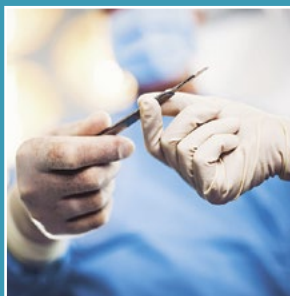


# 2024 FLORIDA PLASTIC SURGERY FORUM



FLORIDA SOCIETY OF  
PLASTIC SURGEONS



Jointly provided by  
The American Society for  
Aesthetic Plastic Surgery, Inc.



DECEMBER 12-15, 2024 THE BREAKERS PALM BEACH, FL






Actual *Natrelle* INSPIRA® patient.  
Individual results may vary.

*Natrelle*

# PATIENT SAFETY IS OUR PRIORITY<sup>1-4</sup>

UPDATE on *Natrelle* INSPIRA® Breast Implants:  
Estimated cumulative Post Market Surveillance (PMS)  
Adverse Event (AE) Rates in the US<sup>1-4,\*</sup>

## The PMS survey identified the following AEs of interest

-  Implant rupture
-  Capsular contracture
-  Device malposition

## The physician-reported rates of these implant- related AEs were each

$\leq 1\%$ <sup>4,\*†</sup>

CONTACT YOUR SALES REP TO LEARN MORE.

\*Adverse event rates are based on Post Market Surveillance (PMS) data. PMS data is physician-reported data and is often underreported. PMS data is used to identify trends in adverse event occurrences and should not be interpreted as complication incidence rates or replace the clinical study data.

†Based on Post Market Surveillance data of 1,623,089 devices reported by HCPs from January 2015 to April 2023.

### *Natrelle*® Breast Implants IMPORTANT SAFETY INFORMATION

#### WARNINGS

- **Breast implants are not considered lifetime devices. The longer patients have them, the greater the chance they will develop complications, some of which will require more surgery**
- **Breast implants have been associated with the development of a cancer of the immune system called breast implant–associated anaplastic large cell lymphoma (BIA-ALCL). This cancer occurs more commonly in patients with textured breast implants than smooth implants, although rates are not well defined. Some patients have died from BIA-ALCL**
- **Patients receiving breast implants have reported a variety of systemic symptoms, such as joint pain, muscle aches, confusion, chronic fatigue, autoimmune diseases, and others. Individual patient risk for developing these symptoms has not been well established. Some patients report complete resolution of symptoms when the implants are removed without replacement**

#### INDICATIONS

*Natrelle*® Breast Implants are indicated for women for the following:

- **Breast augmentation for women at least 22 years old for silicone-filled implants and breast augmentation for women at least 18 years old for saline-filled implants.** This includes primary breast augmentation to increase the breast size, as well as revision surgery to correct or improve the result of a primary breast augmentation surgery
- **Breast reconstruction.** This includes primary reconstruction to replace breast tissue that has been removed due to cancer or trauma or that has failed to develop properly due to a severe breast abnormality. Breast reconstruction also includes revision surgery to correct or improve the result of a primary breast reconstruction surgery

#### CONTRAINDICATIONS

Breast implant surgery should not be performed in:

- Women with active infection anywhere in their body
- Women with existing cancer or precancer of their breast who have not received adequate treatment for those conditions
- Women who are currently pregnant or nursing

#### ADDITIONAL WARNINGS

- See Boxed Warning
- **Avoid damage during surgery:** Care should be taken to avoid the use of excessive force and to minimize handling of the implant. Forcing of implants through too small an opening or applying concentrated localized pressure on the implants may result in localized weakening of the breast implant shell, potentially leading to shell damage and possible implant rupture. An incision should be of appropriate length to accommodate the style, size, and profile of the implants. Use care when using surgical instruments in proximity with the breast implant
- Follow recommended fill volumes for saline implants to decrease possibility of shell wrinkling and crease-fold failure

#### PRECAUTIONS

Safety and effectiveness have not been established in patients with the following:

- Autoimmune diseases (eg, lupus and scleroderma)
- A compromised immune system (eg, currently receiving immunosuppressive therapy)
- Planned chemotherapy or radiation following breast implant placement
- Conditions or medications that interfere with wound healing and blood clotting
- Reduced blood supply to breast tissue
- Clinical diagnosis of depression or other mental health disorders, including body dysmorphic disorder and eating disorders. Please discuss any history of mental health disorders prior to surgery. Patients with a diagnosis of depression, or other mental health disorders, should wait until resolution or stabilization of these conditions prior to undergoing breast implantation surgery

#### ADVERSE EVENTS

Possible adverse events with breast implant surgery include implant rupture with silicone implants, implant deflation with saline-filled implants, capsular contracture, reoperation, implant removal, pain, changes in nipple and breast sensation, infection, scarring, asymmetry, wrinkling, implant displacement/migration, implant palpability/visibility, breastfeeding complications, hematoma/seroma, implant extrusion, necrosis, delayed wound healing, infection, breast tissue atrophy/chest wall deformity, calcium deposits, and lymphadenopathy. Other systemic conditions have been reported with breast implants.

For more information, please see the full **Directions for Use** at [www.allergan.com/products](http://www.allergan.com/products).

To report a problem with *Natrelle*® Breast Implants, please call Allergan® at 1-800-624-4261.

