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ESTHETIQUE & RECONSTRUCTION

# L'EXPANDER

The plastic surgery newsletter from Laboratoires SEBBIN

## EDITORIAL

### by Ilona Dicks, Sebbin Germany Sales Manager for the western zone

*"Wege entstehen dadurch, dass man sie geht". (Franz Kafka). "Paths are made by walking".*

Groupe Sebbin continues its international expansion. After 20 years of experience in companies specializing in the manufacture of breast implants, I joined Diana Lautsch and Jürgen Strecker to create the third Groupe Sebbin subsidiary in Germany.

We offer the market our long experience in the field of implants for aesthetic and reconstructive surgery. We especially hope to bring her innovative ideas.
What's convinced us? A premium offering, marketing concepts customer oriented, the assurance of the safety of Sebbin implants. The German market plays a major role in Europe. Therefore Sebbin Germany created an "Expert Service Online" so that our surgeons partners can be referenced on the website of the company. Thus, patients can easily find in their region, the ad hoc practitioner with a specific skill.

In addition, the partnership with Crisalix allows German surgeons to offer their patients the first breast surgery simulator in 3D since last June. The digital revolution is well underway!

Groupe Sebbin and the Sebbin Germany team welcome surgeons across the Rhine and invite them as many of their colleagues in the world, to enjoy this new issue of the Expander they'll certainly become faithful readers.

Happy reading.

# THE WORD
## from Doctor Julien Glicenstein

The subject matter covered by the Expander's Guest is not a technical development but a reflection on the therapeutic purposes of cosmetic surgery.
No one better than Gerard Flageul could deal with this subject, which appears to each of us, as a matter of course. Are we not doctors before being aesthetic surgeons? Is it possible for us to undertake an intervention without it making life better? Do we not reject any act that, to us, appears to be linked to a simple fad phenomenon or a whim? Gerard Flageul does more than just answer our firm conviction. He develops a real demonstration supported by scientific arguments and the evidence of surgical patients. Yes, cosmetic surgery does have real therapeutic purposes!

Issue 7

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## NEW SEBBIN HOMEPAGE!

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Invited guest of
L'EXPANDER

# THERAPEUTIC PURPOSES OF COSMETIC SURGERY

by Doctor Gérard Flageul


Dr Gérard Flageul

The therapeutic function of cosmetic surgery is evidenced daily by all plastic surgeons. As for the patients, the very large majority of those who benefit from this surgery, they are largely convinced of its benefits and regularly provide us with convincing and very moving testimonials. For several years, this question of therapeutic purpose of cosmetic surgery has been the subject of numerous decisive scientific work. The interest of this question has been recently updated by the French tax authorities. Indeed, following the introduction of a VAT on surgical acts and aesthetic medicine, the administration has adopted the criteria of being reimbursed or not by the social security, to decide on the exemption or the application of this VAT.

In many respects this "accounting" approach is curious and questionable. The State Council, in its order dated 4 October 2012, in response to a petition for suspension by the National Union of Plastic Surgeons, has "nuanced" the position of the tax administration in basing its reasoning essentially on the concept of therapeutic purposes, without the criteria of the reimbursement being mentioned in particular. Pending the judgement of the merits of the complaint, this response of the Council of State confers an additional interest to the study of the various aspects of the therapeutic function of cosmetic surgery. This is one of the reasons that made us choose this subject in order to analyse the very strong arguments that we have to support the fact that the cosmetic surgery is undeniably a true, powerful therapeutic and with great social fruitfulness.

In practice, these arguments are of a medical, societal [1-2], administrative and legal [3] nature.

We will only be studying the medical aspects in this publication. Indeed, it is not our intention here to argue the position of the tax administration. On the other hand, we wish to make the point on the fundamental aspects of our business that constitute its true function, its purpose, and in fact its legitimacy.

In October 2003, under the presidency of Vladimir Mitz, the French Society for Plastic, Reconstructive and Aesthetic Surgery (SOF.CPRE) devoted its annual report to the study of "Benefits and results of cosmetic surgery" [4]. In the framework of this report prepared under the direction of Patrick Knipper and Jean-Luc Jauffret, we have published in collaboration with Michel Godefroy and Georges Lacoeuilhe an article devoted to "the therapeutic function of cosmetic surgery" [2]. In this publication drafted a decade before the discussions raised by the introduction of the VAT in our activity, we discussed the question of the therapeutic purpose of cosmetic surgery from the medico-surgical point of view (Gérard Flageul), psychological (Michel Godefroy) and societal (Georges Lacoeuilhe). It is interesting to see, a decade later, written in this publication without being controversial and with the sole desire to study from a scientific point of view whether the care that cosmetic surgery provides belongs to the health care domain and has, as such, an undeniable therapeutic purpose.

