

## ***Peri- Menopausal Breast Lesions***

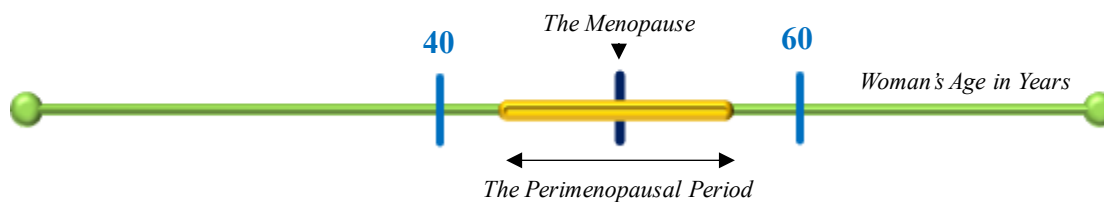
### ***Towards a More Decisive Approach***

*No two rational people would disagree.. It is the time that most profoundly affects Eve's psyche. After the fervor comes the lull, after the bloom comes the wilt, and after action comes stagnation. It is the time of the function's decline.. It is the time of our mother Eve's despair. It is the time of Eve's menopause.*

### ***The Perimenopausal Period***

*In her late forties or early fifties, with familial differences certainly existing, Eve undergoes violent hormonal changes that ultimately lead to a time when ovulation ceases and menstrual blood stops permanently; this is technically known as menopause.*

*The few years preceding menopause, along with those immediately following it, constitute the phase technically termed the Perimenopausal Period; see **Figure (1)**.*



***Figure (1)***  
***The Perimenopausal Period***

*It refers to the years preceding woman's menopause, characterized by disturbances in her menstrual cycles. This period also includes a number of years following the cessation of menstrual bleeding (Amenorrhea). It is a phase that may sometimes extend until woman achieves hormonal, psychological, and physical stability.*

## ***Perimenopausal Breast Lesions***

*During the perimenopausal period, the breasts undergo the same hormonal changes. They enter, willingly or unwillingly, a phase of eternal hibernation... provided circumstances are favorable and intentions are sincere.*

*However, things often do not proceed with such flexibility and smoothness. The breasts frequently act out... they become rebellious. They refuse to surrender to a preordained fate... they disobey. And with the rebellion of her breasts, a continuous stream of suffering begins for our mother Eve, one that is relentless.*

*With the loss of regulatory control, Eve may experience pain in one or both breasts (Uni or Bilateral Mastalgia), discharge from her nipple, either spontaneous or provoked (Spontaneous or Provoked Nipple Discharge), or a mass in the breast (Breast Mass), which could be cystic (Breast Cyst) or solid (Solid Breast Mass). These lesions, along with a few others, form the basis of what is technically known as Perimenopausal Breast Lesions.*

*These are well-studied lesions, classified, categorized, with a globally adopted follow-up and management methodology. Personally, I did not deviate from this consensus and, like others, adhered for a long time to a methodology we were taught by rote and obediently followed. However, times have changed, and circumstances, like convictions, have shifted. No concept or old law, big or small, has been spared from criticism and the audacity of change. I broke away from the fold of submissive followers in many matters, becoming more independent in both opinion and action.*

*The management of perimenopausal breast lesions did not receive from me a privilege that fortified it or an exception that preserved it as it was. Rather, it was subjected to a mindset of modernization and a desire to align with new data. I have become more decisive and resolute in managing these lesions. I now propose to Eve, who is afflicted by the twin challenges of menopause and a breast lesion, early and dual surgical intervention... specifically described as selective removal of the Mammary Gland, bilaterally. We address the symptomatic breast gland early on and, after a short time, conclude with the other breast gland.*

*And so that this matter does not remain the heresy of one who never accepts fixed concepts in science or life, and so that I am not among those who present ideas without justifications, I will explain below the genesis of this idea, after pointing to*

