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SEBBIN PARIS
ESTHETIQUE & RECONSTRUCTION

L'EXPANDER

The plastic surgery newsletter from Laboratoires SEBBIN

EDITORIAL

by Doctor Julien Glicenstein

Daniel Marchac took his leave of us on 18 October last year after a one year battle against a relentless disease.
Daniel was one of the "giants" of our specialty, recognized and invited throughout the entire world. For me, he was a friend for over forty years and this friendship was never broken. At the beginning of the 1960s, we had the opportunity of being the first Interns in Plastic Surgery, and we concluded our career side-by-side in the same clinic.

Daniel Marchac had chosen a specialty within the specialty: craniofacial surgery, and had become one of the uncontested masters in the field. He had been the Chairman of numerous societies and the founder of EURAPS - European Association of Plastic Surgeons, with an annual meeting of the highest standard.
He was the author of numerous publications, and one of the few Frenchmen to have articles accepted regularly by the prestigious journal "Plastic and Reconstructive Surgery".

Daniel reconciled hospital surgery and private practice, reconstructive surgery and aesthetic surgery. He knew how to transfer his knowledge to numerous students worldwide and he had the opportunity to see one of his sons become a brilliant plastic surgeon.

As a great facelift specialist, Daniel had agreed to share his experience with us and be the guest of l'Expander.

This issue is dedicated to him.

macrofill
by ADIP'sculpt

NEW: LIPOFILLING KITS FOR HANDLING LARGE VOLUMES OF FAT

- Kit containing all the sterile material (single use) for processing 100 to 600 cc of adipose tissue in a single procedure;
- Removal, processing and re-injection of adipose tissue in a closed circuit;
- Specific cannulas allowing removal of small-sized adipose lobules promoting revascularization of the graft;
- Graduated 60 cc collection syringes offering optimal ergonomics for the practitioner;
- Application protocol allowing better engraftment than standard lipofilling;
- Ease of procedure and time saving by using collection syringes directly in the ADIP'SPIN centrifuge.

These kits are class IIa medical devices, manufactured by ALCIS on behalf of ADIP'SCULPT and distributed by GROUPE SEBBIN. These kits are in the CE-marking process by the notified body "BSI" number 0086 and will be available in March 2013. These kits are intended for use in the field of reconstructive or aesthetic surgery, to enhance the volume of deficient intra and sub dermal areas, in any area of the body through provision of adipose lobules. Please read the instructions carefully before using these kits.

CONTENTS OF Issue 5

Invited guest of L'EXPANDER

FASHION FOR FILLERS, BOTOX, FAT INJECTIONS DID NOT RENDER THE FACELIFT OBSOLETE. FOR THE PAST 40 YEARS AND THE DESCRIPTION OF SMAS BY MITZ AND PEYRONIE, THE TECHNICAL ASPECTS OF THIS OPERATION WERE EXPLAINED. DANIEL MARCHAC IN HIS LAST ARTICLE DETAILS THE METHOD AND PHILOSOPHY OF HIS TECHNIQUE.

FACELIFT

WHAT ARE THE GOALS THAT WE SET FOR OURSELVES WHEN ACCEPTING RESPONSIBILITY TO PERFORM A FACELIFT ON A PATIENT?

Above all, an improvement in appearance, rejuvenation, a reduction in the signs of ageing, deceleration of ageing, but also that these modifications are not obvious, that the intervention goes unnoticed. The equilibrium is not easy to find and too often the patient who recommends that you carry out a minor operation, without "tucking too much" will be the first to reproach you for an insufficient result.

I decline patients who desire a correction that is over-emphasised, who wish to return to the age of 25, and who will always be dissatisfied with the results of a facelift operation that has been conducted properly.

Dr Daniel Marchac

For the others "do not tuck too much, Doctor", I reassure them by saying that, above all, I am looking for a natural appearance, and I do what I consider to be a good equilibrium for the patient.

