
Letters to the Editor

Pink Brasília

Ricardo Baroudi
Editor-in-chief of the *Revista Brasileira de Cirurgia Plástica*

Dear editor,

I am forwarding one of my own texts, published by the newspaper *Correio Braziliense* on October 8th, 2013, about breast cancer, which I would like to share with my colleagues of the Brazilian Society of Plastic Surgery.

In 1896, Halsted demonstrated that amputation of the breast cured or prolonged the life of patients with cancer. He saved and prolonged the lives of women. However, the amputees suffered from marital and social barriers. In terms of body language, a woman's identity does not reside in her vagina, but in her breasts.

In 1962, Cronin had the idea of putting breast prostheses made of a synthetic material into an intimate part of the human body, specifically to increase breast volume. In 1969, as a student of Pitanguy, I had my first contact with this technique that he was widely using.

In 1972, preventative and reconstructive measures with regard to breast cancer were instated in the department of Plastic Surgery at the Hospital das Forças Armadas (HFA) in Brasília, a facility that I established and managed. We introduced the massive cavitation of breasts and immediate reconstruction with silicone. This technique opened the way for mastologists, who then began to remove glands showing any initial signs of breast cancer.

Early treatment, such as radical mastectomy, has good results with no after-effects. We produced films of 8 mm and 16 mm, which we presented at several conferences in Brazil and abroad. This technique, today referred to as a skin-sparing mastectomy, which Angelina Jolie underwent, is practiced worldwide, despite being originally criticized for not guaranteeing the complete removal of the mammary gland.

What happens when there is a lack of skin? In 1973, while still at the HFA, I attended to a young woman who had plans to get married but did not know how to tell her fiancée that, since birth, she had only one breast. With no known solution, I suggested that we insert a small silicone implant behind the

rudimentary nipple, which would be gradually replaced by larger ones over time. After three surgeries, she acquired the breast that she wanted, and she got married.

I reconstructed the breast of this young woman, but did not describe the principle. Rodovan did this in 1976, when he published an article on expanders: small empty bags inserted into locations where more skin is required. They are gradually filled and they "stretch the skin", similar to what happens in pregnancy, during which the abdomen expands and then becomes flaccid after giving birth. On removing the filled "expander", the skin that was covering it will be surplus, allowing the prosthesis to be inserted for reconstruction.

However, after Halsted, patients did not even have skin to expand. In patients with advanced cancer, still a very common situation in Brazil, all that remains for them is massive cavitation and they are left with unpleasant scars and a flat chest.

With regard to this considerable technical challenge, Brasília was also a pioneer. In 1979, Bostwick published a technique that moved skin from the back to the anterior chest wall. On January 4th, 1980, I reproduced this technique. I wanted to start off the 1980s with a breast reconstruction, a professional dream come true.

In 1983, Brasília was once again a pioneer for Brazil, when the technique of the American Hartrampf was reproduced for the first time; this technique involved transplanting tissue from the lower abdomen into the anterior chest wall by abdominoplasty. It was a fantastic image, due to the abundance of tissue available to reconstruct beautiful breasts. We demonstrated this technique in seven Brazilian states and in dozens of symposia and conferences.

Finally, in 1992, in Brasília, I developed "Breast Island Flaps", an original technique which I published in the United States. This allowed us to reconstruct partial breast amputations following quadrantectomies. As we only knew about total breast reconstructions, we learned to carry out partial reconstructions, which today are used all over the world.

Despite overcoming the technical difficulties, I am still faced with endless lines of women waiting years for treatment. With regard to healthcare plans, as part of which the patient has to pay her own expenses, it is increasingly difficult to gain authorization for surgery. This has reached absurd

limits, whereby only the breast that has cancer is authorized for treatment and not the essential treatment of the opposite breast. I was involved with such a situation recently.

This pioneer city, the center of power, could very well agree to there being no queues or bureaucracy, which would reduce amputations and suffering. Therefore, Brasília, which to me has been pink for 41 years, will now definitely be pink for everybody.

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Use of the latissimus dorsi segment with muscle and fat components in single decubitus position for breast reconstruction after quadrantectomy

Ricardo Baroudi
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Dear editor

We read with great interest the paper by De Araujo et al on the use of Latissimus dorsi with fat components, via an axillary incision, for breast reconstruction at quadrantectomy¹. They must be congratulated on excellent results with this technique. We had previously used this method of reconstruction and reported our results². Our report antedated their paper by more than two² years; therefore their claim in the abstract of “a new option for post-quadrantectomy reconstruction in external quadrants is proposed” is not entirely accurate since it was previously described in considerable detail. They correctly emphasised major advantages as decreased operating time, no need to reposition the patient with its greater safety, decreased risk of contamination/infection and lowered risk of accidental extubation.

We found that their incision appeared much larger than we actually use; it actually extends well beyond the anterior axillary line to the breast (De Araujo et al Figure 1 in contrast to our [Naraynsingh et al.] Figure 1). Unlike their series, we have used this for lesions in all parts of the breasts except the inferior medial quadrant. To achieve greater flap mobility, we divide the tendinous humeral attachment of Lattissimus Dorsi. For lesions in the superior medial quadrant, adding a circu-

mareolar to the axillary incision facilitates both wide local excision and accurate placement of the flap [Naraynsingh et al Case 3, Figure 7 and 8]².

In order to decrease the axillary bulge produced by swinging the muscle anteriorly, only the muscle (without the fat) is left at the upper end while muscle and fat are rotated distally. We should be grateful for the authors' comments on these points of technique as the operative procedure is not very detailed in their paper. Their analysis of the cosmetic outcome and their results are impressive and testify to the value of this operation.

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