want to describe this mastopexy technique, waiting to describe a more extensive experience with the use of the same, to find complication and revision rates.

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Reply: Superior Pedicle Mastopexy with the Three Fat–Glandular Flap Support

Sir:

I would like to respond to Sisti et al.’s Letter on the superior pedicle mastopexy with three fat-glandular support. In their surgical technique, they divide the lower pole of the breast parenchyma into three portions with a central nipple bearing superiorly based flap with medial and lateral parenchyma flaps that are mobilized and sutured inferiorly for support.

My compliments to them on a technique using breast tissue to solve the problem of breast ptosis. Issues to be discussed include the safety of the procedure and the longevity of the results. The blood supply to the central flap, medial and lateral parenchymal flaps, and the cutaneous medial and lateral flaps covering the parenchymal flaps must be considered.

Depending on the position of the nipple on the breast, the degree of ptosis, and the depth of dissection, the superior central nipple-bearing flap may be arterialized by the upper perforators of the internal thoracic artery and can be quite safe. A narrow pedicle with highly positioned nipples may not be arterialized. A superomedial nipple-bearing pedicle would be safer to use.

Depending on the depth of dissection, the medial parenchymal flap may contain the second and third perforators of the internal thoracic artery. These vessels run approximately 1 to 1.5 cm beneath the skin surface.¹ Provided that undermining of breast tissue is limited and breast parenchyma remains attached to the thoracic wall, the medial parenchymal flap may also be arterialized by perforators at the fourth costochondral junction. These could be branches of the anterior intercostal arteries and/or the nipple-areola branch of the internal thoracic artery (posterior mammary arteries described by Salmon).² Complete dissection of the gland from the pectoralis major fascia will, however, sacrifice those vessels and other vessels from the anterior intercostal arteries supplying the nipple-areola complex. If the medial cutaneous flap is thicker than 1.5 cm, it may be arterialized by the lower perforators of the internal thoracic artery.

The lateral parenchymal or cutaneous flaps may contain branches from the lateral thoracic artery, depending on the depth of dissection. However, it must be taken into consideration that branches from the anterior intercostal arteries and lateral thoracic artery are sometimes absent.^{2,3}

The overall safety of this technique depends on the execution of the surgery. Basic principles must be taken into account. Keeping the breast tissue attached to the chest wall as far as possible (especially in the hypervascular zones) is important, and nipple-bearing skin flaps should be thicker than 1.5 cm but not so thick as to cause a problem with venous congestion.

Regarding the longevity of the results of the technique, it will have to stand the test of time. It is generally accepted that mastopexy procedures have a temporary result in most cases. The reason for this is that the tissues used in most techniques will not supply