Obviously, one comes back to the judgement of the practitioner and his personal tastes. Some may like significant tautening, others a milder intervention.

Showing the patient in front of a mirror what one plans to do omits many of the details.

The patient is torn between two contradictory desires: becoming young, stopping the degeneration, and that this intervention is not detectable. It will have to be explained to the patient that the necessary measures must be taken to attain the desired goal, that is, effective rejuvenation which, however, remains natural and has an effect lasting 8 to 12 years.
All patients and the surgeon obviously wish for a straightforward, rapid outcome, but quality and durability of the result must not be sacrificed by conducting an operation that is too restricted.

After having explained and defined the goal to be attained "clear improvement, remaining natural with a long-lasting result", the methods for reaching this objective need to be considered.

We have always sought to conceal, to minimise, the after-effects of a facelift, in particular to conserve implantation and the hair mass, and to conceal the scars.

The facelift that we carry out essentially consisting of a lateral and posterior evaluation, the three zones to treat are:

1. the temporal zone,
2. the anterior auricular zone,
3. the retro-auricular zone.

1. The temporal zone.

For the temporal zone, for almost twenty years we have been using a temporal reduction flap which makes it possible to avoid raising the small zone of temporal hair.

The skin incision on the scalp is vertical from the ear and curves frontwards 3 cm above the ear. After detachment and tautening of the deep planes, elevation of the jugal skin and its pre-auricular fixation, the temporal flap is going to be re-lowered by dissecting a de-epidermised triangle.

In this way the normal level of the sideburn is maintained at the cost of a small subtemporal scar which will be concealed by the hair growing downwards in this region. There is no tension on this subtemporal suture which is normally barely visible, and in all cases, the scar will be concealed by the hair descending to this level.

Classic facelift

2. The anterior auricular zone.

We use an incision on the tragus in the anterior auricular zone. Precise line and dissection carefully conserving the cartilage, an adjustment without any tension, a careful suture (we use an intradermal Prolene 5/0 suture and separate Prolene 6/0 sutures) enabling an invisible scar to be obtained at conversation distance. We use the preauricular vertical incision, in front of the tragus, only in secondary cases where there is no laxity and to avoid tension on the tragus. The lobe of the ear must be put back with no tension, it must be positioned where it "falls" naturally.

Vertical facelift (D. Marchac)

3. The retro-auricular zone.

For a long time, we have been making a transverse incision behind the retro-auricular zone, perpendicular to the retro-auricular fold. With the intention of avoiding a visible retro-auricular scar; 10 years ago we developed a purely vertical incision which avoids all visible scars. The incision reascends in the retro-auricular fold and when this turns off towards the front, the incision leaves the fold and ascends vertically, entering into the scalp at 3 or 4 cm. A broad detachment (approx. 6 cm) under the scalp and the skin of the neck has been dealt with. After the deep planes, which we will speak about, replacement of the cutaneous plane is done. A mooring point is placed at the Frankfort point (middle of the ear). Thus there is a large difference between the anterior and posterior edges. The hairline is first realigned with a d'Assumpcao clamp. The two edges will then be sutured using the principle "small tuck in front, large tuck behind". A minimal re-incision is made on the posterior cutaneous edge. This thus results in a vertical retro-auricular suture that is completely concealed. The lack of an angle also improves viability and reduces the risk of cutaneous necrosis. The operation is normally carried out under neuroleptanalgesia, sometimes under general anaesthetic. In both cases, a generous infiltration of Lidocaine adrenaline is carried out beneath the cutaneous plane. Where there is excess cervical fat, the clinical exam allows detection of whether the surplus fat is located in front of the platysma.

