Reply to “Impact of Apocrine Gland Residue on Bromhidrosis Clinical Efficacy: A Self-controlled Case Series Study”

Wen-Tsao Ho, MD

Sir:

Thank you to the author for his contribution to this article. At the same time, I would like to take this opportunity to give some feedback on some issues. In my clinical experience on postsurgical observation, there are a number of points that are worth exploring: first is the detectable smell, most likely due to the residue of the apocrine gland, and second is the necrosis of the dermis.

First, the 6-month observation period to assess the clinical outcome and histology is, in my opinion, too short. Complaints of recurrence from patients can occur after 6 months or even several years later. This is under the assumption that the sympathetic and parasympathetic nerves will slowly repair after the innervation regulation. In other words, if the nerves are repaired at a later time, the residual apocrine glands will likely cause a clear clinical variability.

Second, if the plane of dissection is too shallow, it is possible that there are remaining residual apocrine glands inside the subcutaneous tissue. An issue worth investigating is whether the residual apocrine glands will simply remain in the subcutaneous tissue or if they will later reestablish ducts to the outer skin for secretion.

Third, I personally recommend reoperation for body odor patients older than 20 years old. I have met very young patients from other medical institutions who have had postsurgical satisfactory results. However, decades later, a recurrence of the body odor takes place. Thus, I speculate that there is a possibility of hair follicle stem cells transforming into apocrine glands.

I often perform surgical procedures of the apocrine glands. The factors that cause necrosis in the axilla are very complex. In my opinion, the biggest reason for this is that the contour area of the axil is relatively large, which contributes to the weak central blood supply.

In the past, I thought that necrosis was a result of the apocrine glands being cleaned thoroughly. Although it is possible, now I think it is not entirely the reason. Please allow me to share how I came to this conclusion. Previously, I solely used a liposuction-assisted curettage to scrape the apocrine glands for the whole duration of the surgery. When the apocrine glands became thin, I realized that the liposuction-assisted curettage can cause great damage to the dermis, thereby, harming the microvascular network. Later, I changed my approach. The new procedure is, first, to scrape two-thirds to three-fourths thickness of the apocrine glands. Then, for the latter part of the operation, I used small scissors to remove manually the remaining gland from the dermis by flipping out the skin flap through one hole. This process, under normal visibility, yielded a better result than scraping with blind curettage, reduced the harm done to the dermis, and minimized the percentage of postoperative necrosis.

The investigation of the clearance of apocrine gland is very complex, and there are still many areas to overcome. Thank you very much for your contribution to this topic, which brought to light some issues.

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DISCLOSURE
The author has no financial interest to declare in relation to the content of this article.

REFERENCES
1. Lan S, Zhao Z, Wu D, et al. Impact of apocrine gland residue on bromhidrosis clinical efficacy: a self-controlled case series study. Plast Reconstr Surg Glob Open. 2022;10:e4320.
2. Ho WT. Reply “A comparison of two different sub-dermal trimming techniques for the treatment of axillary osmidrosis.” J Plast Reconstr Aesthet Surg. 2016;69:1577–1578.