Dr. Pestana and colleagues point out that a critical component of the genital examination is identification of penile soft-tissue contracture. We agree with this point, as many patients with buried penis have poor-quality or restricting penile skin. Removing constricting penile skin allows more of the penis to be exposed and increases the functional penile length.

We would also like to point out that it is possible in most cases to remove penile skin but preserve the underlying Dartos fascia for direct split-thickness skin grafting. This will allow for improved mobility of the skin graft relative to the deep structures of the penis. Dissection should never occur deep to the Buck's fascia, which contains the urethra, neurovascular structures supporting the glans penis, and erectile tissue.

Dr. Pestana and colleagues state that, in contrast to the use of an occlusive foam/elastic dressing, they recommend negative-pressure wound therapy. To clarify, we use occlusive foam/elastic dressing for the donor site. We assume that Dr. Pestana and colleagues use negative-pressure wound therapy for the recipient site. Although negative pressure wound therapy is helpful, we prefer permeable nonstick gauze and cotton gauze that have been soaked in mineral oil. These dressings are fixed in place with suture and removed after 5 days.

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Bradley D. Figler, M.D.
Department of Urology
University of North Carolina–Chapel Hill
Chapel Hill, N.C.

Lisly Chery, M.D.
Department of Urology

Jeffrey Friedrich, M.D.

Hunter Wessells, M.D.
Division of Plastic Surgery
Department of Urology

Bryan B. Voelzke, M.D.
Department of Urology
University of Washington
Seattle, Wash.

Correspondence to Dr. Figler
Department of Urology
University of North Carolina–Chapel Hill
170 Manning Drive
Chapel Hill, N.C. 27599
figler@unc.edu

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REFERENCE

1. Figler BD, Chery L, Friedrich JB, Wessells H, Voelzke BB. Limited panniculectomy for adult buried penis repair. *Plast Reconstr Surg.* 2015;136:1090–1092.

Thoughts about the Name of Our Discipline

Sir:

We read with great interest the letter from Dr. Swanson entitled "The Pursuit of Greatness in Plastic Surgery."[1] The author asks himself whether Michelangelo is or is not a model to follow, or rather, it is better to follow Galileo, more devoted to the scientific method than to creativity.

In a previous letter, Khouri correctly pointed out that we definitely cannot afford a change in work ethic or ambition, but we do need a change in mentality.[2] He observed that a yearning for greatness is essential for success, but personal glorification cannot become our primary motive. Improving the human condition every day means you have already achieved greatness.

Perhaps we have lost sight of the true and original meaning of plastic and cosmetic surgery. A return to the etymologic origins might benefit.[3] Plastic surgery: we practice it every day, but do we really know the meaning of these words? Plastic surgery derives from the Greek *plastiké*, namely, "shaping" or "shape." It is a branch of surgery that aims to correct and repair the morphologic and functional defects or loss of substance of different tissues (e.g., skin, subcutaneous tissue, fascia, muscles, bones). It deals with congenital diseases, outcomes secondary to trauma, tumors, or degenerative diseases. Grafts and flaps represent the fundamental techniques performed.

Plastic surgery is one of the few surgical specialties that does not operate on a particular "district" or "apparatus"; rather, it operates on any body part. This implies that plastic surgery has several subspecialties: surgery of the head and neck, breast surgery, hand surgery, body contouring, surgery of the lower limbs, burns surgery, reconstructive surgery, and cosmetic surgery.

Cosmetic surgery is a branch of plastic surgery, and does not exist as isolated specialization. A significant number of plastic surgeons choose to focus their practice on cosmetic surgery, and the terms are often used interchangeably, but this is not technically correct. Cosmetic surgery and plastic surgery are not the same. Cosmetic surgery is focused on enhancing aesthetic appearance, whereas plastic surgery is focused on repairing defects to reconstruct a normal function and normal aesthetic appearance. In the United States, plastic surgery training is completed through a postgraduate residency program, whereas cosmetic surgery training is completed primarily after residency training (postresidency fellowship).[4,5]

The word "aesthetic" originates from a Greek word that means "perception" and a Greek verb meaning "perceive through the mediation of sense." Originally, the aesthetic fact was not a standalone part of the philosophy but the part of knowledge regarding the use of the senses.

This differentiates us from other types of general and specialized surgeons: the attention to aesthetic, even during a reconstructive procedure. The peculiarity of our specialization is to operate mainly on soft tissues with a direct impact on the appearance of the patient. We can reshape these tissues using the principles of plasticity; the

structure of soft tissues offers us the possibility of remodeling them. In our opinion, "aesthetic" itself could be considered as the bridge that joins plastic surgery closely with pure cosmetic surgery. In fact, in plastic and reconstructive surgery, we cannot disregard the aesthetic result from the functional result. They together constitute the outcome of the operation as a whole.

