

postoperative bleeding. This complication was seen occasionally in our experience (0.5 percent) and was characterized by spontaneous resolution; nasal packing was rarely required.

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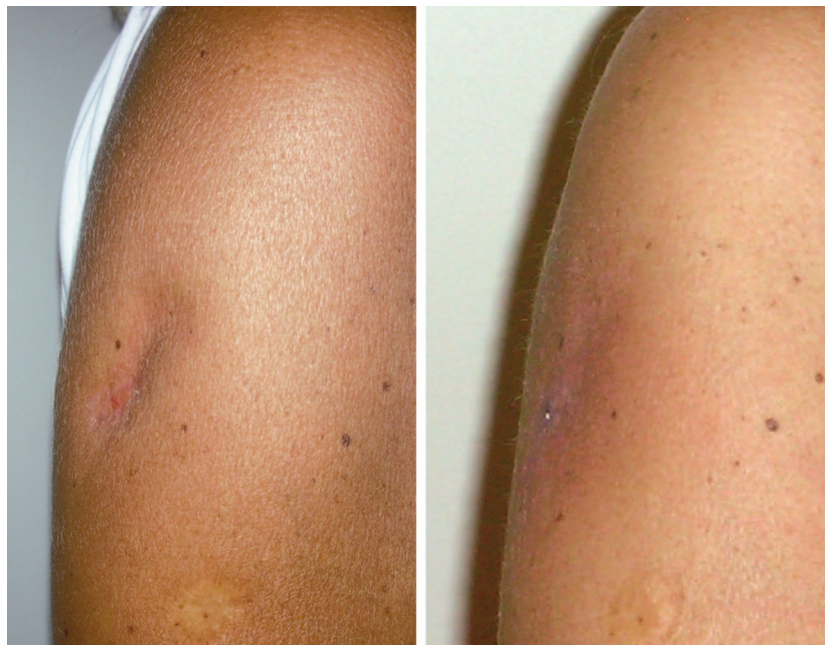
**Core Fat Graft Transplantation for Depressed Scar**

**Sir:**

**W**e read with interest the article entitled “Facial Augmentation with Core Fat Graft: A Preliminary Report” by Guyuron and Majzoub.<sup>1</sup> We would like to compliment the authors on the results of their study, which are very encouraging and point the way to better fat grafting. The authors discuss the use of easy en bloc fat graft harvesting in an atraumatic way for facial augmentation. The technique shown was quick and easy. We present two cases in which the same technique was used for correction of depressed scars on the arm and buttock.

In case 1, a 43-year-old woman presented with a tiny depressed scar in the deltoid region of her right arm caused by overcorrection of a keloid scar with a corticosteroid injection (Fig. 1, *left*). Surgery was performed under a local anesthetic in both the donor and recipient areas. An obliquely trimmed 1-cc syringe was used to harvest 3 cc of fat from the paraumbilical region. The graft was injected to obtain a slight overcorrection. At the 3- and 6-month follow-up visits, correction of the defect was maintained (Fig. 1, *right*).

In case 2, a 35-year-old woman was referred to us for a small depressed scar on her left buttock following multiple hormonal injections. We used the same technique as described above. Under local anesthetic, 4 cc of core graft was harvested from the paraumbilical region and injected in multiple separate blocks to obtain correction of the scar. At 6 months, minimal absorption was recorded.



**Fig. 1.** (*Left*) A depressed scar following corticosteroid injection. (*Right*) Appearance 6 months after the core fat graft injection.

The use of fat grafts under depressed scars is well known as a technique that not only relieves the depression but also seemed to soften or even completely eliminate the scar, making it look like normal skin.<sup>2</sup> The method shown by the authors is easy and practical under local anesthesia; there was no need for any mechanical manipulation, such as centrifugation, washing, or filtering. The graft was injected in multiple separate packets to increase the contact area with the host bed and to enhance graft survival.<sup>3</sup> The core graft was stable with long-term maintenance, which may be related to the atraumatic handling of the graft.

We believe the core graft technique is a useful and reliable tool as permanent filler for any small area.

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#### Reply

**Sir:**

I am delighted to hear that Dr. La Rusca and colleagues have had a positive experience with the core fat graft. This technique has become the main source of fat transplant in my practice, and I have even been able to use the circular, sharp Coleman cannula for harvesting fat in a similar manner when less volume is needed. In fact, if one tries to suction the fat initially with conventional suctioning techniques and uses the coring technique with the same syringe and cannula, one will notice that there is a visible difference in the quality of the fat that is being harvested. Over the years, I have also become convinced that fat harvested from different sites behaves differently. In fact, for reasons that we need to investigate, fat harvested from the gluteal region has a higher chance of success. As Peer has indicated and as has been corroborated with recent studies by Pu et al.,<sup>1</sup> the higher the number of live fat cells, the more volume that will be retained. Intuitively, this technique provides a higher number of live fat cells. However, we must conduct more studies to confirm or reject this point.

Nothing is more gratifying than confirmation of the success of an operation by an independent group who has no bias in their reports. Although only two cases are reported here, this still provides two additional successful outcomes to what my colleague and I reported. I am grateful to Dr. La Rusca and colleagues for sharing their experiences with us.

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#### Avoiding Denervation of Rectus Abdominis in DIEP Flap Harvest: The Importance of Paraneural Perforators

**Sir:**

**W**e read with great interest the article entitled "Avoiding Denervation of Rectus Abdominis in DIEP Flap Harvest: The Importance of Medial Row Perforators" (*Plast Reconstr Surg.* 2008;122:710–716). The authors documented that nerve branches enter the rectus muscle mainly from its posterior surface more medial than the lateral row perforators.<sup>1,2</sup> As medial row perforators were not related to these motor nerves, the authors suggested that these perforators are ideal for inclusion in abdominal flaps.<sup>1</sup> We agree with the authors that the dissection of a dominant lateral row perforator, although usually more straightforward due to a short intramuscular course,<sup>3</sup> carries higher risk of muscle denervation. The authors confirmed with histologic analysis the presence of a nerve plexus running with the lateral branch of the deep inferior epigastric artery, but not with the medial branch. Despite this important finding, we believe that the dissection of a medial row perforator may present risk of rectus muscle innervation, as well. Interestingly, Hammond et al.<sup>4</sup> reported that although most nerves enter the muscle in the lateral third, nerves were also noted to pass two-thirds of the way under the muscle to enter the medial third. It is also our experience that, during deep inferior epigastric artery perforator flap dissection, occasionally motor nerves are noted to enter the muscle at the junction of its middle and medial thirds. Moreover, a medial row perforator may present a long and oblique intramuscular course (Fig. 1) that traverses the motor nerves, and its dissection may jeopardize the anatomic continuity of these nerves.

Computed tomography–microangiography revolutionized the planning of abdominal flaps and enabled