

Table 1. Distribution of Means and 95% Confidence Intervals of the Area Dimensions Treated during the Three Periods of Evaluation

Regions	Evaluations		
	Preoperative	Immediate Postoperative	Subsequent 90 Days
Face and mentum			
Mean \pm SE	30.00 \pm 0.64	27.00 \pm 0.39	23.50 \pm 0.34
95% CI	28.59–31.41	26.14–27.86	22.76–24.24
Right arm			
Third superior			
Mean \pm SE	36.43 \pm 0.78	34.14 \pm 0.67	32.14 \pm 0.77
95% CI	34.51–38.34	32.50–35.78	30.26–34.03
Third medium			
Mean \pm SE	31.86 \pm 0.86	30.43 \pm 0.81	28.43 \pm 0.68
95% CI	29.76–33.95	28.44–32.42	26.75–30.10
Third inferior			
Mean \pm SE	29.14 \pm 0.77	28.00 \pm 0.69	26.14 \pm 0.67
95% CI	27.26–31.03	26.31–29.69	24.50–27.78
Left arm			
Third superior			
Mean \pm SE	36.14 \pm 0.99	33.64 \pm 1.02	32.14 \pm 0.86
95% CI	33.73–38.56	31.16–36.13	30.05–34.24
Third medium			
Mean \pm SE	31.29 \pm 0.71	30.14 \pm 0.80	28.57 \pm 0.84
95% CI	29.54–33.03	28.19–32.10	26.51–30.63
Third inferior			
Mean \pm SE	29.64 \pm 0.47	29.43 \pm 1.17	27.14 \pm 0.86
95% CI	28.49–30.80	26.56–32.30	25.05–29.24
Mammary region			
Mean \pm SE	121.11 \pm 2.55	109.22 \pm 2.27	99.00 \pm 2.09
95% CI	115.23–127.00	103.98–114.46	94.18–103.82
Waist			
Mean \pm SE	80.46 \pm 2.41	74.46 \pm 2.04	69.38 \pm 1.88
95% CI	75.20–85.72	70.02–78.91	65.29–73.48

CI, confidence interval.

Moises Wolfenson, M.D.**Fernando Cerqueira Norberto dos Santos Filho, M.D.**Clínica Multiplástica do Recife
Recife, BrazilCorrespondence to Dr. Wolfenson
Clínica Multiplástica do Recife
Av. João de Barros, 791
Boa Vista
CEP 50100-020, Recife, Brazil
contato@moiseswolfenson.com.br**ACKNOWLEDGMENT***This work was supported by the Federal University of Pernambuco.***DISCLOSURE***The authors have no financial disclosures related to this study. No outside funding was received.***REFERENCES**

- Parlette EC, Kaminer ME. Laser-assisted liposuction: Here's the skinny. *Semin Cutan Med Surg*. 2008;27:259–263.
- Mordon SR, Wassmer B, Reynaud JP, Zemmouri J. Mathematical modeling of laser lipolysis. *Biomed Engin Online* 2008;7:10.
- Badin AZ, Gondek LB, Garcia MJ, Valle LC, Flizikowski FB, de Noronha L. Analysis of laser lipolysis effects on human tissue samples obtained from liposuction. *Aesthetic Plast Surg*. 2005; 29:281–286.

4. Wolfenson M, Cerqueira Norberto F. Lipoenxertia guiada por ultrassonografia. *Rev Bras Cir Plast*. 2009;24:538–543.5. Wassmer B, Zemmouri J, Rochon P, Mordon S. Comparative study of wavelengths for laser lipolysis. *Photomed Laser Surg*. 2010;28:185–188.**Gone in 30 Seconds: A Quick and Simple Technique for Subcutaneous Lipoma Removal****Sir:**

Lipomas are the most common soft-tissue tumors¹ and a common reason for referral to plastic surgeons. In efforts to minimize and conceal scars, plastic surgeons have developed a number of techniques to mod-

Supplemental digital content is available for this article. A direct URL citation appears in the text; simply type the URL address into any Web browser to access this content. A clickable link to the material is provided in the HTML text of this article on the *Journal's* Web site (www.PRSJournal.com).

ernize lipoma removal. Some of these techniques include endoscope-assisted lipoma removal, suction-assisted lipoma removal, minimal-incision lipoma removal, and remote-incision lipoma extraction.²⁻⁵ All of these techniques appear to be successful in lipoma removal, with very low complication and recurrence rates. However, some of these techniques require additional equipment and tedious work through small incisions. We favor a fast and simple technique using a manual pressure “squeeze” technique after a small incision is made directly over the lipoma.

