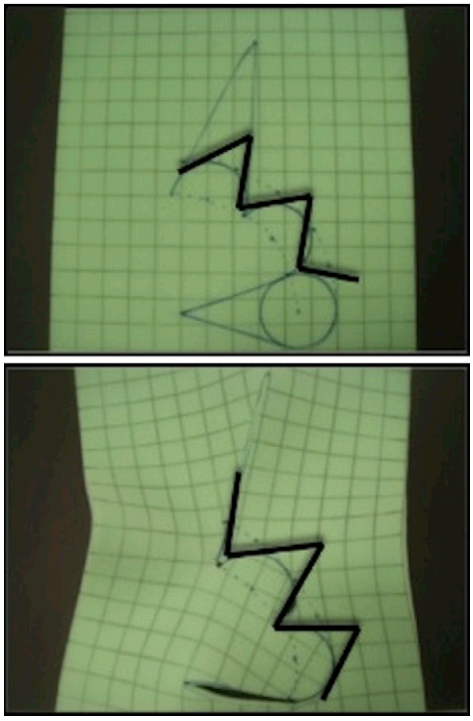

Fig 2. Foam template of bilobed flap with double Z-plasty component illustrated. Lengthening effect of double Z-plasty pushes down on base of foam template simulating downward directed force on alar rim.

of a rotation flap with 2 Z-plasties. The lengthening effect of the Z-plasties preserves the position of the free alar margin by creating a force aimed toward the alar rim (Fig 2). By avoiding an upward-directed tension vector, the bilobed flap alleviates tension on the primary defect and results in little to no alar rim distortion. The disadvantage of the AIRNS flap is that it does not benefit from the lengthening effect of a Z-plasty, making it more likely to elevate the alar rim despite using a similar arc of rotation.

An appropriately designed and executed bilobed flap can provide excellent results for distal nose defects involving the lateral tip, supratip, ala near the tip, or any other defect close to a free margin.[2] The authors correctly identify that certain complications, such as pincushioning, can be minimized through proper technique. Other variables that can influence the results include orientation of the secondary defect, size of the primary and/or secondary flaps, and proper alignment of sutures when transposing the primary flap.[3] Although the AIRNS flap does not share all of these design challenges, it also requires the same meticulous surgical technique to minimize pincushioning. In conclusion, the inherent flap dynamics of the bilobed flap make it a superior choice for the lower third of the nose.

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Reply to: "The bilobed flap versus the AIRNS flap for repair of distal nose defects"

To the Editor: We thank Drs Kirkland and Zitelli[1] for their interest in our article regarding the advancement and inferior rotation of the nasal sidewall (AIRNS) flap.[2] The repair of nasal tip defects is frequently encountered by the dermatologic surgeon and, in our opinion, one can never have too many options for repairing this site. Although one can simply highlight particular nuances and possible benefits of one technique over another, the choice of repair, as on any other site, will depend on the size and depth of a defect coupled with the surgeon's own choice. Claiming superiority, therefore, of a particular technique over another will always be a matter of personal preference.

The Z-plasty lengthening that occurs with the double transposition flap of the bilobed repair is well known. However, if incorrectly designed and executed, this lengthening may contribute toward depression of the ipsilateral alar rim. To date, we have not experienced a single case of alar elevation when performing the AIRNS flap and, furthermore, have not seen any cases of inferior "bulldozing" of the ipsilateral alar rim that may occur in patients with thick, inelastic sebaceous skin.

We believe that our success with the AIRNS flap is inherently linked to its design, which enables a greater margin for error to occur if executed incorrectly. The advancement limb of the flap offsets the secondary defect created by the rotational limb of the flap thus mitigating the risk of alar elevation referred to by Drs Kirkland and Zitelli. Indeed, because of the

length of the rotational arc, the surgeon has a relatively large yet highly mobile arc of tissue that may be easily inset without tension into the desired position ensuring the alar-free margin is not at risk of displacement. As stated in our article however, it is worth reiterating that once the primary defect has been resurfaced, the placement of buried vertical mattress sutures, parallel to the alar-free margin is crucial to ensure the desired alar position is maintained.

We have also previously reported problems with the ipsilateral nasal valve because of pivotal point compression of the underlying subcutaneous tissue in trilobed flap reconstruction of distal nasal tip defects.[3] This has not occurred in our patients in whom an AIRNS flap has been performed. This we believe is a result of the inherent design of an advancement limb linked to a rotational arc creating a broad base upon which the flap rotates toward the distal nose rather than moving on a focal pivot point, as occurs in bilobed and trilobed flap reconstruction.

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Research letters

Anti-bullous pemphigoid 180 and 230 antibodies in asymptomatic subjects: Five-year follow-up

To the Editor: There is a convincing epidemiologic association between bullous pemphigoid (BP) and other medical diagnoses, especially neurologic disorders.[1] Patients with BP are more likely to have neurologic diseases[2] and certain neurologic diseases are strongly associated with the later development of BP.[3] However, the prevalence of BP180 and BP230 antibodies does not vary substantially with age or sex in persons unaffected by BP.[4] Although one report has suggested that the presence of BP180 antibodies may be associated with a diagnosis of dementia in elderly individuals,[5] the significance of BP180 and BP230 antibodies in persons unaffected by BP is unclear. Arguably, the antibodies could be clinically relevant disease markers. However, they could also be false-positives or clinically insignificant epiphenomena. In this study, we reviewed new diagnoses in patients previously identified as having positive BP antibodies without clinical manifestation of BP.

The study was approved by the Mayo Clinic Institutional Review Board. In our previous study,[4] which examined an age- and sex-stratified, random, population-based sample of local county patients seen during 2007, 25 patients without clinical manifestations of BP but with circulating BP180 and BP230 antibodies detected by enzyme-linked immunosorbent assay (ELISA) were identified. We reviewed the electronic medical records for preexisting and all new medical diagnoses since 2007. Symptomatology that did not lead to a specific diagnosis was excluded.

There was no new presentation of BP among the 24 patients with charts available for review. Three patients (12.5%) carried a diagnosis of dementia prior to detection of the antibodies, and dementia developed in one patient (4.2%) during the 5-year period subsequent to initial serum testing. One patient (4.2%) had a stroke during the follow-up period, whereas 4 (16.7%) already carried a diagnosis of past cerebrovascular accidents. Recurrent headaches developed in 3 patients (12.5%) during the study period, whereas 2 (8.3%) had preexisting chronic headaches or migraine. Peripheral neuropathy developed in 1 patient (4.2%), whereas 3 (12.5%) had a preexisting diagnosis of peripheral neuropathy. 12 patients (50%) carried a diagnosis of hyperlipidemia, 11 (45.8%) were hypertensive, and 5 (20.8%) had type 2 diabetes mellitus. No other