

perreflexia), and autonomic dysfunction (fever, diaphoresis, hypertension, and tachycardia). The syndrome usually occurs when two or more drugs are used which enhance serotonin, but monotherapy can also elicit a response.

It is not uncommon for patients to take a "diet pill" and an antidepressant. Common antidepressants [sertraline (Zoloft), paroxetine (Paxil), fluoxetine (Prozac), and lithium] also increase serotonin levels and can induce serotonin syndrome.⁵ All of these medications are contraindicated with Meridia because of the potential to produce serotonin syndrome. The manufacturer of Meridia additionally warns against its use with fentanyl and Demerol. Again, Meridia used singularly or in combination with an antidepressant and fentanyl or Demerol can increase the chance of serotonin syndrome, potentially producing hypertension and tachycardia in patients under anesthesia.

Serotonin syndrome is more easily prevented than treated. Awareness of the syndrome and its inciting agents permits the plastic surgeon to avoid unexpected complications during surgery or last-minute cancellations of operations. Specific questions regarding Meridia and other "diet pills" can be included on the plastic surgeons' intake forms as well as use of antidepressants. Treatment of serotonin syndrome includes discontinuation of the offending agent, supportive management, and nonspecific serotonin antagonists including benzodiazepines.

Most complications associated with Meridia are minor and will not be seen by plastic surgeons. The best way to prevent any untoward effects is to identify patients taking this medication, counsel them as to the complications, and insist on the discontinuation 2 weeks before surgery. Be forewarned of the potential to induce a hyperserotonergic state in a patient taking Meridia when given fentanyl or Demerol for an elective procedure.

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ENDOSCOPIC HARVEST OF THE GRACILIS MUSCLE

Sir:

We read with great interest the results of Lin et al. ("Conventional versus Endoscopic Free Gracilis Muscle Harvest," *Plast. Reconstr. Surg.* 105: 89, 2000). Although they have produced admirable results with a short harvest time, we note

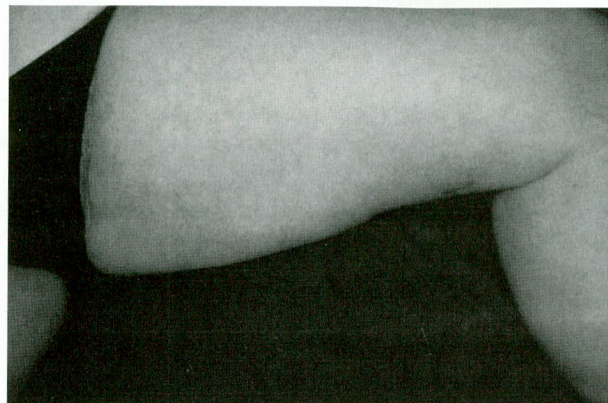


FIG. 1. The proximal scar is incorporated into the groin crease, allowing for better cosmesis. The distal scar has also healed with little disruption of the medial thigh.

with interest the placement of their proximal scar. We believe that a longitudinal scar on the medial aspect of the thigh lends itself to an unsightly wound, which if it became hypertrophied would lead to an overall poor cosmetic result. We ourselves initially used a similar scar for the same procedure, but we found that we gained improved cosmesis from a transverse groin crease scar ("Endoscopically Assisted Gracilis Harvest for Use as a Free and Pedicled Flap," *Br. J. Plast. Surg.* 51: 580, 1998). We felt that the transverse scar would give better access, allowing a more open and therefore easier dissection of the pedicle, as well as following the natural course of the vessels. Although larger, the transverse scar would also help in creating a substantial soft-tissue space during the endoscopic dissection, thus facilitating this part of the procedure. We have also observed that the small scar used to dissect the distal end of the muscle has not appeared to be a problem because it heals up very well and gives excellent cosmesis. Thus, although both techniques are excellent in harvesting the muscle and giving minimal patient morbidity, we believe that although greater in length, this scar would lead to a better aesthetic result, as it would be incorporated into the groin crease, leaving the patient with minimal interference of the medial thigh (Fig. 1).

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BREAST-FEEDING AFTER INFERIOR PEDICLE REDUCTION MAMMAPLASTY

Sir:

We would like to comment on the study of Brzozowski et al. ("Breast-Feeding after Inferior Pedicle Reduction Mammoplasty," *Plast. Reconstr. Surg.* 105: 530, 2000) and offer our own experience on the subject.

