

Comment on "First Russian Experience of Composite Facial Tissue Allotransplantation"

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It was with great interest that we read the article written by distinguished plastic surgeons Volokh et al.¹ However, an attentive reading elicited certain responses on our part. The authors reported the first facial allotransplantation performed in Russia to reconstruct a soldier's central facial area after an electrical burn. The aim was to describe the challenge faced regarding this advanced surgery. Nowadays, the main question regarding any vascularized composite allotransplantation (VCA) procedure remains the long-term management to prevent chronic rejection.

First, the correct name of the team's French surgeon who performed the first face transplant is Dubernard.² VCA is considered an experimental procedure in most countries around the world, but not for all. Indeed, VCA is an established procedure in France (among others), and we do not need to include the patient in a research protocol. The authors mentioned that the patient did 2 suicide attempts. It would then have been interesting to specify the results of the psychological assessment before the VCA procedure. Although the question of the legitimacy of performing a VCA in the context of a suicide attempt is highly controversial, we fully agree with the authors that a suicide attempt in itself is not a contraindication for VCA.³ Furthermore, previous facial reconstruction surgeries performed on the patient, which we consider essential data in this context, have not been described. Autologous reconstruction surgery must be attempted as a first-line treatment, especially for small defect such as the nose and for which many surgical options exist. VCA should be an option when autologous surgery is insufficient. The authors stated that they opted for the most immunologically advantageous solution because the

volume of transplanted tissue is <25%, which results in a low load on the recipient's immune system. The authors then describe a study carried out on animals over a follow-up period of 200 days to support this argument. However, the study cited (see Ref. 8 in the study by Volokh et al¹) is not at all relevant to the subject in question. Nevertheless, we believe that this immunologically optimistic argument must be contrasted with the fact that this is a patient with burns. The patients with burns are at high risk to develop immune rejection due to a high level of sensitization.⁴ Neither the pretransplant panel-reactive antibody status of the patient nor the histology is reported in this study. Concerning the "signal Chinese flap" in the lower third of the left forearm, it is performed very few times on VCA⁵ and is dropped given the risk of increasing the burden of skin component and thus increasing the acute rejection episode. This sentinel marker is tried for solid organ transplantation, theoretically to detect faster the immune rejection process. After weighing the pros and cons, we believe this procedure to be unnecessary. Finally, Figure 14, showing the appearance of the patient 3 years post-transplantation, is of poor quality and makes it difficult for the readers to see the final result.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

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