



Invited Response on: “Does Standardized Practice Reduce Complications in Breast Augmentation Compared with Non-standardized One?”



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Dear authors,

Thank you for your interest and valuable comments on our recent publication that highlight some of the limitations of our study [1].

While we agree that a multicenter prospective study has the advantage of improving the reproducibility and consistency of the results, we are aware of the critical issues in designing and conducting this type of study in aesthetic surgery. Firstly, recruiting centers and training co-investigators are costly and time-demanding activities which depend heavily on the availability of funding.

Secondly, we think that our study design has partially addressed some potential bias related to studies carried out in multicenter settings. One of the advantages of reviews based on a single-surgeon experience is that the assessment of the efficacy and reproducibility of the presented method are not confounded by discrepancies in preoperative consultation, surgical technique, and postoperative care that could be present when more than one surgeon is involved [2]. In other words, the fact that the same surgeon uses both methods within the same cohort of patients minimizes the chances of bias related to study management. Thirdly, we

are aware that measurement bias in aesthetic surgery is problematic because the criteria to establish whether the treatment has resulted in the desired outcomes are highly subjective, and we think that the single-surgeon experience minimizes the chances for this type of error [3].

We recognize that the incidence of wound dehiscence in the two groups is surprisingly high. We believe that the high reported frequency is essentially due to the inclusion in the analysis of all the delayed wound healings, minor suture reactions, suture abscess, or epidermolysis phenotypes that are usually not reported as complications. As a result, even slight distress at the junction of the inverted T was reported as “wound dehiscence.”

Although formally the high rate of wound dehiscence could be attributed more to the learning curve of the single surgeon rather than the closure technique, we also believe that the main advantage of a three-layer closure compared to the two layers is a more consistent reconstruction of the fold. Whenever the fold is disrupted, the repair should be done in a multilayered fashion (thoracic fascia, superficial fascia, dermis) to recreate the three-dimensional configuration [4].

We are also aware that definitive conclusions on the capsular contracture rates could not be drawn since 15 and 32 months are undoubtedly a short time interval for the development of the long-term complications. A longer follow-up would allow a better comparison between the two groups and with previous studies.

Finally, we indeed take into consideration their suggestion to use the BREAST -Q for a more comprehensive evaluation. Our assessment (scale 1–10) could not be considered as a standardized and validated method. However, this method has been added to our practice for the simplicity and ease of use. Evaluation of patient-reported

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outcome measures has become extremely important, and BREAST-Q or an alternate patient-reported outcome measure (PROM) can provide a fully validated patient-centered objective outcome measure allowing comparison and strengthening the evidence essential to any high-quality study [5].

Compliance with Ethical Standards

Conflict of interest We have no conflicts of interest to disclose.

Statement of human and animal rights, or ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent For this type of study informed consent is not required.

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