The sale and distribution of this device is restricted to users and/or user facilities that provide information to patients about the risks and benefits of this device in the form and manner specified in the approved labeling provided by Allergan®.

References: 1. Data on file, Allergan Aesthetics, January 2015 to April 2023. 2. Data on file, Allergan Aesthetics, January 2017 to April 2023. 3. Data on file, Allergan Aesthetics, January 2016 to April 2023. 4. Data on file, Allergan Aesthetics, May 2023.

**Allergan  
Aesthetics**  
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AbbVie company. US-PRM-00415  
05/24 028811

# 2024 OFFICERS & BOARD OF DIRECTORS

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<b>Andrew H. Rosenthal, MD</b> <b>President-Elect</b> Boynton Beach, FL	<b>Pat Pazmiño, MD</b> <b>Director</b> Miami, FL	<b>Morad Askari, MD</b> <b>Director</b> Coral Gables, FL
<b>Amy Simon, MD</b> <b>Treasurer</b> St. Petersburg, FL	<b>Anup Patel, MD, MBA</b> <b>Director</b> Orlando, FL	<b>Devinder Singh, MD</b> <b>Director</b> Miami, FL
<b>Michael A. Harrington, MD</b> <b>Secretary</b> Tampa, FL	<b>Timothy E. Fee, MD</b> <b>Director</b> Jacksonville, FL	

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---

<b>Yoav Barnavon, MD</b> Hollywood, FL	<b>Kendall Peters, MD</b> Orlando, FL
<b>Mauricio J. Castellon, MD</b> Melbourne, FL	<b>Max L. Polo, MD</b> Miami, FL
<b>Onelio Garcia, Jr., MD</b> Miami, FL	<b>Alissa M. Shulman, MD</b> Sarasota, FL
<b>David E. Halpern, MD</b> Tampa, FL	<b>Christopher L. Nuland, Esq.</b> <i>Legal Counsel &amp; Lobbyist</i> Jacksonville, FL

# PROGRAM COMMITTEE

---

<b>Max Polo, MD - Program Director</b>	<b>Manuel Pena, MD</b>
<b>Yoav Barnavon, MD</b>	<b>Andrew H. Rosenthal, MD</b>
<b>Onelio Garcia Jr., MD</b>	<b>Amy M. Simon, MD</b>
<b>David E. Halpern, MD</b>	

## 2024 FORUM FACULTY AND MODERATORS

---

**Morad Askari, MD**  
Coral Gables, FL

**Mauricio J. Castellon, MD**  
Melbourne, FL

**Lynn A. Damitz, MD**  
Chapel Hill, NC

**Onelio Garcia Jr., MD**  
Miami, FL

**Caroline A. Glicksman, MD, MSJ**  
Sea Girt, NJ

**Joseph M. Gryskiewicz, MD**  
Minneapolis, MN

**Michael A. Harrington, MD**  
Tampa, FL

**Jeffery M. Kenkel, MD**  
Dallas, TX

**Timothy J. Marten, MD**  
San Francisco, CA

**Gabriele Miotto, MD**  
Atlanta, GA

**Carl Rick Lentz, MD**  
Ormond Beach, FL

**Alan Matarasso, MD**  
New York, NY

**Christopher L. Nuland, Esq.**  
Jacksonville, FL

**Pat Pazmino, MD**  
Miami, FL

**Galen Perdikis, MD**  
Nashville, TN

**Tracy M. Pfeifer, MD, MS**  
New York, NY

**Max L. Polo, MD**  
Miami, FL

**Andrew H. Rosenthal, MD**  
Boynton Beach, FL

**J. Peter Rubin, MD**  
Pittsburgh, PA

**Marc Salzman, MD**  
Louisville, KY

**Drew E. Schnitt, MD**  
Delray Beach, FL

**Amy M. Simon, MD**  
St. Petersburg, FL

**Roger Wixtrom, PhD**  
Springfield, VA

## RESIDENT PRESENTERS

---

**Lauren Antognoli, MD**  
University of Miami

**Melinda Choi, MD**  
University of Miami

**Anshumi Desai, MD**  
University of Miami

**Nicole K. Le, MD**  
University of South Florida

**Meredith G. Moore, MD**  
University of South Florida

**Kinsey Rice, MD**  
University of South Florida

**Colton Riley, MD**  
Mayo Clinic

**Kristen Whalen, MD**  
University of South Florida

## DISCLOSURE POLICIES & ACCREDITATION

As a program jointly provided by The Aesthetic Society and FSPS, we must ensure balance, independence, objectivity and scientific rigor in our educational activities. All planners, presenters and faculty members are required to disclose all relevant financial relationships with commercial interests in advance of the activity. Anyone who refuses to disclose will be removed. All disclosures are reviewed by The Aesthetic Society & FSPS. Conflicts of interest are identified and mitigated in advance of the activity.

All planners, presenters and faculty members' disclosures will be provided to the audience in advance of the activity and via slides. Additionally, all presenter disclosures will be announced verbally.

Additionally, if any unapproved or off label use of a product is to be referenced in a CME program presentation, the presenter is required to disclose that the product is either investigational or it is not labeled for the usage being discussed. The Aesthetic Society & FSPS shall convey any information disclosed by the presenter to the CME program audience prior to the activity. FSPS does not allow commercial interests to influence the planning of our educational activities. The Aesthetic Society & FSPS adhere to the ACCME Standards for integrity and independence.

