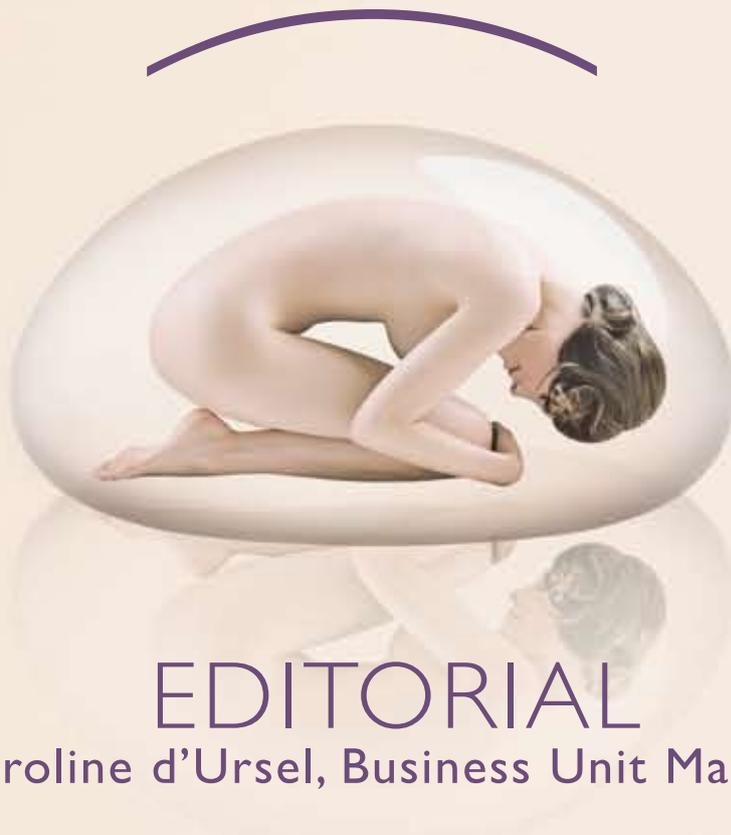


L'EXPANDER

The plastic surgery newsletter from Laboratoires SEBBIN



EDITORIAL

by Anne-Caroline d'Ursel, Business Unit Manager Benelux



This year 2012 will have been a pivotal year for the Groupe Sebbin. After a successful relaunch, initiated in 2010, the time has come for a reorganization. Since 1st January 2012, Sebbin set itself the goal of firmly establishing its brand and the quality of its implants throughout the world. A challenge that is beginning to be fulfilled in Europe and more especially in the Benelux, 1st region where the Groupe Sebbin directly established

itself, where the aesthetic and reconstructive surgery professionals hold a particularly warm and open welcome for our young team.

With a population of more than 27 million individuals and almost 1,000 practitioners, aesthetic and reconstructive surgery has become a dynamic market there.

This is why the Groupe Sebbin wishes to make available to its Benelux partners a range of innovative products and a premium exemplary service in terms of reactivity, listening and proximity to its clients. This 4th edition of l'Expander seeks to express this: we hope that reading it will enable you once again to deepen your scientific knowledge on current surgical topics. Do not hesitate to send us your comments and ideas. It will be our pleasure to take these into account in our forthcoming editions.

Happy reading and until next time.

THE WORD

from Doctor Julien Glicenstein

The human being has always sought to discover the fountain of youth. To regain the appearance of youth, this is the response that more and more of our patients expect. In tackling the problems of surgery for excess skin, this 4th edition of l'Expander intended to play a part in this trend. Thus we asked Dr Jean-François Pascal and Dr Claude Le Louarn to pass on to us their thoughts and the fruits of their experience on this subject. In this edition you will also find our scientific reviews of the last weeks and the continuation to our historical series...



Issue 4

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A TECHNOLOGICAL PARTNERSHIP WITH



By initiating a partnership with Crisalix in France, the Groupe Sebbin is enabling its clients to equip themselves with the Crisalix simulator, the first simulator using a web interface, to integrate the physical properties of the body. Crisalix facilitates simulation of the 3D outcome of a breast augmentation and thus allows patient satisfaction to be optimized.



