Sir:

In reading the article entitled “Breast Reconstruction with Free Tissue Transfer from the Abdomen in the Morbidly Obese” by Jandali et al. (Plast Reconstr Surg. 2011;127:2206–2213), I noticed a key error in their statistics. They state a total flap loss rate of 8 percent in the morbidly obese compared with 0.5 percent in the control group, a statistically significant difference. Their numbers are based on two of 25 patients (8 percent) instead of two of 42 free flaps (4.7 percent). To use flap loss as a complication but not use the number of flaps seems inconsistent.

One wonders whether the correct numbers would result in a statistically significant difference. This calls into question the validity of the conclusions drawn from these numbers. Because one of the main points in the article is that flap loss is significantly higher in the morbidly obese, this error should be addressed by the authors. As America’s waistline grows, so too does the desire for autologous reconstruction, and it would be of great importance to know whether the morbidly obese are indeed at higher risk for flap loss.

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Adam Saad, M.D.

Charles L. Dupin, M.D.

Louisiana State University Health Sciences Center

New Orleans, La.

Correspondence to Dr. Saad
Department of Plastic Surgery
Louisiana State University Health Sciences Center
1542 Tulane Avenue, Room 734
New Orleans, La. 70112
adamsaad97@gmail.com

Gynecomastia: Evolving Paradigm of Management and Comparison of Techniques

Sir:

We would like to congratulate Dr. Petty and his colleagues on a well-written article that makes a significant contribution to the literature on the surgical management of gynecomastia. In particular, it establishes the place of minimally invasive arthroscopic excision of firm to moderately firm and large gynecomastia using remote incisions. What is especially appealing about this technique, unlike ultrasonic liposuction, is the ubiquity of the arthroscopic shaver in almost any general hospital (which performs orthopedic surgery). Its remote incisions cause less scarring than open excisions and can also be combined with liposuction. It is easy to use and easily learned. Most plastic surgery residents have rotated through orthopedics and know how to use an arthroscopic shaver. The precautions that have to be taken (e.g., cutting edge not facing the skin, pinching the tissues to avoid damage to the pectoralis muscle, low oscillation rate) are minimal compared with those of first-generation ultrasonic liposuction machines. In addition, it is not as labor intensive as ultrasonic liposuction and uses much less expensive equipment.

However, we would like to point out the omission of what we consider a key reference in the evolving paradigm of gynecomastia surgery over the past 20 years. Fruhstorfer and Malata in 2003 published the first attempt at rationalizing the various treatment options in their article entitled “A Systematic Approach to the Surgical Treatment of Gynaecomastia.” Their algorithm for the first time provided a useful means of navigation through the different modalities available to the plastic surgeon today. Despite Dr. Petty’s article being a multisurgeon article and therefore introducing interoperator variability, it further validates the role of ultrasonic liposuction as an effective treatment modality of gynecomastia. This is particularly important as, before the above reports, all of the studies of gynecomastia ultrasonic liposuction came from one unit.

Dr. Petty’s algorithm is well formulated, but it is not the first algorithm on the surgical management of gynecomastia and, as the main thrust of their article is an attempt to rationalize surgical treatment modalities, we believe that they should have made reference to our 2003 article. It might interest readers that this article has to date been cited 51 times by others on Google Scholar and, as such, is not esoteric, and we consider it to be a key reference in this field.

In conclusion, we would like to draw the attention of Dr. Petty and colleagues to a significant omission on their part regarding the contribution of others to this field. They should, however, be congratulated on their excellent work.

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Adesola Adekunle, M.R.C.S.
Department of Plastic and Reconstructive Surgery
Addenbrooke’s University Hospital

Charles M. Malata, M.R.C.S., F.R.C.S.(Glasg.), F.R.C.S.(Plast.)
Department of Plastic and Reconstructive Surgery
Addenbrooke’s University Hospital, and
Cambridge Breast Unit
Cambridge, United Kingdom

Correspondence to Dr. Malata
Department of Plastic and Reconstructive Surgery, Box 186
Addenbrooke’s University Hospital
Cambridge CB2 2QQ, United Kingdom
cmalata@hotmail.com

REFERENCES

Disclosures and Registration: Lost in Translation?
Sir:

I was intrigued by the article published ahead of print entitled “The Ideal Split-Thickness Skin Graft Donor-Site Dressing: A Clinical Comparative Trial of a Modified Polyurethane Dressing and AQUACEL.”

The Journal has abided by the Declaration of Helsinki since 2007 by only accepting for peer review prospective clinical trials that have been registered.3 Article 19 of the Declaration of Helsinki clearly states: “Every clinical trial must be registered in a publicly accessible database before recruitment of the first subject [italics added].”5 This article does not state in which publicly accessible database the trial was registered. When I searched the World Health Organization database of clinical trial registries that includes not only clinicaltrial.gov but also the German Clinical Trials Register, the only trial that I was able to find matching this article was clinical trials.gov NCT01055925 that was not registered until January 25, 2010.4 This article states on page 24 that patient enrollment for this study commenced “in full accordance with the Helsinki declaration” in June of 2008. What happened? Is there some other publicly accessible registry not listed with the World Health Organization in which this trial was registered? Is the World Health Organization database incomplete? Did the quality control process of the Journal fail and an article that violated the Declaration of Helsinki and the Journal’s own ethical standards somehow get peer-reviewed and accepted for publication? Is there some other explanation for why the only registry number that I could find for this trial was for a trial that had been registered more than 1 year after this trial began and 6 months after it ended?

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M. Felix Freshwater, M.D.
University of Miami School of Medicine
9100 South Dadeland Boulevard, Suite 502
Miami, Fla. 33156-7815

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