*its father and mother in the charter of the knowledgeable worldwide. For what was valid in one time may be denied by times to come, and what was once celebrated and exalted may become an abomination despised by the taste of future days.*

### ***A Philosophical Argument:***

*The relationship between perimenopausal breast lesions and Breast Cancer is closer and more intimate than we long believed. The two share two important aspects: the timing of occurrence and the causes of occurrence.*

*Regarding the timing of occurrence, I say: while it is true that the peak incidence of breast cancer is in Eve's sixties, it is also correct that the seed of the malignant tumor was sown long before. We have long known that a malignant cell requires five years of active cellular mitosis to produce a tumor 1 cm in diameter:*

*Therefore, malignant tumors in the breast measuring 1, 2, or 3 cm, which are discovered in Eve's sixties or seventies, have deep roots extending back to her forties or fifties. This is the time of occurrence for perimenopausal breast lesions, for those unaware.*

*As for the causes of occurrence, I say: the hormonal changes that underlie perimenopausal breast lesions are the very same ones that lay the foundation for breast cancer. While the statement brooks no question concerning the first, detailing becomes necessary for the second.*

*The Estrogen Hormone has long been accused in the incident of breast cancer, and lengthy discourses have been published on its culpability and aggression towards the breast. This is something I relatively deny, as the matter, in my opinion, requires further research and scrutiny.*

*For estrogen is a hormone conceived by nature to serve a function, not to inflict a calamity. Eve has lived with it and by it for hundreds of thousands of years. During this time, a harmony must necessarily have been established between Eve and her hormone. Updating is a hallmark of living organisms, and interactivity is a privilege bestowed upon God's creations... without exception. Therefore, it is inconceivable, under these circumstances, that Eve did not adapt to her hormone, and that the latter did not align with the needs of the former. Their coexistence was a tale of magic, potency, and growth.*

*Perhaps the most truthful testimony to the good coexistence between Eve and her estrogen hormone comes to us from the Far East...from Japan. There, the Japanese Eve adapted in the most intimate way with her hormone. Consequently, her breasts enjoyed safety and well-being for a long time... or nearly so. She long rested comfortably at the bottom of the list for breast cancer incidence rates.*

*However, blessings do not last unless we maintain the good foundation of that companionship. Recently, the Japanese Eve has leapt up to join her Western cousin (Occidental Eve) in breast cancer incidence rates. And why wouldn't she?! She has borrowed her Western sister's patterns of living and habits of behavior.*

*So, given this situation, can we say that the Japanese Eve previously lacked estrogen, and that it only 'rained' down on her later when she adopted the manners and behaviors of her Western sister? Undoubtedly, you would agree with me that the accused here are the habits, patterns of living, and behaviors, not the estrogen hormone.*

*How I wish to initiate a large-scale scientific study investigating the responsibility of sleep disorders and Vitamin D Deficiency for the ever-increasing incidence rates of breast cancer. A belief, rising to the level of certainty, accompanies me: that these two factors will claim the top spots on the list of Breast Cancer Risk Factors.*

### ***A Statistical Argument:***

*And to those who are only convinced by the language of numbers, I say: Is it not astonishing that the incidence rates of breast cancer rise after Eve's menopause? Her breasts, having been permeated over many long years by the estrogen hormone, and having had estrogen and the progesterone hormone alternately perform the act of irrigation and growth—only for breast cancer to proliferate precisely after the former withdraws from service and the latter becomes almost inactive... or nearly so. And after all this, is estrogen to be accused of breast cancer, when the latter seizes the opportunity of the former's retreat and erupts just as its sources are diminishing?*

*If we examine perimenopausal breast lesions and investigate their causes and imperatives, we find they do not assail the breast with such severity, nor do they garner the same level of attention and apprehension, except during the time of estrogen's retirement and the hormonal imbalances specifically characteristic of this age.*