## The aesthetic surgery: therapeutic "aimed" at a primarily psychological target.

The demand for surgical correction usually corresponds to a disagreement between the patient and his or her body image. This disagreement is usually with respect to a disgrace that the patient has suffered. The presence of this disgrace and the disagreement that exists between the individual and his or her body image generates a moral pain, a true suffering. Beyond the deceptively frivolous appearances, there is underlying and always present suffering in the framework of the request for correction with aesthetic surgery. In view of this often significant suffering, one can speak of a real "pathology of the image of the body" in the etymological sense of the term "pathology". The individual requesting the surgical correction, suffers in his entirety even if we are unable to quantify this psychological, mental and emotional suffering. In this context, one must remember medicine's founding aphorism: "To cure sometimes, to relieve always".

Therefore the goal of cosmetic surgery is to alleviate the suffering of the patient so that he may lead an improved life, to be better. One cannot deny the fact that a surgical approach, which is to alleviate the suffering, constitutes a really therapeutic act.

Thus, as evidenced, the strictly surgical repair implies and allows a psychic repair with an undeniably therapeutic scope.

Beyond these theoretical aspects, the daily practice confirms that if we adhere to a rigorous approach, "it works very well": thus, in the vast majority of cases, a real and important service is actually rendered to the patient both from the point of view of the aesthetic aspect as well as the psychological dynamic. The aim is in fact, not only for an objective improvement, which is appreciable visually and photographically, but also a psychological improvement and a better functioning psychological economy [2].

Thus, we are carrying out an act of medical and surgical intervention on psychological bases with, in fact, a psychotherapeutic objective. These undeniable psychological benefits, attached to the improvement of relational life in the social environment, place the aesthetic surgery at the heart of the health to the extent where the World Health Organization defines health as "being not merely the absence of disease or disability, but also a general state of physical, mental and social well-being" [5].

## How does one explain the therapeutic power of cosmetic surgery?

For a long time, we have pondered about the nature and origin of the therapeutic force generated by an act of correctly performed aesthetic surgery.
In order to explain this therapeutic power, it would seem to us that beyond the correction of the anatomical disgrace and of the strictly aesthetic improvement, these are in fact three therapeutic means that have been jointly implemented.

1. Psychological improvement.
2. Direct surgical action on the body.
3. Therapeutic relationship.

### 1. Psychological improvement:

This is the component that we have just mentioned in the preceding lines. It is one of the most well known aspects of the purpose of cosmetic surgery.
Because of the links that exist between the body and the spirit, the correction of the disgrace soothes the suffering and that allows to live better, with a better psychological dynamic.

### 2. Direct surgical action on the body:

The progress of neuroscience teaches us that we not only "think" with our brains but also with our body. Certainly, the brain is the seat of the cognitive processes involved in the development of the thinking but, in return, the information coming out of the body constantly exerts an influence on brain function, via the autonomic nervous system.
Our mechanisms of reflection are also based on experiences and physical sensations: this is what is called "cognition personified" [6]. The direct action of the surgical procedure on the body is, from this point of view, decisive and powerful, especially as regards the surgery of the breasts and of the silhouette.

### 3. Therapeutic relationship:

The credit goes to Carl Rogers, in his work regarding the approach centred on the person, proving the therapeutic virtues of the helping relationship: "it is the relationship that heals" [7]. The helping relationship is generally defined as "the capacity that a caregiver may have in bringing any person in difficulty to mobilize his resources to better live a situation: it is a relational care".
From the time of the work carried out by Carl Rogers since 1942, a helping relationship's concept relies on the possibility of assisting the person in difficulty to mobilize his or her own resources: thus, the patient's latent internal resources become available and are best realized in a therapeutic accompaniment relationship.

There is no doubt that, in the framework of the support for a patient before and after a cosmetic surgery intervention, we are implementing a genuine helping relationship that has an undeniable therapeutic character. Physicians and surgeons, benefiting with at least 15 years of theoretical and practical training after the end of secondary school, we are, within the framework of this therapeutic relationship, faring at least as well as psychologists do with three years of training.

