VOLUME 115 • NUMBER 1 • JANUARY 2005

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AMERICAN SOCIETY OF PLASTIC SURGEONS

Plastic and Reconstructive Surgery®

Journal of the American Society of Plastic Surgeons

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LIPPINCOTT WILLIAMS & WILKINS

rative manner to share professional experience and by donating medical equipment that allows these professionals to become autonomous in their local efforts. The fact that each operation has a much higher cost when compared with the cost of a locally performed case must not make us forget that at the end of every mission, the local medical community is not only empowered to become autonomous but also energized to volunteer its expertise to its own people. In addition, the higher cost of medical missions is attributed to the continuous commitment of support toward local sustainable foundations (already operating in 22 countries throughout Latin America, Africa, and Asia) that operate with the same organizational ideals of the parent organization to conduct free, local humanitarian missions. The local medical professionals, in essence, gradually replace their international partners in our model. The difference, however, is that they have been empowered through the self-sufficient programs that the parent organization has developed and the volunteer spirit that it has imbued. I do not believe that it is the task of a humanitarian organization to simply offer money to local medical professionals to operate on the children of their country, considering the fact that during such collaboration it is difficult to hope or think of what may happen once the financial backing runs out. The key to effect lasting change and address the overwhelming prevalence of facial deformity, in my opinion, is to grow vital local volunteer spirit as well as long-term sustainable initiatives and programs.

Volunteer Preparation. The preparation and recruitment of volunteer medical personnel, both internationally and domestically, must be of the highest level and must truly intertwine a plan of cultural and professional sensitivity with the already apparent goals of each mission. In the case of Operation Smile, all medical volunteers must pass four separate verification and evaluation processes (curriculum vitae detailing work experience, three letters of recommendation from professional peers, demonstration of professional, humanitarian, and team capacity during a mission, and final approval by the medical specialty councils) before being accredited as eligible to participate on behalf of the organization.

The Medical Mission. It has taken many years to understand how we can properly contribute to the empowerment of local medical professionals to take care of more children on their own. In this regard, however, the organization must leverage and engage its capable mission coordinators and international medical professionals to fully utilize the limited time the missions provide. From personal experience, I can say that there have been times when I have been in third-world hospitals, sometimes for months, without succeeding at working in the productive manner that I have come to know during my participation in numerous Operation Smile's missions, each comprising 10 to 12 days.

In conclusion, I believe that all humanitarian activity depends on the ideals and spirit of individual medical professionals. The task of the organization is to unite those vetted individuals to utilize every faculty to create a cohesive, harmonious, and collaborative relationship with local medical professionals located in places where missions bring us. The medical mission is quite simply the conduit through which we help locally empowered organizations grow, always with one goal: to help them reach more children on their own.

DOI: 10.1097/01.PRS.0000146085.51120.97

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ENDOSCOPIC BROW AND FOREHEAD FIXATION: ALL THAT AND MORE

Sir:

In his usual succinct style, Dr. Owsley, with Dr. Dorner, explained the advantages of the Lorenz LactoSorb (Walter Lorenz, Inc., Jacksonville, Fla.) threaded resorbable screw fixation technique for endoscopic brow and forehead fixation (*Plast. Reconstr. Surg.* 113: 735, 2004). Among the benefits of this system, Dr. Owsley and Dr. Dorner mention minimal hand-operated equipment (not needing a gas or electric drill), lack of permanent foreign material, prolonged stabilization, and postoperative adjustability.

I agree with all of these observations. Perhaps the greatest convenience is the fact that the drill for this system is a simple type of screwdriver handle with a drill bit that is simply rotated by hand to prepare the 4-mm burr hole to accept the screw. In the operating room that already has foot controls for lasers, bipolar devices, and so on, one less foot control (with its associated cords) is appreciated.

I would like to add to their observations and mention an additional simplification of this system. In the past I utilized the threaded screw that they describe. This requires the extra step of tapping the burr, then threading the LactoSorb screw into the tapped hole. The bone quality in some patients does not lend itself well to tapping, and in some instances the tapped hole is not accurate to the threaded screw and the threading forces are significant enough to prematurely separate the screw from the threading post before it is properly seated.[1–4] The manufacturer (Walter Lorenz) also offers a nonthreaded system called the Endobrow push screw which has several advantages (Fig. 1). First, it eliminates the need for a tap, which further reduces the surgical equipment needed. Not having to tap the burr hole not only is quicker but also eliminates some variables of thread tapping—such as bone density and correct tap depth—that may affect the precision tap/thread interface. Since the screw is not threaded, it is held in place by a press fit friction. Unlike the threaded screw, which is tapered, this peg is not tapered and thus has more surface area to contact bone.

In short, these refinements possess all the attributes described by Dr. Dorner and Dr. Owsley, and then some. I believe anyone using the threaded LactoSorb system will be even happier with the Lorenz LactoSorb Endobrow push screw.

