est follow-up period in our series was 2 years for one case. The long-term results over 5 or 10 years should be investigated.

The cosmetic results of prosthesis use are excellent. However, patients are not always satisfied with the results because oronasal discomfort from the prosthesis is unavoidable. Separation of the oral cavity and sinonasal cavities is essential to achieve a good quality of life after maxillectomy. Moreover, an obturator is not practical for extensive defects. To obtain an ideal fitting, multiple revisions are required in most cases.

The ideal reconstruction for teeth is an osseointegrated dental implant on a vascularized bone graft. Our procedure is a step for dental implant on the reconstructed hard palate, which provides the best functional results. Although the use of a palatal or dental obturator is useful for the majority of patients, it is a blind alley in dental reconstruction. Further progress may not be possible with this modality, and only reconstruction with vascularized bone is likely to be the way forward.

I hope our procedure will become a treatment option for extensive maxillary defect managed by outstanding experts in this field. Again, we appreciate Dr. Hardin giving us an opportunity to discuss important aspects of our procedure, which were not discussed sufficiently in our article.

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A USEFUL APPLICATION OF THE DOUBLE-BREASTED VEST PRINCIPLE IN SKIN CLOSURE

Sir:

Port-a-Cath systems are very useful devices for central venous blood sampling and administration of chemotherapeutic drugs, antibiotics, total parenteral nutrition, fluids, and blood products.[1] Complications occur in a low percentage of cases (during the perioperative and postoperative periods and during treatment) and are mainly represented by infections, thromboses, extravasations, migrations, and occlusions.[2–4]

Plastic surgeons are often requested to treat Port-a-Cath decubitus associated with scar dehiscence and partial extrusion of the device, sometimes determining local infection. This is one of the most frequent complications, especially in oncologic patients who are undergoing maintenance chemotherapy and have sometimes received chest irradiation. Drugs and radiation cooperate in reducing the width of subcutaneous tissues and in rendering the skin atrophic and less elastic, that is, less resistant to the tension induced by sutures and by the underlying Port-a-Cath. Moreover, oncologic patients are often receiving steroid treatment, and the negative effects of these hormones on wound healing are well known.[5,6]

We present a simple and effective technique for treating complications of Port-a-Cath insertion scars. A 67-year-old woman with spinocellular esophageal cancer, who had been treated with radiotherapy and was still receiving chemotherapy, was sent to our attention for a partial central dehiscence of a Port-a-Cath insertion scar in her right pectoral region, with decubitus and exposure of the top of the device. The skin edges appeared tense and reddish, but

FIG. 1. Intraoperative view. The superior flap has been deepithelialized and the scar is still visible.

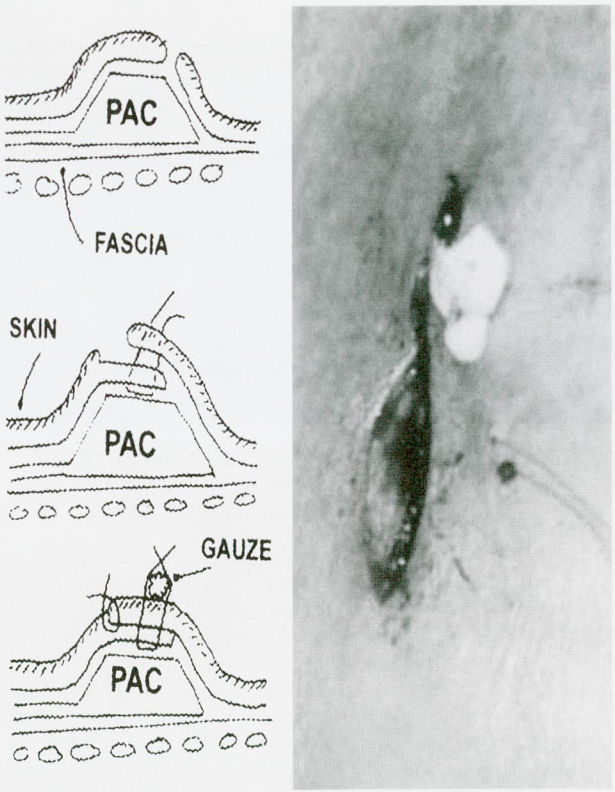

FIG. 2. (*Left*) Schematic representation of the double-breasted vest technique. (*Right*) Intraoperative view. Horizontal mattress sutures are visible.

no signs of infection were detectable. This complication had already occurred twice, and the patient had undergone two surgical wound corrections performed by the anesthesiological team.

Since the skin was atrophic and tense and the subcutaneous tissue was poorly represented, especially over the Port-a-Cath, we determined that a simple revision and direct suture of the wound were not suitable, especially considering the two previous relapses after this type of surgical correction. A technique allowing a thicker Port-a-Cath covering was needed, for an attempt at Port-a-Cath salvaging from substitution.

With the patient under local anesthesia, an area double the width of the scar was deepithelialized, leaving an upper dermal flap (Fig. 1); the scar was removed to expose the Port-a-Cath, but a thin fibrous capsule was left around it. Using blunt curved scissors, in order to avoid damages to the device, the upper dermal flap was undermined to at least double the width of the scar by delicate dissection and minimal manipulation of the flap. Care was taken to preserve the subdermal vascular plexus. The inferior edge of the wound was mildly trimmed and undermined between skin and fibrous capsule.

Bipolar cautery was used for meticulous hemostasis. Consequently, the upper dermal flap was buried underneath the opposite undermined skin flap and fixed by two horizontal mattress stitches (nylon 3-0), covering the Port-a-Cath in a "double-breasted vest" way (Fig. 2, *left*).[7] Before the knots were tightened, a little piece of gauze was positioned under the knot to avoid decubitus of the knot on the thin skin (Fig. 2, *right*). Finally, the skin edges were apposed with minimal tension using interrupted sutures (nylon 5-0).

The postoperative course was uneventful, and the wound healed without problems. One month after surgery, the scar appeared well consolidated and the Port-a-Cath was functioning perfectly (Fig. 3).

Port-a-Cath systems are very useful devices; above all, in oncologic patients, scar ulcerations and dehiscence can occur with extrusion of the Port-a-Cath. A useful application of the double-breasted vest principle of Millard is presented for wound revision.

FIG. 3. Postoperative view at 1 month.

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THE EFFECT OF FACIAL MUSCLE SURGERY ON MIGRAINE

Sir:

The "amaranthine effect" of facial muscle surgery on migraines may be more poetic than causal. Guyuron, Tucker, and Davis (*Plast. Reconstr. Surg.* 109: 2183, 2002)[1] present a radical, invasive treatment for a condition that is known to be remarkably responsive to placebo effect.

The authors observed that some patients who had undergone surgical facial rejuvenation involving resection of "hyperactive" corrugator supercilii muscles noted improvement in migraine headaches. Connecting the dots, the authors designed a study and proceeded to surgically eliminate the offending muscles and other potentially responsible structures (zygomaticotemporal branch of the trigeminal nerve and temporal soft tissues) in an effort to