A primary fascial closure with interrupted, closely approximated permanent suture (<1 cm apart) is performed in the midline (Fig. 1). Once the midline is closed, a large, wide-pore polypropylene mesh (Bard Soft Polypropylene Mesh; Davol, A Bard Company, Warwick, R.I.) is placed over the entire abdominal wall covering the fascial defect, and a loose placket of skin staples is used to hold the mesh in position. It is key to have a large piece of mesh with significant extension in all directions with a minimum of 8-cm overlap of the fascial closure. Fibrin glue (Tisseel; Baxter Healthcare Corp., Deerfield, Ill.) is then prepared and applied over the entire piece of mesh, first to the fascial closure and then to the rest of the mesh. The technique of glue application involves applying the glue in small, steady quantities as the surgeon massages the glue into the mesh and abdominal wall continuously to apply it evenly, providing immediate fixation. With the glue, the mesh over the fascial repair is molded to the contour of the fascia (Fig. 2). In the last year, we have applied these principles to four patients with vertical and transverse rectus abdominis myocutaneous defects, with no bulge or hernia observed at short-term follow-up. A more comprehensive analysis of this technique, including its use in ventral and incisional hernia repair, vertical and transverse rectus abdominis myocutaneous harvest, and breast reconstruction abdominal donor-site repair is forthcoming.

We would like to congratulate the authors on their excellent study. Although breast reconstruction donor sites are usually closed with either primary fascial closure or bridging use of mesh, we respectfully ask whether they think there is a role for our technique in the treatment of abdominal wall repair after breast reconstruction.

DO: 10.1097/PRS.0000000000000816

Jon Peter Ver Halen, M.D.
Nathan Stoikes, M.D.
David Webb, M.D.
Ben Powell, M.D.
Guy Voeller, M.D.
Baptist Cancer Center
3268 Duke Circle
Germantown, Tenn. 38139
jpverhalen@gmail.com

DISCLOSURE
The authors have no financial interest in any of the products or devices mentioned in this communication.

REFERENCES


Reply: Comprehensive Analysis of Donor-Site Morbidity in Abdominally Based Free Flap Breast Reconstruction

Sir:

We thank the authors for their comments and presenting their work regarding the use of fibrin glue as an adjunct to closure of the donor site after autologous free flap breast reconstruction. Although we do not have experience with fibrin glue, the authors’ technique is worthwhile and applicable in the setting in which an onlay mesh is used to close the donor site either to reinforce the closure or reduce the incidence of a seroma.

DOI: 10.1097/PRS.0000000000000791

Edward I. Chang, M.D.
David W. Chang, M.D.
Department of Plastic and Reconstructive Surgery
M. D. Anderson Cancer Center
Houston, Texas

Correspondence to Dr. Edward I. Chang
Department of Plastic and Reconstructive Surgery
M. D. Anderson Cancer Center
1400 Pressler, Unit 1488
Houston, Texas 77030
eichang@mdanderson.org

DISCLOSURE
The authors have no financial interest to declare in relation to the content of this communication.

Studies in Fat Grafting: Part I. Effects of Injection Technique on In Vitro Fat Viability and In Vivo Volume Retention

Sir:

The following comments pertain to “Studies in Fat Grafting: Part I. Effects of Injection Technique on In Vitro Fat Viability and In Vivo Volume Retention,” by Chung et al.1 The authors described the adipose tissue injector as a handheld, sterile, battery-powered, disposable device with a trigger. They stated that precise delivery of a preset fat volume can be achieved, and used 400-μl aliquots in each trigger pull in this experiment.1 According to the previous article, the minimal amount and usual amount of fat injected into the periorbital area was 0.01 to 0.02 ml and 0.03 to 0.04 ml in each release, respectively.2 We would like know why the adipose tissue