

Luis Vásconez, with whom we have been involved in several investigations on the subject of Scarpa sparing techniques, suggested that Scarpa fascia vascularization along with the superficial inferior epigastric vessels may also explain the clinical findings. We are currently undergoing an investigation to clarify this hypothesis using thermographic evaluation in a prospective comparative study. The preliminary results suggest that this possibility may also have a role.

Saldanha et al,¹³ who has a huge experience with his technique of lipoabdominoplasty which applies Scarpa fascia preservation, recently published a letter to the editor which summarizes the current knowledge on the mechanisms we have been talking about.¹⁴

The last 3 editions of our main textbook of plastic surgery recommended using Scarpa sparing techniques in any type of abdominoplasty.^{15,16} Probably, this technique is not adopted more frequently because there is a misconception that deep fat is very thick in the lower abdomen. Surgeons may be concerned that it may interfere with the esthetic result especially in patients with high body mass indexes as fat is supposed to accumulate preferentially in this compartment. We have previously shown in a morphometric study that the deep fat is very thin and does not increase significantly with increased adiposity.¹⁷ This was done in 41 fresh specimens from a full abdominoplasty (82 sides were studied). We verified that the deep fat has a minor contribution to the total abdominal wall thickness (average thickness, 6.9 mm; average maximum thickness, 16 mm) whatever the patient's body mass index.¹⁷ The clinical profile of our study population is clearly defined and is similar to the usual candidate for a full abdominoplasty. We recommend this anatomic article for anyone considering using Scarpa sparing techniques.

We also aim at drainless procedures and abdominoplasty is not an exception for us. The last author of this letter has been teaching an educational course “Scarpa sparing abdominoplasty with concomitant liposuction—no drains needed” in the American Society for Aesthetic Plastic Surgery Annual meeting every year since 2015. To achieve this goal, other variables must also be considered, namely, the dissection method. Nevertheless, some of our patients are still treated with Scarpa fascia preservation and suction drains which are removed regularly between 24 and 48 hours after surgery using strict volumetric criteria.

Based on current evidence, we think surgeons should adopt either Scarpa fascia preservation or progressive tension sutures when performing a full abdominoplasty. The decision to do it without drains should be considered after gaining some experience with the chosen technique.

Andreia Pisco, MD

Department of Surgery and Physiology
Faculty of Medicine

Porto University
Porto, Portugal

Marco Rebelo, MD

Plastic Surgery Department
IPO Porto
Porto, Portugal

Helena Peres, PhD

Interdisciplinary Centre of Marine and
Environmental Research (CIIMAR) and
Science Faculty, Porto University
Porto, Portugal

António Costa-Ferreira, MD, PhD

Department of Plastic, Reconstructive and
Aesthetic Surgery
São João University Hospital
Porto, Portugal
Department of Surgery and Physiology
Faculty of Medicine
Porto University
Porto, Portugal
antoniof@med.up.pt

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Comments on “Defining Plastic, Reconstructive, Aesthetic, and Cosmetic Surgeries: What Can Get Lost and Found in Translation”

To the Editor:

We read with interest the Editorial by Wei, Gu, and Li regarding the definitions of plastic, reconstructive, aesthetic, and cosmetic surgeries.¹ The Oxford English Dictionary has the following descriptors:

*Cosmetic, adj. Of surgery: improving or modifying the appearance. Of prosthetic devices: recreating or imitating the normal appearance.

*Aesthetic, adj. Designating surgery or dentistry intended to restore or improve a person's appearance; of or relating to such treatment.

Although there is a semantic difference between the words “aesthetic” and “cosmetic,” for most practical purposes, there is none, except perhaps in public (consumer) perception.²

From the content of the editorial along with its publishing Journal, there is a presumption that a single surgical craft group (plastic surgery) is uniquely trained to deliver cosmetic surgical procedures. The United Kingdom General Medical Council (GMC) and its counterpart

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in Australia, the Australian Medical Council (AMC) have recognized that this is not the case. The GMC recently warned that the possession of qualifications in a given specialty field does not imply expertise in cosmetic surgery, whereas in 2018, the AMC reported that plastic surgeons trained by the Royal Australasian College of Surgeons had a “deficit” in their experience of aesthetic surgery and a “gap in this area of practice.”³

Across the western world, plastic surgical training is almost exclusively undertaken in *public* hospitals and is reconstructive in nature, such as hand surgery, trauma, burn, and cancer care. Typically, this publicly funded undertaking does not incorporate training in cosmetic surgery, which is almost exclusively undertaken and independently funded in the *private* sector.

It is only through diligence of the individual plastic surgeon who seeks additional specific training that competence in aesthetic/cosmetic surgery can be achieved. Such specific training typically comprises dedicated academic education in conjunction with practical aesthetic surgical fellowships, over and above that offered by standard publicly funded training schemes. The existence, quality, uptake, and outcomes of such training seem variable at best.⁴⁻⁶

In addition, there is no agreed method of accreditation for medical practitioners performing cosmetic surgical procedures. The field is not yet recognized as a specialty, and currently, any medical practitioner may call himself or herself a “cosmetic surgeon.” As a result, there has been an expansion of clinics offering cosmetic surgical procedures performed by nonsurgical entrepreneurs.

As a consequence, patients and regulators find it difficult to distinguish between surgeons competent in cosmetic surgery compared with those who do not have appropriate knowledge, training, and skills to undertake and deliver high-quality cosmetic surgical outcomes.

The situation has been exploited and worsened by various surgical craft-groups producing misleading claims that “they alone” are properly trained in cosmetic surgery, despite the diametrically opposed findings of the GMC and AMC. Such claims are not credible in the absence of completion of specific, comprehensive dedicated education, and training in cosmetic surgery.

Australia has its own Australasian College of Cosmetic Surgery, established in 1999 as a not-for-profit, multidisciplinary fellowship-based body, which has trained and qualified surgeons from multiple subspecialties, including general surgeons, plastic surgeons, maxillofacial surgeons, ear nose and throat surgeons, ophthalmologists, and other doctors who practice cosmetic medicine and surgery.⁷ After 2 years of specific cosmetic surgery training, trainees face written and oral examinations and if successful, graduate with fellowship specifically in cosmetic surgery and with the requirement to recertify in cosmetic surgery annually thereafter.

Although the authors make the statement that “Nowadays, cosmetic surgery is acknowledged as a subbranch of plastic surgery,” Australian legislation stipulates that a medical specialty can only be recognized based on a “burden of disease.” Cosmetic surgical procedures are not undertaken on such basis. In light of the enormous global demand for them, the time has come to rethink contemporary recognition of cosmetic surgery as a specialty in its own right, based on a “burden of demand.” Such recognition would incorporate a multitude of natural professional safeguards to patients.

An initiative has been proposed in Australia to establish a competency-based, national accreditation system for all medically qualified providers of cosmetic surgical procedures that would favor no particular craft group but provide better and safer outcomes. Its purpose is to remove confusion for consumers, allowing them to make informed and potentially safer choices.

“Who performs what” should now be relegated to a position of secondary importance in relation to the partisan viewpoint of traditional surgical groups. For the sake of the patient, what really counts is competency in cosmetic surgery and in its execution.

Acceptance of independent speciality recognition and competency-based accreditation are the key first steps to provide a better standard in cosmetic surgery.

Patrick Tansley, MD, FACCS, FRCS (Plast)
Darryl Hodgkinson, FACCS, FRCS (C)
Tim Brown, MA, FACCS, FRACS,
FRCS (Plast)

North East Plastic Surgery Melbourne
 Victoria, Australia
 patrick@northeastplasticsurgery.com.au

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