as is commonly represented. In only one of the skulls of the 50 examined could a foramen of any size be identified in the general vicinity, and this was less than 0.5 mm in diameter.” For the supraorbital nerve, Miller et al. described, “The supraorbital nerve was found to exit the orbit through a supraorbital notch in 59 of 100 skull sides and via a foramen in 41 of 100 sides.” I am afraid that Janis et al. may have confused the supraorbital foramen and the supratrochlear foramen.

Andersen et al. noted that the supratrochlear nerve usually entered the subcutaneous tissue by exiting the orbit at its upper medial corner, and no foramen or notch was found at the exit site.2 If Janis et al. can provide a picture of the supratrochlear foramen containing a supratrochlear nerve in dissection, which I believe they have, it will be very valuable to anatomists. Janis et al. mentioned that the nerve entrance into the corrugator was found to be at a mean distance of 18.76 ± 2.94 mm lateral to the midline. The location of the exit of the supratrochlear nerve from the corrugator/entrance into the superficial plane was seen to be at a mean distance of 19.62 ± 2.94 mm lateral to the midline.1 Janis et al., in the conclusion, insisted that extension of this myotomy to within 1.8 cm of the midline would likely ensure complete decompression.1

For the location of the supratrochlear nerve, however, Andersen et al.2 already measured the most medial branch of the supratrochlear nerve, which was located between 8 and 30 mm from the midline along the supraorbital margin, and the most lateral branch, located between 6 and 38 mm from the supraorbital notch. If Janis et al. can provide the distance from the midline to the supratrochlear nerve, it will be very valuable to compare their data with the data from Andersen et al.

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DISCLOSURE

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REFERENCES


Fig. 1. The supratrochlear nerve is shown exiting through a true foramen.
to 21.5 mm. Our data are not as variable as Andersen et al.’s, and we did not find any supratrochlear branches this far medial, but we cannot explain why. Perhaps part of the explanation is that Andersen’s group was measuring at a slightly more caudal point, at the supraorbital rim, whereas we were measuring at the entrance to the corrugator. However, it is highly doubtful that the nerve jumps 4 mm in this very short distance. Finally, in their study, Andersen et al. never seemed to have found a frontal notch or foramen, and felt that the supratrochlear nerve simply entered the forehead at the superomedial aspect of the orbit. We only found this to be the case in about 6 percent of our dissections.

Hwang pointed out that in our discussion of the article by Miller et al. we took our frontal/supratrochlear notch/foramen data and accidentally put it into our discussion of the supraorbital notch/foramen. There is more detailed information in our Results section, but this was written in error when writing the Discussion. The sentence the writer is referring to would appropriately read as follows: “…the frontal/supratrochlear foramen was found to be present only 2 percent of the time as a true foramen compared with 18 percent of the time in our study.” However, this would not make sense in this portion of the Discussion as this was a paragraph expounding on Miller et al.’s data concerning the exit of the supraorbital nerve. We thank Dr. Hwang for pointing out this error in our editing.

Concerning Dr. Hwang’s request for a supratrochlear foramen (or frontal foramen) containing a supratrochlear nerve, the reader can see that Figure 5, below panel, of our article demonstrates a supratrochlear nerve coming out of a frontal or supratrochlear foramen. We have included three more examples of a true foramen as Figures 1 through 3.

We reiterate our appreciation to Dr. Hwang for his interest in our article.

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REFERENCES

Rib-Sparing and Internal Mammary Artery–Preserving Microsurgical Breast Reconstruction with the Free DIEP Flap

Sir:
We read with interest the article entitled “Rib-Sparing and Internal Mammary Artery-Preserving Microsurgical Breast Reconstruction with the Free DIEP Flap” by Kim et al.1 We congratulate the authors on their surgical prowess, and we would like to provide some clarification.