We conducted a retrospective review of all lipoma removals performed by the senior author (S.P.D.) between July of 2008 and September of 2011. The principles outlined in the Declaration of Helsinki were strictly observed in this case series study. Informed consent was obtained from all participants. A formal institutional review board process was not available. Our surgical technique is presented in Video 1. (See Video, Supplemental Digital Content 1, which demonstrates lipoma removal by the squeeze technique, <http://links.lww.com/PRS/A521>.) The lipoma is first identified by palpation and its margins outlined. The area is then infiltrated with local anesthesia and prepared and draped in the standard fashion. An incision approximately one-quarter to one-third the diameter of the lipoma is then carried down to the lipoma capsule. Without any additional dissection, the lipoma is then “squeezed” out of the incision. In this video, the elapsed time from incision to lipoma extraction is 30 seconds.

Over the study period, 140 lipomas were removed in 50 patients using the squeeze delivery technique. Four lipomas were in the face/scalp region, 42 were in the neck/thorax, 20 were in the back/flanks, 10 were in the hips/pelvis, 45 were in the upper extremities, and 19 were in the lower extremities (Table 1). The recurrence rate was 1.4 percent (two of 140). There were no complications or revisions.



 Video Available Online

Video. Supplemental Digital Content 1 demonstrates lipoma removal using the squeeze technique, <http://links.lww.com/PRS/A521>.

Table 1. Breakdown of Lipoma Removal by Area

Area	No. of Lipomas (%)
Face/scalp	4 (2.9)
Neck/thorax	42 (30.0)
Back/flanks	20 (14.3)
Hip/pelvis	10 (7.1)
Upper extremity	45 (32.1)
Lower extremity	19 (13.6)
Total	140 (100)

Despite modern advances in lipoma removal, there remains a role for simple excisional techniques. The squeeze delivery technique we use was described by Kenawi in 1995, and since then, the majority of the literature on lipoma removal has focused on minimally invasive techniques with small or remote scars, endoscope-assisted techniques, or liposuction.¹⁻⁵ Although these newer techniques have been shown to be safe and effective, some require additional setup and equipment that increase the length of the procedure. The squeeze delivery technique through a small incision requires only the most basic instrumentation and can be performed in a very short time, as demonstrated in Video, Supplemental Digital Content 1, <http://links.lww.com/PRS/A521>.

This technique should ideally be performed for subcutaneous lipomas with overlying mobile skin. Deep, intramuscular lipomas often found in the back or shoulder region or multilobulated lipomas may require longer incisions and additional scissors dissection for complete removal. Another drawback of our technique is that a small scar will be present directly over the lipoma, although in most instances the incision can be favorably oriented along skin tension lines.

We have demonstrated that the squeeze delivery technique through a small incision is a safe and effective procedure for subcutaneous lipoma removal that can be performed quickly without complications and very low recurrence. It is a simple technique that deserves attention amid an array of modern advances.

DOI: 10.1097/PRS.0b013e3182550439

Samir S. Rao, M.D.

Department of Plastic Surgery
Georgetown University Hospital
Washington, D.C.

Steven P. Davison, D.D.S., M.D.

DAVinci Plastic Surgery
Washington, D.C.

Correspondence to Dr. Rao
3800 Reservoir Road, NW
1 PHC
Washington, D.C. 20007
samirrao@gmail.com

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this article.

REFERENCES

1. Kenawi MM. 'Squeeze delivery' excision of subcutaneous lipoma related to anatomic site. *Br J Surg*. 1995;82:1649–1650.
2. Pozner JN, Canick LM, Ramirez OM. Endoscopically assisted lipoma removal. *Plast Reconstr Surg*. 1996;98:376–377.
3. Al-basti HA, El-Khatib HA. The use of suction-assisted surgical extraction of moderate and large lipomas: Long-term follow-up. *Aesthetic Plast Surg*. 2002;26:114–117.
4. Kargi E, Hosnuter M, Babuccu O, Babuccu B. Lipoma removal with mini incision. *Ann Plast Surg*. 2002;49:220–221.
5. Pereira JA, Schonauer F. Lipoma extraction via small remote incisions. *Br J Plast Surg*. 2001;54:25–27.