*Cysts appear in the breast during all stages of Eve's life. However, those that appear around menopause require special management and an awareness of potential outcomes. The same applies to non-cystic masses around menopause. What is simple and acceptable at other times becomes a transgression at this time. We accept nothing less than an excisional biopsy of the entire mass, followed by a histological study to identify the nature of the new entity. As for needle biopsy, it is reserved exclusively and solely for non-cystic masses in young Eve.*

*I do not lack the boldness to exaggerate and warn about perimenopausal breast pain (Perimenopausal Mastalgia). How many sorrowful occasions has this pain been the only presenting symptom of inflammatory breast cancer in this stage of Eve's life? Whereas breast pain (Mastalgia) is a companion to young, beautiful women—I dare say no girl is deprived of this friend whose visits are, however, unwelcome.*

*Therefore, even common breast lesions take on special importance in this phase of Eve's life. The fear of a lurking serious condition, a concealed malignancy, rises. This is why we increasingly utilize radiological and laboratory investigations in their follow-up and management. We also increasingly resort to diagnostic-therapeutic surgical procedures.*

### ***Bilateral Selective Mastectomy***

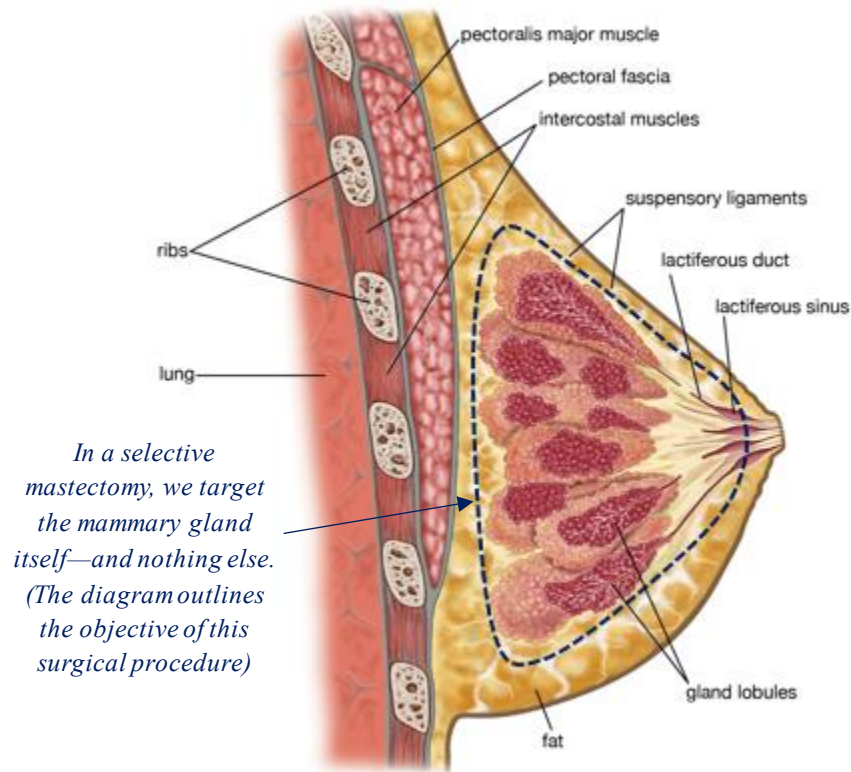
*Bilateral subcutaneous mastectomy may be the most appropriate name and description for the surgical procedure I am proposing. However, I prefer to distinguish between them based on the quantity of adipose tissue removed from the breast. Selective mastectomy of the mammary gland is more economical in preserving adipose tissue compared to subcutaneous mastectomy.*

*The key difference, as stated, is the amount of adipose (fatty) tissue removed:*

- ***Selective Mastectomy:*** *My preferred technique. It is described as more economical, meaning it aims to preserve more of the natural fatty tissue of the breast while removing the glandular tissue (the primary site of concern for developing lesions and cancer). This approach would likely lead to better cosmetic outcomes and preserve more of the breast's natural feel and appearance; please see **Figure (2)**.*



- ***Subcutaneous Mastectomy:*** This is a more extensive procedure where all of the breast glandular tissue and a significant portion of the overlying fatty tissue is removed from beneath the skin. It is a more radical operation.