Invited guests of L'EXPANDER



Doctor Jean-François Pascal Doctor Claude Le Louarn

SURGERY FOR EXCESS SKIN: MAIN PRINCIPLES

PREAMBLE

Fat ablation (liposuction) rather has straightforward after-effects. By contrast, skin ablation (dermolipectomy) is known for its complications. These are even more major in the context of massive weight loss or obesity: seromas, skin or fat necroses, infections, bad scars and finally: poor results and a traumatic experience for the surgeon and his/her patient. This bad reputation is responsible for numerous therapeutic abandonments and refusal of teams (particularly the anesthetists) to perform the operation. Faced with numerous patients, we have tried to develop new technical options.

All the research has 2 underlying concepts: how to avoid the complications and how to improve the results.

To summarize the problem in a few simple words: removing a whole piece of skin with the underlying tissue involves sectioning large lymphatic and arteriovenous vessels with their seepage filling the dead spaces created by the detachments. In other words, the surgeon supplies the liquid and the receptacle to be filled!

The objective of all our technical progress has thus been

to fight against these two phenomena. This requires imagining a means of removing material (cutaneous fat) without cutting essential structures but also how to mobilize the skin without detaching it.

MAIN PRINCIPLES

Thus, in all our operations, we rigorously apply three major principles:

A. Limit detachment to the strict minimum (and even do not carry it out if possible).

This is a choice that must be made before the operation. Detachment is an aggressive intervention for the tissues and full of consequences. It severs an important part of the vascularization, innervation, creates a dead space and initiates the phenomena of healing and thus inflammation. We will see that this can be done differently while maintaining the same surgical efficacy.

First of all, what is the purpose of detaching the tissues?

The answer is two-fold:

- either to mobilize them,
- or to expose a structure for working on (aponeurotic fold, for example).

Let us analyze and understand the logic of tissue attachments: the body counteracts gravity by blocking the descent of tissues via numerous attachments between the underside of the dermis and the underlying tissues. This is logical, if not from middle age one would find an excess of skin at the ankles, concertinaed like an old sock. With age, the skin extends and its attachments are put under tension and become visible, forming numerous dimples on the skin, as on the buttocks or thighs, for example.



Numerous dimples mark the cutaneous attachments, visible only in the standing position.

These dimples are still analyzed by patients and aestheticians as cellulite. They are treated as such by diverse and varied institutes with a result close to zero since this is not a problem of fat but rather of skin extension. Mobility of the tissues is thus blocked in the downward direction but never upwards nor horizontally. In an abdominoplasty, following the logic of these attachments, the tissues of the supra-umbilical part would have to be raised and those of the sub-umbilical part lowered. This would lead to 2 scars (one sub-mammary and one supra-pubic) which is not desirable in standard cases. Thus a low scar was preferred because it is easier to hide and the maximum skin excess is sub-umbilical. But this strategic choice indeed has limitations and procedures must be found:

- not to sever the large inguinal lymph trunks,
- to carry out less detachment while nevertheless tightening up the epigastric region and that of the costal edges.

It is the challenge of abdominoplasty that is resolved by HSTA: high superior tension abdominoplasty. Detachment is thus necessary in abdominoplasty to release the attachment of the supraumbilical median raphe: it must be detached if one wishes to lower the tissues (tunnel detachment principle). But laterally the pseudo-detachment of liposuction is as effective as standard detachment. The difference is that, in the first case, all the vessels and especially the lymphatics are intact and there is no real aggression. This is also the case at the outer face of the thighs for the lateral attachment between the iliac wing and the trochanter, which limits rising of the skin of the thigh.

Outside of these zones, no fibrous attachment blocks tissue mobilization be it for upward or horizontal traction.



No attachment prevents upward tensioning. Therefore no detachment is necessary.

The tissues are already naturally mobile. Example: no need for lateral detachment for a vertical abdominoplasty.

