Correction of Calf Atrophy With a Custom-Made Silicone Implant for Reconstruction: An Update

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We thank Dr Zubowicz[1] for addressing our recent article about correction of calf atrophy with a custom-made silicone implant.[2] We acknowledge 2 significant errors that we let slip in the final correction of our article. We did not use a 3-dimensional database of standard legs as a model in the case of the calf's bilateral medial atrophy. The optimal size of the implants was subjectively chosen by the scenographic analyst. Thus, we made a bilateral symmetric construction with a simple volume increase in 3 dimensions. For patients with a unilateral problem, we used the contralateral leg as the template to be matched by the placement of 1 or 2 implants in the side being corrected. The second significant error in our article concerns the intermuscular wall. This has of course been "respected," not "resected." It is a spelling error that escaped our vigilance. The correct sentence is, therefore "the wall must be respected to preserve the line of perforating septal vessels to the skin."

Regarding the incision size, it depends on the number of implants placed. A 6-cm incision is usually sufficient for 1 implant, and an 8-cm incision is used if 2 implants are inserted. A shorter incision may tear the skin when the implant is inserted, which is undesirable from a healing and aesthetic perspective. We therefore recommend widening the incision by 1 or 2 cm rather than running this risk.

We are convinced of the essential benefits of using 3D elastomer implants rather than classic gel-filled standard implants. The lack of implant models and choice of available sizes was recently strongly emphasized by Andjelkov et al.[3] Moreover, we believe that we have demonstrated the value of computer-aided design and rubber elastomer for the correction of congenital thoracic malformations such as pectus excavatum[4] and Poland syndrome.[5] Overall, these implants are not likely to rupture in the long term and are in place for life. They are also better suited than gel under more fibrous tissue tension, especially in reconstruction. Finally, they are easier to place under muscle fascia, in reconstructive and aesthetic indications.

Regarding compression stockings, their standard sizes are often too large to account for leg atrophies, especially in the case of reconstruction. We did not observe any complications (hematomas, seromas) by combining compression by an adapted soft bandage, worn only during walking, and raising the legs in a lying or seated position. The need for further operations in 7 of 22 patients was for minor outpatient procedures such as lipofilling in the lower part of the leg or scar revision. Regarding the cost, such additional procedures also exist with conventional implants. Otherwise, patients are often very satisfied with small imperfections of the implant(s) without associated lipofilling. We recognize that French patients' opportunity to be fully financially supported for these pathologies

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and minor adjustments may lead to secondary "comfort" surgeries that would not be required if they were at the patient's own expense. On this subject, our procedure could certainly be performed on an outpatient basis in case of aesthetic indications where the tissues are softer, and the pain is more moderate. The cosmetic indication would undoubtedly have a bright future if this type of implant could be used in the United States and Canada, which regretfully is not the case for now. From the patients' feedback during postoperative consultations, we can subjectively state that they are very satisfied with their implants. We thank Dr Zubowic for his interest in our work and for his pertinent remarks.

Disclosures

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