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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.¹ 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.² 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.³

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 lift⁴ 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.⁵ 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.

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DISCLOSURE

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Reply: Avulsion Thighplasty: Technique Overview and 6-Year Experience

Sir:

We applaud Drs. Razzano et al. for bridging the gap between cosmetic and reconstructive surgery with their observation that a thigh lift procedure may compromise a potential future reconstructive donor site, and that this possible future loss of reconstructive option should be included in the preoperative consent form. As the authors noted, the loss of potential future reconstructive sites has already been debated in the abdomen, where an abdominoplasty can void the first-choice reconstructive options.

Although there have been no case reports to our knowledge of the use of the medial thigh tissues as a transverse upper gracilis flap or a profunda artery perforator flap after a thigh lift to perform a reconstructive procedure, the point of *potentially* losing a donor site is interesting, especially in a litigious American society. It is also worth noting that the thigh lift procedure¹ predates the first successful free skin flap performed in a human,² and although an aesthetic procedure can potentially preclude a future reconstructive endeavor in the same body area, the inverse is also true.

Drs. Razzano et al. suggest that the posterior perforating vessels of the profunda artery perforator flap may be preserved after avulsion thighplasty and that it could possibly still be a donor source, whereas the transverse upper gracilis flap is less likely a valid source, as the perforating vessels fall directly over the skin resection pattern for avulsion thighplasty.

We have no experience dissecting these perforators in either case after thigh lift, but theoretically, both vascular pedicles and their perforators would remain intact after an avulsion thighplasty, as the lymphatics and blood vessels are largely undamaged by the technique; however, we do not know how widely these vessels perfuse their newly overlying skin after resection of the redundant skin.

Two other major factors that might still restrict the use of these flaps after an avulsion thighplasty would be whether there would be enough skin laxity after the thigh lift to close a new donor site, and whether the remaining pedicles would perfuse enough tissue across the surgical scars from the avulsion thighplasty to make them reliable options. The timing to potentially reperfuse the overlying skin is also not known and to our knowledge has not been studied.

Currently, there are only theoretical concerns that a free flap from the medial thigh cannot be performed after an avulsion thighplasty. This is certainly an interesting area for future research and we would like to thank Drs. Razzano et al. for stimulating the conversation.

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Correction of Nasolabial Folds Using Hyaluronic Acid Filler Plus Subcutaneous Injections of Carbon Dioxide

Sir:

We read with great interest the article by Joo et al. entitled “A Randomized Clinical Trial to Evaluate the Efficacy and Safety of Lidocaine-Containing Monophasic Hyaluronic Acid Filler for Nasolabial Folds.”¹ The goal of this clinical trial was to compare the efficacy and safety between two different hyaluronic acid fillers containing 0.3% lidocaine for the correction of nasolabial folds. Clinical efficacy and safety were assessed by blinded investigators, independent expert panels, and patients based on the Wrinkle Severity Rating Scale and the Global Aesthetic Improvement Scale at weeks 8, 16, and 24 after the injection. This randomized, double-blind, clinical trial showed good efficacy for both products in terms of wrinkle severity improvement and injection pain reduction.

A prominent nasolabial fold is a cosmetic problem. Currently, numerous therapeutic modalities are available for pronounced nasolabial folds, with variable efficacy. Botulinum toxin, hyaluronic acid filler, subcision technique, growth factor concentrate, and platelet-rich plasma are only some examples.^{2–4}

The main application of hyaluronic acid filling, in aesthetic medicine, is the augmentation of soft tissues. The carbon dioxide therapy, instead, improves quality and