Letter to the Editor on "Guyuron B, Son JH. String fat/dermis graft for correction of wrinkles and scars. Plast. Reconstruct. Surg. 2019; 144

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DISCLOSURE

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String Fat/Dermis Graft for Correction of Wrinkles and Scars

Sir:

With great interest we have read the article of Bahman Guyuron and Ji H. Son regarding the use of string fat/dermis graft for correction of wrinkles and scars.[1] We have also experienced that treating wrinkles and folds with such a graft will lead to a significant improvement. The video of Guyuron and Son[1] clearly demonstrates how the graft is inserted, an original technique described by Carraway and Mellow.[2]

Two aspects with regard to this way of treating skin impressions are worth mentioning to our readers. First, we would like to mention another source of autograft material: when performing a face lift and removing a little of the superficial musculoaponeurotic system (SMAS) after SMAS-ectomy or SMAS shortening, this resected SMAS material can be used for the same purpose with the same great results. In addition, we have used this SMAS material to improve the nasolabial fold.[3]

Second, it may not always be easy to introduce the graft in the tunnel as demonstrated, especially underneath a long wrinkle or fold. We suggest an alternative solution to insert the graft. First, a small incision is made on one end of the wrinkle or fold; this can be done either with a large bore needle or, as in case of the nasolabial fold, with a surgical blade no. 11 in the transverse fold of ala nasi of the nose. Through this wound, a subdermal tunnel is dissected either with the large bore needle or, as in case of the nasolabial fold, with scissors. After this dissection, a long 20-gauge needle is inserted through this tunnel, exiting through the skin on the other side of the fold. A larger bore, 18-gauge needle is then slid in reverse over the first (20-gauge) needle until it exits in the initial incision, after which the first needle is removed. A suture is attached to one end of the strip of SMAS. The long end of the suture is then inserted into the needle and advanced until it appears at the other side of the needle. Now the needle can be carefully removed, leaving the advanced suture out through the skin. Then, by pulling gently on the suture, the SMAS strip can be introduced in the tunnel and nicely advanced underneath the entire length of the wrinkle or fold.

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Secondary Abdominoplasty: Management of the Umbilicus after Prior Stalk Transection

Sir:

Every time, we are going to face an increased demand from patients requesting secondary abdominoplasties who had previously undergone a mini-abdominoplasty with supraumbilical detachment and navel detachment.[1] The reasons are that the abdominal area is increasingly more exposed, there are more frequent changes in partners, and a there is a greater aesthetic demand from society, thereby causing a greater demand for this type of treatment.

Personally, I have had nine cases of mini-abdominoplasty treated using the supraumbilical diastasis with umbilical transection and three cases of previous treatment of umbilical hernia. In those 12 cases, a secondary abdominoplasty was performed (until 2015) without any suffering or vascular damage to the umbilicus. The probable explanation is that the umbilical pedicle behaved like a randomized flap 21 days after primary surgery, and in the worst-case scenario, partial or total necrosis with closure by secondary-intention healing would be acceptable from an aesthetic point of view.

In my opinion, these cases would be an accurate indication for a transverse plication, no undermining, full *liposuction,* neoumbilicoplasty, and low transverse abdominal scar, or TULUA abdominoplasty, as published by Dr. Villegas in 2014. I incorporated the TULUA procedure into my routine for secondary abdominoplasty in 2016, and I have operated on 36 patients using this technique. The TULUA technique allows for vigorous and wide liposuction of the supraumbilical area since it will not be detached, a trans-infra-umbilical wide plication, and amputation of the patient's original navel. At the end of the operation, the new location of the neo-umbilicus is chosen and made through the use of a skin graft.

Our approach is to use epidural anesthesia performed by the anesthesiologist and tumescent infiltration with lidocaine for its bacteriostatic power. Of the 36 patients I have operated on, 14 had previous unsuccessful tummy tucks and 22 patients had extensive lipoaspiration of the anterior abdomen, with adhesions or little elasticity of the supraumbilical flap with which to perform the infraumbilical portion. The TULUA technique allowed us to incorporate a new niche of patients who were dismissed because their cases were complicated.[2] TULUA offers a high degree of safety in its execution. It also allows us to combine other procedures in the same patient without extending the surgical time exceedingly.

With vigorous and extensive lipoaspiration of the supraumbilical flap, it is possible to perform a high-definition liposuction in that area and combine it with the infraumbilical transverse plication of the TULUA, allowing us to offer a very safe high-definition lipoabdominoplasty to our patients.

In the last 2 years, this technique has been disseminated worldwide, beginning in South America. Several colleagues are practicing it and have it within their therapeutic arsenal, allowing us to solve complicated cases of our own or from colleagues who are not specialists in plastic surgery.

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DISCLOSURE

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Reply: Secondary Abdominoplasty: Management of the Umbilicus after Prior Stalk Transection

Sir:

Managing an umbilicus when the stalk has been previously transected and now requires circumscription (i.e., for a full abdominoplasty) can theoretically lead to ischemia.[1,2] Our report[3] about delaying the umbilicus represents a potential solution and preserves the patient's intrinsic umbilical appearance. Neoumbilization, as Dr. Javier Vera Cucchiaro and others have