This year, we are pleased to celebrate the 60 years of the French Society of Reconstructive and Aesthetic Plastic Surgery at its national convention in La Défense. But this is not the only anniversary that Laboratoires SEBBIN celebrates this year! Indeed, there are just 10 years, Sebbin put up a meticulous clinical follow-up of almost 250 patients carriers of our breast implants. The first study SEBBIN was born... and today brings its particularly favorable conclusions.

More recently, very promising preliminary results regarding our range of Lipofilling were presented at conferences of plastic surgery. These clinical studies play for us a double role: they provide to all of our partners precise scientific data on efficacy and safety of our products. But they also act as a powerful catalyst for innovation, allowing us to build a close relationship with the actors of this profession and therefore an optimal understanding of the needs of our partner surgeons and their patients.

Obviously, we will certainly let you know the results of these studies in future issues of the Expander.

Happy reading.
Sixty years ago, three young surgeons created the French Society of Plastic Surgery. The first, Daniel Morel Fatio, the eldest of the three, disappeared 25 years ago. The other two, Claude Dufourmentel and Raoul Tubiana just left us at the age of 98. Dufourmentel was the head of a famous school of plastic and cosmetic surgery at the hospital Saint Louis in Paris. Raoul Tubiana was the “father” of hand surgery in France. This issue of the Expander is dedicated to them.
The French Society for Plastic and Reconstructive Surgery was formally born on 28 September 1953, under the Fourth Republic. Joseph Laniel was Chairman of the Board, Vincent Auriol was ending his seven-year term. The cold war was ongoing. Eisenhower was president of the United States and Khrushchev had just succeeded Stalin who had died in March.

Cosmetic surgery did not have a good reputation in France. Only a few marginal surgeons practised it. Restorative surgery was considered as minor by the hospitals. Digestive surgery was supreme. Yet, plastic and cosmetic surgery had a glorious past in France. During and after the First World War, the treatment of many facial injuries had contributed to the progress of restorative and maxillofacial surgery. After the war, the “broken jaws” surgeons switched over to cosmetic surgery and Julien Bourguet, Louis Dartigues, Maurice Virenque, Suzanne Noël and Raymond Passot had been the pioneers in this discipline and had gained worldwide recognition.

A precursor to the French Society for Plastic Surgery had been founded first, after the sad Dujarier case (a hospital surgeon had to amputate a young woman’s leg, after an attempt at “removal of fat”), that had brought discredit to cosmetic surgery and had diverted hospital surgeons away from plastic surgery. The “French Scientific Society for Restorative Plastic and Cosmetic Surgery” first met on 6 June 1930 and held its first congress on 3 and 4 October 1930. Its first president and general secretary were Louis Dartigues and Charles Claoue.

The records of its congresses were published in the “Plastic Surgery Review” which, a few years later, became the ephemeral “Structive Surgery Review”. This society disappeared with the 2nd World War.

**Creation of the SFCPR**

The French Society for Plastic Surgery saw the light of day because of the desire by young surgeons, who had been affected by the experience of the Second World War. At the end of this war, Claude Dufourmentel, Daniel Morel Fatio and Raoul Tubiana got the idea of creating a “club” where specialists practising restorative surgery would meet and which allowed them to exchange ideas and discuss processes and its outcomes. These meetings would go on to lead to a speciality recognised in its own right. They came into contact with more senior specialists who had practised during the last years of the war with English plastic surgeons such as Sir Harold Gillies and Sir Archibald McIndoe or American surgeons such as John Marquis Converse.