To be even clearer, let us take the example of surgery of the inner faces of the thighs with a vertical scar.



Excess skin of the anterior and inner face of the thighs. Numerous attachments are also visible.



The tissues are naturally mobile around the limb. No detachment is necessary to treat the region.

The tissues are naturally mobile around the limb. In addition, considerable liposuction of the anterior faces mobilizes them even more. Thus, why detach? Most often it is solely a surgical reflex because it is thought that more skin is removed in this way. However, the absence of detachment eliminates discharges, necroses, infections and enables abolishment of drainage. The reasoning is the same for the arms, back, etc.

At the level of the buttocks, there is also no need for detachment for rising, unless a fat strip is positioned: the principle of detachment is only ever where there is a valid reason.

If one analyzes the anatomical charts of the lymphatic vessels (SAPPEY 1874), one notices that the buttocks are the site of anastomosis between the vessels of inguinal and ischiatic origin. It is there that there is a lymphatic no man's land: i.e. nothing other than small caliber vessels are present. As a result, they can be severed without risk of seepage. But in any case there is no justification for detaching the buttocks or the outer faces of the thighs to cause them to lift better as nothing opposes upward mobilization other than gravity; in any case there is no fibrous anchoring to cut.

The greatest risk is at the level of the arms. The inner face is rich in large lymphatic vessels and the return circulation is easily impeded. Sectioning the lymphatics can lead to chronically "swollen arms" precisely as following axillary node dissection. In summary, liposuction is a useful tool. It allows volume reduction and mobilization of tissues without detaching them and thus without severing essential structures (vessels and nerves). The only inconvenience is the extended operating time. A golden rule: in no case can aggressive liposuction be combined with substantial detachment. This combination carries a high risk of tissue necrosis. A choice must be made!

B. Pay attention to the large lymphatic trunks.

In every procedure we seek to know the anatomic presentation of the large lymphatic trunks. Thus it is essential to have good anatomy textbooks.

The principle is always the same: the volume of the zone of the large trunks is slimmed down by deep liposuction (i.e. beneath the fascia superficialis). Thus a lipoaspirated fibrous web is left that no longer has any volume and in which all the vessels and other essential structures are intact. All that remains is to surgically remove the subfascial layer of fat and the problem has been dealt with.

We also note that at a given moment the vessels must be cut, but the basic principle is that this is always performed at the site where they are ramified, i.e. of small caliber.

At the level of the limbs, arms and inner faces of the thighs, the problem is even a little more subtle. In fact there are large lymphatic trunks even in the superficial fat, where sectioning may lead to catastrophic consequences.

Following our logic of non-aggression, we apply the same principle to the superficial layer of fat: volume reduction by liposuction and conservation of the fibrous web that is now devoid of thickness. In the end, all the fat is thus aspirated between the aponeurosis and the skin.

Then all that remains is to remove the very fine layer

of skin by passing to the level of the dermis. This is the principle of separation for ablation of the fat and ablation of the skin: to summarize, the cutaneous and fatty material is removed without cutting a vessel. The positive consequences are manifold: more precision in assessing wide resection (the whole result depends on this) as no fat persists between the 2 edges, no detachment, no necrosis, uncomplicated healing...

The difficulty of the procedure resides in good preoperative planning regarding the scope of the tissues to be worked on. In fact, this surface is aspirated in such a complete way that there is no question of treating the skin aggressively by this method. It must not be forgotten that the remaining skin on each side of the resection zone will then be stretched and sutured. It must not be subjected to any aggression or detachment in order to obtain maximum quality of healing. In addition, the more complete the liposuction, the more the edges can be brought together without tension and the better the quality of the healing.

C. Re-closing dead spaces.

The definition of a dead space is: any space, virtual or not, created by a surgical intervention. If it is not re-closed, the body tends to fill it with seepage from the surfaces especially as:

- the haemostasis is not perfect,
- the large lymphatic vessels have been severed.