In our study of 371 patients who underwent reduction mammoplasty with the inferior pedicle technique (aged 15 to 67 years), 18 patients subsequently gave birth, and 13 (72 percent) were able to breast-feed. There was no cut-off point in our study, as all women able to lactate were included in the

results. Our patient pool included patients of a wide range of age (15 to 67 years), thus explaining the relatively small number of women of child bearing age, and therefore the small number of women giving birth and subsequently trying to breast-feed.

Our percentage of breast-feeding women compares favorably with that of Marshall et al.² (73 percent), but is considerably higher than that of the current study (29.5 percent, or 47.5 percent if we include even those women who failed to breast-feed more than 2 weeks), as well as the studies performed by Harris et al.³ (35 percent) and Caouette-Laberge⁴ (44 percent), but then again different standards were used in defining "successful" breast-feeding. The normal breast contains 15 to 20 lobules, each of which is drained by a lactiferous duct that usually opens independently on the nipple.⁵ Suckling of the nipple initiates a reflex arc through the nervous system to the pituitary, causing the release of prolactin necessary for milk production and oxytocin necessary for milk "let-down."² Successful breast-feeding would thus depend¹ on the number of intact lobules remaining on the breast,² the presence of intact lactiferous ducts draining these lobules to the nipple,³ and the presence of intact nerve supply to the nipple serving the suckling reflex.

The inferior pedicle technique by design leaves the nipple in continuity with (some) glandular tissue and spares the nerves supplying the nipple (namely the perforating branches of the third through fifth intercostal nerves), and should therefore allow for breast-feeding. The variable in this equation is the number of lobules left in situ and in continuity with the nipple. Assuming that the lobules are spread evenly about the breast, fewer than one-third of the breast lobules would remain intact following breast reduction with the inferior pedicle technique, yet the number of women able to produce enough milk to breast-feed is surprisingly high as demonstrated by the aforementioned studies. It would be interesting to see a study comparing the various techniques in this respect, or a study looking into the number of lobules contained in the resected breast tissue.

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SURGICAL OUTCOME: FROM THE PATIENT'S PERSPECTIVE OR THE SURGEON'S?

Sir:

I read with interest the article by Salgado et al. (*Plast. Reconstr. Surg.* 105: 1330, 2000) entitled "Pfannenstiel Incision as an Alternative Approach for Harvesting the Rectus Abdominis Muscle for Free-Tissue Transfer." In fact, I had to read it three times to convince myself that neither the Methods nor the Results substantiate the authors' claim at the conclusion of their discussion: "In our 10 healthy patients, we experienced improved cosmesis at the donor site without any significant morbidity." Unfortunately, the "operative term" seems to be "we."

Even though the authors do not establish a clear objective for their study in their introduction, they suggest that they have developed an alternative approach to the traditional midline or paramedian incision for the harvest of the rectus abdominis flap i.e. the Pfannenstiel incision, in keeping with their goals of "consideration [of] aesthetic components of our reconstructive procedures." Indeed, such goals have merit, but it is imperative that an assessment of results be performed using valid methodology so that surgeon bias does not potentially impugne the data.

For example, in the Methods section there is absolutely no mention of "methods of assessment." The authors simply share with us surgical technique. Would it not have been valuable to have the patients rate their satisfaction with the incision, or lack thereof, using a visual analog scale or the equivalent? Furthermore, would not the allegation that one incision is more aesthetic than another be strengthened by a comparison with two separate groups of patients, i.e. one group with Pfannenstiel incision and one with midline? The authors clearly have the volume to do such a retrospective analysis, telling us that in the past 10 years they have performed 800 free tissue transfers. And yet we are told that only ten of these free flap patients were identified as having the rectus muscle harvested through a Pfannenstiel incision. This is my second criticism of the article. It would seem as though there are a significant number of patients who were not recalled for the study and, therefore, remarks regarding complication rate, etc., must be viewed with a degree of healthy skepticism.

Aesthetic considerations are clearly important, but it is the patient's perspective that is of paramount importance. Salgado et al. may be enamored of the Pfannenstiel approach themselves, but until we hear that patients prefer it, the paramedian incision is the incision of choice. It unequivocally facilitates harvest of the entire muscle, and, one would think, decreases the risk of wound complication. When patients experience nearly miraculous limb reconstruction and salvage following our "surgical feats," we might be surprised that they are less concerned with the appearance of their donor-site incision. It may be, for example, that given a comparable amount of pain at a donor-site incision, its location and visibility are relatively less important. Unfortunately, Salgado et al. missed a tremendous opportunity to answer these questions.