All in all, we have at our disposal not one but three therapeutic capabilities and which we jointly and daily exercise in the care that we deliver to our patients.

Cosmetic surgery, in its definition as well as in its etymology, is therefore as much a surgery of the soul as a surgery of the body.
With the mainly psychological aims that are its constituent parts, the "aimed" therapeutic enters, with full rights, the therapeutic arsenal contributing to preserving or restoring the health according to the different aspects defined by the World Health Organization [5].
The plastic surgeon is always concerned about the complete patient, the human being that he supports and therein lies one of the specific features: he remains as much a physician as a surgeon.

Essentially, the therapeutic function of cosmetic surgery appears to be linked to the success of a psychic repair requested by the patient, but rarely specified by him in so many words and without doubt, just as rarely aware of it [2].

## Defence and illustration of the therapeutic purposes of cosmetic surgery.

This theoretical analysis of the benefits of cosmetic surgery is supplemented by the study of the scientific literature as well as by the opinion and the testimony of the patients which constitute the "heart" of this subject.

### 1. Scientific publications:

The reality of the therapeutic function of cosmetic surgery today is corroborated by a very large number of scientific studies published in the international literature.
In particular, this work aims to measure the impact of cosmetic surgery on the quality of life, on the psycho-social status and on symptoms such as anxiety or forms of depression. One can especially cite, in this regard, the work of J. P. Meningaud et al. [8-9-10], M. Godefroy et al. [11], D. B Sarwer et al. [12], JA Litner et al. [13], DK Murphy et al. [14], A. Penaud [15], PL. Reavey et al. [16] and J. Saboye [3].
The references for these works are appendixed in the bibliography of this article and we highly recommend their reading, which is utterly convincing and probative on the positive influence of the cosmetic surgery on psychological health and the psychosocial status of surgical patients.

### 2. Patients' testimonials:

For several years, we have been collecting, as do many surgeons, testimonials from patients that corroborate the reality and effectiveness of our therapeutic action.

Beyond the medico-surgical arguments we have just mentioned, we want to complete this publication with one of these testimonials, as it is true that in this debate the feeling and the voice of the patients are what is most important.
Amongst these numerous testimonials concerning the whole of the cosmetic surgery, whether it be of the face or the body, we selected a 39 year old patient who had consulted us for a request for the implantation of breast implants.

This patient, Mrs. G. complained that her breasts were "empty" and were "uninhabited" following her pregnancies. Mrs. G. had three children but the last birth was complicated due to post partum haemorrhagia whose importance and the modalities of its occurrence had made it necessary to carry out a hysterectomy. This had cruelly impacted Mrs. G. and she had even more difficulties to live with the chest alterations consecutive to her maternities.

The clinical examination documented two hypotrophic breasts, having lost the bulk of their volume but without the element of skin ptosis. Mrs. G. wanted her breasts to be in harmony with her silhouette. She appeared to us as quite motivated, confident and determined.
The intervention consisted in implanting prostheses each pre-filled with 240cc silicone gel. Mrs. G. was satisfied with the final result and she expressed her view that it was consistent with what she expected and provided her a real service.

We met again more than two years after this intervention was carried out and Mrs. G's satisfaction remained significant and constant.

The words below are excerpts from a letter that Mrs. G. then addressed to us and allowed an interesting and unquestionable assessment of the service actually rendered by the establishment of the breast implants:
*"… a small simple but sincere word to express to you my deep gratitude for the excellence of your work, the rediscovered joy of a proud but not excessive chest, the beginning of a reconstruction after trauma, the injury of the hysterectomy...*
*I actually realized the meaning of the term cosmetic and restorative surgery; restoration of a breast damaged a little over time, but mostly due to the pregnancies, restorative and reconstructive of a part of my femininity that had gone with my uterus.The breasts that I am proud of, give back to me the image of a woman, revive within me cravings that had been buried under the deep and secret wounds…".*

It seems to us that "these patient's words" more than any other technical, legal or scientific argument, quite convincingly illustrate the manner in which the aesthetic surgery in fact seeks to repair, especially on the psychic plane, that it is indisputably therapeutic.
The concept of repair makes all the sense here, repair of the body and repair of the psychic injury, treatment of a suffering that takes the form of a loss of identity, of the female identity in the case that we have just described.