The movements of the body provoke cleansing of the surfaces between them which, as it is easy to understand, do not support healing. Thus all dead spaces created surgically must be re-closed by padding them every 2 to 3 cm. This is the third pillar in effusion prevention: the more the dead spaces are closed, the fewer the complications. The technique appears simple. In fact, this complicates the intervention by the surgeon, who has to anticipate the position of the padding points against the skin displacement. This is also an additional task in an already long procedure. But the reward is enormous: no flowing and no more drainage since, considering the limitations of the detachments and the large lymphatic trunks, there is nothing left to drain!

Padding should be performed everywhere where it is possible including under the suture zones. This intervention described by Baroudi has another advantage: a little more pulling can be applied by putting some traction on each point.

On the pointlessness of drains: plastic surgery without a drain is possible and brings immense comfort to the patient and drastically shortens the length of hospitalization.

Placing a drain is an aggressive intervention that can induce a certain level of iatrogenicity: pain and bleeding upon ablation, especially if the nurse does not remove the vacuum under the pretext of aspirating still more liquid, and sepsis. Patients are afraid of drains. They represent a significant stress factor for them. Thus, we have not been using drains for over 10 years without there being any case where we regretted it. It is fully advisable to drain a natural cavity such as a joint or the peritoneal cavity, for example. By contrast, draining a dead space that no longer exists because it has been re-closed is nonsense in that the vacuum generates auto production through aspiration of the interstitial tissues. Many surgeons place drains solely for the medico-legal aspect, the reason being that diagnosis of hemorrhage is made more quickly. But a drain does not prevent this from occurring and the surgeon has plenty of other means for making the diagnosis beginning with the numerous clinical signs. In the event of hemorrhage, one can ask oneself if drainage does not increase the quantity of blood lost since the vacuum increases the speed of aspiration. In conclusion, it is essential to observe these general principles which transform the after-effects of the operation. It is at this price that all the brakes will be released concerning dermolipectomy surgery. The whole team (anesthetists and care personnel) receiving the patient after the operation will make the difference and will have less difficulty managing the patient.

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ABDOMINOPLASTY AND KIDNEY TRANSPLANT

In the United States, (tomorrow in France) obesity poses a formidable problem in society. Patients afflicted with terminal phase renal insufficiency and having to undergo a kidney transplant often have a hanging abdomen. The pubic inguinal fold is a reservoir of bacteria difficult to destroy and is a source of infectious complications for the kidney transplant. It is tempting to perform an abdominoplasty before the latter. This is what the authors proposed

knowing that this intervention had to be carried out under difficult conditions. In addition to the risks arising in abdominoplasty (infection, cutaneous disunion), the patient factors must be taken into consideration (patients on dialysis under anticoagulants, necessity to modify the incision line of the kidney transplant in order not to leave a band of skin likely to become necrotic). The authors operated on 9 patients (6 women, 3 men) 4 of whom were diabetic with an average BMI of 31kg/m². The average weight of the resected fragment was 3 kg, the duration of hospitalization from 1 to 3 days, dialysis being performed the day before and the day after the intervention. Heparinization was interrupted until ablation of the drains. When healing was complete, the patients were directed to a kidney transplantation center. The latter was performed via the lateral part of the abdominoplasty scar. Let us recall that the first kidney transplant was performed by a plastic surgeon in Boston, (Joseph Murray born in 1919) in 1954 that earned him the Nobel Prize for Medicine in 1990.

Panniculectomy in preparation for renal transplantation. Kuo JE and al. Plast Reconstr Surg 2011; 128:1236-40.

OUR INDUSTRY HEARD BY SENATORS

To prepare the report of the senate mission, the senators visited our breast prosthesis factory and were able to ascertain the strictness of the industrial practices of our laboratory. For Mrs. Chantal Jouanno: "Most proposals from the senate mission emerge from manufacturers themselves who wish for a cleanup to be conducted between good and bad practices".



Chantal Jouanno, Senator of Paris and Olivier Pérusseu, CEO of the Groupe Sebbin.

DUBREUILH'S MELANOMA: WHAT TREATMENT?