**Accreditation:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of The Aesthetic Society and Florida Society of Plastic Surgeons.

The Aesthetic Society designates this live activity for a maximum of 17.25 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the 17.25 AMA PRA Category 1 Credits, 1 has been identified as applicable to patient safety. ▲

**This activity will address the following ACGME/ABMS competencies:**

- Patient Care
- Procedural Skills
- Medical Knowledge
- Systems-Based Practice



Jointly provided by  
The American Society for  
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## 2024 PROGRAM OBJECTIVES

At the completion of this CME activity, registrants will be able to:

- Comply with and take advantage of the new Florida laws affecting plastic surgeons and the specialty that have been enacted over the course of 2024,
- Discuss and evaluate the latest data related to BII and ALCL,
- Discuss presenters' research projects, the results, and the potential application to plastic surgeons' practices,
- Identify and evaluate the latest techniques and technology in face, brow and neck lifts,
- Analyze and identify facial injection techniques and injectables,
- Review current body contouring techniques and technology to increase safe patient outcomes,
- Discuss the safety and efficacy of BBL surgery to improve patient outcomes.



## 2024 FSPS DISCLOSURES

*\* Planner/Reviewer*

Lauren Antognoli, MD . . . . .	Nothing to Disclose
Morad Askari, MD . . . . .	Nothing to Disclose
Yoav Barnavon, MD . . . . .	Nothing to Disclose
Mauricio Castellon, MD . . . . .	Shareholder with BRIJ Medical
Melinda Choi, MD . . . . .	Nothing to Disclose
Lynn Damitz, MD . . . . .	Receives food and beverage with Allergan, Mentor and Motiva
Anshumi Desai, MD . . . . .	Nothing to Disclose
Onelio Garcia Jr., MD . . . . .	Consultant with Mentor, MTF Biologics and Solta; Consultant/Investigator with Bard BD
Caroline Glicksman, MD, MSJ . . . . .	Medical Director US Clinical Trial – IDE-FDA with Establishment Labs, Alequela, Costa Rica; Medical Director GalaFlex Clinical Trail-FDA with Becker Dickerson
Joseph Gyskiewicz, MD . . . . .	Founder of Incisive Surgical – Insorb Stapler – No current benefit, company was sold; Founder with StingRay Medical LLC receives Equity; Inventor with Vitatek LipoSHOT receives equity; Consultant with Mentor receives an Honorarium
David Halpern, MD . . . . .	Consultant/Paid Speaker with BTL; Shareholder with Direct Biologics, Inc.
Michael Harrington, MD . . . . .	Nothing to Disclose
Jeffrey Kenkel, MD . . . . .	Research Grant with Accalaro, Aliform, Brijit, Cytrellis, Inmode, Sciton and Venus Medical
Nicole Le, MD . . . . .	Nothing to Disclose
Carl Rick Lentz, MD . . . . .	Nothing to Disclose
Timothy Marten, MD . . . . .	Nothing to Disclose
Alan Matrasso, MD . . . . .	Nothing to Disclose
Randy B. Miller, MD . . . . .	Nothing to Disclose
Gabriele Miotto, MD . . . . .	Nothing to Disclose
Meredith Moore, MD . . . . .	Nothing to Disclose
Christopher Nuland, Esq. . . . .	Nothing to Disclose
Pat Pazmino, MD . . . . .	Consultant with Clarius Mobile
Manual Pena, MD . . . . .	Nothing to Disclose
Galen Perdikis, MD . . . . .	Advisory Board with BRIJ Medical receives stock options
Max L. Polo, MD . . . . .	Nothing to Disclose
Kinsey Rice, MD . . . . .	Nothing to Disclose
Colton Riley, MD . . . . .	Nothing to Disclose
Andrew Rosenthal, MD . . . . .	Consultant with ModMed
J. Peter Rubin, MD . . . . .	Receives grant funding from NIH and DOD; Advisor with Sofregren and Plastic Surgery Channel
*Susan Russell . . . . .	Nothing to Disclose
Drew Schnitt, MD . . . . .	Speaker for Allergan; Speaker/KOL with Lumenis, TEI Biosciences; Speaker/KOL/Consultant with Apyx Medical
Amy Simon, MD . . . . .	Nothing to Disclose
Kristen Whalen, MD . . . . .	Nothing to Disclose
Roger Wixtrom . . . . .	Consultant/Speaker with Mentor Worldwide, LLC; Consultant with Phase One Health



# FSPS PLASTIC SURGERY FORUM PROGRAM

## DECEMBER 12 - 15, 2024

*The Forum General Sessions and Exhibits will be held in the Ponce de Leon Ballrooms*

### THURSDAY, DECEMBER 12, 2024

11:30 – 12:30 pm	<b>FSPS Board Meeting</b>
12:30 – 2:00 pm	<b>Socio-Political Session</b> <i>Moderator: Christopher L. Nuland, Esq.</i> <i>Panel: Mauricio Castellon, MD, Andrew H. Rosenthal, MD</i>
2:00 – 4:00 pm	<b>Domestic Violence/Human Trafficking</b> <i>Christopher L. Nuland, Esq</i>
4:00 – 6:00 pm	<b>Ultrasound Training Course</b> <i>Moderators: Onelio Garcia, MD, Pat Pazmino, MD , Caroline A. Glicksman, MD, MSJ, Jeffrey M. Kenkel, MD, Marc Salzman, MD</i> <i>Sponsored by: Clarius</i>

