GUIDELINES

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Letters

Preventing Septorhinoplasty Complications: Evaluating the Personal Experience

Sir:

After reading the brilliant article entitled “Prevention and Management of Rhinoplasty Complications” by Cochran and Landecker,1 we would like to provide details derived from our personal experience, with special regard to preventing some of the complications described.

Retrospective analysis of the case records reveals the absence of infective complications, septal hematoma, and intranasal adhesions. The sample analyzed consisted of 865 septorhinoplasties filed on a medical database over a period of 22 years, from 1985 to 2007. The operations were performed by the senior author (V.A.) without antibiotic prophylaxis and with the routine use of x-ray films shaped with Mayo scissors intraoperatively and fixed on each side of the nasal septum (Fig. 1). The x-ray films are cut into 10 × 10-cm squares and kept sterilized. At the end of the operation, they are cut into the shape of the “setting sun” (i.e., a back straight base with a superior flattened curvature, smaller than the undermined area). The bases are placed on the floor of the nasal cavities and positioned on each side of the nasal septum using the appropriate anatomical forceps; a single transfix stitch of 2-0 silk is applied. The stitch is not strongly knotted to prevent necrosis of the mucoperichondral layer. The anterior edge corresponds to the transfixing incision but reaches the columella when containing a graft. Care must be taken to avoid a sharp anterior extremity of the x-ray “minifilm,” to prevent potential decubitus and patient discomfort. Furthermore, the minifilm proves useful when the mucoperichondral layer of the septum is torn off accidentally. They are usually removed on the seventh postoperative day along with the nasal plaster, and on the fourth postoperative day in septoplasty cases.2,3 Occasionally a reactive fever caused by a foreign body can arise and resolves once the devices are removed.

Two additional advantages emerge. First, our method is a useful way of recycling, as it saves money compared with expensive devices. Second, the minifilm consists of activated silver salts on polymeric material, and the antiseptic properties of Ag ions are well known. Indeed, it could probably be effective in preventing infections of the endonasal incisions, though that would necessitate adequate studies. Moreover, successful control of septal hematoma and intranasal adhesions is achieved thanks to the uniform compression obtained on the one hand and to the protective barrier preventing abnormal bridge scars that could lead to nasal valve incompetence on the other.3

Postoperative patient care consists of physical rest for 20 days in a place with a temperature as constant as possible, around 17°C (avoiding sources of heat), to prevent

Fig. 1. Placement of a microfilm on the right side of the nasal septum. On the patient’s left side, a microfilm is already in place. They will later be joined by a single transfix stitch.
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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Tommaso Agostini, M.D.
School of Specialization in Plastic, Reconstructive and Aesthetic Surgery
CTO-AOUC Largo Palagi
University of Florence
Faculty of Medicine and Surgery
Florence, Italy

Vittorugo Agostini, M.D.
Department of Plastic and Reconstructive Surgery
CTO-AOUC Largo Palagi
Florence, Italy

Correspondence to Dr. Agostini
School of Specialization in Plastic, Reconstructive, and Aesthetic Surgery
CTO-AOUC
Largo Palagi
1-50100 Florence, Italy
tommytt23it@yahoo.it

REFERENCES

Core Fat Graft Transplantation for Depressed Scar

Sir:

We read with interest the article entitled “Facial Augmentation with Core Fat Graft: A Preliminary Report” by Guyuron and Majzoub.1 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.\(^2\) 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.\(^3\) 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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Ivan La Rusca, M.D.
Fabrizio Schonauer, Ph.D., M.D.
Guido Molea, M.D.
Department of Plastic Surgery
University of Naples “Federico II”
Naples, Italy

Correspondence to Dr. La Rusca
Via San Domenico 80
80127 Naples, Italy
info@ivanlarusca.it

REFERENCES

Reply

\textbf{Sir:}\n
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.,\(^4\) 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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Bahman Guyuron, M.D.
Department of Plastic Surgery
University Hospitals Case Medical Center and Case Western Reserve University
29017 Cedar Road
Lyndhurst, Ohio 44124
bguyuron@aol.com