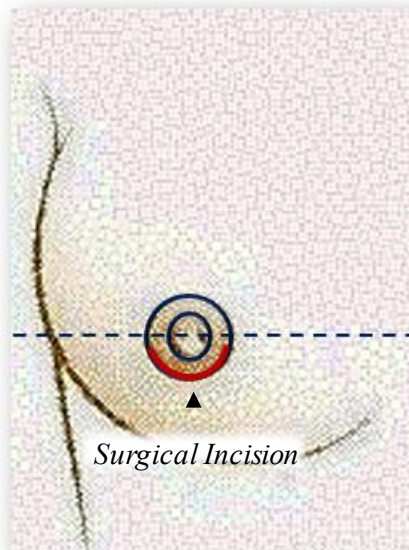
**Figure (2)**  
**Selective Mastectomy**

*The mammary gland, and nothing else, is the target of the selective mastectomy procedure. Here, the nipple, areola, breast skin, and its fatty tissue remain in their original pre-surgical state.*

*Only the endings of the lactiferous ducts, those embedded within the nipple parenchyma, remain as the sole remnants of the mammary gland. There is no way to address them without jeopardizing the survival of the nipple itself. Evacuating the nipple of its ductal content carries significant risks to its viability and the preservation of sensation.*

## ***The Surgical Incision:***

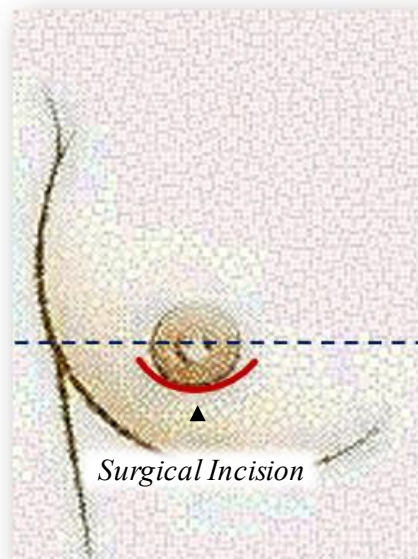
*The surgical incision is made below the nipple, at the junction where the skin of the areola meets the skin of the breast. The surgical incision is arcuate in shape and does not extend beyond the horizontal plane bisecting the nipple. Placing the incision below the nipple safeguards its sensory innervation from damage, as most of it is supplied from superior and superolateral directions. Adhering to the midline horizontal plane of the areola also ensures that half of the blood supply to the nipple and areola remains beyond the reach of a careless scalpel; please see **Figure (3)**.*



***Figure (3)***  
***Selective Mastectomy - Surgical Incision***

*The surgical incision is arcuate (curved) and faces upward. It is positioned at the junction between the skin of the areola and the skin of the breast. It lies entirely below the nipple and does not, under any circumstances, exceed its horizontal midline (Equator). By doing so, we preserve the innervation of the nipple and areola, which primarily originates from the superior and superolateral directions. We also preserve half of their blood supply, ensuring the longevity of the nipple and areola... so we have no fear.*

*Occasionally, the areola is suspiciously small in diameter and/or the breasts are tremendously large. In such cases, do not hesitate to extend the arc of the surgical incision. Allow it to go beyond the boundaries of the areola at both the medial and lateral ends, doing so symmetrically. Consequently, the surgical incision will only share a border with the lower edge of the areolar skin at its midpoint. In return, this allows for easier access to the interior of the breast and provides more secure protection for the vascular supply of its external structures—namely the nipple and areola; please see **Figure (4)**.*



**Figure (4)**  
**Selective Mastectomy - Surgical Incision**

*In some cases, the surgical incision may not strictly follow the lower border of the areola. Instead, it diverges from the areola on both sides, extending toward the breast skin. As a result, the areola and the surgical incision overlap only at the center.*