## Conclusion.

In a simple concern regarding scientific truth, this publication, devoid of any polemics, is committed to meet the medical arguments which, in our eyes, are testimony to the powerful therapeutic function of cosmetic surgery. Cosmetic surgery, irreplaceable for many of our patients and indisputable in the light of the evidence, appears to us to be of incomparable social and human fruitfulness.

To testify about it here is a matter of truth, justice, dignity and respect for the legitimate recognition of our activity. One must never forget, however, that the aesthetic surgery constitutes a difficult and ambitious project, whose conditions are demanding, far from the impression of ease given by the echoes of the media.

*1. Awada T, Bodin F, Weber J, Bruant-Rodier C. Cosmetic surgery and therapeutic necessity: 100 years of debate - communication at the 57th National Congress of the SOF.CPRE, Paris 20 November 2012.*
*2. Flageul G, Godefroy M, Lacoeuilhe G. The therapeutic function of cosmetic surgery. An Chir Plast Esth, 48, 2003: 247-256.*
*3. Saboye J. "Of the therapeutic function of cosmetic surgery" An Chir Plast esth, 2012: 57, 317-322.*
*4. Mitz V, Jauffret JL. Knipper P. Aesthetic surgery: Benefits and results. Report to the 48th National Congress of the SOF.CPRE, October 2003, Paris Elsevier.*
*5. Preamble to the Constitution of the World Health Organization, as adopted by the International Conference on Health, New-York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 States. 1946; (official acts of the World Health Organization, No. 2, p. 100) and entered into force on 7 April 1948.*
*6. Gallagher S. How the body shapes the mind-Oxford, Oxford University Press. 2005, 284 p.*
*7. Rogers C. The helping relationship and psychotherapy, 1942. Translated to French: ESF Ed, 2008, 235p.*
*8. Meningaud JP. Benadiba L. Servant JM, Hervé C, Bertrand JC, Pelicier Y. "Depression, anxiety and quality of life among scheduled cosmetic surgery patients : multicentre prospective study". Journal of Cranio-maxillofacial Surgery, 2001: 29, 177-180.*
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*11. Godefroy M, Flageul G. Psychological basis of the request for breast augmentation surgery. Clinical observations. Ann Chir Plast Esth, 50 ; 2005 : 371-377.*
*12. Sarwer DB, Infield AL, Baker JL, Casas LA, Glat PM, Gold AH, Jewell ML, Don Larossa, Foad Nahai, Leroy-Yound V. "Two-year results of a prospective, multi-site investigation of patient satisfaction and psychosocial status following cosmetic surgery". Aesth Surg Journal, volume 28, n°3, may-june 2008, 245-250.*
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*14. Murphy DK, Beckstrand M, Sarwer DB. "A prospective, multi-center study of psychosocial outcomes after augmentation with natrelle silicone-filled breast implants". Annals of Plastic Surgery, vol. 62, n°2, February 2009, 118-121.*
*15. Penaud A. «Assessment of therapeutic benefits of augmentation mammoplasties with aesthetic aims. Results of a prospective and multicentre study from a series of 181 patients». Thesis for the Doctorate in Medicine, 1 October 2010.*
*16. Reavey PL, Klassen AF, Cano SJ, Mc Carthy C, Scott A, Rubin JP., Shermak M, Pusic AL. "Measuring quality of life and patient satisfaction after body contouring: a systematic review of patient-reported outcome measures". Aesthetic surgery Journal 31, 7, 807-813.*


## GROUPE SEBBIN

was rewarded for its efforts and support to the Congress of the Spanish Society of Plastic, Reconstructive and Aesthetic Surgery in Tenerife in June.
The president of the congress, Dr. Cristino Suárez, in the center, presents the award to Olivier Pérusseau, CEO of Groupe Sebbin, in the presence of Alberto Fabregas, DG of Sebbin Ibérica.

# BLEPHAROPLASTIES : ADD, DO NOT REMOVE!

The ageing of the face causes a very visible loss of adipose tissue in areas of muscle movement: especially the prefrontal and periorbital regions. It is the author's belief that this is due to the disappearance of the periorbital fat and not just the simple skin ptosis that gives a weathered appearance to the eyelids, which is clearly visible when comparing the face of a person in his fifties with one of his pictures during his youth. The standard fatty "hernia" ablation technique, with cutaneous excision, accentuates the periorbital hollows. The reduction of the malar fat pad increases the appearance of pockets.

