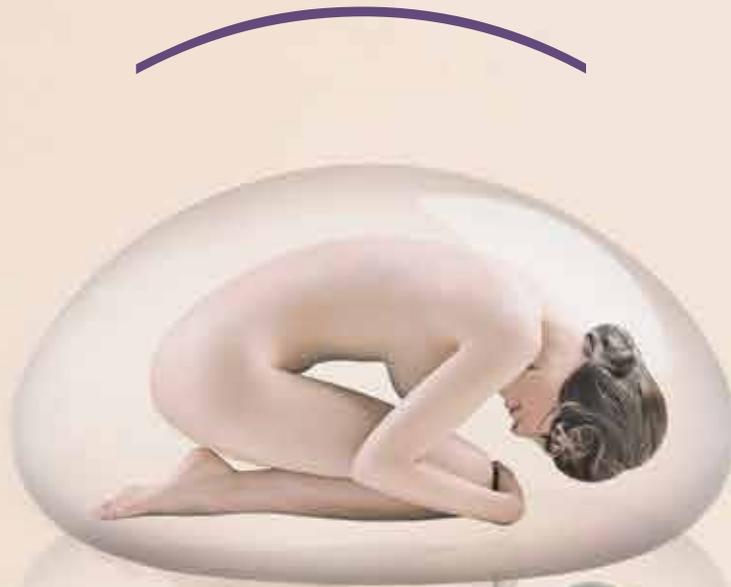


L'EXPANDER

The plastic surgery newsletter from Laboratoires SEBBIN



EDITORIAL

by Willie Burns, General Manager for “Regenerative Medecine”

I'm delighted to join Sebbin at such an exciting point in the history of the company. Sebbin has recently gained exclusive marketing rights for Meso BioMatrix® in the European and Latin-American markets. Meso BioMatrix® is the very latest in a new generation of acellular tissue matrices, which are being increasingly adopted for surgical procedures in Breast Reconstruction and re-enforcement of soft tissue. The



use of such matrices in BR procedures in particular has followed an accelerated adoption pathway in recent years, especially by means of facilitating direct-to-implant procedures and offering enhanced clinical and aesthetic outcomes, especially for certain defined patient profiles, and when compared to the more traditional approaches to reconstructive surgery. Sebbin's supply partner with Meso Biomatrix® is DSM. They are a global science-based company pre-eminent in the development of a wide range of Bio-materials which are used extensively in the area of Regenerative Medicine.

Before joining Sebbin, and for the last 38 years, I have been working in a variety of senior leadership positions in healthcare industries and most recently as European Vice-President and commercial head for the LifeCell Company. Now with Sebbin, my role will be as General Manager for Regenerative Medicine with an obvious focus on the commercial introduction of Meso BioMatrix®. The addition of this exciting product substantially completes and complements the Sebbin products range dedicated to breast reconstruction, revision and aesthetic procedures. I will also be responsible for establishing Sebbin UK Ltd., a new commercial operation in the UK, which represents a significant opportunity in one of the major European markets - especially for Meso BioMatrix®, alongside the already successful Sebbin range of implants and other products.

In the meantime, with this 13th issue of the Expander, you'll discover new scientific analyses upon plastic and aesthetic surgery.

Happy reading.

THE WORD from Doctor Julien Glicenstein



The plastic surgeon is, according to the words of Raymond Vilain (1921-1989), the last general surgeon. Our specialty, in addition to cosmetic surgery, deals with maxillofacial surgery, breast, skin and hand surgery. The latter has been individualized after the 2nd World War through the sharing of plastic and orthopedics surgery techniques. Dupuytren's contracture is still a topical subject.

The Professor Auquit-Auckbur offers a remarkable focus on this disease still somewhat mysterious.

Issue 13

CONTENTS OF

About "Dupuytren's contracture"
Professor Isabelle Auquit-Auckbur p3

Breast augmentation
and dermal matrix p7

Eponym
Abbe Estlander flap p8

Aplasia cutis congenita,
rare but fearsome p9

Yesterday / Today:
Abdominoplasty p10

Flashback on the history of rhinoplasty:
From rhinoplasty
to complex nasal reconstruction p11



Invited guest of L'EXPANDER

ABOUT "DUPUYTREN'S CONTRACTURE":

Professor Isabelle Auquit-Auckbur,
Plastic Surgery and Hand Surgery Department at Rouen University Hospital



Professor Isabelle
Auquit-Auckbur

INTRODUCTION

Dupuytren's palmar fibromatosis is a benign but debilitating disease whose pathogenesis is still unknown in 2015.