Dubreuilh's melanoma (lentigo maligna) represents 4 to 15 % of melanomas, and is especially located at the level of the head and neck, in elderly persons in regions exposed to the sun. Its seriousness, as with other melanomas, is linked to the depth of penetration into the skin. The in situ forms have an excellent prognosis, but those where deep dermal invasion exists can metastasize. Clinical diagnosis is difficult. The lesion is often extended; sometimes pale, other times dark brown, evoking seborrheic keratosis.

Successive examinations of the patient with photographs, dermoscopy, allow diagnosis. The large dimensions of the

lesion, its site make its complete excision difficult for diagnostic purposes. Generally the dark or highlighted zones are biopsied. Surgical treatment of lentigo maligna is difficult as it often involves lesions of a large size, poorly delineated and located on the face. The excision 'safety' margin of 5 mm seems insufficient to avoid recurrences.

The Mohs technique - little used in France - is controversial due to difficulties in the histological interpretation. The authors of the article prefer excisions in stages after delimitation of the lesions using the Wood's light, and by choosing a margin of 5 to 10 mm depending on the depth of the lesion. The marginal zone is divided into 4 quadrants. The results of the exam are known in 24 hours. The excision is repeated until certainty that the subclinical lesion is absent. Coverage of substance loss only occurs at this moment, via graft or flap.

Melanoma of the lentigo maligna subtype Diagnostic challenge and current treatment paradigm. Mc Guire LK and al Plast Reconstr Surg 2012; 129 : 288e-299e.

Have you already performed surgery on a member of your family?

Sumner Slavin and Robert Goldwyn (the former Editor-in-Chief of Plastic Reconstructive Surgery whose shrewd and humorous editorials were little marvels), both plastic surgeons, and Mrs. Slavin, psychologist, sent a questionnaire to the members of the American Society for Aesthetic Plastic Surgery, 465 out of 1513 replied. The goal of this study was to know whether the surgeons had performed or would perform aesthetic surgery on one of the members of their family.

Treating someone in the family raises problems of ethics, objectivity, emotional barrier and performing surgery, even more so.

However, the immense majority of plastic surgeons interrogated (88 %) maintained that they would operate on or that they had operated on (84 %) a member of the family, most often their wife.

The motivations of the surgeons are interesting. Some say that they cannot refuse an insistent request. But the main reason given is that they are the most able and competent (67 %), 34 % consider that this is a practical solution and 8 % that this will save them money!

All the aesthetic surgery operations are performed: rhinoplasty, lifting, liposuction, operations on the breasts and abdomen. 94 % of the operations went without complications and 99 % of the surgeons consider their operated patients satisfied.

A family operation : plastic surgeons who perform aesthetic surgery on spouses or other family members Slavin S. and al Plast Reconstr Surg 2010 ; 125, 1018-23.

FACIAL INJECTIONS AND BLINDNESS

In this important study which ought to be read by all those, physicians and aesthetic surgeons, who inject fat and “fillers” into the face, the authors describe in detail the observations of 32 patients having undergone an injection in the face: 15 of fat and 17 of different products (collagen, silicon, hyaluronic acid and other fillers, corticoids, paraffin) and unilateral blindness casualties. “Lipofilling” had been performed 3 times in the lower 1/3 of the face (nasolabial fold, lips and chin), 7 times in the upper 1/3 (forehead, glabella and nasal bridge) and 3 times in the middle 1/3 (cheeks, periorbit...). In all cases immediately after the injection, blindness occurred with violent pain. It did not regress in any case despite medical treatment attempts.

17 patients were blindness casualties after an injection of a product other than fat. The nose and scalp (7 and 3 cases) were the most numerous sites of injection. The other sites were the forehead, glabella, cheek and temporal region. All the patients except 3 had definitive

blindness. One regained vision 5 minutes after an injection of corticoids, a second recovered after treatment with diuretics, a third regained vision after corticoid treatment, but with oculomotor paralysis and cutaneous necrosis.

