DISCLOSURE
Neither of the authors has any conflicts of interest with the content of this communication.

REFERENCES

Reply
Sir:
We thank Drs. da Costa and Lancelotti for their valuable comments on our article, which defined the oblique branch of the lateral circumflex femoral artery.1 When present, this vessel takes over part or all of the vascular supply to the skin of the anterolateral thigh. The cadaver work by da Costa and Lancelotti reaffirmed the high prevalence and clinical significance of the oblique branch in the thigh. Several key points of our article are reiterated here. First, the anterolateral thigh flap can be harvested based on either the descending branch or the oblique branch of the lateral circumflex femoral artery. Second, the oblique branch is usually shorter and smaller than the descending branch but can reliably be used as the flap pedicle. Third, in harvesting a myocutaneous flap, it is important to determine the source of vessels supplying the skin component by unroofing the skin vessel before committing to any pedicle to ensure viability of the skin.

We would like to clarify the issue on the size and length of the oblique branch as raised by the authors of the letter. We stated that the oblique branch is usually smaller and shorter than the descending branch. Therefore, when a choice exists, we usually prefer the latter as the flap pedicle (Fig. 1). However, not uncommonly, the anterolateral thigh skin is supplied exclusively by the oblique branch and one is then compelled to use it as the flap pedicle (Fig. 2). One can still reliably harvest the flap in such instances but needs to be comfortable with microsurgical anastomosis of small vessels (down to a size of 1 mm). Da Costa and Lancelotti noted that “the oblique branch is larger than the descending branch” on average in their cadaveric study. This contradiction may have arisen from tracing the oblique branch to its higher order branches such as the transverse branch of the lateral circumflex femoral artery. In fact, this was one way of increasing pedicle size and length noted in our article. However, doing this routinely is unnecessary, as it causes much more devascularization of the surrounding muscles, especially that to the rectus femoris and tensor fasciae latae muscles. For this reason, provided that the pedicle length and size are adequate, we prefer to harvest the flap at the level of the oblique branch itself. Despite its smallness, it is safe and reliable in our experience.

Much has been said about the anatomical variations of the anterolateral thigh flap. Several authors have classified its vascular variations.2,3 Such classifications are unnecessarily cumbersome and may cause further confusion, especially in less experienced surgeons. Based on our current understanding of the anterolateral thigh flap, the potential variations that one may encounter when harvesting the flap can simply be classified into two types. The first is the course of the skin vessel supplying the anterolateral thigh. These can be...
either musculocutaneous (88 percent) or septocutaneous (12 percent). The second is the pedicle of the flap, which can be either the descending or the oblique branch of the lateral circumflex femoral artery. These two points summarize all potential variations of this flap. In any case, such variations do not affect its reliability, and the anterolateral thigh flap can be safely procured with meticulous technique. The only contraindication to the harvest of the anterolateral thigh flap is a “true” absence of sizable (≥0.5 mm at the subfascial level) skin vessels in the anterolateral thigh. This occurrence is exceedingly rare (1 percent).

Wei and Mardini pioneered the concept of harvesting flaps in a freestyle manner. With this approach, any skin vessel can be mobilized by retrograde dissection and safely used as a free flap, provided that the pedicle length and caliber are adequate. Although one needs to be aware of variations in regional anatomy, one does not need to be overly concerned about them. We now harvest the anterolateral thigh flap with a freestyle mindset. The vessel supplying the anterolateral thigh skin is selected and mobilized to its pedicle. This may be the descending or the oblique branch. It either case, it is reliable and can be used safely.

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DISCLOSURE

Neither of the authors has a financial interest to declare in relation to the content of these communications or of the article being discussed.

REFERENCES


**Corrections:** “Prospective, Randomized, Double-Blind Trial of Local Anesthetic Infusion and Intravenous Narcotic Patient-Controlled Anesthesia Pump for Pain Management after Free TRAM Flap Breast Reconstruction: Are We on the Right Track?” and “Povidone-Iodine versus Chlorhexidine in Skin Antisepsis before Elective Plastic Surgery Procedures: A Randomized Controlled Trial. Is Statistical Correctness Always Pursued?”