However, it is a condition that is common in Northern Europe.

Since its first description in 1831 by Baron Guillaume Dupuytren during his surgery lesson on "permanent retraction of the fingers" [1], its

treatment has been enriched with numerous techniques and other injections that help to diminish the functional consequences thereof.

The pathology of choice for hand surgeons, the operating procedure comprises dissection of the hand and fingers which is of primary interest to the plastic surgeon.

The aim of this development is to improve current knowledge and management of this disease and to recall the various options and treatment perspectives.

HISTORY

In fact Baron Dupuytren was not the first to describe this fibrosis of the superficial palmar fascia and its treatment. Before him, in the early 17th century, Felix Plater, a Swiss surgeon, described this retraction of the fingers in an observation.

In 1822, Astley Cooper even described the retraction of the fingers and its origin to the palmar fascia, and its treatment by aponeurotomy.

But posterity will remember the name of the one who, in his formidable surgical lesson, raised awareness of this disease [2].

PHYSIOPATHOLOGY AND EPIDEMIOLOGY

Dupuytren's contracture is within the nosology of fibromatosis. It mainly affects the fascial structures of the palmar surface of the hand and fingers.

It is a disease whose pathophysiology is still not clear, but that would be subject to autosomal dominant gene transmission with variable penetrance. [3]

It would affect chromosomes 6, 11 and 16 [4] and seems to have come from northern Europe following the migration patterns of the Viking people.

It affects the superficial palmar fascia causing the proliferation of a particular cell type: the myofibroblast. This will produce immature collagen. The latter will constitute the main structure of the nodules and flanges which constitute the clinical expression of this disease.

Recently, the histological ultrastructure of Dupuytren flanges has been researched [5]. Thus, proteins of the interstitial substance from the metalloproteinase family (MMPs) such as MMP-14 and MMP-2 were highlighted as causing contraction of the myofibroblasts [6].

Other cytokines and growth factors also appear to be involved such as TGF β since its blocking in the cascade of intracellular signals proved the decrease in the proliferation of these pathological fibroblasts [7].

Some contributing factors are known but the publications show a high statistical variability. Thus, the works of Descatha A et al. have shown that heavy manual workers or those using vibrating machines were more likely to develop Dupuytren's disease [8].

Similarly, predisposing factors such as diabetes, chronic alcoholism and the taking of neuroleptics were discussed. [9].

CLINICALLY



Clinical appearance of damage to the 4th space

"lines", "nodules" and "umbilications" that give the palm a raw, bumpy and indurated appearance.

We can observe more or less significant cutaneous involvement, which limits the mobility of the skin relative to the plane immediately below. Mobility when bending the fingers is not usually altered unless the retinacular structures are damaged.

Dorsal manifestations of the disease are indeed rare:

- "Knuckle pads", fibrous nodules on the dorsum of the proximal interphalangeal (PIP): unsightly but do not limit bending
- The hyperextension of the distal interphalangeal (DIP) signals a retraction of the retinacular ligaments (oblique retinacular ligament in particular)
- Exceptionally, an invasion of the triangular ligament on the dorsal surface of the middle phalanx occurs.

The palm and fingers may be affected at different times of a patient's life and present different evolutionary patterns. During the initial clinical examination, it is best to be consistent and to note the seat of these lesions and loss of mobility (metacarpal phalangeal flexum (MP) and PIP, +/- DIP or DIP hyperextension, retraction first commissure) and this, joint-by-joint in the same space, space-by-space, for each hand.

The main classification used in France is that of Tubiana [10], very simple to use and very useful for making treatment decisions. She adds, for each space, the flexum of the MP and PIP joints and DIP flexum or hyperextension. It has four evolutionary stages plus one N stage and one 0 stage, rated for each space:

- Stage 0: no lesions;
- Stage N: nodules;
- Stage I: flexion from 0 to 45°;
- Stage II: 45° to 90° flexion;
- Stage III: 90° to 135° flexion;
- Stage IV: flexion greater than 135°, hyperextension of the 3rd phalanx on the 2nd, itself completely folded on the 1st.