### FRIDAY, DECEMBER 13, 2024

7:00 am	<b>Rise and Shine Coffee Bar</b>
7:30 – 8:40 am	<b>BREAST IMPLANT SAFETY PANEL ▲</b> <i>Moderator: Amy M. Simon, MD</i> 7:30 – 7:50 <b>Roger Wixtrom, PhD</b> – Science-Backed Approaches for Improved Communication of Risks to Patients 7:50 – 8:10 <b>Caroline A. Glicksman, MD, MSJ</b> – Beliefs and Opinions in SSB 8:10 – 8:30 <b>Joseph M. Gryskiewicz, MD</b> – BIA-ALCL Data Including Device and Technique Optimization to Lower Risks of Bacterial Contamination 8:30 – 8:40 <b>Discussion</b>
8:40 – 9:10 am	<b>Breakfast and Visit Exhibits</b>
9:10 – 9:45 am	<b>Lynn A. Damitz, MD</b> – A Unified Medical and Surgical Approach to the Treatment of Hidradenitis Suppurativa

9:45 – 11:00 am	<p><b>PERIORBITAL SURGERY PANEL</b></p> <p><i>Moderator: Andrew H. Rosenthal, MD</i></p> <p>9:45 - 10:05     <b>Gabriele Miotto, MD</b> – Comprehensive Peri-orbital Rejuvenation Based on Anatomy</p> <p>10:05 - 10:25     <b>Timothy J. Marten, MD</b> – Eyebrow Aesthetics &amp; Peri-orbital Fat Grafting: A New Paradigm for Rejuvenation of the Eyelids</p> <p>10:25 - 10:45     <b>Galen Perdikis, MD</b> – Total Brow-Upper Lid Rejuvenation</p> <p>10:45 - 11:00     <b>Discussion</b></p>
11:00 - 11:30 am	<p><b>EDWARD TRUPPMAN HONORARY LECTURE</b></p> <p>One Man's Journey through Medicine and Plastic Surgery</p> <p><b>Carl Rick Lentz, MD</b></p>
11:30 – 12:00 pm	<b>Jeffrey M. Kenkel, MD</b> – Perioral Improvement
12:00 – 12:30 pm	<b>Roger Wixtrom, PhD</b> – Breast Implant 2024 Hot Topics: The Most Significant Updates/Findings
12:30 – 1:30 pm	<b>Lunch/Visit Exhibits</b>
1:00 pm	<b>FSPS Annual Golf Tournament - The Ocean Course</b>
1:00 pm	<b>FSPS Annual Tennis Tournament</b>
<i>Free Afternoon</i>	
5:00 pm	<b>Evening Event – TBD</b>





## SATURDAY, DECEMBER 14, 2024

7:00 am	<b>Rise and Shine Coffee Bar</b>
7:15 – 8:30 am	<p><b>ANNUAL FORUM RESIDENT COMPETITION</b>  <i>Moderator: Michael A. Harrington, MD</i></p> <p>7:15 – 7:22 (p. 12) <b>Lauren Antognoli, MD</b> – <i>University of Miami</i> - The Efficacy of Single- Application NPWTi-d for the Salvage of Infected Breast Protheses: A Multi-Center Retrospective Study</p> <p>7:22 – 7:29 (p. 17) <b>Melinda Choi, MD</b> – <i>University of Miami</i> - A Novel Combined Free SCIP Flap and Starfish Procedure for Trans-Metacarpal Hand Amputation</p> <p>7:29 – 7:36 (p. 20) <b>Anshumi Desai, MD</b> – <i>University of Miami</i> - Revision Surgeries after Proton Versus Photon Post-Mastectomy Radiation Therapy in Pre- Pectoral Implant-Based Breast Reconstruction</p> <p>7:36 – 7:43 (p. 23) <b>Nicole K. Le, MD</b> – <i>University of South Florida</i> - Comparing Direct to Implant with Staged Tissue Expanders in Prepectoral Breast Reconstruction</p> <p>7:43 – 7:50 <b>Discussion</b></p> <p>7:50 – 7:57 (p. 24) <b>Meredith G. Moore, MD</b> – <i>University of South Florida</i> - Alligator Assault: A Systematic Literature Review and Case Series at a Florida Level 1 Trauma Center</p> <p>7:57 – 8:04 (p. 31) <b>Kinsey Rice, MD</b> – <i>University of South Florida</i> - Institutional Experience with Change of Plane in Implant-Based Breast Reconstruction</p> <p>8:04 – 8:11 (p. 32) <b>Colton Riley, MD</b> – <i>Mayo Clinic</i> - Addressing the Aging Neck with Direct Excision</p> <p>8:11 – 8:18 (p. 34) <b>Kristen Whalen, MD</b> – <i>University of South Florida</i> - The Extended Scapular Fasciocutaneous Flap: An Alternative to the Anterolateral Thigh Flap for Lower Extremity Reconstruction</p> <p>8:18 – 8:30 <b>Discussion</b></p>
8:30 – 9:00 am	<b>Breakfast and Visit Exhibits</b>
9:00 – 10:30 am	<p><b>ABDOMINOPLASTY PANEL</b>  <i>Moderator: Michael A. Harrington, MD</i></p> <p>9:00 - 9:20 <b>J. Peter Rubin, MD</b> – Abdominal Contouring After Massive Weight Loss</p> <p>9:20 - 9:40 <b>Onelio Garcia, MD</b> – Abdominoplasty: The Extent of Dissection and How it Affects Abdominal Flap Perfusion</p> <p>9:40 - 10:00 <b>Pat Pazmino, MD</b> – Abdominoplasty Under the Fascia: Muscle Fat Grafting, IM Blocks, and Differential Plication Techniques</p> <p>10:00 - 10:20 <b>Morad Askari, MD</b> – The Many Faces of Abdominoplasty Following Massive Weight Loss: 360 Degree Approach</p> <p>10:20 - 10:30 <b>Discussion</b></p>

