vated triglycerides and coronary artery disease has been more difficult to establish because elevated triglycerides are generally accompanied by several proatherosclerotic comorbidities. This is still an area of controversy, and even the level 1 meta-analysis to which the authors refer concludes that there is "growing recognition of the importance of triglyceride(s) as a risk factor for cardiovascular disease and the urgent need for clinical trials to determine whether lowering plasma triglyceride levels will decrease disease risk."[2] In an article published in 2011 by Goldberg et al. entitled "Triglycerides and Heart Disease: Still a Hypothesis?" the authors concluded that "Human intervention trials, however, have lacked an appropriately defined population and have produced outcomes without definitive conclusions."[3]

The role of leukocyte counts is also unclear and worthy of further investigation, especially when there is a change within a normal range. The referenced *Journal of the American Medical Association* review states that "for leukocyte count, a causal relationship with CHD is particularly difficult to establish because leukocytes have such a wide range of biological effects, some potentially protective against vascular disease and some potentially damaging. Moreover, even if some particular aspect of leukocyte activity was independently associated with CHD, the extent of this activity would not necessarily be associated with total leukocyte count, or even with the circulating levels of some specific type(s) of leukocyte."[4]

Certainly, the specific role of triglyceride levels or leukocyte counts as risk factors for cardiac disease will not be definitively answered in the plastic surgery literature. We recognize that the authors provided an exemplary magnetic resonance imaging scan in the article, and it is admirable that data from multiple patients have been assembled into another article. The lack of measurement following liposuction mentioned in our discussion referred to the fact that neither the Methods nor the Results section alluded to any standard of assessment following liposuction. Indeed, a more precise measurement on the decrease of subcutaneous tissue correlated with laboratory values may be a guide to elucidate which patient group would be ideal for lowering of the triglycerides.

Let us not lose sight of the fact that the key question at hand for the plastic surgery community is the metabolic effect of liposuction and whether or not we should consider liposuction as a useful tool for treating or preventing systemic disease. This has been a difficult topic to study, and the authors have performed a methodical investigation. We are still far from having solid evidence to elucidate the role of liposuction as a metabolic therapy, and we need more carefully conducted studies like this one to determine the impact of liposuction on laboratory values in a wide variety of clinical scenarios and, ultimately, to correlate these changes with long-term outcomes in controlled studies.

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REFERENCES

1. Swanson E. Prospective clinical study reveals significant reduction in triglyceride level and white blood cell count after liposuction and abdominoplasty and no change in cholesterol levels. *Plast Reconstr Surg.* 2011;128:182e–197e.
2. Austin MA, Hokanson JE, Edwards KL. Hypertriglyceridemia as a cardiovascular risk factor. *Am J Cardiol.* 1998;81:7B–12B.
3. Goldberg IJ, Eckel RH, McPherson R. Triglycerides and heart disease: Still a hypothesis? *Arterioscler Thromb Vasc Biol.* 2011; 31:1716–1725.
4. Danesh J, Collins R, Appleby P, Peto R. Association of fibrinogen, C-reactive protein, albumin, or leukocyte count with coronary heart disease: Meta-analyses of prospective studies. *JAMA* 1998;279:1477–1482.

Introducing the Septocutaneous Gluteal Artery Perforator Flap: A Simplified Approach to Microsurgical Breast Reconstruction

Sir:

We would like to react to the Letter by Rad et al. in the August of 2011 issue of the *Journal*[1] about our article "Introducing the Septocutaneous Gluteal Artery Perforator Flap: A Simplified Approach to Microsurgical Breast Reconstruction."[2] We are happy that more groups in the world have interest in the superior gluteal artery perforator flap, particularly if based on septocutaneous perforators. We would like to add that the first anatomical work, "Superior Gluteal Artery Perforator Flap Based on Septal Perforators: Preliminary Study," was presented at the Fourth Congress of the World Society for Reconstructive Microsurgery in Athens, Greece in 2007 and published in November of 2008.[3] We believe that cooperation with other groups can be very fruitful and therefore decided to share and publish our clinical experience with the group of Dr. Allen. In this line, it is of extreme importance to share and join experiences leading to the best qualified scientific work, which results in the best outcomes for patients. We will be very happy in the future to join our experience and data with Dr. Rad.