Note also that the overgrowth concerns the digital segment only or the palm and finger, the precise seat of the palpated flanges (ulnar, central, radial, Y, etc). Recurrence and the other elements of the Dupuytren

diathesis (Lapeyronie and Lederrhose disease) will also be reported.

In addition to the patient's comorbidities and other anamnestic elements, local surgical history is important for the surgical indication. If treatment with aponeurotomy or with needle aponeurotomy has already been carried out, it is important to check the discriminative pulp sensitivity with a Weber test and to perform a digital Allen test to check the continuity of the digital pedicles themselves.

MEDICAL TREATMENT

No treatment (topical, injectable or locally applied) is currently able to stem the tide of this disease which often progresses in spurts and has no predefined evolutionary mode.

However, some authors have reported symptomatic improvements during the use of vitamin E and intralesionally injected corticoids. Anti-inflammatory ointments can also be applied to the palm.

1. NEEDLE APONEUROTOMY

Aponeurotomies appear to have been the first treatments for this disease (Astley Cooper 1822). This treatment gained renewed interest in the 1950s. Since the publication by De Seze in 1957 [11], it is practiced by rheumatologists who, for some, perform it under ultrasound guidance, also accepted by surgeons.

It consists of weakening the line located subcutaneously using the bevel of a needle, under local anaesthesia. Several sessions are sometimes necessary to weaken it enough to rupture.

The locations of these aponeurotomy procedures are very important: in fact, those who regularly deal with this type of pathology know the existence of these flanges that alter the path of the digital collateral pedicles: spiral flanges. They exist more frequently over the last 3 fingers between the distal palmar crease and the PIP crease. The needle aponeurotomy performed percutaneously must avoid these areas or risk a pedicle injury.



The spiral flange of the radial pedicle of the 3rd finger (illustrating the "dangerous" area for needle aponeurotomies performed percutaneously) between the distal palmar crease and the PIP crease

2. COLLAGENASE

Treatment with collagenase works in the same way: weakening of the flange by direct intralesional injection of several IU of collagenase clostridium histolyticum is followed by stretching between D1 and 7, causing breakage thereof [12].

Reactions at the injection site are very common but overwhelmingly benign (swelling, bruising, bleeding, pain) and usually subside in a week or two.

In February 2012, the European Commission authorised Xiapex® to be placed on the market (collagenase clostridium histolyticum) throughout the European territory. But its high cost and lack of perspective on this long-term treatment, especially versus fine needle aponeurotomy, means that collagenase is, to date, only reimbursed in some European countries but not in France (ANSM decision 2012). However, an economic study reported by M. Merle in e-reports from the Surgery Academy stated about the economic benefit represented by this treatment [13].

SURGICAL TREATMENT

Surgical techniques are numerous and must be adapted to each case.

1. SURGICAL APONEUROTOMY

The same principle as the needle aponeurotomy can be practiced using the tip of an 11 knife blade and performing resection of the flange using the "mini-open" approach. This technique can be performed under local or locoregional anaesthesia and has the advantage of directly controlling the pedicles, which limits potential complications and provides a favourable extension, particularly in light of the MP.

2. APONEUROTOMY

These days the palmo-digital aponeurotomy is still the original treatment for this disease. It consists of the total removal of the flange and its palmar or digital extensions. Generalised aponeurotomies on the whole palm (total aponeurotomies) have been abandoned.

The incisions follow the incision and plastic palm surgery rules: broken line incisions according to Bruner or direct central incisions with multiple Z closures according to Skoog.



Lack of preoperative extension of Dupuytren's contracture of the 4th space with the Gosset flange (Y flange of the 4th commissure)

The technique known as Mac Cash's "open palm" technique uses the distal palmar crease as a transversal approach, supported by Bruner's digital incisions leaving a free space at the base of the fingers [14]. The noble elements that can be diverted from their anatomical

paths by fibrous expansions must be followed step-by-step and reclined during this dissection. This dissection is generally conducted methodically from proximal to distal. It requires surgical magnifiers and the use of a tourniquet, and bipolar forceps.



