

## Response to: Comparisons of Submental and Groin Vascularized Lymph Node Flaps Transfer for Breast Cancer–related Lymphedema

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Sir,

Microsurgical treatment of lymphedema has been one of our major activities for more than 14 years. Therefore, while reviewing the literature, we were pleased to read a recently published article by Ming-Huei Cheng demonstrating a comparison between 2 lymph node flaps in the management of upper extremity lymphedema.<sup>1</sup>

The authors compared the results of groin (vascularized groin lymph node [VGLN]) and submental (vascularized submental lymph node [VSLN]) flaps in breast cancer related lymphedema in terms of flap characteristics, operative time, perioperative complications, and limb circumference changes at follow-up. We would like to discuss some conclusions for which we do not agree with the authors.

First, in their article, the authors did not mention the stage of lymphedema of the patients in both groups; instead, they mentioned the duration of symptoms, as we know the lymphedema patients are diagnosed according to standard criteria based on history, clinical examination, and a variety of radiological studies, including lymphoscintigraphy, magnetic resonance lymphangiography, or indocyanine green lymphography, which all collaborated to a standard stage.<sup>2</sup> Whatever the staging system used (eg, International Society of Lymphology), it is important to classify the degree of lymphedema, which is critical in guiding decision-making, as well as in determination of the prognosis and response to reconstructive interventions.<sup>3,4</sup>

Second, in the interpretation of results, the authors found that donor-site lymphedema was statistically significantly higher in the VGLN flap group than in the VSLN group (7.7% versus 0%;  $P = 0.04$ ). However, we all know that the donor-site lymphedema following VGLN harvest is significantly minimized with reverse lymphatic mapping, which is now considered mandatory for all patients subjected to that surgery.<sup>5</sup>

Third, the authors stated that the VGLN is considered more bulky than the VSLN, and so the cosmetic result is much better with the VSLN patients; this is clarified in Figure 1, with the marking of VGLN flap seen below the inguinal crease. VGLN flap has been described in the literature,<sup>6,7</sup> and according to our experience, the sub-Scarpa's lymph nodes located between the inguinal ligament and inguinal crease are the draining lymph nodes of the lower abdomen and hence targeted for VGLN transfer. Usually, the VGLN is the superficial flap located within the territory of the superficial circumflex iliac pedicle. This anatomical description is critical as going below the inguinal crease has 2 drawbacks: first, it could raise the risk of donor-site lymphedema particularly if the authors do not use reverse lymphatic mapping; second, the skin quality of the flap below the inguinal crease is not ideal and could give a poor cosmetic outcome in terms of the donor-site scar in upper thigh and unpleasant bulkiness at the recipient site, as the authors reported.

Finally, the authors found that the donor vein in the VSLN flap is relatively larger than that of the VGLN flap, which is probably responsible for the higher total perioperative complications associated with the VGLN transfer; however, it is obvious that the study lacks proper matching of the perioperative risk of complications and the salvage procedures between the 2 groups of patients. Moreover, the VGLN flap has the advantage of having the superficial inferior epigastric vein or the superficial circumflex iliac vein or both to be included in the flap, with sufficient length up to 6–7 cm when the skin paddle is properly designed.

Nevertheless, we congratulate the authors for their great efforts. However, we need better and well-controlled data in lymphedema management with objective standard evaluation.

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### DISCLOSURE

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

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