Since 2003 the authors have used fat grafting to correct this aspect of the eyelids, and since 2008, they have refined their technique by using a suitable equipment that allows them to collect and to inject micro grafts. The fat is harvested in the sub umbilical region, with a 2 or 3 mm cannula drilled with multiple holes with 1mm sharp edges. The sucked fat is washed in physiological saline on a nylon gauze. It is injected with 0.9 and 0.7 mm cannulas, with a simple lateral hole, adapted to 1 mL Luer Lock syringes. 0.5 to 2 mL of fat is injected in the half or the internal 2/3 of the upper eyelid and, often, in the lower 1/3 of the inner part of the eyebrow. A skin resection may be associated, as well as a temporal facelift. On the lower eyelid, if there is no fatty hernia and if the «valley of tears» is visible, it is necessary to place the grafts at this level as well as in the malar region. If there are any fatty hernias, they are spread out in the top of the orbital rim and of the grafted malar region. There is a risk of hypercorrection at this level, particularly in the lateral section and the fat (4 to 10 mL) should be injected in the anterior part. The authors detail the technique that they have used among 440 women and 60 men. They have found no serious complication, only bruises and a temporary oedema. The precise study of the results with the help of photographs allows them to estimate the natural and sustainable result.

*Tonnard P.L and al. Augmentation blepharoplasty: a review of 500 consecutive patients. Aesth Surg J. 2013; 33: 341-52.*

# LIPODYSTROPHY IN VIH: FILLERS OR FAT?

The authors compare the results obtained in the treatment of lipodystrophy related to the human immunodeficiency virus (or to its treatment) in this article. They found 19 sets of patients after studying the literature. 549 of those had received injections of fillers: polylactic acid or hyaluronic acid or a combination of both, 175 of them had received a lipofilling.
Lipodystrophy linked to HIV reaches the peri oral, peri orbital and temporal fat. It is often quite visible and identifiable. The study confirms the effectiveness of 2 methods and their sustainability. The majority of the patients treated felt satisfied. The complications were more frequent with the fillers: (27% bruising, redness, pain, 13% subcutaneous papules appearing at the end of 3 to 4 months but disappearing in one out of two cases). These papules appear to be related to an injection that was too superficial and are more frequent in the suborbital region. The fat injections are more rarely followed by complications. Some cases of asymmetry and even hypertrophy have been reported. One or two fat injections were sufficient to give a satisfactory improvement. However, 3 or more injections of fillers always seem to be required.
The article does not provide information on the fat sampling areas, leaving us to assume that areas of fatty hypertrophy were used. D. Taplica, in a discussion article, based on his personal experience of more than 650 patients, believes that lipofilling gives a more natural outcome. He thinks that the fatty destruction, related to the disease, even more during antiviral therapy, evolves to the complete destruction of the adipocytes. Some areas of harvesting appear ideal to him because they are not subjected to either fatty hypotrophy or hypertrophy. These are the areas located on the embryologic nipple line (axillary and pubic region, anteromedial thigh region). He insists on the fact that the treatment of facial lipodystrophy may not be regarded as purely aesthetic, but contributes to correct a disgrace caused by the disease.

Shuck J. Autologous fat grafting and injectable dermal fillers for human immuno deficiency virus-associated facial lipodystrophy. A comparison of safety, efficacy and long term treatment outcomes. Plast Reconstr Surg 2013; 13:499-509.

# Transform breasts into a male chest

The modification of a female chest into a male chest is usually the first step in the surgical transformation of a «woman to man» transsexual. It usually follows testosterone therapy that alters the voice permanently. The desire to change sex is four times less frequent in females than in males.

The authors report a series of 100 surgical patients over a period of 3 years. Very few articles have been dedicated to breast transformations. The techniques used are often derived from those of breast reductions and gynecomastias, but the aim is to give a masculine appearing chest, with scars that are as inconspicuous as possible. A multidisciplinary team examines the candidates with a psychiatrist. In the majority of cases: the intervention chosen is the mastectomy with free grafting of the nipple, a periareolar approach in a few, whether expanded or not, and more rarely still a liposuction. In case of a subcutaneous mastectomy, skin excision is done between the crease under the breast and a line above the nipple. The latter is harvested first. The adipo-glandular tissue is not completely excised. The top band is retained (and should be monitored by mammography or ultrasound) and allows giving to the lateral part an angle imitating the edge of the breastplate. The sub cutaneous tissue is preserved, particularly in the area where the nipple will be grafted, so as to avoid the «hollow» appearance of the latter. The position of the areola-nipple complex will be determined on the sitting patient.