"Open palm" technique

After aponeurotomy of the pathological fascia, additional procedures may be needed to achieve full extension of the finger, especially in light of the PIP:

- Opening of the digital channel next to the A 3 pulley, section of the check-reins of the palmar plate: these procedures must be limited, especially those on the PIP joint, because, paradoxically, the risk of causing stiffness during PIP extension is significant.
- Laterodigital flap or Razemon's flap [15,16]. This is a cutaneous procedure made necessary by the lack of coverage of the finger which becomes apparent extension of the finger after aponeurotomy. This laterodigital flap is outlined on the lateral surface of the proximal phalanx and pivots in the basi-digital crease where the problem is located.



Functional outcome after palmo-digital aponeurotomy

3. DERMOFASCIECTOMY OR HUESTON'S TECHNIQUE

Dermofasciectomy using the technique described by Hueston [17] is the technique of choice when cutaneous overgrowth due to the disease is convincing, or in the case of a recurrence. The cutaneous excision should be at the boundaries of functional areas.



Dermofasciectomy using Hueston's technique: intraoperatively before the total skin graft and postoperatively

4. CHIROPASTIC AMPUTATION

This is palliative surgery indicated in cases of repeated recurrence and/or "exceeding" stage 4 with hooked fingers and PIP flexion exceeding 90 degrees. In this case, the trans-PIP amputation associated with a dorsal flap at the expense of the middle phalanx will unclutter the palm and ensure distal and palmar coverage of the remaining proximal phalanx.

5. THERAPEUTIC DECISION

The frequency of this disease in Europe makes it of particular interest to hand surgeons.

In the therapeutic arsenal deployed above (which is of course not exhaustive), the choice of the most appropriate surgical technique will depend on many factors such as local surgical history, cutaneous involvement, the size of the retraction and flexum, age, activities and functional requirements of the patient.

The information provided is essential to prevent the latter from suffering potential complications and recurrences. The greatest rigour is desirable in the indication and timing of surgery.

Indeed, operating too early (nodular stage) presents a risk of worsening the disease and also creates a precedence that can interfere with surgical recovery in case of recurrence (30 to 40% of cases).

6. POSTOPERATIVE COMPLICATIONS

Even though they can reach twenty percent [18], aponeurotomy complications are often benign. Secondary infections are rare as is graft lysis.

The management of postoperative pain and monitoring of the oedema's disappearance can prevent the dreaded complex regional pain syndrome that can worsen the functional outcome, especially in the case of pluridigital surgery.

CONCLUSIONS

Despite more than two centuries having passed since the description of this disease, its origin and activating factors are largely unknown.

Better knowledge of the tissue ultrastructure of Dupuytren's contracture will certainly lead to new treatments in the future. Currently, surgery is still the treatment of choice with many variations to tailor treatment to each case.

Ref. 1- Dupuytren G. De la rétraction des doigts par suite d'une affection de l'aponévrose palmaire. Description de la maladie - opération chirurgicale qui convient dans ce cas. *Compte rendu de la clinique chirurgicale de l'Hôtel Dieu par MM. les Docteurs Alexandre Paillard et Marx. J Univ Hebd Med Chir Pract* 1831;5:349-65.

2- Glicenstein J Les pionniers de la chirurgie de la main Maladie de Dupuytren, histoire d'un éponyme *Chirurgie de la main* 31 (2012) 107-112

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4- Anderson ER et al. Evaluation of a mitochondrial DNA mutation in maternally inherited and sporadic cases of Dupuytren disease. *Clin Med Res.* 2012 Aug;10(3):122-6

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7- Krause C et al. Concurrent inhibition of TGF-β and mitogen driven signaling cascades in Dupuytren's disease - non-surgical treatment strategies from a signaling point of view. *Med Hypotheses.* 2012 Mar;78(3):385-8.

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12- Mickelson DT et al. Prospective randomized controlled trial comparing 1- versus 7-day manipulation following collagenase injection for Dupuytren contracture *J Hand Surg Am.* 2014 Oct;39(10):1933-1941.

13- Merle M et al. Nonoperative treatment for Dupuytren's contracture by collagenase. First results and socioeconomic effects. *e-mémoires de l'Académie Nationale de Chirurgie,* 2013, 12 (1): 051-059 51

14- Foucher G et al. Open palm technique for Dupuytren's disease. A five-year follow-up. *Ann Chir Main Memb Super.* 1992;11(5):362-6.