The authors studied the physiopathology of the blindness: breaking into the vascular system, significant pressure allowing a counter flow embolism in the ophthalmic artery and in the central artery of the retina. They consider that no treatment has yet proven its efficacy and advise precautions at the time of the injection, aspiration prior to injection, application of local vasoconstrictors, small-sized syringes, fine cannula with small holes, blunt, slow injection, in low quantity. Injection into “traumatized” tissues must be avoided (the authors do not advise lipofilling during lifting).

Blindness following cosmetic injections of the face. Lazzeri D. and al Plast Reconstr Surg 2012, 129 ; 995-1012.



LIPOFILLING, STEM CELLS AND BREAST CANCER

Injection of fat at the level of the face, breast and other parts of the body is a technique largely used by plastic surgeons. The authors of the article - two plastic surgeons and one oncology researcher - question each other on the safety of lipofilling following tumorectomy or quadrantectomy. Recent studies tend to demonstrate that there is no obstacle or delay in the detection of breast cancer, linked to difficulties in radiological interpretation. However, the fat injected is not an inert product, but an active metabolic tissue secreting an abundance of hormones, cytokines and growth factors. The quality of the fat as a reconstructive material is linked in part to the presence of mesenchymal stem cells derived from the fat via a process of adipogenesis and angiogenesis.

The authors tried to answer several questions concerning mesenchymal stem cells, abundant in fatty tissue. They have a significant potential for transdifferentiation and secretion of a vascular growth factor found in the proliferation of cancers and metastases.

Experimental models (in the mouse) show that the implanted stem cells can induce metaplasia, dysplasia and cancer and this phenomenon has not been found in man.

They especially have a potential for transformation in conjunctival tissue and, in a more hypothetical manner, in epithelial tissue. The adipocytes in the conjunctival tissue might play a stimulatory role in breast cancer.

The authors consider that after a tumorectomy or a quadrantectomy, injection of fat containing mesenchymal stem cells runs an unacceptable risk in women who have undergone surgery for breast cancer.

This opinion will certainly be discussed.

The safety of autologous fat transfer in breast cancer. Lessons from stem cell biology. Pearl A. and al J. Plast Reconstr Aesth Surg 2012, 201 ; 65 : 283-8.

BOTULINUM TOXIN AND HYPERHIDROSIS

Hyper sudation is a minor abnormality that however often disrupts the social life. Local treatments such as antiperspirants must be repeated daily and entail irritation and skin allergies. Surgical treatments: thoracic sympathectomy under endoscopy, shaving the axillary sweat glands, is burdened with complications, and do not exclude the possibility of recurrence.

Localized, axillary, palmar and plantar hyperhidrosis can be treated with botulinum toxin. The toxin inhibits hyper secretion of acetylcholine, prevents hyper stimulation of the eccrine glands at the source of hyper sudation.

The authors use the type A toxin. The studies published for the past decade show that it reduces transpiration by 75%. The subjects treated are those with severe hyper sudation, impeding daily activity. Hyperactivity of the sudoriparus glands can be confirmed by the Minoz test (daubing with a solution of 3.5 % iodized alcohol). Any local infection is a contraindication.

25 units of botulinum toxin A are diluted in 1 ml saline solution, with possible addition of lidocaine.

In the armpit, the zone to be treated is delineated by the iodized alcohol test or is based on the hairy region. The injection is carried out with a 26 or 30 gauge needle. 40 injection sites 8 mm apart, are necessary, to treat an armpit. The needle is slanted at 45° and penetrates the skin by 2mm. 0.05 ml of solution is injected each time, 50U of toxin are necessary for one armpit.

Injections of the palm of the hand and the sole of the foot are painful and contact anesthesia by nerve block or by cryoanalgesia is performed 15 minutes before the injection. 100 units of toxin are necessary to treat the palm of the hand, 150 for the sole of the foot.

The authors consider the method safe and effective. Unfortunately the improvement is transient (6 to 9 months of efficacy) and the painful nature of the technique often discourages patients from restarting.

Treatment of hyperhidrosis with botulinum toxin. Doft MA and al Aesth Surg J 2012; 32:238-44.

