Dear Editor,

We read with great interest the article by Shridharani et al. (2009) describing the banking of a surplus hemiabdominal deep inferior epigastric artery perforator (DIEP) flap for future use. The authors describe a novel surgical technique and useful indication, particularly in the case of difficult flap harvest and/or junior microsurgical staff. We have also described a similar technique of banking the surplus hemiabdominal flap (article still in press), however, our experience comprises a different surgical technique and different indications for its application, the discussion of which may contribute to the more widespread applicability of the technique.

Shridharani et al. describe a series of cases in which the banking of a hemiabdominal DIEP flap was able to maintain a reconstructive option for 4–5 days in the case of potential flap failure. While this indication may have its applicability, we have employed the technique for oncologic reasons. In cases of oncologic resection where immediate reconstruction with a DIEP flap is required, usually for skin coverage, but where the need for further resection may necessitate a subsequent reconstructive option, the banking of an unused hemiabdominal DIEP flap can spare the need for a secondary donor site. Histopathological examination of the initial specimen is usually performed within 5 days, and thus, this can be achieved during the same in-patient stay. In addition, this technique is appropriate for cases in which palliative surgery for local control of a locally recurrent tumor may ensue, even in coming months to years.

The technique described by the authors of burying (“banking”) the surplus DIEP flap beneath the upper ab-

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dominal flap is one way of preserving this tissue, but another option that we use is that of including the tissue between abdominal flaps as a means of aiding abdominal closure. Direct closure of the abdomen following DIEP flap harvest is essential to achieve good donor site outcomes, and while tension during closure is not sought, some cases often necessitate tight closure. Few studies have described techniques aiding closure following DIEP flap harvest, with several techniques reported to improve donor site outcomes including anterior rectus sheath plication, external oblique plication, and dermolipectomy. Modified rectus sheath incisions have been described to improve outcomes, and the use of intraoperative tissue expansion has also been described. By incorporating the banked DIEP flap into the wound for closure, advancing the flap to the midline as a perforator flap, significant tension is removed from the wound (Fig. 1). This technique provides the additional benefit of being able to monitor the vascular integrity of the flap in the interim period until its use.

With several techniques and several indications now described, this technique of banking a surplus hemiabdominal DIEP flap for future use may prove to be an increasingly utilized reconstructive option.

REFERENCES