REFERENCES

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

\textbf{Sir:}\n
\textit{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.\(^1,2\) As medial row perforators were not related to these motor nerves, the authors suggested that these perforators are ideal for inclusion in abdominal flaps.\(^3\) We agree with the authors that the dissection of a dominant lateral row perforator, although usually more straightforward due to a short intramuscular course,\(^3\) 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.\(^4\) 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...
us to identify perforators from the deep inferior epigastric system that follow a retromuscular plane and then either pierce the deep fascia in the linea alba (paramuscular perforators) or pierce the most medial part of the muscle, have a short vertical intramuscular course, and then pierce the deep fascia (paraneural perforators). Both types of perforators essentially have a retromuscular course and, most importantly, a paraneural course, since they emerge medial to the rectus motor nerve supply. To ensure the paraneural course of the perforators with the minimal medial trajectory, we have included in our criteria only those vessels that perforate the undersurface of the muscle less than 15 mm from its medial border (Fig. 2). This distance corresponds to one fourth of the rectus width on average, which is unlikely to involve segmental nerves.1,2,4

We reviewed retrospectively the computed tomography–microangiography scans of patients who under-

Fig. 1. Medial row perforator (long arrow) and lateral branch of the deep inferior epigastric artery (arrowhead). The perforator pierces the muscle at a distance 31.36 mm from its medial border, which corresponds to half the width of the muscle (57.58 mm). The perforator will follow a long oblique intramuscular course and will pierce the deep fascia (short arrow) 14.21 mm from the rectus medial border.

Fig. 2. Paraneural perforator (arrow) and lateral branch of the deep inferior epigastric artery (arrowhead). After taking a retromuscular course, the perforator pierces the muscle at a distance 10.82 mm from its medial border, which corresponds to one-fifth of the muscle’s width (60.21 mm). The perforator will follow a short rectilinear intramuscular course and will pierce the deep fascia (short arrow) 4.74 mm from the rectus medial border.
Sir:

We thank Dr. Gravvanis et al. for their interest and discussion of our recent anatomical studies relating deep inferior epigastric artery (DIEA) perforators to the innervation of rectus abdominis during DIEA perforator (DIEP) flap harvest. The discussion by these authors is certainly of interest, as the sparing of these motor nerves is essential to maximize the donor-site benefits of this muscle-sparing procedure. The findings of our anatomical study highlighted that the motor nerves innervating the rectus abdominis are intimately associated with the lateral-most branch of the DIEA and the perforators that it distributes. The medial-most branch of the DIEA (if present) is not associated with these nerves.

It is important to note from these findings that in up to 30 percent of cases, there is only a single branch of the DIEA, in which this branch is associated with motor nerves. Another important point is that although the motor nerves encroach upon the rectus in a segmental fashion, they are distributed within the muscle with extensive branching. Ultimately, all rectus muscle is innervated, and thus there are small nerve fibers throughout the medial muscle. The major nerve branches, however, are associated with the more lateral perforators.

The authors go on to describe medial row perforators, using the term “paraneural” to describe those perforators selected on preoperative computed tomographic angiography that follow a very medial course and avoid these nerves. Although perforators can be selected preoperatively on computed tomographic angiography based on location and course, the relationship to motor nerves is not possible on computed tomographic angiography. Given the variation in the course of the motor nerves, it would seem that labeling perforators as “paraneural” preoperatively would be imprecise and would have high false-positive and false-negative rates (by missing cases where the nerve may have an unusually medial course, or missing many cases where there is only a very lateral nerve and all perforators are in fact paraneural).

The authors also describe a “paramuscular” perforator as a perforator that pierces the deep fascia in the midline to avoid an intramuscular course altogether. We have utilized this term in the past to describe a perforator that not only has a paramuscular penetration pattern but also runs throughout its course medial to the medial border of the rectus abdominis. In other cases, where the penetration of the deep fascia is in the midline but the perforator then has a retromuscular course, the term “circummuscular” has been applied (Fig. 1). These perforators have long been described, with Godfrey et al. first describing these perforators, after identifying two cases intraoperatively, as medial row perforators that avoid an intramuscular course. Subsequent case reports have increasingly described these variations, and this has particularly been the case with the more widespread use of computed tomographic angiography to aid visualization of this anatomy.