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REFERENCES

1. Rad AN, Flores JI, Rosson GD. Introducing the septocutaneous gluteal artery perforator flap: A simplified approach to microsurgical breast reconstruction (Letter). *Plast Reconstr Surg.* 2011;128:592–593.
2. Tuinder S, Chen CM, Massey MF, Allen RJ Sr, Van Der Hulst R. Introducing the septocutaneous gluteal artery perforator flap: A simplified approach to microsurgical breast reconstruction. *Plast Reconstr Surg.* 2011;127:489–495.
3. Tuinder S, Van Der Hulst R, Lataster A, Boeckx W. Superior gluteal artery perforator flap based on septal perforators: Preliminary study. *Plast Reconstr Surg.* 2008;122:146e–148e.

Reply: Introducing the Septocutaneous Gluteal Artery Perforator Flap: A Simplified Approach to Microsurgical Breast Reconstruction

Sir:

Thank you for the opportunity to respond to Tuinder and Van Der Hulst's comments in reference to their article "Introducing the Septocutaneous Gluteal Artery Perforator Flap: A Simplified Approach to Microsurgical Breast Reconstruction," published in the February of 2011 issue of the *Journal*.[1] We also thank them for again bringing to our attention the Viewpoint article published in the November of 2008 issue of the *Journal*.[2] In our 2010 publication, we did, in fact, reference this important cadaver study (reference 16 in Rad et al.), as it helped form the basis for our clinical application of the technique. In our discussion, we note the following:

> Tuinder et al.[16] recently published a small study examining the cadaveric anatomy and color flow Doppler flowmetry of septal SGA perforators. . . . we agree with their conclusion that using the lateral septal perforator may be technically easier in dissection and microanastomoses because of gain in pedicle length.[3]

It is reassuring to know that our anatomical cadaver study corroborated her findings and that these studies supported successful independent clinical series.[1–3] We are certainly open to collaborative efforts in gaining more experience with this important refinement of the traditional superior gluteal artery perforator flap.

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REFERENCES

1. Tuinder S, Chen CM, Massey MF, Allen RJ Sr, Van Der Hulst R. Introducing the septocutaneous gluteal artery perforator flap: A simplified approach to microsurgical breast reconstruction. *Plast Reconstr Surg.* 2011;127:489–495.
2. Tuinder S, Van Der Hulst R, Lataster A, Boeckx W. Superior gluteal artery perforator flap based on septal perforators: Preliminary study. *Plast Reconstr Surg.* 2008;122:146e–148e.
3. Rad AN, Flores JI, Prucz RB, Stapleton SM, Rosson GD. Clinical experience with the lateral septocutaneous superior gluteal artery perforator flap for autologous breast reconstruction. *Microsurgery* 2010;30:339–347.

Perforator Anatomy of the Fibula Osteocutaneous Flap

Sir:

We read with interest the article by Yu et al. entitled "Design of a Reliable Skin Paddle for the Fibula Osteocutaneous Flap: Perforator Anatomy Revisited" (*Plast Reconstr Surg.* 2011;128:440–446). Although the authors should be applauded for their large prospective clinical study, we would like to point out two issues associated with the article.

The first issue is that Yu et al. clarified the origins of the proximal perforators (perforator P) in only seven patients. We agree with the authors about the usefulness of proximal perforators. If such a proximal perforator is present and arises from the peroneal artery, two skin islands can be harvested, and primary closure of the donor site can be achieved more easily than when distal perforators are used. However, it is generally believed that most cutaneous branches distributed in the proximal third of the lateral leg arise from arteries other than the peroneal artery.[1] Yu et al. reported that proximal perforators were consistently found at a point one-third of the length of a line from the fibula head to the lateral malleolus in all 70 patients.[2] We have two questions regarding these perforators. What percentage of the perforators arose from the peroneal vessels? Did the authors explore the origins of the perforators in the remaining 63 patients? Furthermore, Figure 2 of the article is misleading because it gives the false impression that all perforators shown arose from the peroneal vessels.

A second issue is that the authors did not mention two important cadaveric studies of the perforator anatomy of the fibula osteocutaneous flap by Yoshimura et al.[3] and Beppu et al.[4] Although Yu et al. stated that "precise mapping of the perforators has been lacking,"[2] these two studies mapped the courses and origins of the perforators in great precision and detail and had findings similar to those reported by Yu et al. It is the responsibility of the authors and the reviewers to be fully aware of the articles published in their area of interest. We think these omissions are a major flaw of this article.

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