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REFERENCES

1. Medical Devices Agency, 1999.
2. Davies, D. M., and Kirkpatrick, W. N. A. Lipid emulsification after implant rupture. *Br.J. Plast. Surg.* 52: 238, 1999.
3. Cole, R. P., and Morris, A. D. P. MRJ scan diagnosis of Trilucent breast implant rupture. *Br.J. Plast. Surg.* 53: 251, 1999.
4. Monstrey, S., Delanghe, J., Christophe, A., et al. Biocompatibility and oxidative stability of radiolucent breast implants. *Plast. Reconstr. Surg.* 105: 1429, 2000.
5. Young, V. L., Lund, H., Ueda, K., Pidgeon, L., Watson Schorr, M., and Kreeger, J. Bleed of and biologic response to triglyceride filler used in radiolucent breast implants. *Plast. Reconstr. Surg.* 97: 1179, 1996.
6. Choudhary, S., Cadier, M. A. M., and Cottrell, B. J. Local tissue reactions to oil-based breast implant bleed. *Br.J. Plast. Surg.* 53: 317, 2000.
7. Papanastasiou, S., Odili, J., Newman, P., and Evans, J. Are triglyceride breast implants really biocompatible? *Ann. Plast. Surg.* 45: 172, 2000.
8. Adams, W. P., Jr., Robinson, J. B., Jr., and Rohrich, R. J. Lipid infiltration as a possible biologic cause of silicone gel breast implant aging. *Plast. Reconstr. Surg.* 101: 64, 1998.
9. Varga, J., Schumacher, H. R., and Jimenez, S. A. Systemic sclerosis after augmentation mammoplasty with silicone implants. *Ann. Intern. Med.* 111: 377, 1989.
10. Giltman, L. I. Asteroid bodies in fibrocystic mastopathy. *Hum. Pathol.* 13: 767, 1982.

AREOLA MARKER FOR VERTICAL MAMMAPLASTY

Sir:

Limited-scar breast reduction, also known as vertical breast reduction, is rapidly gaining popularity and acceptance in the United States. One of the most difficult aspects of this type of procedure is correct pattern marking, usually done freehand by the surgeon. The superior portion of the markings, the so-called mosque pattern, seems to be the most challenging. I have designed a pattern for an areola marker that makes this process significantly easier and predictable (Figs. 1 and 2). In the last few years I have experimented with various types of

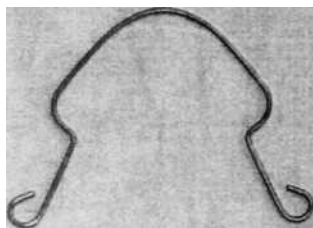


FIG. 1. The areola marker, manufactured by Padgett Instruments, Inc.

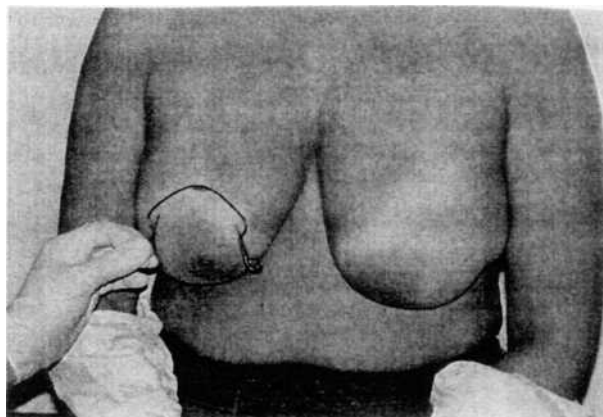


FIG. 2. The original prototype, created by the author, being used on a patient.

patterns including ones using x-ray paper, silicone sheeting, and even large gauge wire. I have found that the wire pattern was easiest to use and quite versatile for a wide range of breast shapes and sizes.

The technique is rather simple: first, the two vertical markings are placed on the breast, using the surgeon's preferred method. Next, the superior aspect of the new areola position is marked, usually in reference to the inframammary fold. At this time, the areola marker pattern is used, either 16-cm circumference or 14-cm circumference for breast lift and smaller reductions. The limbs of the marker are adjusted to meet the vertical markings appropriately. This method obviates the typical freehand method for marking the most difficult part. This pattern is manufactured by Padgett Instruments, Inc., Kansas City, Mo.

Disclaimer: The author is receiving royalties from Padgett Instruments, Inc.

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SAVING ONE STEP IN LIPOSTRUCTURE: M-AGO (MAGIC NEEDLE)

Sir:

Lipostructure, described by Coleman in 1997, is one of the most useful tools available to plastic surgeons to correct contour defects. Simple and relatively inexpensive, it provides durable aesthetic results in both the recipient and donor regions. Autologous fatty tissue is harvested in small, intact parcels and then transplanted to areas where filling is needed. The instruments required are a harvesting cannula, Luer-Lok syringes, closure caps, a centrifuge, and centrifuge sleeves.

On one occasion, due to a delay in material delivery, our department ran out of Luer-Lok caps. An effective solution had to be found. The alternative device to close Luer-Lok syringes needed to be sterile, immediately available, hermetic, and inexpensive. It also had to be short and small enough to allow the correct positioning of the syringes inside the centrifuge. A 25-gauge disposable needle has all these characteristics when its lumen is closed by compressing it with a Cocker and the needle is folded on itself. The newly created device was tested and found to be perfectly effective. Normally, after centrifugation, three layers are present inside the syringe: blood and lidocaine at the bottom; oil, from ruptured