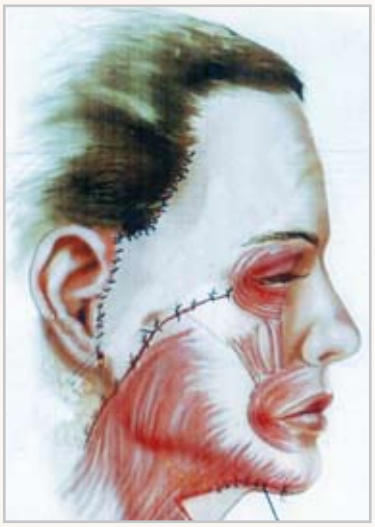
It is by contraction of the platysma that the location of the fat can be detected. Where the excess is in front of the platysma, we carry out liposuction. A short, sub-mental incision allows subcutaneous detachment of the sub-mental zone where the excess fat is located. Thus we use a size 8 gynaecological cannula which allows effective liposuction. It is then necessary to carry out complete detachment of the neck via the lateral access to retighten the neck. In the case of very limited excess fat, we use a size 3 or 5 cannula and complete detachment is not necessary.

Deep planes: when the temporal, jugal and cervical detachments have been carried out, we tension the subcutaneous plane to see the effect of elevation on the lower region, jowl, cheek. Where this manoeuvre is positive and leads to good elevation of the lower region, cheek and neck, we perform retensioning of the temporal,

Vertical facelift (D. Marchac)

jugal and cervical SMAS, according to the principles set out by Vladimir Mitz.

The SMAS incision is made high up, on the zygomatic arch, descends in front of the ear, then onto the posterior edge of the platysma. The detachment, after infiltration, will be carried out in front of the parotid plane, at 3 to 5 cm. A horizontal section of the platysma is made at 3 to 4 cm, making a low incision, at least 2 cm below the mandibular angle. The SMAS will be fixed to the temporal aponeurosis, superimposed, normally with a detachment of 3 cm, being completed with an intradermal continuous suture with Biosyn 4/0. If the traction on the deep plane is not sufficient for cheek elevation, the SMAS is not to be dissected. In such cases before, we carried out a plication. Since 2006, we have been making a circular suspension following the method of Ithamar Stocchero from Sao Paulo. A Vicryl 2/0 thread is threaded at the detachment limits and in the scalp, 3 cm above the ear. The vertical incision allows this thread to be inserted easily with a guide thread. The strong traction lifts the cheeks and reduces the detachment zone. A bulge appearing in front of the ear is easily flattened with a continuous suture.



Short scar facelift (D. Baker)

Numerous variants have been described for carrying out a cervico-facial lifting procedure.

According to the initial goal that we had set "a natural result without visible after-effects", we would like to criticise the "short scar lifting" supported by D. Baker and P. Tonnard. Daniel Baker, considering that the usual retro-auricular scar with its transverse incision must be avoided, proposes vertical elevation of the cheek.

This retightens the neck and allows the retro-auricular incision to be avoided but leads to a temporal precapillary incision being made in a visible zone to absorb the excess skin created by the vertical elevation. Zig-zag, bevelled incisions can allow fewer visible scars to be obtained, but in fact often these precapillary temporal scars remain clearly visible in this exposed zone. Revision of the scar, micrografts, can improve the situation.

We prefer not to take this risk and to avoid the precapillary temporal incision. Our vertical approach allows the visible retro-auricular transverse scar and the temporal precapillary scar to be avoided.

Unfortunately, we see patients being subjected to both the temporal precapillary incision and the transverse retrocapillary incision, thus adding visible after-effects of the operation and condemning patients to forward-swept hairstyles.

The duration of effectiveness of the facelift is usually 8 to 12 years, and it is possible to repeat the operation several times without any particular difficulty if the initial dissection has been carried out properly. We have carried out several repeat facelifts, always keeping the hair in a normal position and the scars concealed.

Utilisation of the fat following the principle of Sydney Coleman is a major advancement. These fat droplets can be implanted during the facelift, especially at the level of the cheekbones and of the cheeks or even 6 months later when the face has stabilised. It is also possible to use injections of hyaluronic acid, but in our case only as a supplement to superficial wrinkles and not for filling in an attempt to avoid a facelift.