DOI: 10.1097/01.PRS.0000146086.29907.D8

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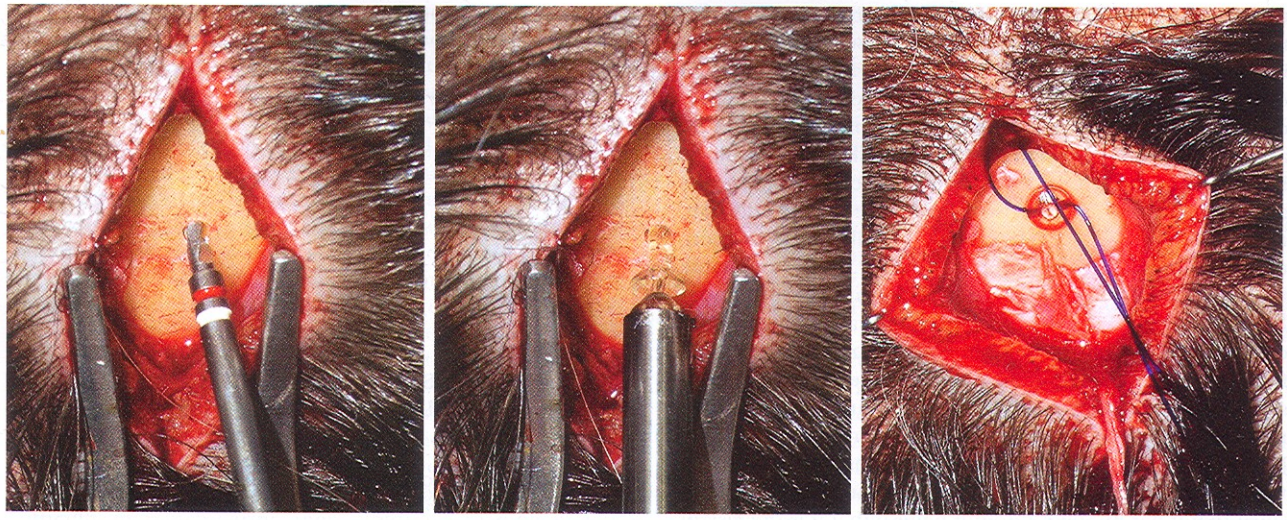

FIG. 1. (*Left*) The hand drill is used to burr the hole. (*Center*) The push screw is seated. (*Right*) The fixation suture is threaded through the push screw.

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CORRECTION OF POSTBURN BREAST DEFORMITY

Sir:

I would like to congratulate Payne and Malata on the excellent results they obtained in their surgically complex and challenging burned breast case ("Correction of Postburn Breast Asymmetry Using the Lejour-Type Mammaplasty Technique," *Plast. Reconstr. Surg.* 111: 805, 2003). However, I believe that the authors did not give enough credit to the article published by Erol and Spira in 1982.[1–6] This article describes an innovative surgical technique in the management of breast deformities caused by burns, including the management of the displaced nipple-areola complex and reshaping of the breast mound after burn

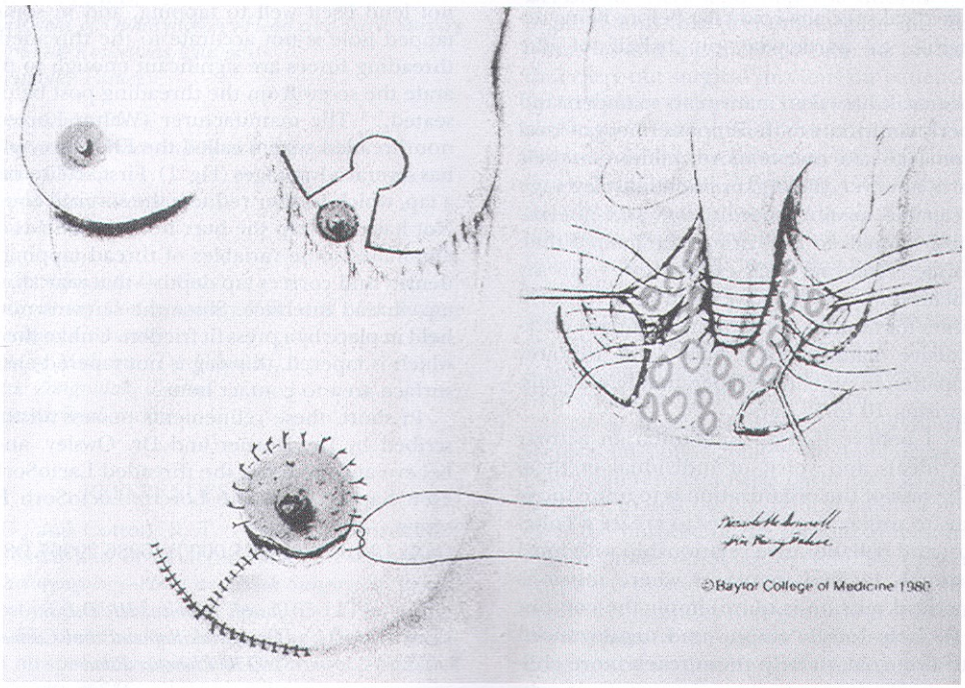

FIG. 1. Diagrammatic explanation of the technique.