Two restorative surgery centres for the treatment of war-wounded had been set up at the Leopold Bellan Hospital in Paris and then at the Foch Hospital in Suresnes at Robert Merle d’Aubigné’s initiative, a young orthopaedics professor who had distinguished himself in the Resistance. It is at these centres that Raoul Tubiana, Paul Tessier, Gaston Ginestet, Maurice Aubry, Gaston Duchet could get a measure of the lead taken by Anglo-Saxon medicine in anaesthesia (intubation was virtually unknown in France), resuscitation and restorative surgery, over the techniques practised in France, that had hardly evolved since the First World War. During the post-war years, scholarships allowed young surgeons to do internships in England, at East Grinstead where Gillies and McIndoe practised their trade, in the United States, in New York with J.P. Webster, in Saint Louis with J.S. Davis, in Boston at the Cope burns centre, which was unmatched in France, in San Francisco with Sterling Bunnell, an indispensable pilgrimage to the great pioneer of hand surgery. Thus, Daniel Morel Fatio, Claude Dufourmentel, Paul Tessier, Raoul Tubiana, Maurice Gosserez, Maurice Pierre, Raymond Vilain, Andre Goumain decided to spend several months or years in Great Britain or the United States. They were so impassioned with plastic surgery, that upon their return they chose to practice it in a predominant or exclusive manner.

Everything needed to be created in France, where there was no hospital service or recognized speciality or scholarly organization.

On 03 December 1952, ten surgeons gathered at the home of Maurice Aubry (1900-1989), associate otorhinolaryngology professor: Paul Bregeat (1909-1989), ophthalmology specialist, Claude Dufourmentel (1915-2012),

The title of the new society, “French Society for Plastic and Reconstructive Surgery” (SFCPRE), did not mention the word “cosmetic”. Maurice Aubry was designated as first President, Daniel Morel Fatio (1909 - 1988), absent at the first meeting, was appointed as general secretary, Claude Dufourmentel, as treasurer.

**SFCPRE’S FIRST FEW YEARS**

At the beginning, the Society functioned as a club that consisted of designated members - elected later on - and invited guests and they would meet 3 or 4 times per year with a congress being held in autumn. The first congress took place on 28 September 1953 at the Domus Medica, 60 boulevard de la Tour Maubourg in Paris. That same day Daniel Morel Fatio registered the association at the Police Prefecture under the number 53/823. The Congress was opened by a keynote address by Maurice Aubry who set out the “working plan” of the new society. He said: “we are determined to bar the road to charlatans... we will avoid any contact, abuses and we will be severe while choosing our members...”.

Since then, Congresses were held each year in October and then in November, always in Paris except in 1973 and 2006 when it was held in Marseille. In 1975, from 25 to 29 August, the Society hosted the International Federation’s Congress at the Palais des Congrès in Paris.

Every year, a theme was planned for the Congress, and then from 1970, two young surgeons were asked to make a paper presentation, to bring together many presentations on topical issues. It was not until 1983 that a subject on cosmetic surgery (facial skin ageing) was selected, showing how much the first presidents and general secretaries were wary about cosmetic surgery’s bad reputation. However, in October 1982, the Society added “cosmetic” to its title (SFCPRE), something that the Annals of Plastic Surgery also did.

In 1990, a group of young members of the SFCPRE created a new society (SOFCEP) that was entirely devoted to cosmetic surgery.


Currently the Society (SOFCPE since 1994) has 800 active members and associates.

Plastic surgery has been completely transformed from 1953 to 2013. All the techniques have been modified, improved and new ones created. Thus emerged breast implants in 1963 (Cronin and Gerow), cranio-facial surgery in 1967 (Paul Tessier), microsurgery around 1970 (Harry Buncke), liposuction (Illouz) in 1977, skin expansion (Radovan) in 1979, facial endoscopic surgery (Ramirez) during the 80’s, lipostructure (Coleman) in 1990, more recently post-bariatric surgery, allotransplantations of the face and limbs (Devauchelle and Lantieri), use of stem cells, etc... The face lifting technique has been transformed after the description of SMAS by Vladimir Mitz in 1974, breast reconstruction after mastectomy has improved steadily since the 70’s...

Plastic and cosmetic surgery has now become a major discipline.