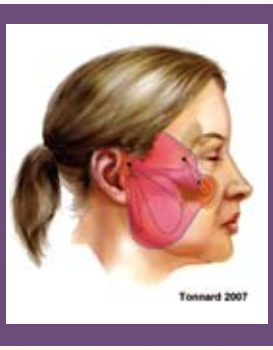
In any case, more and more often we see patients who have been injected for years. The base of the face appears heavy, the tissues are fibrous and a facelift will be difficult to perform and often deceptive in terms of the results. It must be realised that ptosis of the face cannot be corrected by adding filling products.

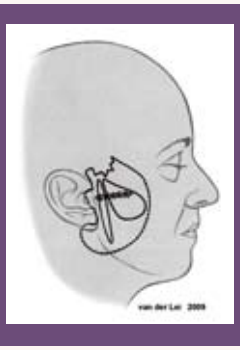
The indication is thus a fundamental factor in the battle against ageing and one must know when the time has come for minor interventions in a young woman and when the time has come for a cervico-facial lifting procedure in the case of ptosis!

Marchac D, Brady J.A and Chiou P ; Face lifts with hidden scars : the vertical U incision. Plast reconstr Surg 2002 : 109 (7) : 2539-51.

Marchac D. Against the "visible" short scar facelift. Aesthetic Surg Journal 2008 : 28 ; 200-208°.

Short scar facelift





Parotid injury during a facelift

Salivary secretion or a parotid fistula can complicate the outcome of a facelift. This eventuality is considered to be rare (only 12 articles and 20 observations have been published) but doubtlessly underestimated.
The authors describe 3 new cases. The anatomical study of the parotid shows that an adhesion zone exists between the parotid fascia and the SMAS, at the lower pole of the gland and it appears that this region is the most exposed to lesions. The clinical signs of a parotid lesion are oedema and localised swelling, erythema, a painful sensation of tension. A clear liquid can effuse from the scar, the swelling can be accentuated during meals. These signs usually allude to a haematoma or an infection. It is the non-haematic nature of the effusion, looking for amylase in the liquid, if not sialography that enable the diagnosis. The main author of the article observed 3 cases of parotid fistula in a series of 2000 facelift procedures. Each operation included a dissection and a resection or a plicature of the SMAS. The effusion was treated by prolonged drainage and reabsorbed in 3 to 4 weeks.

The authors study the usual methods of treatment of parotid gland or duct injuries after trauma or iatrogenic lesion and deduce a treatment algorithm in the case of a post rhytidectomy fistula.
Retro-masseter gland lesions (which was the case in all of the observations) must be treated medically with prolonged drainage and use of scopolamine patches placed behind the ear and changed every 3 days, or by multiple intraglandular injections of botulinum toxin (100 U), which has the effect of reducing salivary secretion. Surgical treatment is only indicated in the case of a highly anterior lesion involving the duct of Stensen.

An unusual complication following rhytidectomy. Iatrogenic parotid injury resulting in parotid fistula-sialocele. Lawson GA, Kreyerman P and Nahai F, Aesth Surg J 2012 ; 32 : 814-21.

