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DISCLOSURE

Dr. Visconti is medical advisor for Fujifilm. The other authors have no financial interest to declare in relation to the content of this communication.

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Reply: A Safer Way to Harvest a Superthin Perforator Flap

The letter sent by Dr. Visconti and colleagues appears to have three principal goals: (1) demonstrating that the described technique has previously been reported; (2) claiming the superiority of a pure suprafascial dissection; and (3) promoting an expensive device for safe and elegant preoperative planning of ultrathin flaps. Apparently, the only reference supporting their statements is a review article.[1] After reviewing the most significant articles reported in the review, we have the following observations.

First, Isao Koshima is cited as the first to describe the anterolateral thigh flap harvest, in 1993, with partial preservation of deep fascia and surrounding subcutaneous fat tissue. If Visconti and colleagues had read beyond the title of the article by Agostini et al.,[1] they would have realized that only a defatting technique is reported by Koshima et al.,[2] as even Professor Koshima has confirmed to us by personal communication. Looking at the articles of the "other authors worldwide," and not limiting our search to the conclusions drawn in the review article, we did not find any reference reporting the refined harvesting technique we described, the conceptual background for it, or the results in a homogeneous series of cases as in our article.[3]

Second, in 2003, Alkureishi et al.[4] published an anatomical study reporting the pattern of distribution of the vascular network depending on a single perforator after piercing the deep fascia in a series of 10 cadaveric dissections. They stated that "large branches from the perforator were seen to form an arterial plexus at the level of the deep fascia, which communicates with the subdermal plexus supplying the skin. Further branches arose from the perforator and travelled obliquely through the fat to reach the subdermal plexus." They also found that the quality of skin perfusion was directly proportional to the amount of deep fascia and overlying fat tissue left intact around the perforator, concluding that "thinning of [the anterolateral thigh] flap reduces arterial perfusion in cadaver specimens."[4] Therefore, leaving a variable amount of tissue around the perforator is not a "blind procedure," as Visconti et al. claim, but has its basis in anatomical principles and represents a "safer way" to harvest a thin flap by maintaining an additional vascular supply to the subdermal plexus thanks to tiny collateral arteries contained in the suprafascial network. The complication rate reported in the review article cited by Visconti et al. actually accounts for 18 percent in the case of a skeletonized perforator, while in our series, we had 100 percent total survival rate of flaps harvested with the described technique. In addition, there is no question that the suggested procedure is technically easier and more comfortable for the average microsurgeon and has the same morbidity as a pure perforator flap.

Third, Visconti et al. claim that the ultrasound-based method is "a real paradigm shift in thin flap elevation." However, only a few articles are available in the literature, written mainly by the same authors, Visconti et al. themselves. While perhaps a promising, and expensive, diagnostic tool, it is far from being the new standard, as claimed by Visconti et al.

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DISCLOSURE

The authors declare that they have no financial interests or conflicts of interest to disclose.

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Board Certification in Cosmetic Surgery: An Evaluation of Training Backgrounds and Scope of Practice

In the article published in the November 2020 issue of *Plastic and Reconstructive Surgery*,[1] Ms. Long and Drs. Gabrick, Janis, Perdikis, and Drolet seek to "examine the training backgrounds and advertised scope of practice of the American Board of Cosmetic Surgery (ABCS) diplomates using a nationwide sample." However, in their discussion, the authors focus on patient safety and argue that, essentially, patient safety is at risk if the patient does not choose an American Board of Plastic Surgery (ABPS)–certified surgeon.

Surely the editorial staff of a prestigious journal such as *Plastic and Reconstructive Surgery* understands the distinction between a scientific article and an editorial. It is concerning that this article made it through the review process: in the discussion, the authors state that patients are safer having surgery with ABPS-certified rather than ABCS-certified physicians, but their data provide no evidence of safety to support this. They cite "current literature, media reports, and legal proceedings" to make their argument, but sensational anecdotal media cases or medicolegal cases are patently unscientific. It is hoped that these comments were not designed to be inflammatory, but a layperson reading this article might fail to understand the difference between scientific data and anecdotes.

With regard to the actual data, which are described in the authors' Table 2, an important methodologic flaw regarding ophthalmology is that the authors assigned the scope of training for these American Board of Medical Specialties disciplines based on residency training. However, most ophthalmologists who sit for the ABCS board are fellowship trained in ophthalmic plastic and reconstructive surgery, which is a 2-year fellowship overseen by the American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS), with a published curriculum approved by the Accreditation Council for Graduate Medical Education that includes aesthetic facial surgery. Because the authors cite case numbers for plastic surgery residencies, it is worth noting that the mean number of cases documented by ASOPRS fellowship graduates was 1783 for our 2020 cohort (in addition to many hundreds of cases already performed in ophthalmology residency.)

Certainly, patient safety is a paramount goal for training and for certification. The mission of specialty boards is appropriately focused on patient safety. Any study that intends to compare the safety results of different specialty boards is fraught with political and economic overlays. Therefore, the bar for careful study design, impartial data analysis, and unbiased discussion based on data is, appropriately, extremely high. The authors of this study failed to demonstrate these benchmarks.

As a consequence, we request that the *Journal* publish this letter, as well as an acknowledgment of the many deficiencies in the article by Ms. Long and Drs. Gabrick, Janis, Perdikis, and Drolet.

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Reply: Board Certification in Cosmetic Surgery: An Evaluation of Training Backgrounds and Scope of Practice

In their letter, Goldberg et al. criticize the *Journal* itself as well as the peer review process, which is a