The authors have observed a high enough percentage of complications, especially haematomas, sometimes early and requiring a return to the operation theatre: 3 interventions were followed by infection, one nipple was completely necrosed, 8 scars were considered as hypertrophic, 16 secondary re-interventions were required.

The constraints of these interventions are numerous: the usual breast reduction techniques are to be rejected (T or vertical scarring). Liposuction found little evidence. After treatment with testosterone, there is a fatty transformation of the gland, but there still persists a glandular area that can be excised with the periareolar approach. The position of the nipple is difficult to determine, and it is a better idea to rely on experience rather than on a pre-established formula. The surgical patient's satisfaction was found to be variable. Before reaching the complete transformation of the body, this intervention is only the first in an often long series.

*Berry MG and al Female-to-male transgender chest reconstruction; a large, consecutive single surgeon experience. J. Plast Reconst Aesth Surg 2012 ; 65: 711-9.*

# SYMMASTIA: POORLY UNDERSTOOD, POORLY OPERATED

Symmastia is defined as the confluence of two breasts across their medial part. It may be acquired, iatrogenic or congenital. Very few articles have been written about it, giving no compelling rule for treatment. The authors review the problem by doing a review of the literature and with regards to 4 cases.

The acquired iatrogenic form, results from a medial dissection, gone too far during the course of a breast augmentation or reduction, which detaches the skin of the sternum area. The congenital form is rare. It is linked to a fatty or fibrous glandular bridge that connects the two breasts. The authors have found only 26 articles in the literature on symmastia, of which 11 were on the congenital form.

The cause of congenital symmastia is unknown, possibly genetic. Different techniques have been attempted to correct the deformation: cosmetic operation in V-Y, leaving a visible scar in the sternal region (whose tendency to leave hypertrophic scarring is well known); cosmetic operation for breast reduction, liposuction, excision of the intermammary tissue, subcutaneous sutures, bolster etc… The authors analyse the symmastia according to the Blondel classification that defines: the base, the mammary cone, the cutaneous envelope. In symmastia, the internal edge of the base does not adhere to the sternum. The mammary cone extends in front of the sternum and takes a flat aspect. The skin is not attached to the sternum. There is no excess of skin, except if the patient had a breast reduction.

Among the two patients operated upon by the authors, a bolster had been placed between the two breasts, after a breast reduction in one case, a presternal liposuction in the other. For the second surgical patient, the subcutaneous sutures had been placed later on, with small incisions.

If during a breast reduction cosmetic operation, it is possible to excise the presternal tissue and to place the mounting sutures between the internal edge of the gland and the presternal plan, in case of normal breast volumes, the problem is more complex. The authors advocate a liposuction via the areolar path with transcutaneous or subdermal sutures. Compression by bolster is useful in all cases.

When there is an iatrogenic symmastia, each article on the subject has proposed a different solution: dermal graft, glue, transcutaneous fixation... which indicates that, in these cases, prevention remains the best treatment.

*Sillesen NH and al. Congenital symmastia revisited J Plast Reconstr Aesth Surg 2012 ; 65: 1607-13.*

# MERKEL CELL CARCINOMA, MORE SERIOUS THAN MELANOMA

Merkel cells are cells of the basal layer of the epidermis, embriologically originating from the neural crest and adapted to the tact. In 1972 Cyril Toker described a "trabecular carcinoma of the skin", whose origin was attached to Merkel cells in 1980. Some cast doubt on this origin and prefer the name "neuroendocrine carcinoma of the skin". This is a rare cancer (0.6 out of 100,000 inhabitants in the United States) but its frequency is regularly on the rise. There seems to be a relationship with insolation.

Almost half of the tumours reach the head and neck. They are also found in immunocompromised individuals (AIDS, transplant patients). The clinical aspect of the tumour is not specific. It presents itself usually in the form of a red or purplish nodule, firm, intradermal and increasing in size rapidly. The Merkel cell carcinoma may reveal itself by a lymphatic or visceral metastases. The clinical aspect is often reassuring, and we can be reminded of an epidermal cyst. A biopsy is necessary to affirm the diagnosis, finding bluish round cells with large kernel, typical of neuro endocrine tumours. An immuno-histochemical examination is required.