CORRECTION OF FACIAL PARESIS IN ONE SESSION

Numerous techniques have been suggested for correcting unilateral facial paresis involving a relevant functional gene and significant deformity. In 1990, the Chinese surgeon Jiang Hua suggested using liberal transfer of the abductor hallucis as the resuscitating muscle with a transfacial nerve graft. This technique may be carried out in one or two sessions. The authors prefer to turn the two surgery sessions into a single operation.
They performed surgery on 45 patients of both sexes with long-standing paresis (17 months to 48 years!) of all aetiologies.
Facial preparation and removal of the muscle are carried out simultaneously by two teams under the direction de Jiang Hua. At the foot, the muscle and its pedicle are removed after having detached the distal insertion and opened the tarsal tunnel. At the face, two types of nerves can be used: the buccal branch of the contralateral facial nerve and the mylohyoid branch of the facial nerve of the same side. A pocket is formed on the afflicted side between the skin and the SMAS. The proximal part of the muscle is split into two strips of 3 or 4cm, inserted into the 2 lips and the buccal commissure. The distal part of the muscle is fixed to the temporal aponeurosis. The pedicle is slipped into the superior lip and sutured from the healthy side to the buccal branch of the facial nerve and to the facial vessels. In the case of anastomosis with the trigeminal branch, the pedicle crosses the inferior lip from the afflicted side. On average, the operation lasts 5 hours 30 minutes. Facial rehabilitation is started two months after the operation. The subjects who underwent surgery are tested at 3, 6 and 12 months. The authors followed 41 of their 45 operated patients, with an average follow-up of 5½ years. Only 4 patients had complications (one muscle necrosis, two infections, one hypertrophic scar). The pre- and postoperative photographs of 4 patients show satisfactory results at rest and during muscle contraction. These results are comparable with those of muscular translocations and transfacial grafting.

Facial reanimation by one stage micro neurovascular free abductor hallicis muscle transplantation. Personal experience and long term outcomes, Liu AT and al. Plast Reconst Surg 2012; 130: 325-35.

THE RISKS OF PLASTIC SURGERY

Plastic surgery is often considered to be a minor branch of surgery, as it is not necessary and is practised on subjects who are usually in good health. Despite this, it is not without its risks, some associated with "local" problems (haematomas, infection, scarring), others much more serious with it being essential to guarantee prevention.

The practice of plastic surgery must be based on safety. The preoperative examination identifies the risks associated with each individual, which anaesthetists have classed into 4 categories.

THE RISKS OF SURGERY ARE MANY AND OF VARYING IMPORTANCE

1. Hypothermia.
Hypothermia is often underestimated. It is linked to the temperature of the operating theatre, infusions, irrigation, prolonged exposure of areas undergoing surgery. Temperature regulation in the operating theatre, heating blankets, covering of non-operated areas are necessary.

2. Malignant hyperthermia.
Malignant hyperthermia, rare occurs in some predisposed subjects exposed to volatile anaesthetics (halothane, isofluorane) and muscle relaxants. It becomes manifest by tachycardia, hypercapnia and high fever.

3. Thromboembolic complications.
Thromboembolic complications are the most serious. Their risk is often underestimated (multiple operations, abdominoplasties or circular lipectomies, liposuctions). The authors recommend the Seruya risk score (PRS 208: 122; 1701) which classes the risks according to several factors into 4 categories of increasing severity, with a suitable prophylactic treatment (walking around, periodic perioperative compression, support stockings, low molecular weight heparin). Careful perioperative evaluation of bleeding (aspiration and liposuction fluid, compresses and cloths soaked with blood), allows evaluation of blood loss. In addition to the preoperative tests, a blood reserve must be planned where there is a risk of effusion of more than 500 ml of blood.

4. Infection.
Infection of the surgical site presents the problem of preventative antibiotic therapy limited to long interventions, infected tissues and prostheses.
Administration of antibiotics must be carried out more than 30 minutes before the operation or even earlier in the case of possible allergy.

The authors conclude their study of the complications by underlining arterial hypertension, often linked to anxiety, nausea and vomiting and to the cause of postoperative haematoma, such as perioperative hypertension. They also underline the risks of the "wet" method during liposuction. It was good to be reminded of all these often known, but neglected, concepts.

Patient Safety in Plastic Surgery Trussler AP, and al., Plast Reconstr Surg 2012; 130 : 470e-8e.

SATISFACTION OF PATIENTS WHO RECEIVED SEBBIN BREAST IMPLANTS IN AESTHETIC SURGERY:

- 93% judge the natural appearance of the result to be satisfactory or even very satisfactory;
- 88% feel that they have regained their femininity;
- 81% assess the sensitivity of their breasts as satisfactory or even very satisfactory.