In our own experience using preoperative computed tomographic angiography for DIEP flaps (150 patients), we have encountered a circummuscular course in 15 percent of patients. A large medial row perforator that also avoids the motor innervation of the rectus abdominis would also be present in the significant majority of other cases. In our cadaveric dissections, we similarly found the intramuscular course of perforators to show marked variability. The authors have contin-
ued to demonstrate the wide variation of the vascular anatomy of the abdominal wall, and further affirm the benefit of preoperative computed tomographic angiography before use of DIEP flaps.

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M. W. Ashton, M.B.B.S., M.D.
Jack Brockhoff Reconstructive Plastic Surgery Research Unit
Department of Anatomy and Cell Biology
The University of Melbourne
Parkville, Victoria, Australia
Correspondence to Dr. Rozen
Jack Brockhoff Reconstructive Plastic Surgery Research Unit
Room E533
Department of Anatomy and Cell Biology
The University of Melbourne
Parkville, Victoria 3050, Australia
warrenrozen@hotmail.com

REFERENCES

Reoperation: Rationalization or Good Care?

In our editorial “Is Reoperation Rate a Valid Statistic in Cosmetic Surgery?”1 we reviewed some subjective features of cosmetic surgery that could prejudice reoperation rate, in both a positive direction and a negative direction, bringing into question the validity of this statistic as a valid benchmarking criterion. In his editorial “Reoperation as a Benchmark: The Rhetoric, the Logic, and the Patient,”2 Dr. Tebbetts refutes this as a rationalization that he believes ultimately works against the patient. He states, “What should matter most to every surgeon is the patient. What matters most to patients is their outcome.” However, while the editorial repeatedly states that the patient’s needs are foremost, its arguments contradict this point.

The editorial calls for eliminating subjectivity in favor of science. The logic falls short in its failure to accept that there is a subjective aspect to cosmetic surgery (and often this is the only aspect a patient con-
Sir:


Reply

Sir:

The authors are mistaken. My editorial did not, as they suggest, neglect the patient’s subjective needs. It did contain a strong message about subjectivity versus science. The message in the editorial is that surgeons should prioritize objectivity over subjectivity and science over opinion if optimal patient outcomes in breast augmentation are the goal. History, U.S. Food and Drug Administration premarket approval data, and published data in this Journal, not subjective opinion, prove that position.1–8

As residents, when we were confronted with a patient who was supine, unconscious, had rapid, shallow breathing, and was as white as the gurney sheet, we were not taught to think, “I wonder if she is sick? I wonder what she thinks about whether she is sick? Maybe she knows better than I what is best for her at this point. If I treat her, and she’s not quite happy, perhaps I can treat her again.” We were taught to measure her blood pressure, pulse, and temperature and perform a physical examination, all of which generated objective data on which we based decisions for treatment. When we initiated treatment, we were not taught to think, “Maybe I’ll just try this” or “this seems like a good idea” or “it’s okay if it is not quite right the first time, I’ll just adjust it later.” Instead we based actions on scientifically validated processes that had been shown to optimize her chances of survival and an optimal outcome. Being an aesthetic surgeon, and the fact that aesthetic surgery is medically unnecessary, does not change the reality that optimal outcomes derive from implementation of scientifically validated processes—evidence-based medicine. Rationalizations that somehow aesthetic surgery is different, and that aesthetic surgeons can acceptably rationalize and prioritize subjectivity above objectivity, do not change reality or improve outcomes for patients. Optimal patient outcomes derive from evidence-based medicine, even in aesthetic surgery.

