Letter to the Editor

Comments on “Semipermanent Filler Treatment of HIV-Positive Patients With Facial Lipoatrophy: Long-Term Follow-up Evaluating MR Imaging and Quality of Life”

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We read with great interest the article by van Rozelaar and colleagues,1 entitled “Semipermanent Filler Treatment of HIV-Positive Patients With Facial Lipoatrophy: Long-Term Follow-up Evaluating MR Imaging and Quality of Life.” The authors described their experience performing facial lipoatrophy rehabilitation with poly-L-lactic acid (PLLA) and calcium hydroxylapatite (CaHA). We also have experience with CaHA fillers for facial lipoatrophy rehabilitation.

In their study, van Rozelaar et al1 combined the prefilled 1.5-mL syringe contents with 0.5 mL of lidocaine 2%. Therefore, 25% of the volume of injected material was lidocaine. This prompted us to pose the following questions: (1) Does this represent an excessive amount of lidocaine for the procedure? (2) Could the authors’ relatively large number of injection sessions (3 on average) reflect the difficulty in achieving full facial restoration due to resorption of the lidocaine?

In a recent article,2 we described our 1-step CaHA rehabilitation procedure for human immunodeficiency virus–related facial lipoatrophy. The contents of 3 vials, each containing 1.5 mL of CaHA product, were injected into a 5-mL syringe (BD Biosciences, Franklin Lakes, New Jersey) by means of a sterile, rapid-fill Luer-Lok to Luer-Lok connector (Baxa, Englewood, Colorado). Then, 0.5 mL of local anesthetic with adrenaline was added (mepivacaine clobidrate 36 000 mg and adrenaline 0.018 mg; 1:100 000; Scandonest 2% [Septodont, Saint-Maur des Fosses, France]). The syringe was connected to another empty 5-mL syringe via the Luer-Lok connector, and the product was mixed with the local anesthetic. Once the product appeared to be well mixed with the anesthetic, it was stored in five 1-mL syringes (BD Biosciences), ready for administration. These quantities of local anesthetic and vasoconstrictor (added to the 3 vials of CaHA filler) were chosen because they are sufficient for pain prevention due to the low degree of dilution. Moreover, a “final” result is usually achievable with only 1 filling session, and overfilling is avoided. The material needed for the mixture is readily available throughout the world (under different trade names).

With our protocol, it is possible to inject a larger amount of product; almost all of our 32 patients required only 1 treatment session (Figure 1).2 This is consistent with a commentary by Dr Jones3 on the article “Evaluation of Injectable Calcium Hydroxylapatite for the Treatment of Facial Lipoatrophy Associated With Human Immunodeficiency Virus,” authored by Carruthers and Carruthers.4

In the study by van Rozelaar and colleagues,1 there were 3 cases of nodules, all of which were treated surgically. In our experience with CaHA fillers, we have not seen any nodules. In a recent article, Graivier et al stated, “There is no evidence of granuloma formation occurring with CaHA. Although the presence of nodules visible through the skin has been reported, these nodules are technique related due to too superficial injection of CaHA or inappropriate use of CaHA. If such nodules occur, they can be easily reduced using aggressive massage techniques.”5 Thus, the surgical excision of such nodules is questionable.

Disclosures

The authors declared no potential conflicts of interest with respect to the research, authorship, and publication of this article.

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Figure 1. (A) This 47-year-old white human immunodeficiency virus–positive man presented with complaints of facial lipoatrophy. (B) One month after a single-treatment session in which 9 mL of product was injected. (C) Five months after the single-treatment session.