Letter to the Editor:

In his recent article, Dr. Niamtu outlined an important issue of facial esthetic surgery.\(^1\) Complications of face lifting quite often derive from expanding hematomas. If these are promptly recognized, common hemostatic techniques resolve them, and the surgical site heals without major complications. On the contrary, when treatment is delayed, results can be devastating and difficult to deal with. We report a successful salvage, out of five cases recorded, of a necrotic bilateral area with a conservative approach that consisted in waiting for necrosis stabilization and in preventing infections with local medications.

A 66-year-old woman was admitted last July for a mid face-neck lifting. Her history was positive for essential hypertension, controlled with calcium channel blockers, and smoking (15 cigarettes/day from 40 years), stopped 30 days before recovery. We performed a bilateral superficial musculo-aponeurotic system dissection with subsequent mobilization, advancement and closure of flaps. The exceeding portions were resected. Two days later, flap vascularization was normal and only a mild tissue edema persisted. The patient was discharged and instructed to present for follow-up after 1 week. She came back only 2 weeks later because of terrorist attacks in London. She had a wide bilateral area of necrotic tissue in both the cutaneous flaps and extending 3 cm into the neck (Figure 1). The necrosis had no signs of infection. All vital signs and blood chemistry were normal.

We allowed the patient to recover and began a systemic antibiotic therapy (intravenous cephradine 2 g/day), combined with local medications (topical gentamicin...
and betadine solution). After 3 days, she was discharged and continued flucloxacillin orally (500 mg/day for 5 days) and local medications. Six weeks after the lifting, both necrotic areas appeared well demarcated and clean (Figure 2). At this time, we removed, with local anesthesia, the superficial necrosis and medicated with betadine solution. Two weeks later (2 months from the first operation of face lifting), we found an amelioration of the local conditions and an almost complete healing (Figure 3).

In these cases of unrecognized postoperative expanding hematomas, the correct approach is not standardized and should be planned on a patient-to-patient basis. In our experience, a conservative management yielded positive results in five patients because it did not complicate the local situation and gave the possibility to tissues to circumscribe the necrotic area preparing for the definitive treatment. In any case, any immediate action in the presence of local tissue edema or ischemia should be avoided.

References

The authors report 5 cases of post rhytidectomy flap necrosis presumably after hematoma. They make the point that delaying definitive treatment until the tissue and necrosis have stabilized has produced positive results in these cases.

In residency, one of my mentors told me that, “sometimes if you just leave a patient alone, nature will take a positive course”. I feel that this applies to the points made by these authors. Although each case warrants specific treatments, once the vascularity is compromised and the necrotic process begins, little can be done to halt or reverse the process. Some practitioners advocate the use of topical nitroglycerine paste or hyperbaric oxygen treatment. Generally, when this unfortunate and oftentimes catastrophic process begins, a cosmetic case becomes one of wound management.

I agree with the authors that aggressive treatment initiated too soon can further compromise the situation. The focus of the treatment to come must focus on prevention of infection, conservative debridement and ensuring revascularization of the tissue bed. Managing such a complication can be extremely stressful for the surgeon, the patient and their