text. Their statement therefore is devoid of any scientific basis; thus, the evidence level is none.

The authors also mention the complications of polyacrylamide gel in women who were treated with polyacrylamide gel injections for breast augmentation in Ukraine.³ Again, the citation does not apply to our study because the injected polyacrylamide gel was not the same as that used in our population (Aquamid; Contura International A/S, Soeborg, Denmark), the anatomical region is not comparable (breast tissue versus face), the indications are different (breast augmentation versus human immunodeficiency virus–related lipodystrophy), and the volumes injected were much larger (mean, 230 ml versus 7 ml).

The second case reported by Wang et al. describes a patient who was continuously treated with polyacrylamide gel for 8 years and who developed facial ulcers and infection. The skin ulcers and scars shown in Figure 1 could have been caused by an inadequate injective technique (too superficial an injection), excessive volume of injected material per cubic millimeter (repeated injections for 8 years are certainly suspicious), inadequate filler (not all polyacrylamide gels are the same), inadequate patient behavior and, in some cases, injection in areas different from those used in patients with human immunodeficiency virus–related lipodystrophy. More information should be provided to correctly interpret this case report.

Finally, Dr. Wang presents a case of the deleterious effects of golden threads. Golden threads are not used for human immunodeficiency virus lipodystrophy; therefore, the example has no relevance to our case.

Regarding the necessity of a follow-up longer than 5 years, it should be noted that in our series, 5 years was the minimal duration of follow-up, with some patients being followed for up to 6.85 years, the longest follow-up reported in the literature to date. The previously described complications of polyacrylamide gel (localized accumulation, material migration, and infection) had a low incidence in our study where a correct injective technique and careful avoidance of contamination were meticulously followed.

Side effects of fillers should certainly be monitored carefully, with well-designed (if possible, blind and randomized) studies. Conversely, unsubstantiated hypotheses based on case reports will only create untoward panic in a community of already fragile patients. DOI: 10.1097/PRS.0b013e318254b639

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A Horizontal V-Y Advancement Lower Eyelid Flap: Our Experience Performing a Bilateral Suspension to the Periosteum

Sir: **W** e have read with great interest the report by Marchac et al. on their positive series of 21 patients with defects of the lower eyelid using a V-Y horizontal advancement flap to repair lower eyelid defects.^{1,2} In this regard, we present our experience with the use of the V-Y island flap in which we routinely perform a bilateral suspension to the periosteum in patients undergoing resection of oncologic lesions located at the lower eyelid. In the past 5 years, 24 patients presented to us with defects of the lower eyelid as a result of oncologic surgery.

For the reconstruction, we draw a triangular flap; we harvest the island flap, preserving the orbicularis muscle through a blunt dissection of its fibers and always performing a bilateral suspension of the flap's margin to the periosteum by using 4-0 Prolene suture (Ethicon, Inc., Somerville, N.J.). Then, it is secured to the periosteum inside the lateral and medial orbital rims to apply the same amount of tension laterally and medially, to provide support to the lower eyelid. Finally, we close the defect in V-Y fashion corresponding to the advancement of the tail of the flap.

In their series, Marchac et al. report the occurrence of one case of late lateral ectropion.¹ None of our patients developed postoperative complications or flap necrosis. At follow-up at 1, 3, 6, and 12 months, none of the patients showed late complications or tumor recurrence.