10:30 – 11:15 am	<b>KEYNOTE PRESENTATION</b> <b>Joseph M. Gryskiewicz, MD</b> – Beauty May Be Only Skin Deep, But for Most People, That's Deep Enough
11:15 – 11:45 am	<b>Gabriele Miotto, MD</b> – Global Facial Rejuvenation Surgery
11:45 – 12:15 pm	<b>J. Peter Rubin, MD</b> – Mastopexy, Upper Bodylift, and Brachioplasty on the Massive Weight Loss Patient
12:15 – 1:00 pm	<b>Lunch and Visit Exhibits</b>
12:15 – 1:00 pm	<b>RESIDENT SESSION WITH SPECIAL GUEST LECTURERS</b> <b>Gabriele Miotto, MD and Caroline A. Glicksman, MD, MSJ</b>
12:15 – 1:00 pm	<b>FSPS BUSINESS MEETING</b>
1:00 – 2:00 pm	<b>FACIAL INJECTABLES PANEL</b> <i>Moderator: Max Polo, MD</i> 1:00 - 1:25 <b>Gabriele Miotto, MD</b> – Facial Injectables & The Algorithm for Facial Harmonization 1:25 - 1:50 <b>Jeffrey M. Kenkel, MD</b> – Injectables: Filler and Toxin 1:50 - 2:00 <b>Discussion</b>
2:00 – 3:30 pm	<b>Jeffrey M. Kenkel, MD</b> – Live Injection Session
7:00 – 9:30 pm	<b>Dinner Reception - The Breakers Front Lawn</b> <i>(Separate registration and fee apply)</i>



## SUNDAY, DECEMBER 15, 2024

7:30 – 8:00 am	<b>Breakfast and Visit Exhibits</b>
7:45 – 8:15 am	<b>The Aesthetic Surgery Education and Research Foundation</b> <i>Onelio Garcia, MD</i> <b>The Aesthetic Society Update</b> <i>Tracy M. Pfeifer, MD, MS</i>
8:15 – 8:45 am	<b>Timothy J. Marten, MD</b> – Contemporary Facelift – Milestones in Evolution and Improvement of Technique
8:45 – 10:00 am	<b>BREAST PANEL</b> <i>Moderator: Manuel Pena, MD</i> 8:45 - 9:05 <b>Lynn A. Damitz, MD</b> – Breast Reconstruction - Who, When and Where? 9:05 - 9:25 <b>Caroline A. Glicksman, MD, MSJ</b> – Pearls for Explant Surgery 9:25 - 9:45 <b>Galen Perdikis, MD</b> – Augmentation Mastopexy: Lessons the Hard Way 9:45 - 10:00 <b>Discussion</b>
10:00 – 10:30 am	<b>Break and Visit Exhibits</b>
10:30 – 10:45 am	<b>ASPS Update</b> <i>Alan Matarasso, MD and Andrew H. Rosenthal</i>
10:45 – 11:05 am	<b>Alan Matarasso, MD</b> – Buccal Lipectomy and Psuedoherniation of the Buccal Fat Pad: Diagnosis and Intraoral Excision
11:05 – 11:30 am	<b>Drew E. Schnitt, MD</b> – Staying at the Top: Transgender Surgery 23 Years Above the Waist
11:30 – 12:45 pm	<b>BBL/FAT GRAFTING PANEL</b> <i>Moderator: Devinder Singh, MD</i> 11:30 - 11:50 <b>J. Peter Rubin, MD</b> - Fat Grafting and Fat Stem Cells: The Latest Science to Support Clinical Applications 11:50 - 12:10 <b>Onelio Garcia, MD</b> – Gluteal Fat Grafting: The Mortality is Decreasing but is the Morbidity Increasing? 12:10- 12:30 <b>Pat Pazmino, MD</b> – How the Florida Society of Plastic Surgeons Decreased BBL Mortality and Improved BBL Result 12:30 - 12:45 <b>Discussion</b>
	<b>Meeting Adjourns</b>

