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Reply: Patient Satisfaction in Unilateral and Bilateral Breast Reconstruction

I would like to thank Drs. Bonomi et al. for their commentary on our recent article.¹ While this retrospective study did show higher patient satisfaction with autologous reconstruction in the unilateral setting, not all patients are candidates, nor necessarily desire, this approach. I applaud Bonomi et al.'s insight into their method for improving patient satisfaction with implant-based reconstruction, since we all collectively strive to improve our patients' outcomes.

Although not highlighted in the article, the vast majority of our patients go on to have contralateral symmetry procedures after both implant-based and autologous unilateral reconstruction. We did not do a subgroup analysis looking at the small number of patients who did not have such a procedure and its impact on their satisfaction. However, I agree with the authors that achieving symmetry is critical to improving patient outcomes. Similarly, we also discuss options for eventual contralateral shaping procedures at the initial consultation. Our group does not have any experience with the extraprojection implants cited by Bonomi et al., but I am cautious about their ability to extend implant-based reconstruction to virtually all women. The use of prosthetics in the previously irradiated patient can be fraught with complications. Our group has recently looked at the impact of complications on patient satisfaction following breast reconstruction; when looking only at patients who developed a complication, those with an implant reconstruction were 16 times as likely to be aesthetically dissatisfied as those with another type of reconstruction.² Further, we cannot discount the impact of the so-called fourth dimension of plastic surgery—time. All types of unilateral reconstructions will change as the patient ages, and the symmetry initially achieved, and the patient's overall satisfaction, may be significantly affected.^{3,4} This negative effect has been reported to be more significant for implant-based reconstruction compared with autologous tissue over the long term.³

I applaud the authors' innovative use of new technologies and evolving techniques to improve both patient satisfaction and outcomes. In conclusion, I will borrow from the excellent critique by Dr. Crosby of our article: "[T]he next step in this endeavor will be a more complete, objective evaluation of out-

comes based on prospectively evaluated variables most critical to maximizing treatment outcomes."⁵
DOI: 10.1097/PRS.0b013e318230bfa0

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Chest Wall Reconstruction for Locally Advanced Breast Cancer with the V-Y Thoracoabdominal Perforator Flap

Sir:

We read with great interest the article by Munhoz et al. entitled "Immediate Locally Advanced Breast Cancer and Chest Wall Reconstruction: Surgical Planning and Reconstruction Strategies with Extended V-Y Latissimus Dorsi Myocutaneous Flap," and we congratulate the authors on their study.¹ Plastic surgeons play an important role in the treatment of locally advanced breast cancers because they can provide adequate coverage of the chest wall, allowing wide resections that would have been otherwise unachievable. There are many methods for chest wall reconstruction, and these include the transverse rectus abdominis musculocutaneous flap, the latissimus dorsi myocutaneous flap, and the deep inferior epigastric artery perforator flap. Contralateral breast, external oblique myocutaneous V-Y,² and extended V-Y latissimus dorsi flaps³ have been successfully described for the resurfacing of large chest wall defects as well. All of these techniques present variable morbidity for patients, who often have comorbidities in addition to the advanced breast cancer.

We would like to take the opportunity to briefly describe the use of a V-Y advancement fasciocutaneous flap based on anterior thoracoabdominal wall perforators. This flap involves a large triangular area of the anterolateral abdominal wall. The three edges of the flap are dissected down to the muscular level. The flap is centered on perforators arising from the deep superior epigastric artery and intercostal arteries, which are identified and preserved. As these perforators are lo-

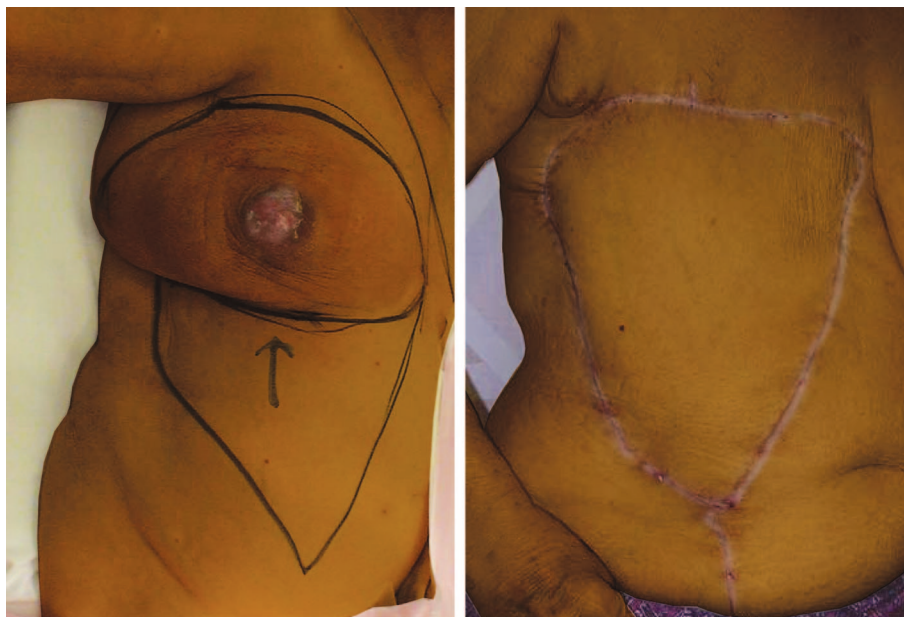


Fig. 1. Preoperative and postoperative views of a 65-year-old patient with locally advanced right breast cancer. The patient underwent breast amputation and chest wall resurfacing with the V-Y advancement fasciocutaneous flap based on anterior thoracoabdominal wall perforators.

cated centrally, the boundaries of the flap can be dissected free to allow mobilization. The flap is then advanced and the defect closed directly (Fig. 1).

This technique represents a reliable option for coverage of large defects after breast amputation. It is easy to perform, does not require change of position, has minimal morbidity, involves no incisions to sheath and muscle, and does not require muscle transposition. Furthermore, no wide donor-site undermining is required, the operating time is short, and the flap is safe and reliable, even in old patients and those whose prognosis is poor, and it has a low complication rate.

DOI: 10.1097/PRS.0b013e31823af0f9

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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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Reply: Chest Wall Reconstruction for Locally Advanced Breast Cancer with the V-Y Thoracoabdominal Perforator Flap

Sir:

We appreciate Dr. Bonomi et al. for their insightful comments regarding our article¹ and congratulate the authors for considering chest wall reconstruction with the V-Y thoracoabdominal perforator flap. We are also grateful to the authors for giving us the opportunity to further discuss our point of view and to clarify the main benefits regarding its use. Refinements in reconstructive surgical options have changed the surgical treatment of complex chest wall defects. It has been our experience that recon-