Lower Limb Reconstructive Surgery—Thoughts on the Way Forward…

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We appreciate the decision of the Editor to dedicate an issue of the *Indian Journal of Plastic Surgery* for lower limb reconstruction. We think it is a timely decision. While starting to write the editorial, we thought about the practice of lower limb reconstructive surgery in our country and it led to some interesting observations.

Plastic surgery is neither an organ-specific nor a region-specific specialty. Having said that, the myriad of advances that took place in the field made many plastic surgeons narrow their field of work. It led to the development of many subspecialities like hand and microsurgery, cleft and craniofacial surgery, breast surgery, reconstructive surgery of the head and neck, burns, and aesthetic surgery. By concentrating on specific areas, surgeons refined the existing techniques, produced better outcomes, and pushed the boundaries of care. Plastic surgeons also identified themselves as cleft and craniofacial surgeons, hand surgeons, head and neck surgeons, burn surgeons, and aesthetic surgeons. Subspecialty training fellowships were established in all these fields. Subspecialty associations were founded and annual meetings are held with considerable attendance. Lower limb reconstructive surgery (including trauma) forms a significant workload of every plastic surgery unit. Lower limb-related plastic surgery comprises 25% of total surgeries done in the Plastic Surgery Department at Ganga Hospital. Yet we are not able to think of any individual styling himself of herself as lower limb reconstructive surgeon. There are no fellowships in lower limb reconstructive surgery in India that we know of nor any subspecialty association in our country. Things are changing. An instance is the tremendous interest shown by plastic surgeons in diabetic foot reconstruction. It is in this backdrop we have to view the decision to bring out the issue and its contents.

The issue contains articles on trauma reconstruction, including one from the unit of Scott Levin who championed the concept and the terminology "Orthoplastic Reconstruction."[1,2] Collaboration between orthopaedic and plastic surgeons is most vital to get good outcomes in trauma.[3] Even in the best of centers, the orthopaedic and the plastic surgeons have the unenviable role of producing better outcomes in major open fractures than primary amputation and fitting the patient with best available prosthesis. Most literature on this subject is from the west[4,5] Salvage versus amputation has to take into account cultural variations, social acceptance, and factor in availability of the facilities for the differently abled persons to integrate into the society. Here lies a great opportunity for plastic surgeons from countries like India to bring out data for or against salvage of severely injured lower extremities. While some significant work has been done in this field,[6,7] the scope is enormous. Guidelines on the number of centers and manpower required will be a great boon because it will have a direct bearing on issues covering 70% of world's population.

The issue also has articles from the emerging fields of oncoplastic reconstruction and lymphoedema. In the former, the plastic surgeon has to very closely work with the oncosurgeon.[8] In this field again, the gap between the need, availability, and access is very wide. The excellent work done in a few musculoskeletal oncology units must serve a beacon of light for the creation of more units and reach the masses. While communication and collaboration are the key in the above-mentioned fields, what distinguishes the changes in the field of lymphoedema is the fresh ideas in basic sciences and the wider use of modern imaging techniques such as the near-infrared fluorescence imaging (*Fluoptics*, Grenoble, France) and supra microsurgical techniques. This area again shows great promise. To make it a reality, communication and collaboration are the key. In the field of lymphology, the plastic surgeon has to be closely associated with medical specialists, community medicine specialists, and pediatricians.

We do hope that the contents of this issue will stimulate young surgeons to delve deeper into the possibilities in this field and for the established units to rethink the quantum of attention they pay to the subspecialty of lower limb reconstructive surgery. We raised the question as to why lower limb reconstructive surgery has not got the same level of recognition among the plastic surgeons. The answer probably lies in the fact that greater level of collaboration is required with different specialities in most cases of lower limb reconstruction. Communication is the key but also the most difficult to achieve. Someone has to champion the cause.

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It is worth to quote Joseph Murray, the plastic surgeon who won the Nobel Prize for performing the first kidney transplant. He said, “It is in the interface of the specialities that progress is made.” It appears so apt for lower limb reconstructive surgery and the scope of that interface appears to be enormous.

The day may not be far off before an association of lower limb reconstructive surgery comes up in our country. This issue and this editorial will become very relevant at that time.

Conflict of Interest
None declared.

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