The carcinoma first develops locally, and then the metastases reach the regional lymph nodes and then the viscera. The authors use the 4 stage classifications of the American Joint Committee on Cancer: the first two correspond to the purely local development, the other two to the regional or remote metastases. The treatment depends on the clinical stage. The importance of the primary excision is discussed. A margin of more than 1 cm must be kept when excising tumours of less than 2 cm in diameter and a margin of more than 2 cm for the others. Local irradiation is desirable since tumours are radiosensitive. It seems useful to find the sentinel lymph node. The presence of tumour cells, at this level, has a prognostic value and justifies the lymph node dissection. The prognosis is very poor in node-positive cases. Chemotherapy in the form of multidrug therapy is used in this case.

Two years after the surgery, the survival rate is 72%. There is local recurrence of Merkel cell carcinoma in 25% to 30% of cases; 52 to 59% in the lymph nodes and sending of distant metastases in 35% of cases.

Even small tumours, whose sentinel node is healthy, have a mortality of 21% in five years. The Merkel cell carcinoma is rare, but even more serious than the malignant melanoma.

*Sencherkov A, Moran SL, Merkel cell carcinoma. Diagnosis, management and outcomes. Plast Reconstr Surg, 2013, 131: 771-8e.*

# Why are men bald?

A group of doctors were able to study the importance of exogenous factors among homozygous twins at a meeting of hundreds of pairs of twins in the city of Twinsburg, Ohio, in the United States. Numerous studies have shown that the dihydrotesterone levels were high with a high concentration of androgen receptors in the scalp, and that there was a genetic factor acting at this level. However, within the same family, there are differences in the location and the extent of the baldness. The authors study the importance of extrinsic factors (personal and environmental) in the androgenic baldness. They were able to bring together 46 pairs of twins for their studies, that they photographed from the front, back and profile, noted the location of the frontal, temporal and vertex baldness, the testosterone levels in the salivary samples, and the thickness of the hair. The results of the study indicates that there is often a relationship between an external factor and a type of baldness. Smoking and dandruff increase the prominence of frontal baldness. Substantial physical exercise, consumption of more than four glasses of alcohol per week, excessive use of capillary maintenance products accentuate temporal hair loss. All the previous factors promote vertex baldness. Lean subjects who drink a lot of coffee, but not alcohol, are likely to have thinner hair.

Androgenic alopecia is directly linked to testosterone and its metabolites. The authors believe that the extrinsic factors that exacerbate androgenic alopecia, play an identical role on capillary transplants. Finally, it seems that stress also promotes hair loss.

*Gathewright an al. The contribution of endogenous and exogenous factors to male alopecia: a study of identical twins. Plast Reconstr Surg 2013, 131: 794a 800a.*

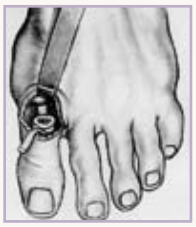
YESTERDAY TODAY

# GRAFTING THE TOE

The amputation of the thumb leads to major disability, especially if it is the dominant side. Since the 70s, the usual practice has been to graft the second toe to correct this mutilation.

Before 1870, the amputation of the thumb was regarded as irrecoverable. Surgeons invented processes for the reconstruction of the thumb as soon as anaesthesia, asepsis, antisepsis became the norm.

Carl Nicoladoni (1847-1902), a Viennese surgeon, thought about using the big toe for replacing the thumb. With the technical procedures as they were in the nineteenth century, it being impossible to anastomose small blood vessels and nerves, his intervention was in several stages. Firstly, the scar of the stump on the thumb was excised till the emergence of the first metacarpal. The base of the first phalange of the big toe of the opposite side was released and the bone cut at this level.



*Preparation of the big toe*

*Preparation of the stump of the thumb*

The hand was then approached towards the opposite foot. Bones and tendons were sutured.

*Establishment of the big toe on the stump of the thumb*

The hand and foot were wrapped in a plaster apparatus and remained associated for 3 weeks. A second step took place 21 days later. The plantar pedicle was sectioned, the hand detached from the foot. Suturing of the tendons and skin of the neothumb was then completed.