## FLORIDA SOCIETY OF PLASTIC SURGEONS PAST PRESIDENTS

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1957	George W. Robertson III, MD*	1991	Barry M. Schwartz, MD
1958	George W. Robertson III, MD*	1992	Carl W. Lentz III, MD
1959	Grover W. Austin, MD*	1993	Harold Michael Bass, MD
1960	Clifford C. Snyder, MD*	1994	Harry V. Eisenberg, MD
1961	Joseph E. O'Malley, MD*	1995	Charles H. Hill, MD
1962	Bernard L. N. Morgan, MD*	1996	Nathan Mayl, MD
1963	Thomas J. Zaydon Sr., MD*	1997	Gary J. Rose, MD
1965	D. Ralph Millard Jr., MD*	1998	Edward S. Truppman, MD*
1966	William M. Douglas, MD	1999	M. Reza Samiian, MD
1967	James Robertson, MD*	2000	Dean L. Johnston, MD
1968	John M. Hamilton, MD	2001	Dean L. Johnston, MD
1969	Thomas J. Baker, MD	2002	Enrique J. Fernandez, MD
1970	Diran M. Seropian, MD	2003	L. William Luria, MD
1971	Gilbert B. Snyder, MD	2004	Yoav Barnavon, MD
1972	William Taylor, MD*	2005	Onelio Garcia Jr., MD
1973	Alvaro Alfonso, MD*	2006	Ralph M. Rosato, MD
1974	Dorthea Weybright, MD*	2007	John J. Obi, MD
1975	Harold G. Norman Jr., MD*	2008	Victoria A. Vitale-Lewis, MD
1976	Bernard L. Kaye, MD*	2009	James A. Matas, MD
1977	William F. Hogan, MD	2010	John J. O'Brien, MD
1978	Alan S. Rapperport, MD	2011	Randy B. Miller, MD
1979	John R. Royer, MD	2012	Galen Perdakis, MD
1980	Jay D. Ellenby, MD	2013	Braun H. Graham, MD
1981	Jack D. Norman, MD	2014	C. Cayce Rumsey III, MD
1982	C. Gary Zahler, MD	2015	Thomas J. Zaydon, Jr., MD
1983	Jeffrey Lang, MD	2016	Thomas Fiala, MD
1984	H. Hollis Caffee, MD	2017	Christopher G. Constance, MD
1985	James L. Baker Jr., MD	2018	Mauricio J. Castellon, MD
1986	Charles Radlauer, MD	2019	Bruce A. Mast, MD
1987	Lawrence B. Robbins, MD	2020	Alissa M. Shulman, MD
1988	John S. Bruno, MD	2021	Kendall K. Peters, MD
1989	Mutaz B. Habal, MD	2022	David E. Halpern, MD
1990	Calvin R. Peters, MD	2023	Max L. Polo, MD



# FLORIDA PLASTIPAC

PROMOTING SAFE PLASTIC SURGERY IN FLORIDA

## Help Our Voice be Heard. Join Florida PlastiPac Today!

**Current Florida PlastiPac Members, and Growing...**

*Chairs:* Christopher L. Nuland, Esq, Mauricio J. Castellon, MD, Andrew H. Rosenthal, MD

David Applebaum, MD  
Yoav Barnavon, MD  
Marguerite Barnett, MD  
Dana Coberly, MD  
Brian Derby, MD  
Anit Desai, MD  
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### The Efficacy of Single-Application NPWTi-d for the Salvage of Infected Breast Prostheses: A Multi-Center Retrospective Study

**Authors:** Jason C. Llaneras, Robert C. Clark, Lauren Antognoli, Emily Finkelstein, Luci Hulsman, Luther Holton, Devinder Singh, Aladdin Hassanein, Risal Djohan, Jason VonDerHaar, Chris Reid

**Introduction:** Breast prostheses infections are challenging to treat and can be devastating for patients. Traditional management focuses on explantation followed by delayed reconstruction. Use of single-application negative pressure wound therapy with instillation and dwell (NPWTi-d) has been described for implant salvage, but studies are limited to small series with heterogeneity between protocols. In this study, salvage protocols and outcomes from four institutions are presented.

**Methods:** Data from single-application NPWTi-d salvage attempts in 56 patients with peri-prosthetic breast infections was collected from four institutions. Patients with fewer than three months post-intervention follow-up were excluded. Demographics, clinical data, and salvage protocols were recorded, and outcomes analyzed. Protocols included explantation, NPWTi-d application, antibiotic therapy, and replantation of a new prosthesis. Successful salvage was defined as retention of the new prosthesis without explantation for 90 days after NPWTi-d treatment.

**Results:** 56 patients (59 breasts) underwent single-application salvage attempt with NPWTi-d. NPWTi-d was continued for a median 48 hours (IQR 41-74). There were no inpatient complications, and all subjects were discharged with new prostheses (65% expander, 35% implant). Average inpatient stay was 4+/-2 days. At 90-day follow-up, 71% of patients had no further complications and 83% of breasts were successfully salvaged

**Conclusions:** This is the largest study to date that evaluates use of single-application NPWTi-d for salvage of infected breast prostheses. The high success rate (83%) confirms the efficacy of this approach, and protocols described are simple and safe. The maintenance of reconstruction demonstrates significant positive effects for patients and yields favorable economic impacts.

