among wide hemorrhagic fields (Fig. 1). These cells showed a storiform growth pattern and had clear nucleolated nuclei with no nuclear atypia or mitotic activity. Staining with Prussia blue dye showed widespread hemosiderin deposits (Fig. 2). Wide hemorrhagic fields were lined with spindle cells rather than endothelium. There was positive staining with lysosim, alpha-1 antitrypsin, and CD68 in the histiocyte cells. Only vascular structures within the lesion were stained with CD34. The patient is still under periodic observation, with no local recurrence or lymph node metastasis at the 1-year follow-up.

Aneurysmal histiocytomas make up about 1.7 percent of all dermatofibromas.[1] They are seen in the lower extremities of middle-aged adults (50 percent), in the upper limb (20 percent), and in the trunk (17 percent).[1]

Clinically, they start as a red papule, enlarge and turn blue-black in color, and then turn either yellow or brown depending on the amount of lipophages and siderophages. Finally, with increased myofibroblastic activity and decreased cellular activity, they may become hard nodules. They may be associated with pain or an episode of rapid growth due to spontaneous hemorrhage. The differential diagnoses include malignant melanoma, hemangioma, Kaposi's sarcoma, spindle cell hemangioendothelioma, angiosarcoma, and angiomatoid malignant fibrous histiocytoma.[2]

Histologically, aneurysmal fibrous histiocytomas are characterized by large, blood-filled tissue spaces, a lack of an endothelial lining, and a surrounding lining of histiocytes, many of which contain hemosiderin pigment, fibroblasts, and foam cells.[2] Larger tissue microhemorrhages due to blood extravasation cause slit-like tissue cracks within those cellular areas of the lesion that have little or no stromal support. These tissue spaces become filled with blood and continue to enlarge under pressure to finally form the typical cavernous or angiomatoid areas.[3] The reason for the formation of these blood-filled cavities is not clear. This phenomenon occurred almost exclusively in those cellular areas devoid of collagen or elastic fibers,[2] along with increased vessel fragility due to older age.[4] Aneurysmal fibrous histiocytoma shows a higher tendency to recur locally than ordinary fibrous histiocytoma and incompletely excised histiocytomas were reported to be capable of metastatic dissemination.[5] Risk factors for metastasis include large size, tumor necrosis, repeated local recurrences, high cellularity, aneurysmal changes, marked cellular pleomorphism, and high mitotic activity.[5] Although they are accepted as benign lesions, aneurysmal fibrous histiocytomas are slow-growing lesions, and one might consider them to be low-grade sarcomas. Thus, long-term follow-up is required in case of lymph node metastasis.

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Z-PLASTY IN ABDOMINAL DERMOLIPECTOMY

Sir:

The article by El-Khatib and Bener in the September 15, 2004, issue of the *Journal*, entitled "Abdominal Dermolipectomy in an Abdomen with Pre-Existing Scars: A Different Concept" (*Plast. Reconstr. Surg.* 114: 992, 2004), makes a significant contribution to the literature on abdominal dermo-

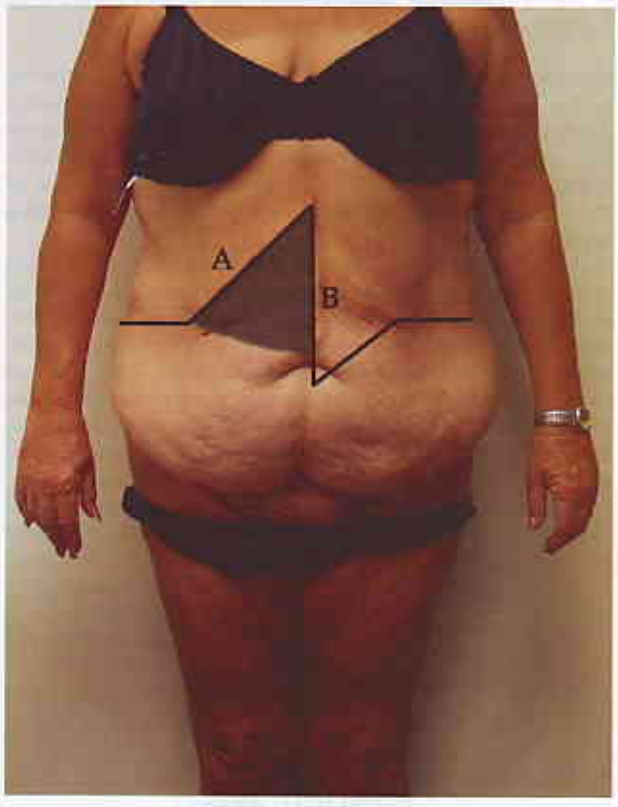

FIG. 1. Preoperative view. The *shaded area* between the Kocher scar (*A*) and the midline scar (*B*) is at risk of devascularization if a traditional cephalic based flap is raised. This area was excised along with the remainder of pannus below the incision line (*white*).

FIG. 2. Four-week postoperative view shows primary healing without incident.

lipectomy. A scenario it does not address is dermolipectomy in the presence of both a subcostal (Kocher) scar and a supraumbilical midline scar (as from gastroplasty). Undermining in the triangle between these two scars creates a triangle of ischemic tissue. This letter describes excision of the ischemic triangle and reconstruction of the defect with a Z-plasty transposition.

A 52-year-old diabetic woman with a 20-pack year smoking history presented for abdominal dermolipectomy. As shown in Figure 1, the shaded area between Kocher and midline scars would have been at risk for devascularization if a traditional cephalic based flap had been raised. This area was excised along with the remainder of the pannus below the incision line. Wound closure included transposition of the adjacent skin flap. At 4 weeks postoperatively, the patient showed primary healing without incident (Fig. 2).

This technique also has application when only the subcostal scar is present, because Z-plasty transposition permits narrowing of the waistline and revision of the Kocher scar.

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COLEMAN'S LIPOSTRUCTURE IN THE CREASED UMBILICAL AREA

Sir:

Isolated correction of the creased umbilical area, following overloaded pregnancies or repetitive weight taps, which are sometimes hereditary, had only benefited, until recently, from concentric skin resections. Those produce scars, which are sometimes very unsightly.

In these past 3 years, we have put into practice, in 15 cases in this area, Coleman's lipostructure.[1,2] We describe our experience with this technique, including the technical details and failures.

Most cases of faded navels that we have dealt with are horizontal and very pronounced depressions (Fig. 1). Centrifugation of lipospirate taken with a syringe guarantees a fat free of adjuvant (such as oil, anesthetic liquid, or blood). Reinjections of pumped-out fat already worked out, without the ingenious Coleman device and without particular explanation, especially in the lower limbs and the hips, after volumetric losses due to excessive liposuctions.[2,3]

For reinjection of centrifuged fat, we used 10-cc syringes. The usual, thin cannulas should be used for the fat infiltration. The device can be used several times in succession or over a period of time.

Using this technique, it is necessary to make hypercorrections, by injecting fat only into fat, gradually, and often from the periphery to the center of the depression, while slightly massaging, with the finger, the areas of hypercorrection (Fig. 2). There has been difficulty in fat graft take when the skin and fascia are in direct contact.

Patient satisfaction (that can be considered definitive) is proportionate to the result after 3 months, but some patients, when the resorption is important, wish to repeat the procedure, because of the absence of scars in the umbilical area.

FIG. 1. A 32-year-old patient with a very faded navel.

FIG. 2. Immediate postoperative view of the same patient shown in Figure 1.