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“Eyes are open windows to the world”, “The look mirrors the Soul”. Assertions such as these are enough to stress the importance of palpebral and periorbital surgery. The part of the face that is the most scrutinised and the one that ages most rapidly is certainly the region of the eyes. The activity of the mimic muscles causes the appearance, over time, of many stigmas such as crow’s-feet wrinkles, frown lines and forehead wrinkles as well as the wilting of the palpebral skin, which is the thinnest in the body. The muscle relaxation associated with the more general damage related to ageing, such as the loss of elasticity, thinning and the ptosis of teguments, adipose melting and the emergence of fat deposits are the cause of an unpleasant appearance. In other words, eyelids tend to fall down and pockets are formed above and below the eyes that are often compounded by real dark coloured circles giving a sickly or tired appearance in patients, thus giving them an image of themselves that does not reflect their true identity. The image returned by the mirror is not the one that the patient expects and who gradually begins to dislike himself even more as the signs of ageing begin to impact the rest of the face. The harmony of the look must be restored and delaying it is not advisable. The patient feels betrayed by a tired and sad look. Treatment is mainly surgical and must restore without transforming. Surgery of the eyelids contributes in restoring the harmony of the look thanks to the upper and lower blepharoplasty. After the intervention, the look appears more open, rested and rejuvenated. This surgery is indicated in cases of excess skin, muscle relaxation, fatty hernias. The scars are not visible. For the upper eyelid they are located at the natural palpebral fold which sometimes has disappeared or been displaced. For the lower eyelid, the approach can be conjunctival, i.e. the inner edge of the eyelid. Thus, there is no external scar. In other cases, it is located 2 mm below the ciliary margin and may extend laterally into a crow’s foot wrinkle.

CLINICAL CASES AND TYPES OF INTERVENTIONS

The patients’ requests encompass various kinds of cases. Indeed, it may be a droopy eyelid, pockets, crow’s feet, shadows, position of the eyebrow, eyes that are round or hollow or globular or even Asiatic. Each case is unique and must be carefully analysed.

For the upper eyelid, the basic intervention is to resect the surplus skin, the inner nasal fatty pocket while taking care to get a well defined and symmetrical upper palpebral fold, by means of a supratarsal fixation of the latter if required.

For the lower eyelid, the basic intervention is either the conjunctival approach with preseptal or retroseptal resection of the excess fat, or the sub-ciliary approach with resection of the excess fat and careful mucocutaneous resection, or finally the pinch blepharoplasty that consists of direct resection of the lower creased epidermis without danger of a round eye. This surgical procedure often complements other surgical procedures.

The operative indications are widely nuanced and are even more so with a better understanding of the ageing process for the last few years.

The 2010 title of the annual report of the French Society for Reconstructive and Cosmetic Plastic Surgery best illustrates what has just been said: cosmetic surgery of the eyelid.

Thus, the resection of the lower palpebral pockets due to fat accumulations that lift the skin of the lower eyelid may, in itself, harmonize the look.
Lower palpebral pockets

Outcome after resection by conjunctival approach

On the other hand it may be necessary to carry out:
- a temporal facelift
- an upper eyelid blepharoplasty with:
  • sectioning of eyebrow and supercilii muscles for correcting frown lines,
  • sectioning of the orbital fibres of the orbicular muscle in order to reduce the crow's feet wrinkles,
  • temporal facelift for lifting the tail of the eyebrow and increasing the eyelashes-eyebrow distance,
  • resection by abrasion of the orbital margin bone for obtaining a milder look due to an excessive prominence of the bony margin,
  • lipostructuring of the upper orbito-palpebral sulcus, from the lateral side of the eyebrow and the temporal gap,
- a lower eyelid blepharoplasty with:
  • submerging of palpebral pockets by consolidating the septum or arcus marginalis release and spreading the fat in front of the orbital margin for filling the orbito-palpebral sulcus,
  • skin resection on demand,
  • a peeling for the improvement of the lower eyelid skin condition,
  • a lipostructure,
  • a canthoplasty.

These two contrasting examples allow understanding the importance of the consultation and preoperative examination in order to establish a real operational strategy. It is at this time that the surgeon will explain in detail the choice of the surgical techniques that will be required for obtaining a natural and rejuvenated look. He will also identify a ptosis, a palpebral malposition, a ptosis of the lacrimal gland and ask for a preoperative ophthalmological examination. He will also have to point out an asymmetry of the eyes to the patient so that afterwards it is not assigned to the surgical procedure. Finally, the difficult problem of cheekbone pockets that leads the patient to consult for a palpebral surgery; it must be explained to the patient, so that he clearly understands, that this is a different treatment and that he must consider a centrofacial facelift, which is a more cumbersome procedure.

