

thus explaining the difficulty in eradicating such infections. Thus, given the ability of biofilms to favor bacterial survival, the rationale for removal of infected devices is provided.

We believe that the optimal treatment of breast implant infections is not well established and is at best derived from case studies. For suspected infections, culture should be obtained and empiric antibiotics directed at the previously mentioned organisms started. Response to antibiotics will determine whether surgical intervention is required. For persistent mild infections, local débridement with closed-suction drainage may be successful.

In conclusion, the authors have performed a thoughtful study with a retrospective design. Although this study has limitations regarding its measures and analyses, the authors described important risk factors that are relevant to the informed treatment decision-making process. The validity of the results is dependent on the quality of the measures along with statistical efforts to control for potential biases. It is well understood that randomized controlled trials are the standard means of producing high-level evidence. However, and especially in the breast augmentation field, it is not always feasible to perform these trials when evaluating surgical treatments that are highly dependent on patient and surgeon preferences. The authors are to be commended for their insightful approaches to these problems.

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Rib Fracture as a Complication of Tissue Expansion in Breast Reconstruction

Sir:

We read with great interest the article entitled “Rib Fractures: A Complication of Radiation Therapy and Tissue Expansion for Breast Reconstruction” by Tseng et al.¹ We compliment the authors on their work. We totally agree with the recommendation that plastic surgeons counsel patients requesting tissue expanders

in an irradiated field about the possibility of rib fracture and subsequent need to alter reconstructive plans. We report a case of two rib fractures subsequent to a breast reconstruction tissue expansion.

A 45-year-old woman was admitted for a skin expansion postmastectomy. A 500-cc tissue expander was implanted in the submuscular plane. We inflated 50 cc of saline solution every week for 4 months. A total of 600 cc on each side was inflated. After 1 month, following a sneeze, the patient reported sudden onset of chest pain under her left breast tissue expander. We removed 100 cc of saline solution from the left skin expander, which resulted in improvement of the symptoms. After 3 months, at periodic scintigraphic control, the appearance of a “hot-spot” was observed on the costal left bone (Fig. 1). A chest computed tomographic scan confirmed the presence of left fourth and fifth rib fractures and a moth-eaten appearance to the surrounding left ribs, consistent with postirradiation skeletal changes (Fig. 2).

After 2 months, the skin expander was replaced with a 450 mammary implant. No complication followed the operation. At 2-year follow-up, the outcome was satisfactory to the patient.

We agree with the authors that caution should be used in skin expansion in postirradiation patients, who are predisposed to a rib fracture more than nonirradiated patients. We would argue for a slow skin expansion in postirradiation patients to avoid rib fracture. In particular, it is important to not overexpand the implant because of the high risk of rib fracture in these patients.² We think that appropriate and well-performed planning in addition to a consent form is appropriate in irradiated patients before reconstructive surgery with skin expansion.

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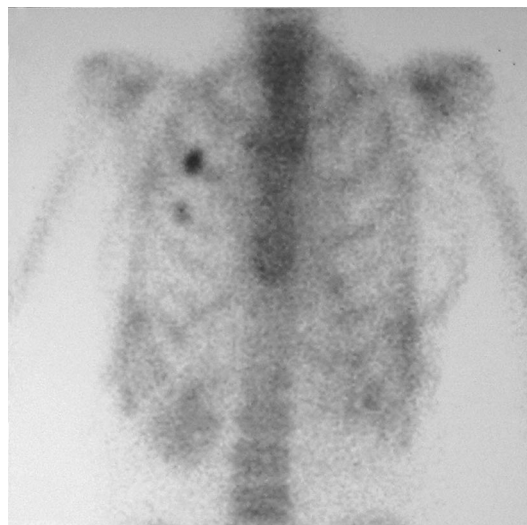


Fig. 1. Postoperative scintigraphic control showing appearance of a hot-spot on the costal left bone.

