

I have really enjoyed both the reconstructive and aesthetic aspects of body contouring for massive weight loss patients, a perfect marriage of cosmetic body contouring guided by reconstructive principles from both general and plastic surgery. I also enjoy the multidisciplinary approach to the massive weight loss patient and the manner in which specialists with different yet complementary areas of expertise come together to create a satisfied, healthy, functional patient. Mostly, I have enjoyed learning from the dialogue I share with my plastic surgery colleagues, who are evolving and improving their techniques, taking results to the highest possible level while holding patient safety as a priority. I look forward to seeing more in the literature about this unique and growing population.

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The “Reverse” Latissimus Dorsi Myocutaneous Flap for Reconstruction of the Gluteal Region

Sir:

We read with interest the article by Muramatsu et al. entitled “Experiences with the ‘Reverse’ Latissimus Dorsi Myocutaneous Flap” (*Plast. Reconstr. Surg.* 117: 2456, 2006) and would like to commend the

authors for an interesting article. It is refreshing to see, in this age of ultramicrosurgery, that basic plastic surgery techniques and time-proven flaps still have their use, even if only as “lifeboats,” as Sir Harold Gillies wrote in *The Principles and Art of Plastic Surgery*.¹

The authors state, “with the exception of spinal cord syndrome, use of the reverse latissimus dorsi myocutaneous flap for reconstructive surgery has to our knowledge been very rare.” We would like to draw the authors’ attention to our own communications presenting our experience with the use of the “reverse” latissimus dorsi flap in the reconstruction of difficult lumbar, gluteal, and flank defects in four cases.^{2–4} One case in particular is very similar to cases 2 and 3 presented by the authors (Fig. 1).

We have found the “reverse” latissimus dorsi flap to be a very reliable reconstructive option, and we would like to remind readers of some of its advantages:

- It does not require a microsurgical setup.
- It does not suffer from the complications of free flaps in general.
- It submits the patient to a much shorter operation.
- If the defect is relatively small, only a portion of the muscle needs to be harvested, leaving a functional part behind, which is very important in paraplegic patients.
- The flap retains its sensory innervation from the intercostal nerves, and thus is sensate.

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Fig. 1. A 55-year-old man with a well-differentiated liposarcoma. (Left) Preoperative markings for a “reverse” latissimus dorsi myocutaneous flap. (Right) Postoperative view at 6 weeks.

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Free Microdissected Thin Groin Flap Design with an Extended Vascular Pedicle; Thin Anterolateral Thigh Perforator Flap Using a Modified Microdissection Technique

Sir:

We read with great interest two articles recently published in *Plastic and Reconstructive Surgery*, namely "Free Microdissected Thin Groin Flap Design with an Extended Vascular Pedicle"¹ and "Thin Anterolateral Thigh Perforator Flap Using a Modified Microdissection Technique and Its Clinical Application for Foot Resurfacing."²

If microsurgical reconstruction is to be advanced, then it is essential to further refine flap reconstruction procedures in three main ways: to improve the quality of the outcome (both aesthetically and functionally) at the recipient site, to reduce overall morbidity, and, finally, to simplify procedures to reduce operative time and broaden applicability. These factors are clearly interdependent in many ways, and the two articles beautifully demonstrate elegant technical modifications to permit uniform, radical, primary thinning of skin flaps with low donor-site morbidity. Kimura and Saitoh¹ should be particularly commended in this regard for their refinement of the groin flap. In so doing, they minimized secondary revisionary procedures, and by enhancing outcomes, they broadened the flap's indications to encroach into the traditional territory of the skin graft as the first choice for reconstruction.

To facilitate hemostasis, thinning is appropriately carried out in both articles before flap transfer, using the differing morphologies of the superficial and deep fat layers as a guide to preserving the subdermal vas-

cular plexus by which the thin perforator flap perfuses. For both techniques, the thinning procedure is carried out using microscope magnification. Kimura and Saitoh¹ first confirm the pedicle anatomy, microdissecting it into the superficial fat before completing elevation of the flap in the superficial fat layer, whereas Yang et al.² raise the flap subfascially and only thin it after completing proximal pedicle dissection. Both techniques have logic, and demonstrable efficacy, but it is our belief that neither technique optimally addresses the need to reduce operative time and simplify flap procedures to enhance uptake within the reconstructive community, while retaining safety and quality of outcome.

Cadaveric anatomical dissection of perforator flaps at various sites confirms perforator arborization into the subdermal plexus, as is depicted in the illustrations in Kimura and Saitoh's article.¹ This plexus lies both within the basal dermis and immediately beneath it, where the dermis blends with the superficial adipose layer (Fig. 1). We contend that the smaller, brighter lobules of this layer can be easily differentiated from the deeper adipose layer using loupe, rather than microscope, magnification, and it is our experience that thin perforator flaps can always be raised in this plane, after identification of the source perforator. Since the right layer can be found easily, primarily raising the thin flap is faster and no less reliable than thinning after raising the full-thickness flap as described by Yang et al.² The most important thing is to leave a continuous layer of subdermal fat on the flap to ensure that damage to the subdermal plexus is avoided. Once the region of perforator arborization is reached, dissection is deepened to the suprafascial plane, and perforator dissection proceeds proximally to include the source vessel as required. Finally, one uses finer instruments to ante-

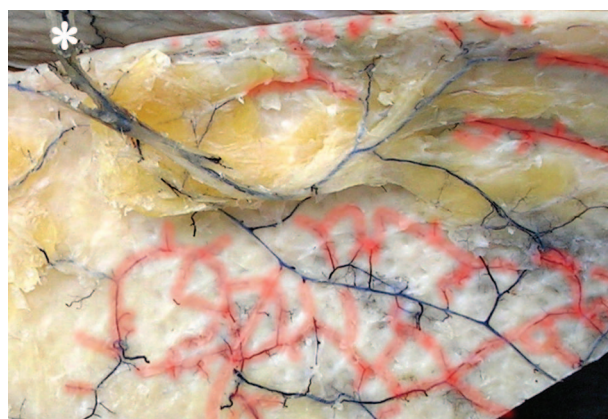


Fig. 1. Cadaveric dissection of a thin anterolateral thigh flap. The perforator (*) arborizes into the subdermal plexus via several branches that run through the deep and superficial fat layers. The subdermal plexus is seen to be located within both the deep dermis and the immediate subdermal fat. Ramifications of the plexus are highlighted in red and provide communication between different perforator arborizations and perforators.