*This approach is adopted when dealing with a suspiciously small areola and/or an exceptionally large breast.*

### ***Surgical Principles:***

*Initially, I elevate an upper flap comprising the areola, nipple, and 2-3 mm of the underlying subcutaneous soft tissue from the tissue beneath it, which at this level consists predominantly of breast gland tissue. Preserving a cushion of fat and*



*subcutaneous soft tissue adherent to the deep surface of the flap is essential for the vascular safety of the nipple and areola.*

*Naturally, the terminal few millimeters of each lactiferous duct will remain fused to the flap—a circumstance we cannot mitigate. The ends of the lactiferous ducts constitute the substance and structure of the nipple; they cannot be excised without removing the nipple itself. This carries aesthetic and psychological consequences that may burden Eve, often leading her to hesitate about such a surgical intervention.*

*Subsequently, I proceed with the en bloc resection of the breast gland. To facilitate this excision, I use a long-toothed Allis clamp to secure a firm grip on the exposed mass of lactiferous ducts following the elevation of the nipple-areola flap. Guided by gentle and continuous traction on these ducts, I continue the dissection.*

*I begin by removing the central mass of the breast gland, then proceed to pursue its axillary tail. This effectively equates to the removal of 90-95% of the mammary gland—the fundamental objective of this surgery.*

### ***Surgical Complications:***

*The safety and simplicity of the procedure are two significant advantages in favor of the proposed surgical intervention. I rely heavily on these aspects when advocating for such a radical surgical approach to lesions that have long been praised for their histological benignity.*

*Complete or partial necrosis of the nipple and/or areola, along with reduced nipple sensation, are potential complications mentioned in some medical literature. However, I have not personally confirmed their occurrence, as my own record remains clear of these two complications. Adherence to the recommendations regarding the location and extent of the surgical incision, and those concerning the elevation of the nipple-areola flap, is the guarantee for a procedure free from complications... or nearly so.*

*In the few days following surgery, Eve might report a difference in sensation in the nipple on the operated side. Nevertheless, nipple stimulation consistently elicited the cutaneous nipple reflex—erection and changes in topography. This indicates the integrity of the nipple's reflex arc, involving both an afferent sensory pathway and*

*an efferent motor pathway. In all cases, sensation normalized to near baseline levels after the first postoperative week.*

*I harbor doubts about the accuracy of what Eve truly felt. My insistence on inquiring about nipple sensation might have suggested to her the need to scrutinize and analyze it, leading to potential misjudgment in assessing sensation in her nipple. Therefore, I have recently refrained from asking and left the matter to her own spontaneous and voluntary reports.*

*As for nipple retraction and inversion, it occurred in my practice on one occasion. It was a partial collapse that responded rapidly to self-induced nipple stimulation and repeated, gentle outward traction.*

*Regarding the reduction in breast volume, I find no concerning basis for it. The change in volume is simpler than what Eve might imagine. Satisfaction has always characterized the outcome, and gratitude has been the state of her speech after much debate and great apprehension.*

### ***A Research Inquiry:***

*Suppose I intentionally and deliberately aimed to create a hematoma within the surgically operated breast. I then tasked you with determining the possible outcomes of such an intentional hematoma. Many of you would say it could be completely reabsorbed, and this is what I used to say as well. In that case, we would conclude that the living organism managed the situation optimally... and the matter ends. The quality of the control and regulatory mechanisms served the living organism, but it left the breast suffering from emptiness and reduced volume.*

*However, some of you will undoubtedly predict the possibility of the hematoma becoming cystic. Here, the organism would fail to resorb the hematoma, which then becomes isolated within a cloak of epithelial cells. The result is a capsule—or to be more accurate, let's say a pseudo-capsule—flexible enough to encase a serous fluid occupying the void left by the removal of the breast gland. Thus, the deviation from the ideal path proved beneficial, allowing the breast to regain some of its lost volume... and I say, fortunately so here.*