THROMBOEMBOLIC DISEASE AND ABDOMINOPLASTY

The authors of the article performed surgery on 404 patients over ten years: 247 straightforward abdominoplasties with or without liposuction, 157 abdominoplasties combined with aesthetic breast surgery or extended liposuction. All cases involved an operation with transposition of the navel. All those who received surgery were treated as «outpatients» (after 2 to 3 hours on the recovery ward) and left the clinic on the same day. The operation lasted on average 100 minutes for the cases of isolated abdominoplasty, 140 for the case of combined surgery.

The authors think that auto coagulation treatment is usually pointless, if a very strict protocol is applied:

- utilization of compression stockings and of an intermittent pneumatic compression device set up prior to induction of anesthesia,
- early rising and walking around a few hours after the operation, avoiding prolonged sleep in the decubitus position,

- abdominoplasty with progressive wall tensioning and without drainage, ablation of the drains being a post-operative anxiety factor,
- persistence of “normothermia”, patients arriving in the operating theatre dressed in pajamas, and wearing a cap, covered in a heating blanket, the temperature of the room must be at least 24 degrees,
- analgesic treatment via pump with catheter,
- limited duration of surgery.

The surgical team must be especially trained so that each of these conditions is met with precision and speed. The absence of anticoagulant treatment is, of course, debatable, but the methodology is worth taking into consideration.

Venous thromboembolism in abdominoplasty. A comprehensive approach to lower procedural risk. Somogyi RB and al Aesth Surg J. 2012 ; 32; 322-31.

YESTERDAY TODAY

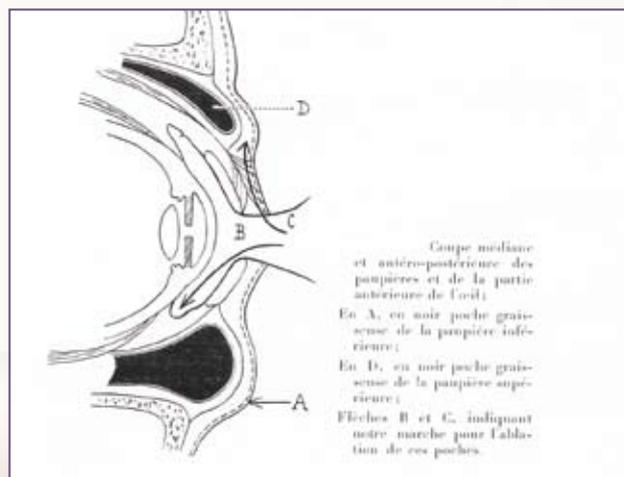
BLEPHAROPLASTY VIA THE CONJUNCTIVAL ROUTE

In 2008, the theme of the report of the French Congress of Plastic Surgery was “aesthetic surgery of the eyelids”. In the chapter on “bags”, a large space was reserved for the “conjunctival route”, for which the technique was given in detail. In a commentary, Daniel Marchac pointed out that this technique



Julien Bourguet

had been rediscovered in the 1970s by Paul Tessier and that its author was Julien Bourguet in 1928. In fact, Bourguet’s description was made at the Academy of Medicine on 25 November 1924, then published in 1925 in the Franco-Belgian Archives of Surgery [Archives franco belges de Chirurgie]. At the time of his communication at the Academy of Medicine, Bourguet first called it “fatty hernias”, peri-orbital fat lobules the bulging of which defined the “bag”. He first performed the ablation via the subciliary approach, but feared that this incision was the origin of a visible scar and even an ectropion, he had the idea of making an incision into the conjunctival sac. In his work “true aesthetic surgery of the face” (Plon, Paris 1936), numerous photographs illustrate the technique.



Conjunctival route



Result:
Before / After

Join the GROUPE SEBBIN AT THE CONFERENCES:

ISAPS (International Society of Aesthetic Plastic Surgery):
from 04 to 08 september 2012 in Geneva.

IQUAM (International Committee for Quality Assurance, Medical Technologies and Devices in Plastic Surgery):
from 01 to 04 november 2012 in Athens.

