



Fig. 2. Postoperative result at 1 month.

Paolo Persichetti, M.D., Ph.D.

Beniamino Brunetti, M.D.

Barbara Cagli, M.D.

Stefania Tenna, M.D., Ph.D.

Plastic and Reconstructive Surgery Unit
Campus Bio-Medico, University of Rome
Rome, Italy

Correspondence to Dr. Brunetti
Plastic and Reconstructive Surgery Unit
Campus Bio-Medico, University of Rome
Via Alvaro del Portillo, 200
00128 Rome, Italy
b.brunetti@unicampus.it

DISCLOSURE

The authors who have taken part in this study declare that they do not have any commercial associations that might pose or create a conflict of interest with information presented in this communication. No intramural or extramural funding supported any aspect of this work.

REFERENCES

1. Munhoz AM, Montag E, Arruda E, et al. Immediate locally advanced breast cancer and chest wall reconstruction: Surgical planning and reconstruction strategies with extended V-Y latissimus dorsi myocutaneous flap. *Plast Reconstr Surg.* 2011; 127:2186–2197.
2. Bonomi S, Salval A, Sorbi F, Settembrini F, Musumarra G. Chest wall reconstruction for locally advanced breast cancer with the V-Y thoracoabdominal perforator flap. *Plast Reconstr Surg.* 2012;129:361e–362e.
3. Persichetti P, Tenna S, Cagli B, Scuderi N. Extended cutaneous ‘thoracoabdominal’ flap for large chest wall reconstruction. *Ann Plast Surg.* 2006;57:177–183.
4. Sharma RK, Mehrotra S, Nanda V. The perforator “plus” flap: A simple nomenclature for locoregional perforator-based flaps. *Plast Reconstr Surg.* 2005;116:1838–1839.
5. Mehrotra S. Perforator-plus flaps: A new concept in traditional flap design. *Plast Reconstr Surg.* 2007;119:590–598.

Reply: Chest Wall Reconstruction with the Perforator-Plus Thoracoabdominal Flap

Sir:

My colleagues and I appreciate the interest of Dr. Persichetti et al. in our letter,¹ and thank you for giving us the opportunity to respond to their insightful comments regarding the use of thoracoabdominal perforator flaps for chest wall resurfacing following breast amputation. Pedicled perforator flaps are the best choice for facing reconstruction of large chest wall defects in patients with locally advanced breast cancer because of their reproducibility, acceptable morbidity, and low interference with oncologic treatment.

A few of the statements made by Dr. Persichetti et al. deserve particular attention. The authors described the use of the extended thoracoabdominal flap,² where the vascular supply is provided by cutaneous perforators from intercostal, subcostal, and lumbar arteries, allowing for prefascial dissection. To obtain flap rotation and proximal advancement, a generous back-cut incision is needed at the flap base as far as the most distal perforator. In our opinion, the aforementioned flap can be improved further as a totally islanded propeller perforator flap to have greater flap mobility and advancement (Figs. 1 and 2). If the isolated perforator vessel is

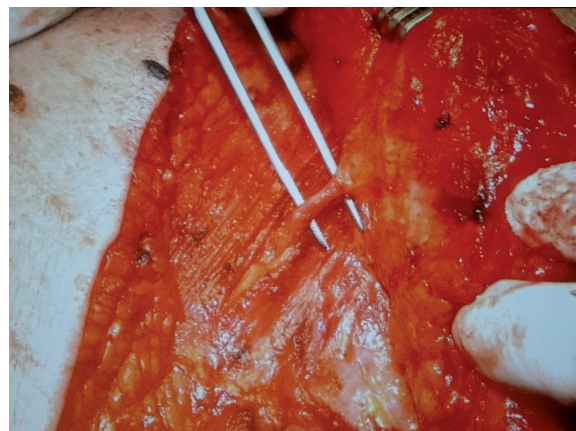


Fig. 1. Intraoperative photographs of a pedicled propeller flap based on superior epigastric perforator vessel used for a chest wall defect following breast amputation.