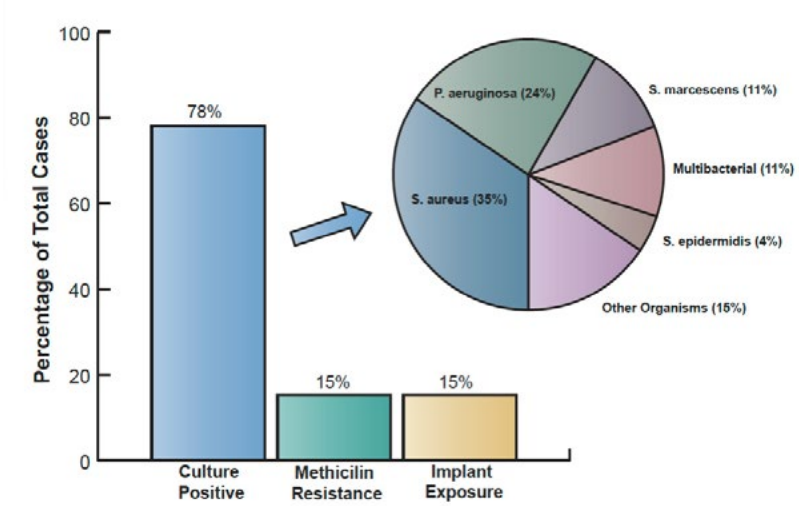
#### Figure Legends

**Figure 1. Technical Methodology:** Example of NPWTi-d foam application demonstrating our two methods of preservation of the implant pocket. A. Over-filling the breast pocket with foam, or B. Inserting a foam wrapped implant/sizer. C. Completed NPWTi-d application.

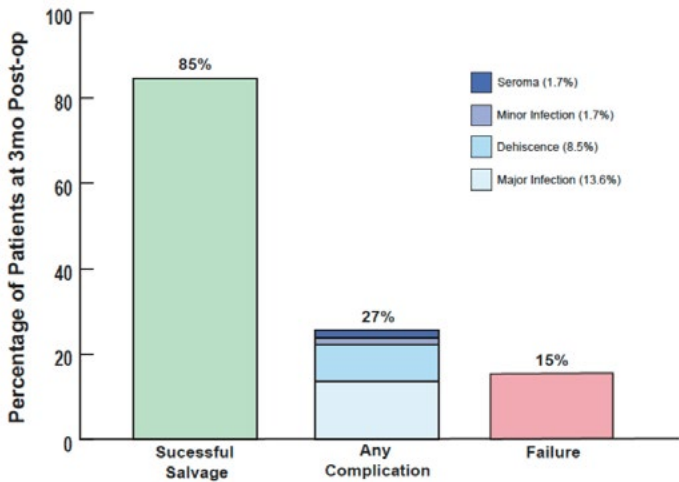




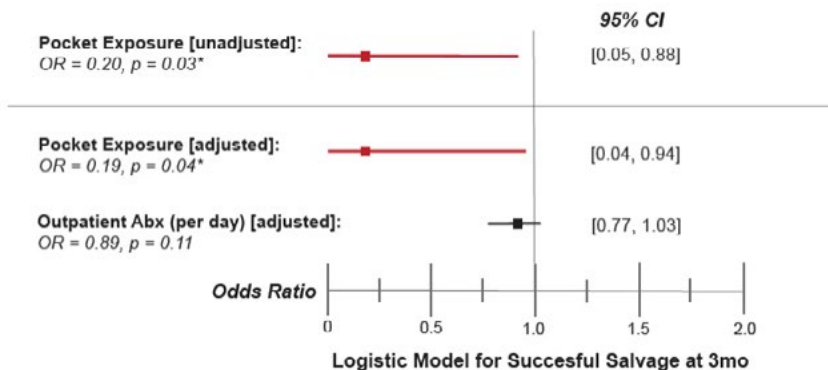
**Figure 2. Infection and Organism Overview:** Among all breast implants, 78% yielded positive intraoperative culture results, with 15% showing methicillin resistance. Additionally, 15% of the implants presented with some degree of exposure on physical examination.



**Figure 3. Post-Intervention Outcomes:** A graph that demonstrates the single-application NPWTi-d across all four institutions.



**Figure 4. Logistic Regression Model for Successful Salvage:** Implant exposure at presentation was significantly associated with lower odds of success. Initial model included: Diabetes, BMI, Radiation, Pocket Exposure, Resistant Organism, Mesh/ADM at Salvage, and Outpatient ABX days. Model built by backwards selection with  $p < 0.15$  for variable retention.



**Figure 5. Successful salvage in a patient with implant exposure at time of presentation:** (A) findings at presentation. Patient underwent immediate washout, removal of tissue expander and placement of NPWTi-d. After 48h of treatment the NPWTi-d was removed and tissue expander re-implanted. (B) 3 weeks after salvage reimplantation. (C) 2 weeks after bilateral Tissue expander exchange for permanent implants.



