the efficacy of triamcinolone, botulinum toxin type A, and a combined therapy of these two drugs for treating human hypertrophic scars in an animal model. The authors implanted drug-injected scars into the subcutaneous pocket in nude mice. By comparing the weight change, decorin expression, and fibroblast proliferation of the implanted scars, the authors found that the combined therapy exhibited a significant therapeutic effect compared with either treatment as monotherapy.

It is quite innovative to evaluate the synergistic effect of triamcinolone and botulinum toxin type A in human hypertrophic scars implanted in nude mice. However, there were several aspects of the study design that might impact the study result. First, as the authors have mentioned in the article, the scar specimens were from different patients. The general condition (e.g., age, comorbidity, smoking habit) of the patients and the severity of burning would influence the decorin expression and fibroblast proliferation of the scars. Second, we noticed in Figure 1 that the scar specimens were adjacent to each other. Why not implant them at a fixed distance to avoid potential interaction of different groups? Third, the comparison of decorin expression was through the judgment of colors presented on photographs. Digital software might be used here to provide more objective data. Fourth, in this article, postimplantation decorin expression and fibroblast proliferation were used as parameters to assess the effect of the drugs. As the baseline data (preimplantation decorin expression and fibroblast proliferation) have a considerable chance to differ from each other, the change of the decorin expression and fibroblast proliferation before and after implantation might be more persuasive as the evaluating parameters.

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DISCLOSURE

The authors report no conflict of interest.

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Reply: Comparison of Steroid and Botulinum Toxin Type A Monotherapy with Combination Therapy for Treating Human Hypertrophic Scars in an Animal Model

Sir:

We appreciate that Drs. Chen and Li have read our article and have given us valuable suggestions that have enhanced the overall content of our article.[1] Shetlar et al.[2,3] developed the first animal model involving the implantation of human hypertrophic scar tissue into nude mice, which reliably reproduced all of the characteristics of a keloid scar and exhibited similarities to the progression of human hypertrophic scars in human patients. Although it is an indirect model, it was proven to be a major advancement in the study of keloid scars in vivo. On the basis of this model, we designed our study. We agree that the general condition of the patients and their burn severity might have influenced our study results. Thus, we may include only healthy patients with similar severities of burn injuries and ages in our future study.

During human human hypertrophic scar tissue implantation, we avoided implantation over the middle back or close to the four limbs of the mice. The middle-back skin above the spine is thin, and the implanted human hypertrophic scar tissue might be exposed. The implanted human hypertrophic scar tissue close to the four limbs would interfere with the activities of the mice. The back area of the mice is too small, and sometimes, keeping each implanted human hypertrophic scar at a fixed distance is difficult.

The quantification of decorin was assessed subjectively by a researcher using a microscope. Image analysis or biochemical methods may provide a more sensitive quantification.[4] We agree that digital software might be useful for decorin quantification in the future to provide data that are more objective.

Changes in decorin expression and fibroblast proliferation before and after implantation could be considered baseline parameters with which to evaluate the implantation process. However, in this in vivo study, human human hypertrophic scar tissue was implanted into mice after drug injection to simulate the progression of human hypertrophic scars in human patients. It is an in vitro experiment without the implantation process. Comparing the efficacy of the drug between the in vivo and in vitro groups is difficult.

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Outpatient Circumferential Lower Body Lift: Is the Lipo-Body Lift an Ideal Method?

Sir:

We read with great interest the article entitled "Safety of Outpatient Circumferential Body Lift: Evidence from 42 Consecutive Cases," by Makipour et al.[1] The authors presented their retrospective review of 42 consecutive patients who underwent circumferential lower body lift and assessed the feasibility of this intervention in outpatient surgery. We would like to congratulate them on achieving this objective for such a complex operation, which usually requires hospitalization, and for performing it in this challenging population. Their study is in line with the current focus on reducing public health care costs.

The surgical technique involved liposuction of epigastric subcutaneous fat followed by skin and fat resection according to preestablished markings. Suction drains were placed in both the anterior and posterior surgical bed and left in place for approximately 1 week postoperatively. Phlebitis prophylaxis was performed with sequential compression devices and compression stockings.

The lipo–body lift described by Bertheuil et al.[2] presents interesting technical principles with respect to its application in outpatient surgery. We would like to develop these principles.

The lipo–body lift is a less invasive technique than the traditional lower body lift. Extensive liposuction is performed in relation to cutaneous resection of certain areas. A single epigastric undermining is then performed with the addition of a suction drain, left in place for a mean of 3.56 ± 0.65 days.[2] Cutaneous resection is performed just under the dermis. Tension-free closure is possible because of skin laxity resulting from massive weight loss. The association with buttock autoaugmentation without a flap[3] by suturing the posterior plane from outside to inside also limits undermining and ensures that the mean operative time remains under 4 hours (229 ± 34 minutes). Phlebitis prophylaxis is treated using compression stockings and subcutaneous administration of low-molecular-weight heparin for 15 days.

Makipour et al. reported a complication rate of 36 percent; the complications were mostly minor, and 4.7 percent were related to seroma. They had a surgical revision rate of 26 percent, with three patients (7.1 percent) showing major complications. No cases of rehospitalization were reported, and no thromboembolic events occurred.

Our series of 25 cases,[2] subsequently expanded to 46 patients,[4] included no major complications, surgical revisions, seroma, or thromboembolic events. There was a minor complication rate of 40 percent (mainly wound dehiscence). Extensive liposuction (2760 ± 1011 ml) was not associated with an increased risk of complications,[4] even though this was highlighted previously.[2] Preservation of the connective tissue and the microvascular network may explain the absence of postoperative seroma.[5] Reduced drainage simplifies postoperative care and facilitates patient ambulation. Both authors included similar populations in terms of age, American Society of Anesthesiologists scores, and preoperative body mass index.

The lipo–body lift technique is safe, as shown by the absence of any major complications and thromboembolic events, and thus should be considered in the context of outpatient surgery. A larger clinical trial would be useful to further assess patients' tolerance to the pain associated with the lipo–body lift, and recovery.

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