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Andrea Sisti, M.D.
Juri Tassinari, M.D.
Giuseppe Nisi, M.D.
Luca Grimaldi, M.D.
Division of Plastic and Reconstructive Surgery
Department of General and Specialist Surgery
University of Siena
Siena, Italy

Correspondence to Dr. Sisti
Plastic and Reconstructive Surgery
Department of General and Specialist Surgery
University of Siena
S. Maria alle Scotte Hospital, Viale Bracci 16
Siena, Italy 53100
asisti6@gmail.com

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REFERENCES

1. Swanson E. The pursuit of greatness in plastic surgery. *Plast Reconstr Surg.* 2016;137:907e–908e.
2. Khouri RK Jr. Chasing greatness. *Plast Reconstr Surg.* 2015;135:464e–465e.
3. Williams D. Paying and playing with plastic: The meaning of plastics, plasticity, and plastic surgery. *Med Device Technol.* 1996;7:7–10.
4. Morrison CM, Rotemberg SC, Moreira-Gonzalez A, Zins JE. A survey of cosmetic surgery training in plastic surgery programs in the United States. *Plast Reconstr Surg.* 2008;122:1570–1578.
5. Momeni A, Kim RY, Wan DC, Izadpanah A, Lee GK. Aesthetic surgery training during residency in the United States: A comparison of the integrated, combined, and independent training models. *Plast Surg Int.* 2014;2014:281923.

Plastic Surgery, Greatness, and Keeping Our Edge (Reply to Sisti et al.)

Sir:

Sisti et al.[1] concur with Khouri[2] that plastic surgeons need to look beyond personal glorification for motivation. The problem is, Khouri is conflicted on this point, stating that part of his motivation for enrolling at medical school was a yearning for greatness.[2] Khouri reports that his fellow students become depressed and even suicidal when they fall short of greatness,[2] reflecting the (unfortunate) contemporary demand for conspicuous achievement by students.[3] Stating that to "improve the human condition every day means you have already achieved greatness"[1,2] sounds wonderful, but is naive. We cannot all be great. The reality is, half of us are destined to be below average. Plastic surgeons do better to focus on making a contribution to the specialty, and not one that is motivated solely by profit.[3] As a famous American president might have phrased it, Ask not what plastic surgery can do for you but what you can do for plastic surgery.

Sisti et al.[1] consider cosmetic and plastic surgery to be dissimilar, with different objectives: form versus function rather than form and function. They view aesthetics as the bridge that joins plastic surgery (meaning reconstructive surgery) with cosmetic surgery.[1] In fact, plastic surgery encompasses both reconstructive and cosmetic surgery, which is one reason our society name was abbreviated to the American Society of Plastic Surgeons. Incidentally, cosmetic surgery training *is* considered an essential part of the American plastic surgery residency curriculum.[4]

Great as he was, I would not want Michelangelo to be my surgeon, chipping away and trying to liberate a human form in my body, believing he was uniquely touched by genius and divinely inspired.[5] It is not reassuring that he had no use for measurements, perhaps explaining why David's hands, particularly the right hand, are disproportionately large, or perhaps that was intentional (at least that is the contemporary spin). With some hubris, plastic surgeons often cultivate the public perception that we are artists.[6] Goldwyn[6] joked about wishing he were wearing a beret and a paint-spotted frock when asked by a patient if he paints in his spare time. In truth, plastic surgeons are not sculptors; we do not model clay or marble. Few patients would want their surgeon to indulge his or her artistic impulses in the operating room.[5] The template is already there. Plastic surgeons are renovators.[3,5] We seek to bring existing tissues to their original (or in the case of cosmetic surgery, their ideal) form.[3,5,7] Plastic surgeons require excellent manual skills, but also a critical (and scientific) mind to select valid surgical methods.

Even today, it is possible to sit through an entire day of breast surgery, face lift, body contouring, buttock augmentation, or rhinoplasty presentations, listening to the surgeons' clinical impressions, without seeing a single set of standardized before and after photographs with measurements. Plastic surgeons attend medical school, and not a fine arts academy, for a reason.[3] We need to rededicate ourselves to the scientific method.[5] We need to use a ruler (or its computerized analogue) along with a scalpel. In the absence of measurements, we make no progress. Without the scientific method, nothing is ever proven and nothing is ever disproven, a sort of nonscientific purgatory.[5] Sadly, we are now in our fifth decade of published articles (>100 and counting) claiming autoaugmentation using existing breast tissue and suspension sutures.[5]

The scope of our specialty is changing.[8] We need to hold on to cosmetic surgery and make sure we protect