Fig. 2. Postoperative view.

not providing sufficient arterial inflow or, especially, sufficient venous outflow, an extra pedicle can be added. A vein of the flap, superficial or perforating, can be anastomosed microsurgically to a recipient vein to increase venous drainage.

The propeller flap concept was first described by Teo,³ especially for distal lower limb reconstruction. It is a local island fasciocutaneous flap based on a single dissected perforator, and the ability of this flap to rotate to any angle up to 180 degrees makes it extremely versatile for reconstructing various defects in different parts of the body.

Perforator flaps can be raised anywhere on the body, have a reliable defined blood supply, and have greater freedom of movement. With the present approach, local flaps can be planned and raised over known or Doppler-identified perforator sites (i.e., thoracodorsal artery perforator flap, superior epigastric artery perforator flap, lateral intercostal artery perforator flap). Care is taken in identifying and safeguarding all perforators to the flaps. The perforators can be completely dissected to allow flap inset without tension.

Furthermore, the vast majority of locally advanced breast cancer patients undergo multidetector computed tomographic scanning for oncologic staging, and this type of imaging can be a very useful tool for studying and localizing abdominal wall perforators vessels, on which safe island pedicled perforator flaps can be raised. In conclusion, we applaud the authors' use of this modified perforator flap to improve chest wall coverage in patients with large defects.

DOI: 10.1097/PRS.0b013e31825dc586

Stefano Bonomi, M.D.

Andrè Salval, M.D.

Flavia Sorbi, M.D.

Gaetano Musumarra, M.D.

Fernanda Settembrini, M.D.

Department of Plastic Reconstructive Surgery and Burn
Unit Center
Ospedale Niguarda Ca' Granda
Milan, Italy

Correspondence to Dr. Salval
Department of Plastic Reconstructive Surgery and Burn
Unit Center
Ospedale Niguarda Ca' Granda
Piazza Ospedale Maggiore, 3
20162 Milano, Italy
andresalval@gmail.com

DISCLOSURE

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

REFERENCES

1. Bonomi S, Salval A, Sorbi F, Settembrini F, Musumarra G. Chest wall reconstruction for locally advanced breast cancer with the V-Y thoracoabdominal perforator flap. *Plast Reconstr Surg.* 2012;129:361e–362e.
2. Persichetti P, Brunetti B, Cagli B, Tenna S. Chest wall reconstruction with the perforator-plus thoracoabdominal flap (Letter). *Plast Reconstr Surg.* 2012;130:490e–491e.
3. Teo TC. The propeller flap concept. *Clin Plast Surg.* 2010;37:615–626.

Digital Photography in Plastic Surgery: The Importance of Standardization in the Era of Medicolegal Issues

Sir:

We read with great interest the article by Sannic et al. entitled “Adherence to Photographic Standards: A Review of Plastic Surgeon Websites,”¹ and we agree with the authors that photographs are essential in a plastic surgeon’s practice. Although several articles have been published on this subject, medical publications/presentations and Web sites continue to appear that fail to satisfy clinical photography standards.²

These images are valuable for various purposes, including the following: creating models for preoperative planning, providing visual references during surgery, assessing surgical outcome, sharing data and experience with colleagues, communicating with patients to clarify their treatment plan, educating residents, and preparing presentations and publications.

Moreover, photographs should be an integral part of the patient clinical record, in addition to informed consent, because they could represent one of the few elements of a physician’s defense in medicolegal issues. In fact, today, most plastic surgeons, at some point in their career, have to address a complaint filed by a patient about their clinical performance, which may be followed by litigation.

Because of the increasing importance of photographs, standardization according to well-established criteria is necessary to obtain significant and comparable images to be used in lawsuits. Very small variations can cause notable changes and may decrease markedly the value of clinical photography.³