Before ptosis treatment

After ptosis treatment

IN PRACTICE

The upper eyelid blepharoplasty is carried out under local anaesthesia. A neuroleptanalgesia is required when all four eyelids are concerned. In most cases, the intervention is carried out in ambulatory care and the escorted patient returns to his home the same day. The threads are removed 3 to 5 days later. Generally the swelling and bruising will disappear between 8 and 12 days. The risks are minimal on the upper eyelid but can be much more significant on the lower eyelid. A modification of the look due to a round eye or of a significant ectropion must always be avoided with the help of a good preoperative evaluation of the palpebral tone, canthal support and extreme caution during skin resection.

Finally, surgery of the eyelids allows restoring a natural look and a rejuvenated and rested appearance. Blepharoplasty is one of the most satisfactory interventions for patient and his surgeon.
The use of antibiotics for the prevention of post-cosmetic breast surgery infectious complications is discussed and often left to be subjectively assessed by the surgeon and the anaesthetist. The authors have tried, by means of a statistical study of the literature, determining if this use was relevant. Antibioprophylaxis is recommended in Great Britain in all cases but in the United States it is limited to breast reductions, according to the recommendations of the American Society of Plastic Surgeons (ASPS). The authors have compiled the observations of 2,971 surgical patients (5,891 breasts). The infection rate was ten times higher after breast reduction than after augmentation.

The study shows a significant fall in the number of postoperative infections in reduction mammoplasties after injection with a single dose of an anti staphylococcus antibiotic, this bacterium being involved most often in infections. Extending the antibiotic therapy for several days (up to 8 weeks in the United States) is not required. The conclusions are rather mixed for breast augmentation. There is no evidence of the effectiveness of the antibioprophylaxis. The role of the latter in the prevention of periprosthetic cocci has not been proven, although antisepsis by local irrigation seems, in this case, useful.

The authors consider that breast surgery, due to contamination by the milk ducts, can be considered as a surgery with a potential for infection (Clean Contaminated), which justifies the prophylactic antibiotic therapy.

Is straight muscle plication effective?

The closure of a diastasis of the rectus abdominis muscles, with or without umbilical hernia repair, is a frequently used technique during an abdominoplasty. The intervention replaces the muscles in their anatomical position and restores the abdominal contour. Many surgeons use an absorbable thread to bring the muscles closer. The authors have verified the long-term effectiveness of this technique.

To check the results, they associate a careful clinical examination with an abdominal ultrasound and provide a questionnaire to the patient for identifying specific aetiologic circumstances (number of pregnancies, type of delivery, prior abdominal interventions, duration of the interruption of activity).

The authors have brought together 2 groups of patients. One group included 51 surgical patients having had a recti muscle plication and the other 10 were nulliparous, forming a control group. In all cases, with or without umbilical hernia repair, the abdominoplasty was carried out according to the same technique. The recti muscles were brought closer and sutured with a PDS 0 stitch.

All the surgical patients were reviewed 12 months after the operation. An ultrasound allowed measuring the intramuscular distance at 3 levels: mid-distance between the xiphoid and umbilicus, just above the umbilicus, and mid-distance between umbilicus and pubis. The same distances were recorded at the level of the rectus abdominis muscles of persons in the control group.

The reference distances are 10.41 mm; 8.77 mm and 9.41 mm on an average. The authors did not find any significant differences between the surgical patients group and the control group.

It therefore seems justified to carry out suturing of the rectus abdominis muscles using absorbable thread. It may be regrettable that the authors did not insist on the dangers of a too tight suture that can increase the intra-abdominal pressure at the level of the inferior vena cava.

The American “Aesthetic Surgery Journal” published a supplement to its July 2013 edition devoted to American statistics about surgical procedures and cosmetic medicine practised from 1997 to 2012. In the “top 5” of cosmetic surgery for the year 2012, we find breast augmentation to be in first place (330,631 interventions) and then liposuction (313 013) and fast growing abdominoplasty (156 508). Then come two facial interventions: blepharoplasty (153 171) and rhinoplasty (143801). Facelifts are less numerous (119 006).