In 2005, Cheong et al. reported a case of a patient with a basal cell carcinoma involving part of the lower eyelid that was reconstructed with a superiorly based nasolabial flap. The distal end of the flap was deepithelialized, tunneled to the lateral canthal region, and anchored to the dermis to avoid ectropion.³

In this regard, Calderón et al. described a V-Y lateral or medial advancement flap for the reconstruction of lower lid defects following surgical excision of a basal

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cell carcinoma. They experienced good cosmetic outcomes, without caudal traction of the lower lid and no need for canthal fixation.⁴ Despite this, no data are mentioned about the number of patients who underwent this operation, and there is no report regarding postoperative details or follow-up (Fig. 1). Marchac described the same V-Y flap in a series of 21 patients, advocating horizontal repair of lower lid defects.⁵

On the basis of our experience, the reconstruction of lower lid defects through an island flap harvested from the adjacent skin is a safe and effective technique and results in a functional and aesthetically satisfactory reconstruction. In our cases, bilateral fixation of the flap's margins to periosteum allows stabilization of the lower lid, minimizing the incidence of late complications such as scleral show and ectropion. In conclusion, we believe that fixation of the flap's margins to the periosteum improves the functional and cosmetic outcome, offering better stability to the reconstructed lid and likely reduces the development of complications such as ectropion and eyelid eversion. Thus, we suggest that the reconstructive surgeon keep in mind this option as a strategy for repairing lower lid defects following oncologic surgery.

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Fig. 1. Island flap harvesting. Orbicularis muscle is preserved through blunt dissection of its fibers. Bilateral suspension of the flap to the periosteum at the level of medial and lateral orbital rims is performed. The defect is closed in V-Y fashion.

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PATIENT CONSENT

The patient provided written consent for use of the patient's images.

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Reply: A Horizontal V-Y Advancement Lower Eyelid Flap: Our Experience Performing a Bilateral Suspension to the Periosteum Sir:

We thank Monarca et al. for their letter regarding our article on V-Y horizontal flaps.¹ Monarca et al. are pleased with their recent experience with the horizontal flap for eyelid repair but feel that it is necessary to perform a bilateral suspension to the periosteum.

They report 24 successful cases, but in their Figure 1, one sees only operative views of the mobilized flap, and no early or late results. It is not a new flap; we have presented it in a book published in 1988,² and we are happy to see that it is used. We never felt the need to perform a periosteal suspension. Periosteal suspension means more dissection and the risk of a palpable knot. When you cut a flap large enough, especially wide enough laterally, on a good muscular pedicle, there is no need, in our experience of many cases, for a deep suspension. We do report one case of ectropion: it is not a "late" ectropion as reported in the letter, it is an early

one because I had used a flap that was too narrow in a patient who had previously undergone blepharoplasty. A periosteal suspension would not have helped because there was a lack of skin.

With a wide enough flap, we never have felt the need for a suspension. Of course, if one feels safer by adding this suspension, it can be done, especially for patients with heavy eyelids. We thank Marcasciano et al. for their comments and encourage colleagues to use this horizontal V-Y eyelid flap that allows one to obtain remarkable results functionally and aesthetically. DOI: 10.1097/PRS.0b013e318254f656

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The Facial Aging Debate of Deflation versus Attenuation: Attenuation Strikes Back

e congratulate Gierloff et al., the authors of "Aging Changes of the Midfacial Fat Compartments: A Computed Tomographic Study,"¹ and applaud the Journal's choice of the sentinel image from this article as the cover art. In a month of Plastic and Reconstructive Surgery devoted to "About Face," it is appropriate that a well-written, excellent scientific examination of the newest frontier in facial anatomy should be given this attention. Inferior migration of the midfacial fat compartments was seen in their study, demonstrated by an increased mean distance between the superior border of the compartments and the inferior orbital rim. It was felt that this inferior migration was not necessarily a sequela of gravity. The authors theorize that this change is secondary to deflation of the buccal extension of the buccal fat pad. Assigning the inferior migration seen with facial aging to being a consequence of volume loss is currently in vogue, as it has been demonstrated that volume loss does play an important role in the aging process.²

The authors may have given us evidence that fatty deflation is not the major contributor to the process of facial aging. Importantly, in their analysis of the shape change of the fat compartments on computed tomography, Gierloff et al. demonstrated that the caudal third of the fat compartments increases in sagittal diameter with age. They also found that the cranial third of the