15- Razemon JP. Lateral digital rotation flaps in the treatment of forms of Dupuytren's contracture. 141 cases. *Ann Chir Main.* 1982;1(3):199-209.

16- Ould-Slimane M, et al. Razemon's lateral digital rotation flap in severe Dupuytren contracture of the fifth finger. *Chir Main.* 2013 Oct;32(5):317-21

17- Hueston JT. Dermofasciectomy for Dupuytren's disease. *Bull Hosp Jt Dis Orthop Inst.* 1984 Fall;44(2):224-32

18- Karabeg R et al. Results of surgery treatment of Dupuytren's contracture in 115 patients. *Med Arch.* 2012;66(5):329-31

Breast augmentation and dermal matrix

Every year more than 200,000 women in the United States have a cosmetic breast augmentation using prostheses. 12 to 30% of them are re-operated on within 6 years of the initial operation, due to capsular contracture, malposition, hematoma or seroma and rarely for asymmetry or creases ("rippling"). A new recurrence of the problem occurs in 20% of cases.

The authors searched the literature to see whether some surgeons had used dermal matrices during reoperation. They found 7 articles and compared their technique to conventional methods: changing the prosthetic seat (sub glandular to retro pectoral or reverse), mastopexy, prosthesis change.

In case of malposition, linked to a too large periprosthetic pocket or tissue atrophy, movement of the prosthesis or the capsuloplasty have a high recidivism rate.

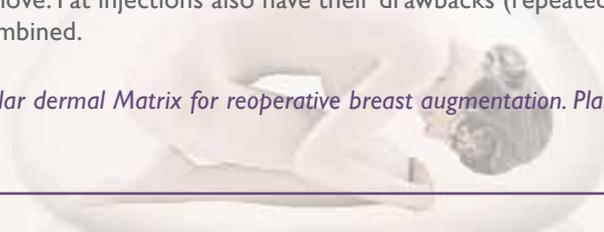
Similarly, if there is "capsular contracture", changing the site and type of prosthesis, the capsulectomy does not prevent reoccurrence. The secondary ptosis of the prosthesis ("bottom out") is rarely corrected sustainably by mastopexy and changing the prosthesis site. Creases which are usually seen if the implant is too big or textured, are not modified by capsuloplasty or changing the prosthesis.

During breast reconstruction, the establishment of an acellular dermal matrix, decreases the number of capsular contractures. It secures the crease under the breast.

The 7 articles studied by the authors totalize 500 re-interventions after breast augmentation on 400 women with 89-99% success. Recidivism of capsular contracture stands at 1.1 to 4.3% after 1.7 to 3.1 years. However, the results are not as good if creases need to be eliminated (11% recidivism).

This study has limitations (limited postoperative period, no comparative series using conventional methods). However, it shows that it is worth using acellular dermal matrices in the case of capsular contracture or prosthetic malposition. The creases are difficult to remove. Fat injections also have their drawbacks (repeated injections, irregularities, cysts). The two methods could be combined.

Ref. Maxwell GP, Gabriel A. Acellular dermal Matrix for reoperative breast augmentation. Plast Reconstr Surg 2014, 134: 932-8.2014.



Meso BioMatrix®

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by DSM

Meso BioMatrix® is a porcine-derived acellular peritoneum matrix. Chosen for its natural strength, elasticity, flexibility and porosity, Meso BioMatrix® is particularly suitable for surgical procedures in breast reconstruction.

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Eponym

Abbe Estlander flap

Every plastic surgeon knows about this technique to repair a loss of lip substance, which consists of filling the latter with a flap containing an artery from the opposite lip. Several surgeons described this procedure in the 19th century. Both are known, both were forgotten.



Robert Abbe (1851-1928) is most often quoted in articles and American books. Yet he was the last of four to publish the technique in 1898 [1]. He used a flap from the lower lip to correct insufficient volume in the upper lip, sequelae after a bilateral cleft lip.

A native of New York, Robert Abbe was a professor of surgery at St. Luke Hospital in the city. He became interested in hand surgery and plastic surgery (skin grafts, vaginal aplasia). Fascinated by the discovery of radium, he met Marie Curie and contributed to the development of radiation therapy. He died of anaemia which may have been related to excessive radiation.



Jakob August Estlander (1831-1881) was Finnish (Finland was then part of the Russian Empire).