Analysis performed with the responses from 384 female patients enrolled in the Sebbin Guarantee programme via the internet site www.sebbin.com between 18 November 2011 and 05 November 2012.

"COMPLEMENTARY" MEDICINES: A DANGER TO THOSE UNDERGOING SURGERY?

"Complementary" medicines (phytotherapy, homoeopathy, food supplements) are becoming increasingly popular. In the United States, 60% of candidates for surgery consume herbal teas, food supplements or receive homoeopathic treatment, which they do not always mention at the time of the preoperative consultation. Many patients ask for arnica to reduce preoperative ecchymoses. Many take these products on the simple advice of friends, without medical prescription.

Yet, these non-prescription drugs are not harmless and can be the cause of complications, which the authors of this well-researched article have listed, highlighting the risk of peri- and postoperative bleeding. It is impossible here to list all the reviewed products and their risks. It would be important to take them into consideration for the preoperative consultation by the anaesthesiologist or surgeon.

The effects of around thirty herbs, mixtures and homoeopathic compounds have been reviewed including garlic (anti-platelet aggregation effect especially in the presence of anticoagulant treatment), ginger (which prolongs the bleeding time), ginkgo (long-lasting anti-platelet effect), ginseng (risk of postoperative bleeding), arnica (which can have an anti-platelet effect), vitamin E etc.

Medicinal plants are extremely popular in South-East Asia and are sold on Asian markets throughout the world. These plants are all the more offensive since they can contain arsenic, lead, mercury, and, in some cases, coumarin and warfarin. The American Society of Anesthesia requests that consumption of these products should be discontinued 3 weeks before the operation.

In conclusion, this article must be read and kept. It brings into question the concept of «complementary» medicine.

Bleeding risks of herbal, homeopathic, and diatery supplements. A hidden nightmare for plastic surgeons ? Wong W.W. and al Aesth Surg J. 2012 ; 32 : 332-47.

WHY DO BREASTS SAG?

The authors took advantage of the Twins Festival of Twinsburg (!) Ohio in 2009 to select 161 pairs of true twins, with an average age of 47 years and 6 months, to determine if breast changes with age were linked to genetic factors or lifestyle conditions. Each twin had to provide answers to a questionnaire of 150 sections and – if she agreed – had to be photographed under strictly comparable conditions.

6 experienced plastic surgeons served as the inspectors and had to mark them according to 16 criteria (skin quality, scars, mammary gland ptosis, position, size and shape of the nipple, shape and size of the breast, symmetrical projection, folds, stretch marks, skin patches, position of the submammary fold, lateral rolls of fat, flattening of the superior pole). The results of this study are not really surprising.

Women who moisturise their breasts (how?) have more beautiful skin. Those who take hormonal treatment after menopause, have a better outline, better projection and a better shape of the areola. Elevated body mass, repeated pregnancies, significant breast volume are factors promoting ptosis and shape degeneration, as is alcohol and cigarette abuse. Breast-feeding often misshapens the areola. Finally, breasts become more damaged in women who sleep on their side than those who sleep on their back.

The article shows comparative photos of 20 women. Their breasts show differences linked to extrinsic factors. However, all are overweight. The article merely confirms factors of breast ageing that were already suspected. Can preventative advice be derived from it, such as writing on cigarette packs: caution tobacco makes breasts sag!

Determinants of breast appearence and aging on identical twins Soltanian H.T and al. Aesth Surg J 2012; 32-846-67.