It is interesting to compare these results with those of 1997. Brachioplasty is the intervention whose frequency has increased the most (8 times more), cruroplasty (nearly 5 times), lower bodylift (4 times), breast ptosis surgery (5 times), and abdominoplasty (3 to 4 times). This would suggest that Americans have lost weight massively and are in need of retouching! It is not possible to delve deeper into the evolution of all the interventions here. But cosmetic surgery is alive and well: in 2012, 1,688,694 surgical interventions were carried out in the United States, an increase of 80% as compared to 1997. This progression is considerably lower as compared to the explosion in the number of cosmetic medicine procedures. At first place in the top 5: botulinum toxin: 3,257,913 procedures carried out, preceding hyaluronic acid injections: 1,423,705. In total, nearly 5 million American women received an injection for cosmetic purposes in 2012. The authors of the statistics place the laser ablation of hair (883,893), microdermabrasion (498,821) and chemical peeling (443,824) in 3rd position. From 1997 to 2012, injections for cosmetic purposes grew by 900 %. On the other hand, the frequency of other cosmetic medicine techniques has had little or no increase, with the exception of the laser. These statistics show that the traditional cosmetic surgery has evolved in two different directions: the surgery leaving little scars: breast augmentation, liposuction, blepharoplasty and on the opposing side, surgery for remodelling, after a large weight loss. As to the cosmetic medicine, it mainly owes its growth to injectables.

Cosmetic surgery’s top 5

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Cosmetic surgery and the French

Cosmetic surgery is often presented in the media as two extreme aspects, namely, miraculous (in “reality shows” such as Extreme Makeover) or catastrophic, as practised by charlatans. Do these stereotyped images influence the French? The authors of the article (French themselves, but publishing in an American journal), gave an anonymous questionnaire to 250 consecutive patients who wanted a cosmetic surgical intervention. They had to answer 7 questions: Who has advised you? What is the difference between medicine and cosmetic surgery? Which doctors practise cosmetic surgery? Which words can be associated? What is it that incites people to opt for surgery? What do you think of medical tourism? The results of the questionnaire are rather surprising, as the candidates for the surgery in France do not seem to be affected by the media. It is the general practitioner’s advice which is preferred over media articles and advice of friends. 82 % of the respondents were able to differentiate surgery from cosmetic medicine, 96 % believe that the risks are the same as surgery, cosmetic or not; 96 % think that a specific qualification is required. The words most often associated with cosmetic surgery are repair, comfort and health, well ahead of “money”! The 3 most important criteria for choosing a surgeon are the quality of the pre-operative information (70 %), the surgeon-patient relationship (65 %) and the results already observed with friends or relatives. Finally, 98 % of the respondents believe that they are not interested in “medical tourism”.

Some factors put this study in perspective: the small number of respondents (179 out of 250 analysable answers), the fact that the questionnaires were distributed in public hospitals. It was not asked whether any surgeons’ internet websites had been consulted that could influence the choice of surgeon, as it is the case in Great Britain and the United States.

The plastic surgery newsletter of Laboratoires L’EXPANDER

34 % of the American people use alternative medicines and food supplements (vitamins, minerals, plants and more or less related dietary substances), and this without any monitoring from the FDA. These products are not harmless though, and may act on blood pressure, heart rate and the immune system. It is necessary to eliminate them 2 or 3 weeks prior to the surgery.

The authors have carried out a study of 200 patients who had undergone a facial cosmetic surgical intervention and classified them as consumers and non-consumers of “supplements”, the first group was subdivided into 3 categories: mineral and vitamin consumers, plants and animal products, and of both. 25 % of the patients fell into the first category; 2.5 % in the 2nd, 22 % in the 3rd.

Nearly 50 % of all the surgical patients (83 % women) took “supplements”. The 5 most widely consumed products were: vitamin D, multi-vitamins, calcium, fish oil and omega-3, and vitamin B.

Patients often conceal the consumption of these products which they do not consider as drugs. Some plants can have side effects: echinacea may, in the long run, reduce the immunocytic system, ephedra can cause a hypertensive crisis, and, can be very dangerous when associated with a volatile anaesthetic. Garlic, ginkgo, ginger can cause bleeding, ginseng can cause haemodynamic instability etc.