Born in the small town of Lapväärt, he studied and practiced in Helsingfors (Helsinki) as a professor of surgery. In 1872 in a German magazine he published observations concerning a patient with a tumour of the lower lip near the labial commissure.

Estlander used a flap from the upper lip and, during a second operation, deepened the commissure [2]. Estlander died suddenly at the age of 50.

Before Estlander and Abbe, two surgeons had already described an autoplasty based on the same principle. The first was the Italian Pietro Sabattini (1810-1864), who in 1838 used the technique that was later used by Abbe. The Dane Sophus Stern (1797-1866) detached two flaps from the upper lip to fill a defect of the lower lip in 1848.

Sabattini and Stern made the mistake of publishing in their mother tongue. Publications in Italian and Danish had no international distribution unlike those in English (Abbe), German (Estlander) and French.

Ref. 1. Abbe R. New plastic operation for the relief of deformity due to double harelip. *Med Rec* 1898, 53: 477-8.

2. Estlander JA Eine method aus einer lippe substanz verluste deranderen zu erset zar *Arch Klin Chir* 1872, 14: 622-6.

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- Allows the collection, processing and transfer of fat up to 800mL
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* SOF-CPRE: Société Française de Chirurgie Plastique Reconstructrice et Esthétique – French Society of Plastic Reconstructive and Aesthetic Surgery.



Aplasia cutis congenita, rare but fearsome

One newborn in 10,000 is born with part of their body surface - usually the scalp - uncovered by skin. At birth, the lesion presents as an area where the skin is replaced by a thin membrane, typically at the vertex, of variable size between one and several tens of square centimetres. In 15-30% of cases, the underlying skull bone is absent and the dura, sometimes the brain, is exposed. The longitudinal venous sinuses may be visible. In this case, there is a significant risk of extremely serious bleeding, thrombosis or infection. Mortality is high (20-55%) in the days or weeks following birth due to bleeding or infection, after intervention, or fall of pressure ulcers.

Rarely the aplasia can affect the trunk or limbs. It is, in the latter case, often bilateral and symmetric. It can be associated with many congenital syndromes including epidermolysis bullosa.

The cause of aplasia cutis congenita is discussed (genetic or related to a teratogenic agent).

The treatment is controversial because whether the surgery is carried out or not, there is a risk to life.

The article's authors identified all cases of aplasia cutis congenita in their hospital for a period of 13 years, that is to say 22 out of 167 865 births, all related to the vertex except one.

The aplastic area is not excised unless there is a pressure ulcer. The latter is only detached very carefully using hydrodissection. Usually an antibiotic ointment is applied under an occlusive dressing and the child is hospitalised in the intensive care unit. If the meninges or the longitudinal sinus is exposed, a thin mesh graft is placed in the hours after birth.

The authors emphasize the difficulty of the choice of treatment. Conservative treatment or surgical intervention both represent complications. 3 of the 22 children died from bleeding in the days or weeks following birth.

They propose a 5-stage aplasia classification:

- 0: mere absence of scalp,
- I: simple skin defect (conservative treatment),
- II: bone loss (conservative treatment or transplant),
- III: vein exposed (emergency coverage by autograft or dermal matrix or allograft),
- IV: brain exposed (cutaneous autoplasty knowing the risk of flap necrosis).

Ref. Silberstern E and al : Aplasia cutis congenita: clinical management and a new classification system. Plast Reconstr 2014, 134: 766e.

Join the GROUPE SEBBIN



GAERID: on March 6 and 7th, in Leipzig, Germany.

JOURNÉES DE SÉNOLOGIE HENRI PUJOL:
on March 13 and 14th, in Montpellier, France.

JOURNÉE DES JEUNES PLASTICIENS:
on March 14th, in Paris, France.

PARIS BREAST RENDEZ-VOUS:
from March 26th to 28th, in Villejuif, France.

COMPLICATIONS DE LA CHIRURGIE DU SEIN:
on April 3 and 4th, in Nice, France.

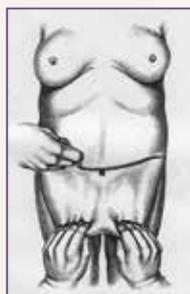
SEMCC : from May 8 to 10th, in Sitges, Spain.