Marrakech World Aesthetic Congress - Intensive Course on Volumetry & Volume Restoration:
on 09 and 10 november 2012 in Marrakech.

SOFCPRE (Société Française de Chirurgie Plastique Reconstructrice et Esthétique):
from 19 to 21 november 2021 in Paris.



FLASHBACK

ON THE HISTORY OF TRANSPLANTATION

CHAPTER IV: JACQUES-LOUIS REVERDIN AND THE EPIDERMAL GRAFTS



On 08 December 1869 at the Imperial Society of Surgery of Paris, a young surgeon at the Félix Guyon Hospitals presents the “work” of one of his interns, of Swiss nationality, but having been appointed as an Intern of Paris Hospitals. Guyon expresses himself with caution before the learned assembly: “the communication... addresses a

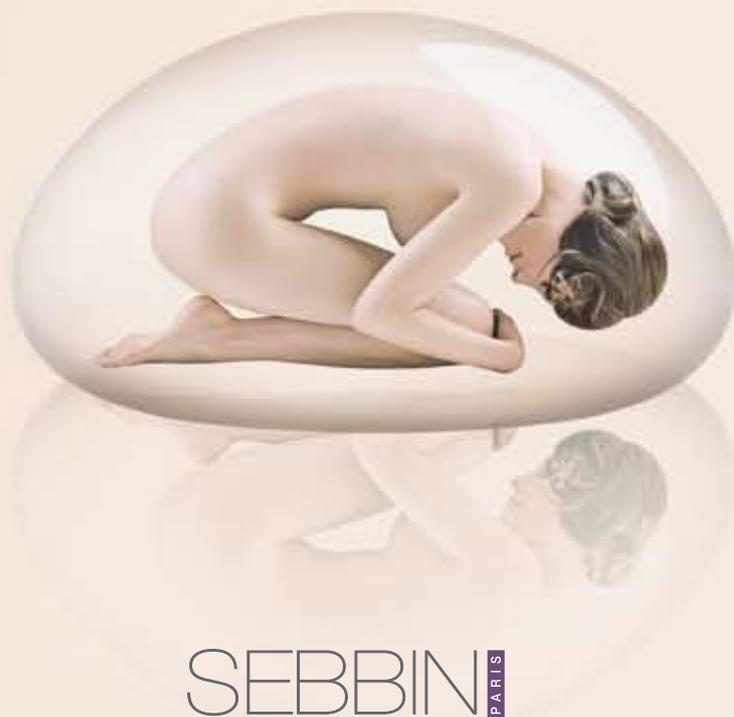
very common question of pathology... that however also presents some obscure and interesting points to elucidate. It involves second intention healing”. Reverdin had treated a 35-year-old man who was an accident casualty. The skin of his left forearm had been torn, and the resulting wound was only healing very slowly. With the “tip of a lancet” Reverdin removed two small strips of epidermis from the right arm of the patient that he placed in the middle of the wound, the underside on the granulations, apart from one another. Three days later: a new graft was placed on the wound. 10 days later the skin islets had extended and joined to form a thin patch

comparable to the epidermal border at the wound edges. Guyon finished his presentation by pointing out that a second experiment was underway.

Reverdin had performed the first skin graft in man. The communication sparked off an animated discussion among the surgeons present, among the broad skepticism. Some pointed out that a single experiment signified nothing, another that the graft was really dermoepidermal, and not simply epidermal, others that this type of intervention exposed the patient to fatal erysipelas. Only two participants considered the experiment of interest. Reverdin persevered and published a significant clinical and physiological study several years later in 1872 based on 50 patients. Despite his detractors, Reverdin’s idea spread rapidly in Europe and from 1870, the Englishman Lawson (1831- 1903) presented 3 cases of successful skin grafts.

Jacques-Louis Reverdin (1842-1928) left France after the Franco-Prussian war of 1870-71 where he was employed in the French Health Service, and became Professor of Surgery in Geneva.

Next episode: *Ollier and the autoplasic skin grafts.*



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