Clinical utilisation of adipose-derived stem cells (continued)

Human stem cells derived from adipose tissue have manifold potential. In the previous issue of l'Expander, we presented the conclusions of the American Society of Plastic Surgery concerning their application. The authors (among them, the Frenchman Ali Mojollal) collected the results of different studies on the clinical applications of adipose-derived stem cells, identified by Zuch in 2001, which possess the characteristic feature of being able to differentiate into different mesenchymatous cell lines. These cells are generally extracted from adipose tissue using collagenases. After centrifugation, the stromal vascular fraction (SVF) is collected, which contains blood cells, fibroblasts, macrophages, endothelial cells and stem cells of adipose origin that can be isolated. These stem cells possess the ability to differentiate into cells with adipogenic, osteogenic, chondrogenic and myogenic (cardiac and skeletal) potential. The adipose-derived stem cells secrete angiogenic cytotoxins, immunosuppressants and antioxidants.
Clinical applications of stem cells are the subject of speculation and discussion on the risk of cancerous proliferation, due to their angiogenic potential.

The authors provide a detailed list of the different clinical trials. 33 trials, of these 3 in the United States, 17 in Europe (15 of which in Spain and one in France), 12 in Asia, one in Brazil. The 5 trials published in plastic surgery (lipodystrophy, Romberg syndrome, depressed scars, breast reconstruction following tumorectomy) did not provide properly workable results. However, aside from these trials, some authors such as the Japanese researcher Yoshimura utilised SVF in cases of breast augmentation, for depressed scars, to improve trophicity of the irradiated tissues with interesting results. Stem cells are the subject of numerous clinical trials and experimental studies in many domains other than plastic surgery (digestive system, autoimmune, cardiovascular and neurological disorders). In the future, utilisation of stem cells will be of great importance, but for the moment no protocols have been defined for their experimental or clinical application.

Human adipose cells : Current clinical applications. Gir P and al. Plast Reconstr Surg, 2012 ; 129 : 1277-1290.

LYMPHOMAS AND BREAST PROSTHESES (CONTINUED)

The authors of the article observed two cases of anaplastic large cell lymphoma in women with breast prostheses in 2009. In the first, who underwent surgery 3 years ago, it was the existence of a peri-prosthetic effusion that led to the intervention (ablation of the silicone textured prosthesis and of the thick and irregular peri-prosthetic shell). Histopathological examination of the "shell" enabled the diagnosis. The patient was treated with chemotherapy and radiotherapy then bone marrow transplant. Two years later, she is still in remission. The second patient with textured prostheses filled with saline solution for the past 4 years had come for consultation due to an increase in breast volume with a skin rash. Examination of the peri-prosthetic liquid facilitated the diagnosis. The peri-prosthetic shell was apparently normal. The patient whose check-up for lymphoma spread was normal, was treated by radiotherapy, with no chemotherapy and was in good health 18 months later.
The authors of the article contacted the members of the Australian Society for Plastic Surgery in an attempt to find other cases. They gathered 3 of them. The first patient had had a breast reconstruction following mastectomy and two consecutive prostheses: smooth, then textured, filled with saline solution. A tumour appeared 11 years after the first intervention, 7 years after the second. Treated with radiotherapy and chemotherapy, she was in good health 30 months later. The second had had a breast augmentation 25 years earlier (textured implants made from silicone). She complained of lethargy and malaise. There was a peri-prosthetic effusion. She was treated by chemotherapy and is in good health 2 years later. The last patient had had a mastectomy then a reconstruction with a textured silicone prosthesis. The diagnosis was made following histological examination of two tumours that were thought to be siliconomas. She received chemotherapy and radiotherapy. She is in good health, but she recently underwent surgery.

The authors conclude their article with a literature review.

Anaplastic large cell lymphoma and breast implants : five australian cases.
Taylor K.O. and al. Plast Reconstr Surg 2012 ; 129-610e-617e.

YESTERDAY TODAY

FROM THE TOURNIQUET TO THE INFLATABLE CUFF

The inflatable cuff is mainly used for limb surgery. It was invented by the American surgeon Harvey Cushing in 1904. It was the German, Friedrich von Esmarch, who, during a traffic accident in 1873, had the idea of using his rubber braces to provide compression to a crushed limb.