YESTERDAY TODAY

ABDOMINOPLASTY

In 2013 US plastic surgeons performed over 160,000 abdominoplasties. Every year - like their French colleagues - they perform more and more. Modern techniques, such as the "high superior tension" technique from Le Louarn and Pascal [1] and liposuction have significantly improved the results of a procedure that Raymond Vilain (1921-1989) called abominoplasty!

In the 15th issue of the *Pratique Chirurgicale*, in 1930, his abdominoplasty technique was published. It includes all the principles of the operation as it was practiced until the 1980s: transposition of the umbilicus, approximation of the recti muscles, drainage, etc.



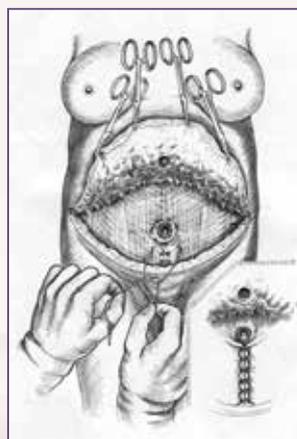
Upper incision

Abdominoplasty, a procedure not without incidents and complications, is not a new concept. The first cutaneous fat resection of the abdominal wall was performed by two Frenchmen,

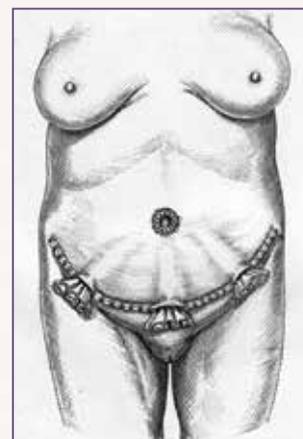


Lower incision

Demars and Marx in 1890. The American Kelly is considered as the "father" of the transverse abdominal lipectomy. In 1899 he performed tapered resection of the wall sacrificing the umbilicus.



Suturing the recti muscles



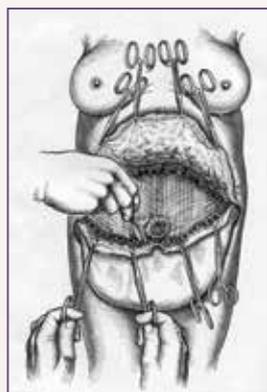
Results

The first to advocate the conservation of the umbilicus was the Frenchman Pierre Mornard (1884-1923). The latter was one of the first French cosmetic surgeons. His premature death meant he was forgotten. He published numerous articles in the "*Pratique Chirurgicale illustrée*", an atlas of surgical techniques, run by Victor Pauchet (1869-1936), a prolific surgeon with whom he worked. It includes his description of the facelift and the correction of breast ptosis in the 1920s.

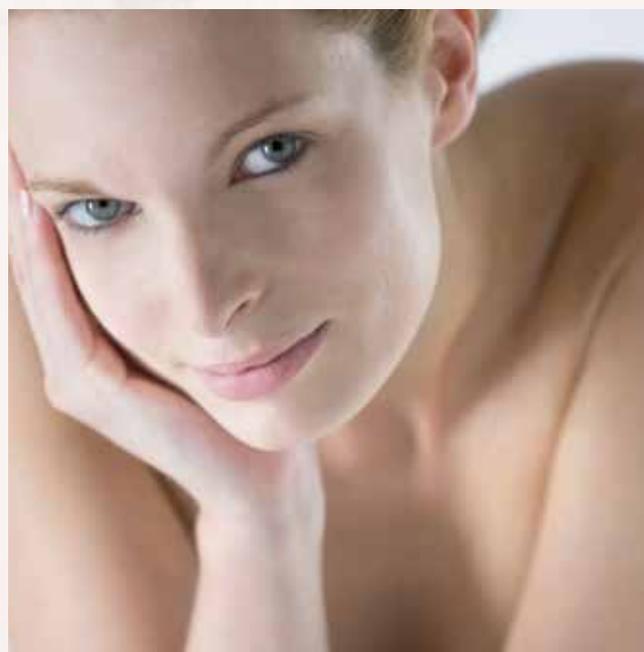
- Ref. 1. Le Louarn C, Pascal JF High Superior tension abdominoplasty *Aesth Plast Surg* 2000, 24: 375-81.
 2. Kelly HA Excessive growth of fat *Bull Johns Hopkins Hospt* 1899, 10: 197.
 3. Mornard P. Résection esthétique d'un ventre en tablier *Prat Chir. Illustr* 1930, 20, 39-52.