*Others might suggest the transformation of the hematoma into a giant clot. This clot then organizes, becoming invaded by newly formed blood vessels (Angiogenesis).*

*Consequently, the blood clot turns into a piece of spongy, flexible consistency... or nearly so. Here again, the breast benefits from the inadequacy of the control and repair mechanisms, retaining the hematoma trapped within its depths. We would say the intentional hematoma bore fruit once more, yielding a mass that restored the breast's diminished volume.*

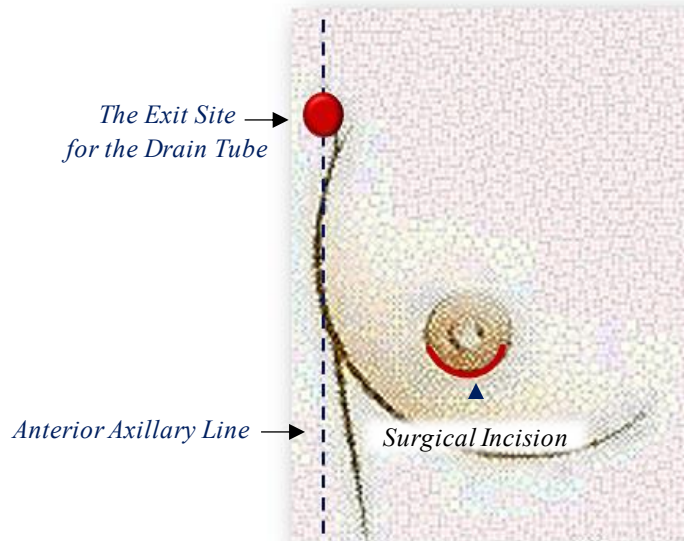
*Therefore, if we can overcome the control and regulatory mechanisms in the breast, preserving the hematoma—the product of our intent and awareness—we might succeed in filling the void and compensating for the volumetric loss in the gland-removed breast... It is for this purpose that I explain to you in detail the intricacies of my strategy and cunning.*

### ***The Intentional Hematoma***

*Following the complete surgical removal of the breast gland and ensuring good hemostasis, I place a closed drainage system, such as a Redon drain. I do not activate the system's negative pressure. Instead, I will utilize only its patency and its capacity to function when I desire it to do so. In practice, the drain's valve remains closed except for specific times, which will be detailed later. The drain exits from a point superior to the dissection surface. The drain's exit site is typically on the anterior axillary line at the border of the axillary fossa (Axilla); please see **Figure (5)**. I then fill 75% of the resulting void in the gland-removed breast with physiological saline (such as normal saline solution). Subsequently, I close the surgical incision in an airtight manner.*

*Eve leaves the operating room with the drain closed and inactive. Subsequently, the core of the management is to wait and monitor for any emergent changes in breast volume. If the change in breast volume is negligible, I leave the drain in a state of functional inertia, as if it weren't there. It is then removed three days after the surgery—the time by which the destabilized biological processes have stabilized.*

*If, however, the breast volume increases significantly due to ongoing bleeding and exudation from the surgical dissection planes, I activate the pre-placed drainage system. The drain will evacuate some of the accumulated blood and fluid within the breast. I do not activate the negative pressure in the collection reservoir; instead, I rely on the growing positive pressure within the breast to expel the excess beyond what is necessary and intended.*



**Figure (5)**

***Selective Mastectomy - The Exit of the Closed Drain***

*I choose a superior location on the Anterior Axillary Line as the exit site for the drain tube.*

*This allows me to achieve two objectives simultaneously:*

- 1. An exit site on the anterior axillary line is distant from the field of vision.*

*Consequently, any resulting scar, should one form, will be more acceptable and tolerable.*

- 2. A superior exit will unequivocally eliminate the possibility of fluid leakage due to gravity, particularly after the drain tube is eventually removed.*

*This ensures the preservation of the intentional hematoma's volume, preventing any loss from such leakage.*