This intervention required that the surgical patient stays in a bent back position for three weeks, the hand attached to the opposite foot. More often, the patient would ask to cut short the painful immobilization and that the attempt be put to an end. There were many failures and, even in the event of success, the thumb was rarely stable and always insensitive.
Other processes were proposed before the advent of microsurgery: skin tube reinforced with a graft, pollicization of another finger. However, Nicoladoni's operation had supporters until 1970, in particular for the treatment of thumb aplasia in children.

*Nicoladoni C. Daumen plastik wiener blinsche wochenchrift. Wien klin Wchuschr 1897, 10: 663-70.*

## Join the GROUPE SEBBIN

DGPRÄG: from September 12 to 14th in Münster, Germany.

1st international meeting about Body Contour: from September 20 to 22nd in Sao Paulo, Brazil.

SEMAL: from October 3 to 5th in Madrid, Spain.

EUROPHARMAT: from October 8 to 10th in Montpellier, France.

ISAPS COURSE TUNISIA: from October 11 to 13th in Tunis, Tunisia.

EUROPEAN BREAST MODELING SYMPOSIUM: on October 12th in Lyon, France.

# FLASHBACK
## ON THE HISTORY OF TRANSPLANTATION

### CHAPTER VII: DAVIS GRAFTS - EPITHELIAL IN LAY

*John Staige Davis*

At the beginning of the twentieth century, the use of skin grafting is widespread in the United States, Great Britain, and Germany. France was lagging in this area until the 50's. Several surgeons developed new techniques for difficult cases.

John Staige Davis (1872-1946), one of the fathers of the modern plastic surgery, was the first to lead a department of plastic surgery (at the Johns Hopkins Hospital in Baltimore) and to publish a book on the subject. Incorporating Reverdin's idea, who had placed small "epidermal" fragments (dermo-epidermal in fact) on a burgeoning wound to facilitate healing. He developed a new skin graft technique in 1914. He would harvest small fragments of skin with the tip of a scalpel that were raised by a needle.

These grafts, which he called small deep grafts, were placed side-by-side on the burgeoning surface. In France this type of graft, always used on large burgeoning surfaces, is called the Davis graft (fig. 1-2).

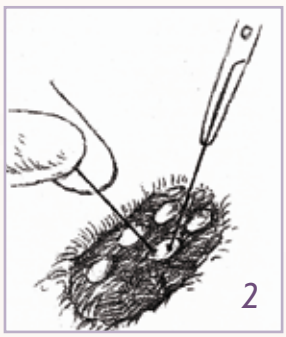
*Johannes Fredericus Samuel Esser*

Johannes Fredericus Samuel Esser (1877-1946) was a relatively unknown Dutch surgeon, even though he was at the origin of numerous techniques that are still in use today, such as the island pedicle flap. He had played an important part in maxillofacial surgery, with the «broken faces», especially during the First World War. He had practiced in Berlin and then in Monaco. One day Esser had to treat a toothless casualty, whose labial gingival groove was completely blocked by scar tissue. He hit upon the idea of putting a mould "stent" in the cavity formed between the lower lip and gums; the stent was made with dental moulding plaster, covered with a graft, with the raw surface facing outwards and called it epithelial in lay, the gingival labial vestibule could be grafted at the same time and the dental appliance put in place. (fig. 3-4).

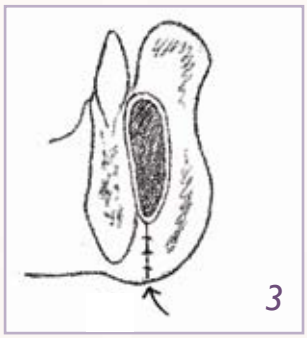
*Davis JS The use of small deep skin graft JAMA 1914, 63: 985.*
*Esser JFS Neue Wege für Chirurgische Plastiken durch Heranziehung der Zab naert zlichen Technik, Beitr Z Klin Chir 1916, 103: 547.*

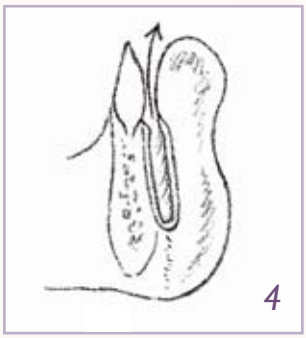
*Next and last episode: from straight razor to dermatome.*


*Harvesting of a Davis graft*




*Establishment of the grafts*




*Esser's epithelial in lay technique*

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ESTHETIQUE & RECONSTRUCTION

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