Decisions determine outcomes. Surgeons cannot deliver what surgeons and patients cannot define. When surgeons utilize subjective processes or indefinable cup size for implant sizing, implant selection, and informed consent, it is not surprising that a substantial number of patients who were “satisfied” return and request changes or larger implants. History clearly shows the price patients pay when surgeons use subjective methodologies and rationalize reoperation rates: a consistent, three-decade track record of up to 23 percent reoperation rates in independently supervised, Food and Drug Administration premarket approval studies in just 3 years after augmentation.1–7 Contrast that 23 percent reoperation rate with what is possible for patients in a Food and Drug Administration study with the same follow-up when objectivity and proved processes are applied to their care: a zero percent reoperation rate at 3 years, obtained by applying proved processes derived from evidence-based clinical studies.8

Three decades of prioritizing subjectivity over objectivity (with the convenient exclusion of accountability, except in independently monitored Food and Drug Administration studies) has generated a factual track record that does not bode well for patients, despite subjective arguments about “patient satisfaction.” When surgeons argue subjectivity and the right of patients to choose whatever they want whenever they want, those surgeons rarely mention that informed consent law is not discretionary to surgeons. Surgeons are responsible for...
Replantation Using Arterial Conduit Graft and Dorsal Vein Transposition: Is It “Innovative and Safe”?

Sir:

The homepage of the September 2008 online Journal highlights the “Image of the Month” from the article “Replantation Using Arterial Conduit Graft and Dorsal Vein Transposition.”1 The authors audaciously make the unsubstantiated claim to have devised an “innovative and safe” technique. In their Discussion, the authors have downplayed, if not ignored, the deficiencies of their technique.

The authors’ innovation is a melding of Shafrir’s back table vein-grafting technique for thumb replantation with Godina’s concept of arterial grafting.2 The authors properly cite both Shafrir’s and Godina’s work. However, analysis of the authors’ results fails to demonstrate that this innovation is better than prior methods. (On a historical note, Shafrir and Godina served as hand fellows together in Louisville. Their discussions of the merits of their respective philosophies, namely Godina’s concept of “emergency free flaps” and Shafrir’s belief in the benefit of Morrison’s toe wrap, resulted in the first emergency toe wrap being performed by Shafrir and Tsai in 1979 on one of Kleinert’s patients.)

The authors list 12 thumbs in their series, but only five thumbs had deep inferior epigastric artery (DIEA) grafts, with three of the five thumbs surviving. There is no statistically significant difference between these results and those from the Mayo Clinic series from 1979 to 1985 that used vein grafts (p = 0.26 with a Fisher exact probability test).2 Thus, the authors have obtained results comparable to those of the older hand surgery literature that used a vein graft but with an “innovative” technique of using an artery that cardiac surgeons have found useful for coronary revascularization. Is that “safe”? Curiously, the authors’ own references 16 and 17 cite the efficacy of using the DIEA in cardiac surgery.3,4

Shafrir mentioned that an advantage of his technique was that the vein graft could be harvested from the injured extremity’s volar forearm. This prudent approach allows the replantation to be accomplished with regional anesthesia and avoids needlessly sacrificing an artery that may ultimately serve to preserve the patient’s life not limb.

Almost 60 years ago this Journal published Gillies’ fundamental plastic surgical principles, including “Never steal from Peter to pay Paul unless Peter can afford it.”5 In these days of global financial crisis due to imprudent loans, we should not ignore Gillies’ principles. We must be responsible to our patients by not using grafts that in the end may prove to be unaffordable to our patients, no matter how much we may be impressed by the editor’s imprimatur of the “Image of the Month.”

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John Tebbetts, M.D.
2801 Lemmon Avenue West, Suite 300
Dallas, Texas 75204
jbt@plastic-surgery.com

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REFERENCES


Reply

Sir:

We appreciate Dr. Freshwater’s comments. Thumb replantation is a technically difficult procedure. Comments and discussion about this procedure should benefit us all.

The intent of the article was to present a different technique for revascularization of an amputated thumb. The technique combines a vein transposition from the dorsum of the index metacarpal to the thumb, providing venous outflow with one anastomosis. An arterial conduit, rather than a venous conduit, is used to re-establish arterial inflow. As cited, others have described these techniques for different circumstances. We combined these techniques to provide blood supply to the replanted thumb.