Upper dissection



Lower dissection



FLASHBACK

ON THE HISTORY OF RHINOPLASTY

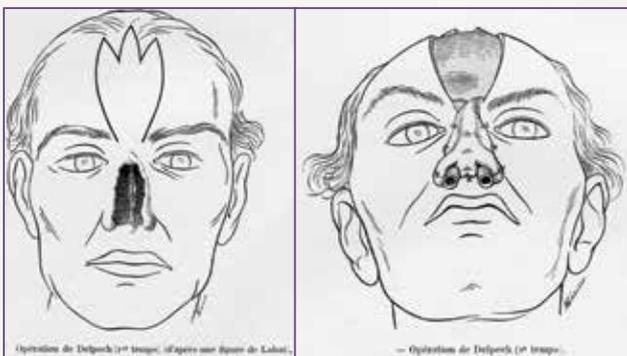
CHAPTER V: FROM RHINOPLASTY TO COMPLEX NASAL RECONSTRUCTION

All surgical texts from the 19th century dedicate a chapter to rhinoplasty, that is to say nasal reconstruction. A considerable number of patients were willing to undergo surgery despite the dramatic conditions of the procedure, which was terribly painful before the discovery of anaesthesia in 1846, practiced in unhygienic or aseptic conditions, with a significant risk of fatal infection.

The patient was seated on a simple chair and held down by two strong assistants. Sometimes they fled during the procedure with a bloody face and a piece of skin hanging off the front. Indeed, the "Indian" method using a forehead flap was usually practiced. If some accepted a rather traumatic event, is that the nasal mutilation was most often linked to syphilis, an acknowledged stigma.

Until the mid-nineteenth century, surgeons were content to replace the loss of nasal substance by a unlined and armature-free forehead flap. The flap was retracted and had no projection. The results discouraged many surgeons who refused to perform the procedure, advising the wearing of a simple paper maché or porcelain prosthesis.

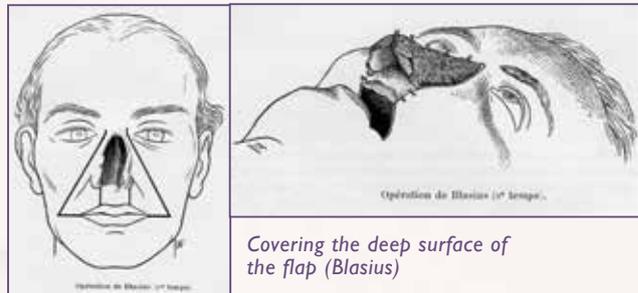
Some surgeons persevered despite ridicule from their peers, to improve the technique, by folding the flap to try to create the nostrils.



Creating nostrils (Delpech)

Others thought it was necessary to cover the deep surface of the flap.

They used autoplasties from the cheeks, residual nose integuments or skin grafting.



Covering the deep surface of the flap (Blasius)

The result of the operation was sometimes acceptable when the loss of nasal substance did not affect the skeleton; it was often unacceptable in case of complete nasal reconstruction.

By 1880, most surgeons said they were disappointed with the rhinoplasty. Dolbeau estimated that he had replaced a patient's nose with a shocking tuberosity. Tillaux compared "before and after" for one of Ollier's patient and preferred the patient "before".

It became clear that a bone or cartilage armature was needed to reconstruct the structure of the nose.

Several surgeons followed this path at the end of the 19th century.

To be continued...

In the next issue of the Expander: Complex nasal reconstruction.

According to the Medical Device Directive 93/42/EEC the Fat Washer is a medical device of class IIa and acellular matrix Meso BioMatrix® is a medical device of class III. They are intended for use in plastic, reconstructive and aesthetic surgery. GROUPE SEBBIN reserves the use of its devices to physicians trained in plastic, reconstructive and aesthetic surgery. Please read the instructions for use carefully before using these devices. The Fat Washer is CE marked by the notified body mdc medical device certification GmbH number 0483. The Meso BioMatrix® matrix is manufactured by DSM Biomedical and distributed by GROUPE SEBBIN. It is CE marked by the notified body BSI number 0086.



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