thin, pliable tissue. Third, the bilobed heart-shaped tailoring allowed us to perform a fish-mouth closure and contour the flap to the defect (Fig. 2). Fourth, it also allowed a T-shaped donor-site closure, avoiding a longer longitudinal scar to correct possible dog-ears. We have found this flap suitable for large, three-dimensional defects requiring different thicknesses in the same flap.
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DISCLOSURE

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Reply: The Search for the Ideal Thin Skin Flap: Superficial Circumflex Iliac Artery Perforator Flap. A Review of 210 Cases

Sir:

We thank the authors for their interest in our work. As they have shown, the application of the modified superficial circumflex iliac artery perforator flap can be applied to defects where thin skin resurfacing is required.[1]

The modification whereby they elevated the medial plane on the deeper level to include more fat and possibly the deep fascia is in accordance with tailoring the flap to its need (elevator approach).[2] Like all perforator flaps, the superficial circumflex iliac artery perforator flap can to be tailored to provide multiple compositions of tissues from skin, bone, subcutaneous fat, lymph nodes, and fascia. A little difference by adding the extra fat and deep fascia can provide the ideal thickness according to the defect. Using this approach of elevation in the superficial fascia plane allows one to obtain various thicknesses of the flap with different composition of tissues. Using the design in a bilobed fashion is another way of making the elevator approach match the defect as closely as possible. Previous reports show that bilobed pedicle flaps do very well with moderate sizes based on one perforator.[3] They have practically raised the superficial circumflex iliac artery perforator flap in this manner, and the authors have shown that it can provide advantages for repairing the donor site.

The dissection of the pedicle at the level of the proximal source vessel is a good way to extend the pedicle length. However, the dissection of the perforator, in our experience, does not put the overall flap survival at risk, as we have raised superficial circumflex iliac artery perforator flaps as large as 10 × 25 cm, providing a relatively large skin flap for a moderate sized defect. However, we do agree with and recommend dissecting the pedicle proximally to obtain longer length and larger diameter for vessels.

We are optimistic that the superficial circumflex iliac artery perforator flap can provide an ideal approach to defects where thin flaps are needed and even in cases where a step-like flap is needed to contour different thicknesses. The authors demonstrate further versatility of this flap, and we look forward to more variations and approaches to this flap.
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Microsurgical Scalp Reconstruction in the Elderly: A Systematic Review and Pooled Analysis of the Current Data

Sir:

We read with interest the article "Microsurgical Scalp Reconstruction in the Elderly: A Systematic Review and Pooled Analysis of the Current Data" by Sosin et al.[1] The authors illustrate the state of the art of an interesting and debated topic, on which little evidence exists in the literature.

It seems to us that there is a misleading mistake in flap sizes reported from the article by Shonka et al.[2] Although Sosin et al. report flap sizes of 100 cm^2 in one "small" defect, of 1250 cm^2 in one "moderate" defect, and of 2500 cm^2 in nine "large" defects, in the original article, defect sizes are categorized as small (<10 cm^2), medium (10 to 50 cm^2), or large (>50 cm^2). It is not clear where values as high as 2500 cm^2 come from, but it is unlikely that a defect in the head or a latissimus dorsi flap can be so large. Also, being "range" values, they should be excluded from calculation of mean, with a resulting mean value of 310 cm^2 (range, <10 to 946 cm^2).

Another confusing factor in the review is that in some cases—although two flaps were used for reconstruction—this mean value is always referred to as "flap size," whereas it better reflects the defect size: the mean defect size of defects requiring one free flap was 294 cm^2 (range, 80 to 920 cm^2), whereas this value doubled (602 cm^2; range, 150 to 946 cm^2) for defects requiring two free flaps. This would better indicate a threshold for which the use of two flaps is often required.

We would like to contribute to the discussion by mentioning a useful flap that we published after submission of the systematic review[3]: the muscle-sparing vastus lateralis muscle flap. We have successfully used it for scalp reconstruction in four patients, two of whom were older than 65 years. Flap size ranged from 99 to 286 cm^2.

Compared to a conventional vastus lateralis flap, which we have often used in the past for scalp reconstruction, the muscle-sparing flap harvest reduces morbidity and flap thickness, characteristics that have made the vastus lateralis our muscle flap of choice for scalp reconstruction. Similar to the latissimus dorsi, the vastus lateralis has a long and large-caliber pedicle, but allows an easier and faster two-team approach and thus a reduction in operative time that can contribute to minimize medical complications related to age.[4]

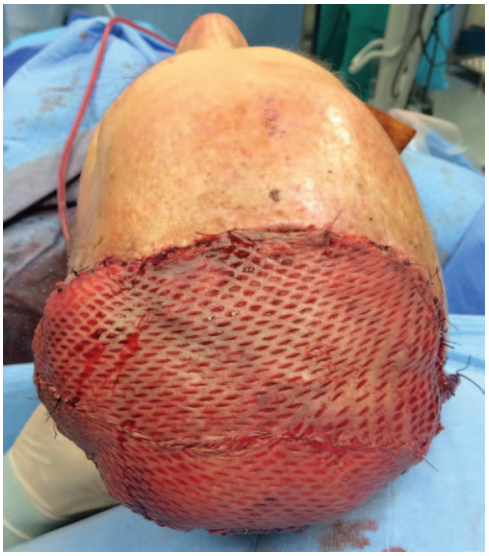

Fig. 1. Final intraoperative view. A large scalp defect following squamous cell carcinoma removal was reconstructed with a muscle-sparing vastus lateralis flap in a 72-year-old patient. Flap size was 25 × 15 cm.

Compared with the anterolateral thigh flap, the vastus lateralis flap allows for an easier and faster dissection, and for harvesting of a very large flap (Fig. 1), avoiding the need for skin grafting the donor site. For these reasons, we believe that the vastus lateralis flap deserves to be mentioned among the options for microsurgical scalp reconstruction in elderly patients.

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