

- American Medical Association
- American Osteopathic Association

I encourage your continued collaborative support in promoting truth in advertising legislation about board certification to inform and protect the public.

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**DISCLOSURE**

*Dr. Avram is president of the American Society for Dermatologic Surgery. He is on the medical advisory board for Sciton and the scientific advisory board for Soliton, is a consultant for La Jolla Nanoparticle, is on the scientific advisory board for and owns intellectual property, royalties, and stock options in Cytrellis, Inc., is a consultant for and on the scientific advisory board (Zeltiq) of Allergan, Inc, and is a consultant for Galderma.*

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**Reply: Board Certification in Cosmetic Surgery: An Evaluation of Training Backgrounds and Scope of Practice**

We thank Dr. Avram for the comment regarding our article.<sup>1</sup> We agree that dermatologists have made numerous contributions to aesthetics and we value the collaboration of board-certified dermatologists with American Board of Plastic Surgery (ABPS)–certified plastic surgeons.<sup>2–5</sup> Becoming an ABPS-certified plastic surgeon is a commitment that requires significant Accreditation Council of Graduate Medical Education (ACGME)–accredited training and congruity in that career path, and this contrasts markedly with a 1-year aesthetic surgery fellowship required by the American Board of Cosmetic Surgery (ABCS). Our research demonstrates that nearly two-thirds of ABCS diplomates advertise surgical procedures outside the scope of their ACGME-accredited training backgrounds.<sup>1</sup> It is concerning that noncongruent, unaccredited fellowship training is used to “credential” surgeons to operate outside the scope of their accredited residency training.

Consider that the American Academy of Mohs Surgery only considers applicants who have completed an accredited dermatology residency.<sup>6</sup> One could not complete training in an incongruent “related field” to dermatology without sufficient prerequisite experience and then expect to complete an unaccredited Mohs fellowship and practice Mohs surgery.<sup>6</sup> This exclusion criterion includes plastic surgeons, which in and of itself is an interesting paradox, as we have significant experience with skin cancer and skin-related procedures. Nevertheless, the argument that dermatology residents receive relevant training throughout the course of their accredited residency program before entering the fellowship is valid. Therefore, a physician looking to perform and advertise comprehensive aesthetic surgery should complete either a 6-year

integrated plastic surgery residency or a 3-year independent plastic surgery fellowship. An “add-on” 1-year fellowship after an unrelated ACGME residency is not something we support when little or no formal, relevant, prerequisite aesthetic experience is obtained during residency. Plastic surgery residency, which is open to all, offers this prerequisite experience.

Again, we fully support the collaboration between dermatologists and plastic surgeons. We likewise support the performance of cutaneous surgical procedures and Mohs surgery by dermatologists. However, in agreement with the California Board of Medicine, we do not believe the ABCS provides equivalency with the ABPS for credentialing an aesthetic surgeon. Finally, we agree with Dr. Avram’s policy on truth in medical advertising and wish to advocate for patient safety and transparency.<sup>7</sup> ABCS diplomates should be transparent about their residency background so that patients can make an informed choice about their surgeon. Disclosure is essential for both autonomy and for ethical practices in advertising.

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#### DISCLOSURE

*The authors have no financial interest to declare in relation to the content of this communication.*

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#### Human CD206<sup>+</sup> Macrophages Show Antifibrotic Effects on Human Fibroblasts through an IL-6–Dependent Mechanism In Vitro

With great respect and appreciation, we read the recently published article entitled “Human CD206<sup>+</sup> Macrophages Show Antifibrotic Effects on Human Fibroblasts via an IL-6–Dependent Mechanism In Vitro,” by Kurachi et al.,<sup>1</sup> in *Plastic and Reconstructive Surgery*. By presenting a well-designed experiment, the authors concluded that CD206<sup>+</sup> macrophages have antifibrotic effects on fibroblasts via a paracrine mechanism involving interleukin (IL)-6 which help elucidate the mechanism of scar control in wound healing and contribute to the development of new scar treatments. Inspired by the authors, we would like to express our considerations for this study.

Interestingly, the results in this article showed that CD206<sup>+</sup> macrophages had an antifibrotic effect on fibroblasts in vitro. However, as published evidence revealed, the patients who developed hypertrophic scars had higher baseline M2 macrophages compared with patients who developed normal scars. M2 is the predominant macrophage population in the late proliferative and remodeling stage of scar formation which can produce collagen precursors to stimulate fibroblasts during tissue repair. The delayed and prolonged expression of M2 macrophages and the tissue-resident macrophages are related to progression of the hypertrophic scar.<sup>2</sup> These are the factors that we think should be taken into account when designing in vitro experiments.

The authors further report that CD206<sup>+</sup> macrophages have antifibrotic effects on fibroblasts via a paracrine mechanism involving IL-6 and that a direct administration of IL-6 has the potential to prevent and treat keloid scars and hypertrophic scars. However, IL-6 is a kind of proinflammatory cytokine possessing a strong ability to activate inflammation and is closely