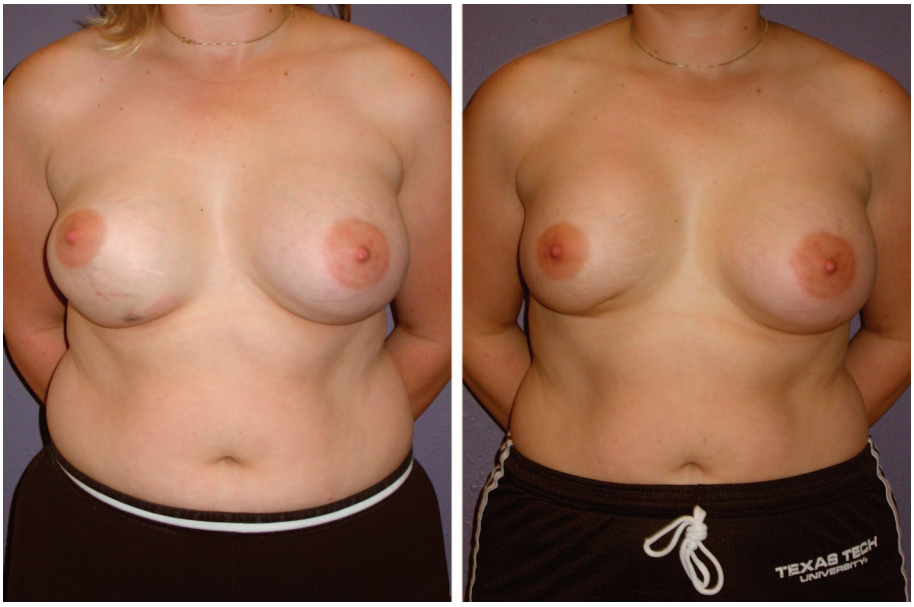

Fig. 1. (*Left*) Exposure of the right breast implant after transaxillary breast augmentation. (*Right*) Status after removal and replacement of implant with soft-tissue coverage.

provided enough of an additive effect to produce implant extrusion.

In conclusion, the obvious appeal of the transaxillary approach to breast augmentation is that it leaves no scar on the aesthetic unit of the breast. This appeal must be balanced with the major disadvantage of the procedure, which is diminished direct visualization of the operative field. In many facilities, endoscopic dissection is now being utilized for improved exposure and positioning. We recommend this approach, rather than blind dissection, during transaxillary breast augmentation. In addition, we hope practitioners will take note of our experience and exercise a heightened level of awareness of this rare but potentially avoidable complication.

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Mark A. Jabor, M.D.
Cosmetic Laser and Surgery Center of El Paso
El Paso, Texas

David H. Harley, M.D.
Department of Plastic Surgery
The Methodist Hospital
Houston, Texas

Correspondence to Dr. Harley
Department of Plastic Surgery
The Methodist Hospital
1401 Street Joseph Parkway
GWS 3rd Floor
Houston, Texas 77002
dhharley@hotmail.com

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Aesthetic Abdominal and Breast Reconstruction with Reverse Lateral Thoracodorsal Flap

Sir:

Regarding the difficult task of performing breast reconstructions, the choice among different methods is still a dilemma. Hölmstrom and Lossing[1] introduced the lateral thoracodorsal flap, which was modified by the senior author. We report three cases in which this flap was used.

A 34-year-old woman underwent mammaplasty at age 19 with disastrous results. In 1998, liposuction of her anterior abdomen was performed and resulted in multiple areas of deep adherences located on the superior abdomen. Years later, she underwent further surgery in which the reverse lateral thoracodorsal flap was applied.

The second and the third patients suffered from postoperative infections and so had this flap applied months later.

The flap, a laterally based, fasciocutaneous, wedge-shaped flap, whose base was placed on a line extending from the anterior axillary fold to the sternal region, was applied bilaterally. Its axis was long and extended from the level of the submammary fold along the sixth and seventh ribs (Fig. 1). It was deepithelized and attached to the pectoralis major muscle to provide projection of the areolo-mammalar complexes, volume, and a pleasant, conical form to the breasts.