*Once the breast volume stabilizes at the desired level and Eve's pain subsides, I deactivate the drain's function again. I keep the drainage system silent and on standby, only allowing it to operate when necessary to unload unwanted accumulations of blood and exudative fluids.*

*If this calm state persists for three consecutive days with the drain in a non-functional, dormant state, I remove the drain immediately to prevent a potential infection with unfavorable consequences. The drain's pathway and its superior exit site prevent leakage from the exit orifice, which could otherwise cause discomfort for Eve and, if persistent, might even lead to a reduction in the volumetric gains*

*achieved in the breast. You may now understand the reason for my preference of a high exit point for the drainage system.*

***Important Note:***

*In very rare cases, where there is a significant increase in the size of the intra-breast hematoma and/or stretching of the breast skin to accommodate the excess volume, I may be compelled to utilize gravitational force by positioning the drainage system's fluid collection reservoir below the level of the operated breast, or I may activate the negative pressure within it.*

***Important Note:***

*Initially, I did not employ this drainage system but resorted to repeated therapeutic aspiration when necessary. The negative psychological impact this had on Eve is undeniable.*

***Important Note:***

*The closed drainage system does not conflict with same-day surgery. Eve can leave the hospital on the evening of the surgical day if she wishes. I instruct her on the necessity of monitoring her breast volume and attentively listening to her breast's complaints of pain and/or tension that exceed the ordinary. All she needs to do is briefly open the drain's valve, after which she will quickly regain her comfort, and her breast will return to its baseline volume. I advise her not to hesitate to inform me of any developments in her condition... and even if she doesn't need such advice from me, her phone is on, and her intention is clear... so I have no fears.*

***A Surgical Case:***

*To fully understand the benefits of this management strategy for addressing volume loss following selective mastectomy, I present a surgical case of a lady who promised, should the proposed management meet her aspiration for a natural-looking breast, to permit its publication. As it did... she did. So here is the result; please see **Figure (6)**.*

*In detail, I explain: Both breasts underwent the same surgical procedure, albeit for different indications in each case. The indication for the right side was ductal ectasia with the appearance of cystic and nodular formations in the breast of a forty-year-*



*old lady with a family history of breast cancer. The indication for the left side was a proactive, preventative act against the triad of ectasia, cysts, and cancer.*

*The surgical aim in both cases was a Selective Mastectomy. The surgery also respected all the aforementioned principles in both cases, but with one fundamental difference at the end.*

*On the right side, where the patient's primary concern was ruling out malignancy, aesthetics were overlooked. Thus, any therapeutic procedure to manage the inevitable volume deficit post-excision was omitted. On the left side, however, the patient paid special attention to her breast volume once she was reassured about the absence of cancer:*

*I filled the void left after the excision of the left breast gland with normal saline solution and sealed the surgical incision over a closed, inactive drain, exactly as I previously described. The drain was removed after three days during which it remained dormant and inactive. The patient was lost to follow-up for four months, only to return later grateful and fulfilling her vowed obligation.*




**Figure (6)**  
**Follow-up Observation Months After Surgery**

*The left breast appears natural in shape, size, and consistency. It received special care to compensate for volume loss and fill the void after its gland was excised. In contrast, the right breast shows signs of tightness: evident wasting, misdirected nipple orientation, and skin adhered to the underlying muscles, from which it has not separated since.*

*Now our patient is stepping forward to rescue her right breast, to rectify the injustice that has befallen it. She demands fairness and equity, urging us to extend the same care and consideration to the left breast.*

### ***Important Note:***

*For further empowerment and to ensure a decisive and fair judgment regarding this volume-restorative procedure, please watch the following video:* 

### ***Conclusions:***

*In summary, what I wish to convey—a view that diverges from prevailing opinions—is that as long as the hormone of femininity, estrogen, courses through Eve's vascular pathways and permeates every corner of her body, Eve remains at ease, and so do her breasts. She need not worry about pain that afflicts her breast, or a cyst that swells here, or a mass that emerges there, for in the vast majority of cases, these are products of physiological evolution. Soon enough, order will be restored, and the breast will regain its clarity and stability.*