Our data do not allow us to claim that this technique is better than another. Rather, it is a suitable alternative. Arterial grafts have advantages and disadvantages over vein grafts. The article discusses these elements. Having used both arterial and venous grafts, we prefer arterial grafts, but we cannot prove that they are better. To our knowledge, to date, the use of an arterial graft has not impaired subsequent medical care to a patient. Our patients have had no local vascular issues following arterial graft harvest. Our cardiac surgeons do use radial artery for coronary bypass but have not progressed to using the deep inferior epigastric artery. In that regard, our patients have been fortunate.

Are arterial grafts more than is needed? We cannot say. Have we used a free flap for reconstruction when a less invasive technique would have allowed healing of a wound? Yes. But in the end, the sum total of the advantages and disadvantages of the free flap outweighed that of the less involved alternatives. We believe the same is true of arterial grafts in this instance.

We appreciate the reviewer’s insightful comments on our article and will incorporate them into future medical decisions.

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W. Bradford Rockwell, M.D.
Jaime Haidenberg, M.D.
K. Bo Foreman, Ph.D.

Plastic Surgery
University of Utah
Salt Lake City, Utah

Correspondence to Dr. Rockwell

Plastic Surgery
University of Utah
30 North 1900 East
Salt Lake City, Utah 84132-1

Why Doctors Are Required to Work for Free

Sir:

I would like to congratulate Dr. Zbar et al. for their excellent article entitled “Ethical Issues for the Plastic Surgeon in a Tumultuous Health Care System: Dissecting the Anatomy of a Decision” (Plast Reconstr Surg. 2008;122:1245–1252). The authors tackled an extremely complex problem in a concise and understandable manner.

Their comment that “no other individual in society is required to work for free” suggests a need for looking back in the causal chain to find out why this is the case. The reason is that doctors are the only individuals who do not insist on being paid for their work. For example, in my state (Maryland) attorneys perform millions of dollars worth of work for virtually every hospital and they are paid fair and reasonable fees by the hospital. A contract that would require an attorney to work for free would be laughable.

Yet this is exactly what doctors accept.

Doctors should understand that the bylaws of the professional staff at each hospital represent a contract between the hospital and the doctors, and we will live and die by this contract. Unfortunately, the bylaws are years out of date and look out for the interests of the hospital only, because they were authored by hospital attorneys. A reasonable contract addresses the concerns of all of the parties, but the doctors need to insist on changes. In fact, Zbar et al. wisely point out in their article that “the ethical surgeon must address any onerous on-call requirements through the bylaws of the medical staff.”

This is an area where our local plastic surgical societies can make a real contribution. Members can make their voices heard loud and clear for fair and reasonable rules, working conditions, and/or compensation for work performed for the hospital by insisting these be placed in the bylaws.

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Correction: Some More Technical Points in the Use of the Abbé Flap

In the March 2009 issue of the *Journal*, in the letter entitled “Some More Technical Points in the Use of the Abbé Flap” (*Plast Reconstr Surg.* 2009;123:1126–1127), the name of the second author was misspelled because of an error in copyediting. The correct spelling is Parag Telang. The publisher regrets the error.

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Correction: Preventing Postsurgical Dissatisfaction Syndrome after Rhinoplasty with Propranolol: A Pilot Study

In the March 2009 issue of the *Journal*, in the article entitled “Preventing Postsurgical Dissatisfaction Syndrome after Rhinoplasty with Propranolol: A Pilot Study” (*Plast Reconstr Surg.* 2009;123:1072–1078), Dr. Roger K. Pitman’s affiliation was inadvertently omitted due to a copyediting error. He is affiliated with the Department of Psychiatry, Massachusetts General Hospital/Harvard Medical School, Boston, Mass. The publisher regrets the error.

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Retraction: BMP-2 Does Not Influence the Osteogenic Fate of Human Adipose-Derived Stem Cells

The article entitled “BMP-2 Does Not Influence the Osteogenic Fate of Human Adipose-Derived Stem Cells,” by N. S. Grewal, J. S. Gabbay, R. K. Ashley, K. L. Wasson, J. P. Bradley, and P. A. Zuk (*Plast Reconstr Surg.* 2009;123(2S):158S–165S), is retracted. An intermediate version of the manuscript was submitted, reviewed, and published by mistake. The *Journal* and the paper’s authors regret the error.

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