During the pre-operative anaesthetic examination it is important to carefully examine the future patients, not only about the medications taken but also on the “supplements” consumed, because they are at the origin of unexpected complications. The authors of this article had previously claimed that arnica, very often used in France as in the United States in homoeopathic doses, could cause hypertension.

It is likely that the use of these alternative products is less widespread in France than in the United States where vitamins, for example, are available over the counter, but the popularity of some products (magnesium, arnica, omega 3, etc...) encourages caution.

In a previous issue of the Expander, we had analysed an article of the PRS devoted to precautions to be taken before the intervention. The study will be extended in the same issue with an article on the risks incurred by the surgical patient during and after the operation. It is estimated that in the United States 50,000 deaths per year are related to human error. The risk of a deep vein thrombosis and an embolus is well known to surgeons, but the latter, plastic surgeons in particular, are often reluctant to consider an anti-thrombosis prophylaxis, due to the risk of haematoma. Preventive treatment is used in the United States in 45% of the face lifts, 43% of the liposuctions and in 60% of the multiple intervention cases. A strict protocol must be used, linked to a scale that takes into account the antecedents.

The maintenance of normothermia (stressed in articles previously analysed in the Expander) is often neglected. Practical studies on this subject show that the risk of cardiovascular complications and infections are increased in case of prolonged hypothermia.

A malignant hyperthermia is rare but can be fatal. It is linked to a hypermetabolic disorder of skeletal muscles. It is often triggered due to an inhalation anaesthesia and involves release of heat, calcium, glycogenolysis and increases muscle contractility. Mortality remains high. It is difficult to screen during the pre-anaesthetic examination (history of “heat stroke”, “reaction” during anaesthesia). It is important to prevent fires in the operation theatre (100 per year with one or two deaths in the United States). The oxygen inhaled by patients through the nasal tube should not exceed 30%, especially if the electrocautery pen is used. The latter is the cause of many accidents (324 in one year in the United States), especially burns, but also fires and interference with a pacemaker.

The use of a CO2 laser in particular, must entail a strict protection of the surgical patient (humidification of the fields, eye protection). The pernicious role of smoke, linked to the use of the electrocautery pen remains controversial. It is possible that it contains carcinogenic factors. The use of suction or evacuation is recommended. The scrub nurse must count, not only the gauzes but also the needles and electrocautery pen blades used and compare the remaining instruments to the list of those that have been used and record the same. Finally, the authors are considering the risks related to piercings, jewellery (but do they have a place in an operation theatre?) and the precautions to be taken for the transport of the surgical patients from the operation theatre to the recovery room. They establish a detailed fact sheet for each of these risks.

In the next issue of the Expander, we will consider the risks incurred by the surgeon!


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Almost all patients that undergo a surgical intervention under local anaesthesia fear, above all, the pain of the injection. In fact it is possible to attenuate it and this article provides a series of means for making it bearable. There is a pain alert system below the skin made up of Pacinian and Ruffinian corpuscles and free nerve endings that activate “fast” myelinated and “slow” unmyelinated nerve fibres. Local anaesthesia blocks the inflow in the free nerve endings and prevents the transmission of painful stimuli. Injection and infiltration give two kinds of pain, the first by activation of the Pacinian and Ruffinian corpuscles, the second by chemical irritation and distension of the tissues. Lidocaine and adrenaline are most frequently used together. Addition of sodium bicarbonate to adrenalinated lidocaine appears to reduce the pain by reducing the acidity. The authors advise adding 1 mL of 8.4 % sodium bicarbonate solution to 10 mL of adrenalinated lidocaine and to heat the solution. They also propose a number of technical details for reducing the pain: using a thin needle (27 to 30 gauge if possible), changing the needle often as its tip gets worn out very quickly.

It is also important to prepare the patient. We must divert the patient’s attention by speaking to him, not allowing him to see the injection, by tapping lightly on another part of the body.

Anaesthetic creams significantly decrease the pain of the injection, but require a waiting period of 90 to 120 minutes. Applying ice is also useful, especially before injecting the palatine mucosa. The pressure, the pinch near the injection site changes the perception of the receivers.