Preparing for the Storm

Sir:

Many years ago, in the 1990s, we saw the right to use a medical device stripped from our practices by a bureaucratic organization. Most American Society of Plastic Surgeons (ASPS) members were in disbelief that such an event could occur. Breast implants were a major part of almost all plastic surgical practices as they certainly are today. How could such a catastrophic event occur? Obviously, we were not prepared for the storm created by the media and the political fallout that followed. Yellow journalism took over the public like a grain field being accosted by a storm of locusts. Lay individuals who presented themselves as victims became the experts, as our organization had little to no clinical data or a logistical process to support a medical device they had been using for decades. Yes, we had left ourselves adrift, our boat was gone, and the sharks were circling.

The president of the ASPS at that time was Norm Cole, M.D. Dr. Cole has long since retired but, the lessons he learned and the process he created very recently helped the ASPS stop such a locust storm. The concern was a major one, namely, that lymphoma was possibly directly related to breast implants. A very small portion of patients who had breast implants were developing anaplastic large-cell lymphoma (ALCL), a type of non-Hodgkin's lymphoma. The proactive ideals ingrained and research funding organizations created decades earlier helped prepare us for this storm. How was this possible? Because of strong leadership within our plastic surgery societies and funds stored in the Plastic Surgery Foundation.

The issue of ALCL and breast implants broke in the press in January of 2010. An immediate strong media response was made by our leadership, with our then ASPS president, Dr. Phil Haeck, leading the parade. Ignoring the issue and hoping it would go away was never a consideration. Allowing history to repeat itself was not going to happen. Again, everybody from occupational/preventive medicine physicians to the lay patient victims suddenly became self-proclaimed experts on the most studied biomedical device in human history, the breast implant. Plastic surgeons were portrayed as foxes guarding the hen house. However, this time we had been proactive and made preparations and

were ready for the storm of locusts. This time, we had acquired real data, which supported that ASPS members were acting in the best interest of their patients and not their bottom lines. Publications were rapidly distributed in *Plastic Surgery News* and journals such as *Plastic and Reconstructive Surgery*. The public was made aware of our primary concern for patient safety and dedication to the integrity of our profession. A \$200,000 RAND Corporation research project funded by the Plastic Surgery Foundation helped amplify the unusualness of ALCL and breast implants. Cooperative efforts across society lines (e.g., ASPS, American Society for Aesthetic Plastic Surgery) solidified our position. The crisis came to a head in the fall of 2011 with the U.S. Food and Drug Administration once again center stage. Our proactive evidence-based patient safety approach; clear and concise position on the rarity of ALCL and breast implants; and a talented, trained, and experienced panel from our plastic surgery societies were praised by this regulating agency. The list of actions, efforts, and funds required by all parties involved to inform and convince the medical community, the public at large, and the media to the real facts of this issue are too numerous to list. Fortunately, reason, responsibility, and science persevered to prevent another implant moratorium. The storm had been averted.

So why should the average ASPS member care? Consider if the vast funds made ready by the Plastic Surgery Foundation to assist in the resolution of the issue of ALCL and breast implants had not been available. What would the loss of the ability to use breast implants mean to your patients and your practice in plastic surgery today?

Yearly contributors to the Plastic Surgery Foundation by ASPS members are at an all-time low (<25 percent of members). Recently, a request was made of the ASPS membership to become part of the "Drive for 75" in an attempt to return the Plastic Surgery Foundation donor rate to that of the 1990s (80 percent). The response has been less than favorable. Based on our experiences at our 2011 national meeting in Denver, Colorado, most ASPS members seemed unaware of how contributions to the Plastic Surgery Foundation are used. A Plastic Surgery Foundation Web site has been created to enlighten our membership (<http://www.the-psf.org/>). Many ASPS members refused to donate, stating "The economy is bad; this should be why I pay my dues." They believe that preventing such storms is what any good national organization is supposed to be doing for them, and they are absolutely correct! Unfortunately, ASPS membership dues fall very short in preparing for such events. According to Dr. Cole, this was one of the reasons why the Plastic Surgery Foundation was created. He relayed that relying on manufacturers and vendors for long-term hard clinical data could be wishful thinking. Possibly, as an ASPS member you can begin to see what is being done with your Plastic Surgery Foundation funds. Please join our "Drive for 75" group so we can continue preparing for these locust storms that