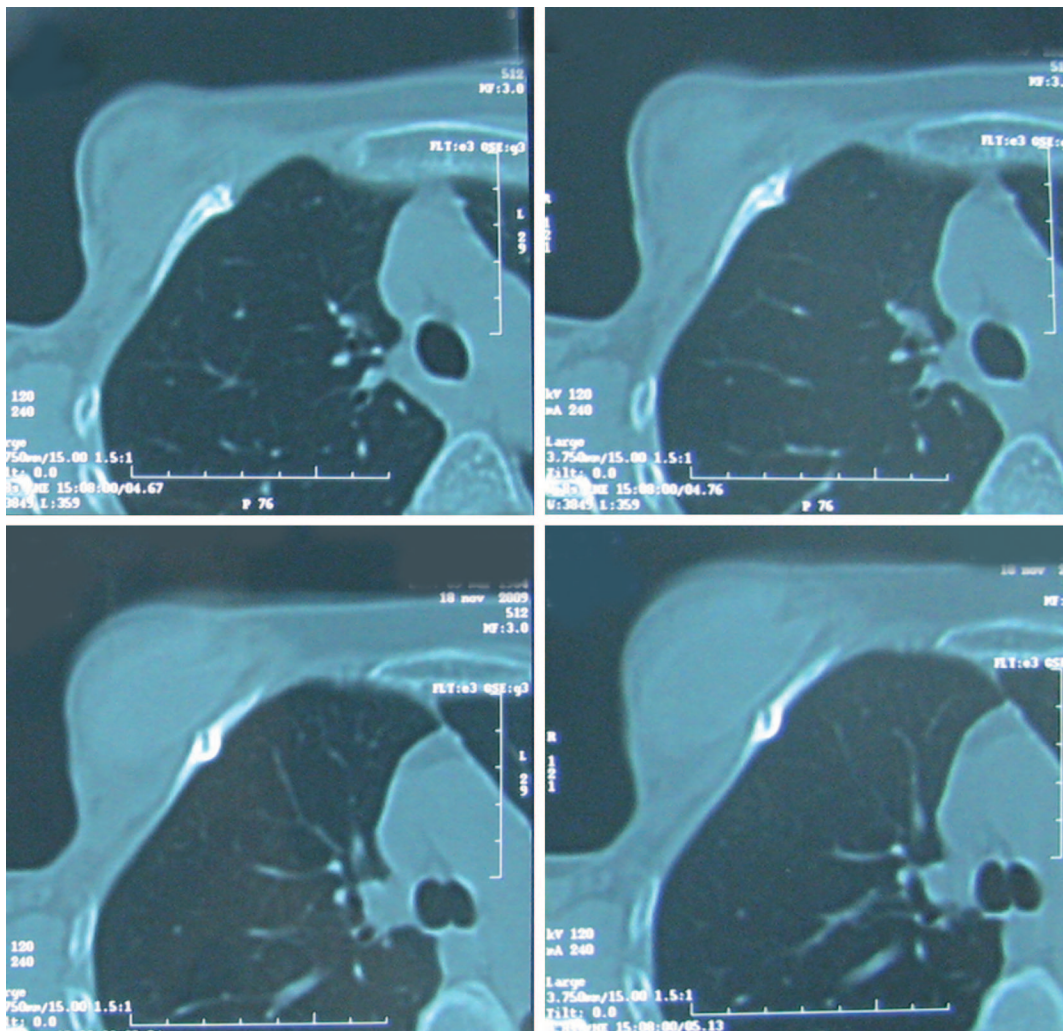


Fig. 2. Chest computed tomographic scans showing presence of left fourth and fifth rib fractures and a moth-eaten appearance to the surrounding left ribs.

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Gynecomastia: Evolving Paradigm of Management and Comparison of Techniques

Sir:

We read with interest the article by Petty et al. entitled “Gynecomastia: Evolving Paradigm of Management and Comparison of Techniques.” Under a perfect title, we found this article precise and easy to read, most of all, because of its conclusion: arthroscopic mastectomy for gynecomastia is a safe and effective technique, with excellent cosmetic results and an acceptable complication rate. We found a major flaw in this retrospective study, namely, “undercitation,” which many of us consider to be a serious offense in scientific misconduct for not giving credit to previous publications.^{1,2}

This operation, described in 2005 as an arthroscopic mastectomy for gynecomastia, was published before in this same *Journal* (*Techniques in Cosmetic Surgery*) under the title “Minimal Surgical Access to Treat Gynecomastia with the Use of a Power-Assisted Arthro-