It is preferable to inject the subcutaneous fat layer for anaesthetising the edges of a wound. The pain is milder when the injection is perpendicular to the skin, if the syringe is stable during the injection. This must be done subdermally and not intradermally, in small quantities and very slowly.

When an extended area must be temporarily anaesthetised, the reinjection must be made inside the area “cleared” by the adrenaline.

This well illustrated article is not just intended for young surgeons. Any surgical intervention under local anaesthesia should be virtually pain-free.

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THE "CROSS LEG"

Until the middle of the 1970s, covering the loss of skin substance of the leg that exposed the bone, such as in open fractures - was a long and difficult surgical undertaking. Transporting skin from one part of the body to another required many operating hours before discoveries, such as the vascular pedicle flap, mucocutaneous flap, fasciocutaneous flap and microsurgery. One technique used with success from the nineteenth century: the “cross leg flap” (leg-to-leg flap and not crossed leg flap).

F. H. Hamilton, a surgeon from Buffalo, is the one who successfully carried out the first cross leg in 1854 [1]. He called the procedure “elkoplasty”. Horace Driscoll, the first surgical patient, was a 30 year old Irish worker, victim of an accident at work that resulted in a loss of substance of the skin and the soft parts of the right leg (A). Two months after the accident, Hamilton harvested a 20 cm x 12 cm flap from the opposite leg that he left in place after having detached three of its edges and its deep side (B-C). Fifteen days later, the receptor area was prepared and the deep side of the flap was revived (D). Then the two legs were brought closer together and the flap was put in place and stitched (E). The two legs were maintained close together with a bandage (F). Two weeks after the second intervention, the pedicle was cut on the donor leg. One hundred days later, both the flap and donor area were healed. The surgical patient felt that only by consuming beer could he tolerate the immobilization! By the end of the nineteenth century, the “cross leg” technique was used by many surgeons. Successive improvements were applied to the method: skin graft placed on the harvesting area, autonomisation, prefabricated plaster, and use of external fixators [2].

One hundred and sixty years after its creation, the cross leg is still used when modern techniques are not feasible.

At the start of the twentieth century, many surgeons were using skin grafting for covering loss of substance. The technique was very popular in the United States, Great Britain and Germany, but was accepted much later in France. The “thin” or “split-thickness” grafts are most often selected because their engraftment is easier than those of complete skin grafts.

The technical processes began to proliferate. Initially, the surgeons used a simple barber’s razor: a “straight razor”, but the latter proved a little awkward as the harvests were irregular and of variable thicknesses. Thiersch was the first to modify the razor by making the handle fixed and by modifying its thickness (fig. 1).

Other surgeons (Hoffmann) invented a specific instrument with a “guard” to avoid dragging adjacent skin (fig. 2).

The Argentine Finochetto, described a razor whose thickness could be adjusted. Then several surgeons struck upon the idea of using interchangeable blades (Ferris Smith). A model of a razor dermatome with blades, designed by a young English surgeon, George Humby (fig. 3), had a great deal of success. During the 30’s, an electric dermatome allowed harvesting regular grafts (fig. 4).

A dermatome of quite a different design was manufactured for the American surgeon Padgett (fig. 5). It was made up of a movable half-cylinder that was applied to the skin with a biological glue and a blade attached to the cylinder. A thick and homogeneous skin layer was separated by rotating the cylinder. Knowing how to use the Padgett dermatome was of great satisfaction for young surgeons.

After the 2nd world war, the French surgeon Felix Lagrot sketched a model of a razor dermatome that was improved upon by Leon Dufourmentel. This was the most widely used device in France till the 1970’s (fig. 6).

Currently, there is a wide variety of manual, electrical and pneumatic dermatomes for harvesting grafts from almost all parts of the body.

In 1967, two surgeons, J.C. Tanner and J. Vandeput invented a device for carrying out small incisions on the grafts, that allowed spreading them in an accordion (mesh grafts). This very ingenious process is widely used for the treatment of burn victims, when the areas for harvest are limited in numbers. In fact, this was not a new idea and in 1908, the Dutchman Lanz had designed a small device that incised grafts and allowed them to be spread (fig. 7).

1. Padgett EC. Skin grafting from a personal and experimental viewpoint. CC Thomas Springfield 1942.
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