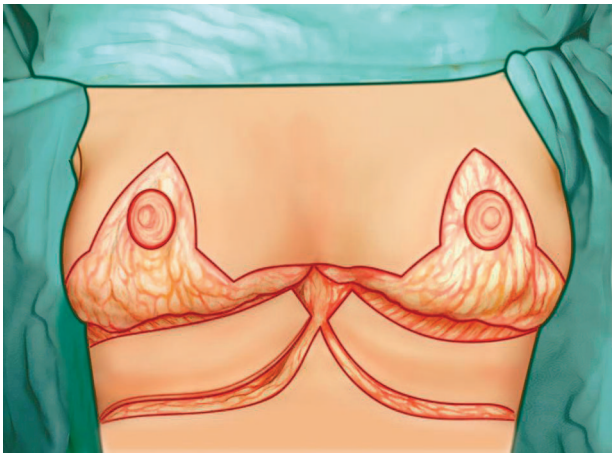

Fig. 1. Flap incisions and Swartzman's maneuver.

Two parallel incisions were carried out on the pectoralis major muscle, in the same direction as its fibers. The variation in distance between these two parallels was 4 to 5 cm. The reverse lateral thoracodorsal flap was inserted into the strip of the muscle and sutured with 3.0 mononylon. The deepithelized dermal fat flap covered part of the superior pole where it was secured and projects the areolo-mammalar complex (Fig. 2). This type of pectoralis major muscle flap has been reported by Caldeira and Lucas.[2]

The reverse lateral thoracodorsal flap was elaborated to provide more versatility compared with the inadequacies of previous reconstruction methods. It may be used in patients with previous inframammary scars or tissue exuberance on the thoracodorsal region after a massive weight loss associated with breast reduction/ptosis, and also in the treatment of disturbances caused by infection or technical inadequacies in the mammary region related to a previous operation.

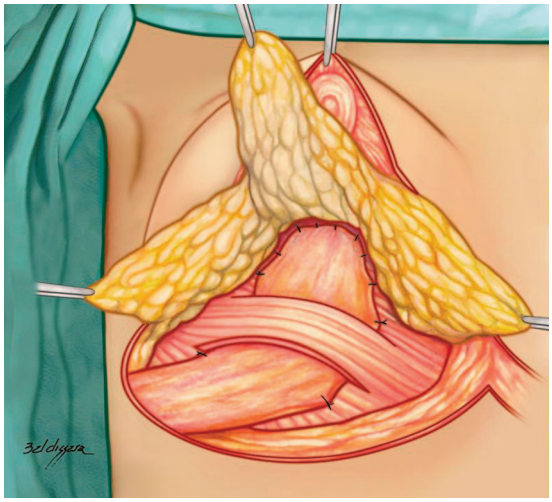

Fig. 2. Inset of the reverse lateral thoracodorsal flap. It was deepithelized and attached to the pectoralis major muscle.

The flap is irrigated by the cutaneous branches of the intercostal arteries, originating from the internal thoracic artery and aorta, and by cutaneous branches that come from the local arteries.[3,4]

The reverse lateral thoracodorsal flap has another notable aspect: the absence of a muscle attachment, which rules out the possibility of muscular atrophy and lipolysis, which frequently occur in myocutaneous transposition flaps.[5] Another advantage is that its use does not significantly affect the function of the pectoralis major muscle.[2]

In addition, the following reconstructive principles can be satisfied by use of the reverse lateral thoracodorsal flap: (1) resurfacing of the chest wall with healthy tissue; (2) reconstruction of the breast mound itself; (3) reconstruction of the axillary tail of the breast, and, what we regard as most important, (4) achievement of a conical and symmetrical breast shape.

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Alberto M. L. Caldeira, Ph.D.
Sumara M. Barral, M.D.
Ivana D. Araújo, Ph.D.
Daniel R. Thomaz, M.D.
Servico de Cirurgia Plástica
Dr. Alberto Magno Lott Caldeira
Belo Horizonte, Brazil

Correspondence to Dr. Barral
Servico de Cirurgia Plástica
Dr. Alberto Magno Lott Caldeira
Av Contorno 8351
Belo Horizonte, MG 300110-120, Brazil
sumara@terra.com.br

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Cerebrospinal Fluid Leak after Immediate Tissue Expander Breast Reconstruction in a Patient with Dandy-Walker Syndrome

Sir:

Dandy-Walker syndrome is a congenital posterior fossa malformation that causes a communicating hydrocephalus of infancy. When treated appro-