*Conversely, if estrogen recedes and retreats, Eve must be cautious of every new occurrence in her breasts. She should not view breast pain, a cyst, or a non-cystic mass as trivial symptoms. Rather, it is incumbent upon her and her treating physician to regard the matter as a profound structural abnormality requiring their special efforts.*

*And just as it succeeded in sowing the seed for a benign lesion in the breast, who knows—perhaps those very hormonal changes characteristic of the perimenopausal stage also simultaneously planted the seed for a malignant growth. Thus, both the benign and the malignant may lie concealed within the breast of an unsuspecting Eve. The benign lesion grows early, capturing the attention of both Eve and her treating physician. Both become preoccupied with the "loud minor issue," overlooking the "silent major one" lurking behind the clinical presentation. The latter grows slowly and steadily, only revealing its malignant head years later, by which time it has firmly entrenched itself in Eve's breast and body.*

*Faced with such a plausible scenario, nothing less than a bilateral selective mastectomy addresses all these necessities: the need for early surgical management*

*of perimenopausal breast lesions and the need for proactive action against breast cancer simultaneously.*

*Perimenopausal breast lesions have long been a proximate target for the surgeon's scalpel, and prevention of breast cancer has always been a precious goal worthy of every effort and care. Thus, the latter becomes a gift of the former: Eve finds relief from an immediate nightmare and pushes far away another that lies in wait, potentially threatening her in the years to come.*

*My rationale, inferred from the previous philosophical arguments, is that by proactively removing the glandular tissue (the "soil" where cancer may develop) in a conservative, tissue-preserving way, they can prevent future cancers decisively. This is presented as a modern, more aggressive update to the standard "wait-and-see" or biopsy-focused approach for managing perimenopausal breast lesions, which I now view with greater suspicion.*

.....  
*In other contexts, you can also read the following articles:*



[DOI The Spinal Reflex, New Hypothesis of Physiology](#)



- [The Hyperreflexia, Innovated Pathophysiology](#)



[DOI The Spinal Shock](#)



- [The Spinal Injury, the Pathophysiology of the Spinal Shock, the Pathophysiology of the Hyperreflexia](#)



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[DOI Hyperreflexia \(1\): Pathophysiology of Disproportionate Motor Response](#)



[DOI Hyperreflexia \(2\): Pathophysiology of Bilateral-Response Hyperreflexia](#)



[DOI Hyperreflexia \(3\): Pathophysiology of Extended Hyperreflexia](#)



DOI [Hyperreflexia \(4\): Pathophysiology of Multi-Motor-Response Hyperreflexia](#)

- [The pathophysiology of Triple flexion Reflex](#)



- [The Clonus, 1<sup>st</sup> Hypothesis of Pathophysiology](#)



- [The Clonus, 2<sup>nd</sup> Hypothesis of Pathophysiology](#)



DOI [The Clonus, Two Hypotheses of Pathophysiology](#)



DOI [The Nerve Transmission through Neural Fiber, Personal View vs. International View](#)



- [The Nerve Transmission through Neural Fiber \(1\), The Action Pressure Waves](#)



- [The Nerve Transmission through Neural Fiber \(2\), The Action Potentials](#)



- [The Nerve Transmission through Neural Fiber \(3\), The Action Electrical Currents](#)



- [The Function of Standard Action Potentials & Currents](#)



- [The Three Phases of Nerve transmission](#)



DOI [Neural Conduction in the Synapse \(Innovated\)](#)



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 - [\*Adam's Rib, could be the Original Sin?\*](#)

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-  [DOI \*The 'Iddah \(Waiting Period\) in Islamic Law: A Comparative Analysis of its Rationale for Divorced Women and Widows\*](#)
-  [DOI \*The IVF/ICSI-Conceived Child: A Biologically Suboptimal Outcome\*](#)

24/08/2025