Friedrich von Esmarch

The Frenchman Nicaise replaced the braces with an elastic strip still used today in addition to the secure, automatic inflatable cuff.
We will not discuss the concern and risks of these instruments for everyday use, but we remind you that use of the compression garrotte is very old. The act of placing a tight bond around a limb to stop the blood circulation was known by the Romans.

Simple compression garrottes tightened with a piece of wood have been in use for 1,500 years. This heroic procedure only allowed healing of amputations, as leaving the compression garrotte in place for longer than one hour led to paralyses and gangrene.

Traditional garrotte

It was the Frenchman Jean Louis Petit, who, in 1718, had the idea of a system enabling localised compression of the vessels of the limbs: the tourniquet. This device consisted of several components: a circular bandage from chamois skin, a mobile compression pad and a system formed from 2 blocks of curved wood, which by means of a screw moved away from each other and progressively increased the compression.

Jean-Louis Petit

The tourniquet of Jean Louis Petit was used until the end of the XIX century.

Tourniquet of Jean-Louis Petit

XIX century Tourniquet

BEST INTERNATIONAL SUCCESS PRIZE PME CONFIRMED

During the "Faites de l'International", on 21 November, the Chamber of Commerce of Versailles Val d'Oise / Yvelines and its partners Ubifrance and Air France awarded their Export 2012 trophy to the Laboratoires Sebbin for their international status supported by reliable assets: its French manufacture, its knowhow in the development and manufacture of the products, its R&D, its experienced and qualified team, a dynamic and "results" orientated operational management, an assured innovation and international development.

FLASHBACK

HISTORY OF TRANSPLANTATION

CHAPTER V : LOUIS-XAVIER-EDOUARD-LÉOPOLD OLLIER AND ALLOPLASTIC GRAFTING

Louis Xavier Edouard Léopold Ollier (1830-1900), is one of the greatest French surgeons of the XIX century, the pride of the School of Lyon. He was born in Vans (Ardèche) and did his medical studies in Montpellier then in Lyon. At the age of 30, he received the title of Professor of the Surgery Clinic in Lyon. He studied the osteogenic role of the periost and, in 1867, published a remarkable "Experimental study of bone regeneration and artificial production of bone tissue".

Three years after Reverdin, on 02 April 1872, he gave a presentation to the Academy of Medicine entitled "Cutaneous or alloplastic grafting". In contrast to Reverdin who placed small epidermal fragments directly on the developing wounds, Ollier had the idea of covering the tissue loss with fragments of skin of complete thickness (including the dermis) from 4 to 8 cm2. It was not longer a matter of promoting healing, but rather of covering tissue losses. Ollier had used his grafts in the treatment of congenital syndactylies and burn scars. He advocated excision of the scar tissue and placing the graft on the raw surface. He removed the skin from the same subject, or from limbs amputated from other patients.

He thought that the grafts could be conserved by the cold. He insisted on the importance of postoperative immobilisation. Ollier also indicated that he used partial thickness dermo-epidermal grafts.

Ollier concluded his presentation to the Academy of Medicine by presenting colour observations, which unfortunately have not been provided to us.

Ollier LXEL, Greffes cutanées ou auto plastiques. Bull Acad Med Paris 1872 ; 36-243.

Next episode: Thiersch, Wolfe et Krause.

Join the

GROUPE SEBBIN AT THE CONFERENCES:

IPRAS (International Confederation for Plastic Reconstructive and Aesthetic Surgery)
from 24 February to 01 March 2013 in Santiago - Chile.

Symposium organized by Laboratoires Sebbin on Monday 25 February at 18h:
"PIP Scandal: Last Update about European Regulatory and Clinical Aspects related to Breast Implants".

SOFCPRE (French Society of Plastic, Reconstructive and Aesthetic Surgery) - Resident Plastic Surgeons' Meeting
Paris 09 March - Maison de la Chimie.

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SEBBIN PARIS

ESTHETIQUE & RECONSTRUCTION

This document is intended for health professionals.

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