tion. There is also a relative abundance of scrotal skin available for matching what is usually a contralateral areola of small diameter. Several techniques are available for creating a new nipple, but one of the best ways has been nipple sharing if the nipple on the contralateral side is substantial enough.[5]

Another aspect to consider in male breast reconstructions is chest wall symmetry. After unilateral mastectomy, one method of achieving symmetry involves performing a contralateral subcutaneous mastectomy. This achieves two goals: (1) it serves as a prophylactic mastectomy and (2) it makes the chest wall more symmetric, because an implant would not generally be used in a man. If that was not a good option in any given patient, the use of a flap (such as a latissimus dorsi muscle flap or transverse rectus abdominis musculocutaneous flap) or customized alloplastic chest wall implant and fat grafting could be added to the mastectomy side for a better balance.

The patient shown in Figures 1 and 2 had a scrotal graft for areola reconstruction, nipple reconstruction by contralateral nipple sharing, and a contralateral subcutaneous mastectomy. There was a quick recovery without undue morbidity.

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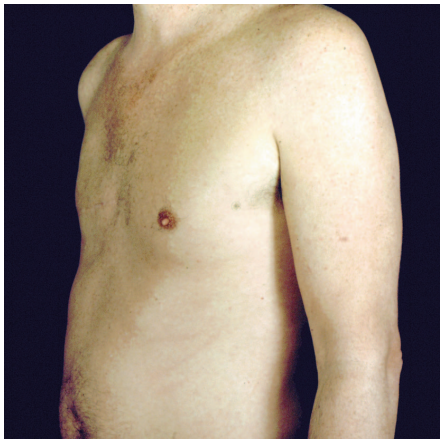

Fig. 1. Preoperative photograph shows absence of right nipple-areola complex and fullness of the left side of the chest wall.

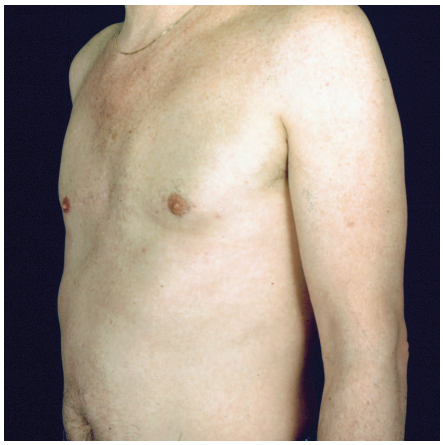

Fig. 2. Three-month postoperative result shows reconstructed nipple-areola complex with good projection, color match, and symmetry between right and left sides of the chest wall after left subcutaneous mastectomy.

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Abdominoplasty Consent Forms Do Not Caution against the Potential Loss of a Reconstructive Option for Breast Reconstruction

Sir:

More than 1.2 million cases of breast cancer in women occur worldwide annually.[1] Breast cancer is the most frequently diagnosed malignancy in women worldwide.[1] Twenty-two percent of new cancer cases in women are due to breast cancer.[1] The lifetime probability of a woman developing breast cancer worldwide is one in eight.[1] Death rates from breast cancer have

steadily decreased in women since 1990.[2] This decrease is due to a combination of earlier detection and improved treatment.

Fewer than 20 percent of eligible women undergo breast reconstruction after treatment for breast cancer.[3] For these women undergoing mastectomy, significant advances in reconstruction techniques provide several options for breast reconstruction.[4] The abdominal wall represents a major source of tissue for autologous breast reconstruction.[4] It provides the most sizeable tissue for the breast mound and provides sufficient tissue for bilateral breast reconstruction.[4] Among technical alternatives, abdominal flaps have been recommended as the option of choice to produce the most natural results.[4]

A total of 140,155 women had an abdominoplasty in 2006 in the United States.[5] This is a 36 percent increase in patients undergoing abdominoplasty since 2004 and a 132 percent increase since 2000.[5]

The incidence of women undergoing abdominoplasty and women developing breast cancer is so high that they may frequently occur metachronously in the same patient, so there must be prudence that the consequences of abdominoplasty might reduce future potential options in the course and outcome of reconstructive breast cancer therapy, particularly in women with a high risk of future breast cancer.

Patients rely on surgeons for guidance. We collected 83 preprinted abdominoplasty consent forms from hospitals worldwide in Arabic, Chinese, English, Finnish, French, German, Italian, Portuguese, Russian, Spanish, and Ukrainian. These consent forms were examined to see whether they stated that abdominoplasty may reduce future potential options in the course and outcome of reconstructive breast cancer therapy. None of these 83 consent forms mentioned this potential future consequence.

We advocate that female patients who wish to undergo abdominoplasty are informed that they may lose a potential option for breast reconstruction to receive enough information on which to base their decision. Ensuring that patients are appropriately and adequately informed ensures that they can make a rational decision about their treatment and sits well with worldwide medical and governmental recommendations to that effect.

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Free Superficial Inferior Epigastric Artery Flap for Aesthetic Correction of Mild Pectus Excavatum

Sir:

Pectus excavatum disease is also known as funnel chest and describes the most common chest wall abnormality (male-to-female ratio, 3:1).[1] Respiratory or cardiac functional impairment is described in one-third of the patients and is a clear indication for surgical treatment.[2] Conventional treatment of the "aesthetic cases" without any functional impairment includes soft-tissue augmentation with customized silicone implants. Although sophisticated techniques have been described for the creation of three-dimensional computerized templates, long-term complications associated with synthetic material are frequent and include capsular contracture, implant dislocation, and visible con-