



* *Retractile* replaces "umbilicated"

FIG. 1.

posed to an invaginated nipple, which would never become erect (Fig. 1).

All congenitally inverted nipples look umbilicated, yet the decision on what to do depends on their permanently static (invaginated) or temporary retractile state.⁴

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A SIMPLE DEVICE FOR MARKING THE AREOLA IN VERTICAL MAMMAPLASTY

Sir:

I have an even simpler device for marking the areola in the vertical mammoplasty technique than that mentioned by Paloma et al.¹ Cut off a segment from a wire coat hanger, and mark off 14 or 16 cm. Bend it at the midpoint, and bend the remainder into a symmetrical mosque-dome shape. Leave handles at each end for manipulation, just like the McKissock keyhole pattern. The spring of the steel will allow the pattern to be widened or narrowed as needed, and it will not distort the original shape.

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PREOPERATIVE INFILTRATION WITH LIDOCAINE AND EPINEPHRINE FOR BREAST REDUCTION

Sir:

We read with great interest the article "Preoperative Injection Using a Diluted Anesthetic/Adrenaline Solution Significantly Reduces Blood Loss in Reduction Mammoplasty" (*Plast. Reconstr. Surg.* 102: 373, 1998) by Wilmsink, et al. We would like to compliment the authors on a well-written article, and we would like to submit our own experience on the subject.

We have been using preoperative infiltration with lidocaine and epinephrine in breast reduction since 1984. The injection fluid we use is a 0.5% lidocaine solution with 1:400,000 epinephrine, as opposed to the 0.25% prilocaine solution with 1:800,000 epinephrine used by the authors. We inject 60 ml of this solution into each breast, 15 minutes before the beginning of the operation, in the sites mentioned by the authors. Blood loss has been minimal, and the inclusion of lidocaine in the solution allows for a more superficial anesthesia. All operations were performed as day cases, and all patients were discharged 12 to 24 hours after the operation. In the cases in which we use adjuvant liposuction to make the breast smaller and to reduce lateral breast fullness, instead of the above-mentioned solution, we use Klein's solution.

We would also like to refer to a recent article by Samdal et al.² on lidocaine plasma levels. According to the authors of this article, the maximum dose of lidocaine recommended by Astra Pharmaceutical (7 mg/kg or 500 mg as a total dose) is based mainly on studies using lidocaine in epidural, caudal, intercostal, and peripheral nerve blocks, and it can be safely exceeded. In fact, the authors of that article² used up to five times the recommended maximum dose of 7 mg/kg (35 mg/kg), without observing toxic symptoms.

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REEVALUATING THE NEED FOR ROUTINE DRAINAGE IN REDUCTION MAMMAPLASTY

Sir:

I would like to comment on a recent article, "Reevaluating the Need for Routine Drainage in Reduction Mammoplasty" (*Plast. Reconstr. Surg.* 102: 1917, 1998). This article, authored by Matarasso et al., asks whether suction drainage after bilateral reduction mammoplasty has any advantage. Matarasso et al. conclude that it does not. Perhaps they are right, but I think there are several aspects of the study that are flawed, as they themselves admit at the end of the article.