## Tables

**Table 1: Institutions + Demographics**

<b>Institution</b>	<b>Patients (Breasts)</b>	<b>% of Cohort</b>
<i>Indiana University</i>	10 (11)	18.6
<i>UC San Diego</i>	12 (12)	20.4
<i>University of Miami</i>	15 (16)	27.1
<i>Luminis Health</i>	19 (20)	33.9
<b>Total</b>	56 (59)	100

### **Demographics**

	<b>Mean</b>	<b>Standard Deviation</b>
Age (y)	49	11
BMI (kg/m^2)	29.7	6.4
	<b>Prevalence</b>	<b>% of Cohort</b>
Smoking History	11	19.6
Current Smoking	4	7.1
Hypertension	15	26.8
Diabetes	7	12.5
Previous Chemo	20	35.7
Previous Radiation	5	8.9

**Table 2. Index Procedure**

	<b>Prevalence</b>	<b>% of Cohort</b>
Delayed	16	28.6
Second Stage	7	12.5
First Stage: Implant	13	23.2
First Stage: Expander	36	64.3
Pre-pectoral	44	78.6
Mesh/ADM Used	51	91.1
Post-op Outpatient Abx	43	76.8
Adjuvant Chemo	9	16.1
Adjuvant Radiation	3	5.4

**Table 3. Intervention Detail**

	Median	Interquartile Range
NPWTi Time (h)	48	41 - 74
Length of Stay (d)	3	3 - 5
Instillation Interval (h)	3	3 - 4
Instillation Volume (ml)	150	100 - 300
Instillation Dwell (minutes)	20	10 - 20
Outpatient Antibiotics (d)	10	10 - 14
	Prevalence	% of Cohort
Inpatient Salvage	59	100
Tissue Expander	38	64.4
Permanent Implant	21	35.6
Mesh/ADM	18	30.5
Inpatient Complication	0	0
Outpatient Antibiotics	59	100

**Table 4. Success by Institution**

Institution	Interventions	Salvages	Success Rate (%)
<i>Indiana University</i>	11	9	81.8
<i>UC San Diego</i>	12	10	83.3
<i>University of Miami</i>	16	11	68.8
<i>Luminis Health</i>	20	20	100
<b>Total</b>	59	50	84.7

## A Novel Combined Free SCIP Flap and Starfish Procedure for Trans-Metacarpal Hand Amputation

**Authors:** Melinda Choi, MD1; Lee Weber, MD1; Kashyap Tadisina, MD1; Christopher Alessia, DO2; Natalia Fullerton, MD1

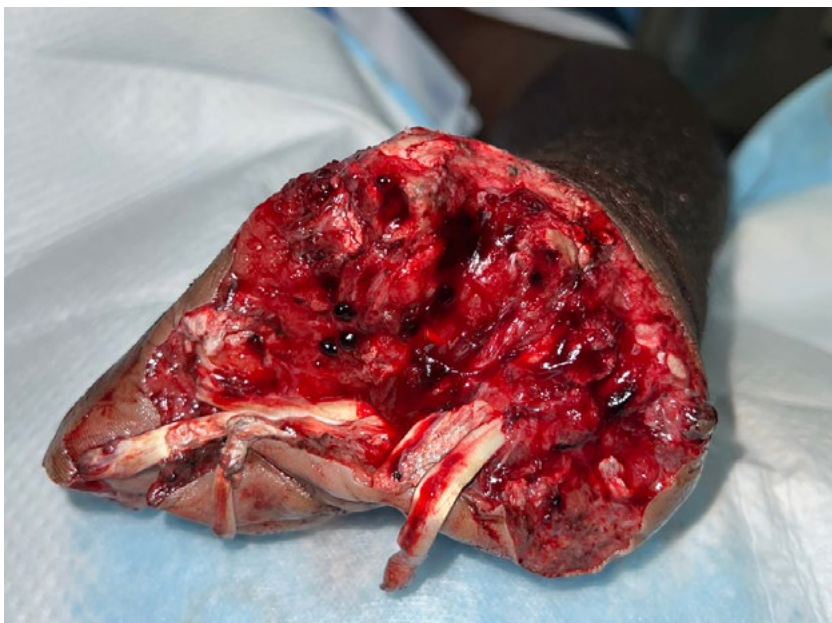
1Division of Plastic Surgery, Department of Surgery, University of Miami

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**Introduction:** The treatment of mutilating hand injuries is complex and multifactorial, with goals of restoring function and improving pain.<sup>1</sup> We present the case of a 44-year-old male who sustained a trans-metacarpal hand amputation from a radiator fan injury. The patient was treated with a combined free superficial circumflex iliac artery perforator (SCIP) flap and Starfish Procedure for hand reconstruction. He was the first patient to receive a manufactured myoelectric prosthesis with individual digital control. The goal of the Starfish Procedure is to improve electromyogram signals and individual digit prosthetic control by transferring intrinsic musculature closer to the upper extremity surface.<sup>1-3</sup>

**Results:** On initial presentation, index through small fingers were not viable for replantation due to gross contamination and degree of avulsion (Figures 1-2). The thumb proximal phalanx was preserved. A free SCIP flap for distal stump soft tissue coverage was performed in combination with the Starfish Procedure, with transposition of dorsal interossei to dorsal metacarpal surfaces (Figure 3). Digital nerve stumps were implanted into muscle to prevent neuroma. Post-operatively, the patient recovered well. He required a second procedure for skin grafting of partial flap necrosis and ulnar-sided flap debulking for improved prosthetic fit. Six months post-operatively, he was the first patient placed into a manufactured myoelectric prosthesis with the ability to move individual prosthetic digits (Figure 4).

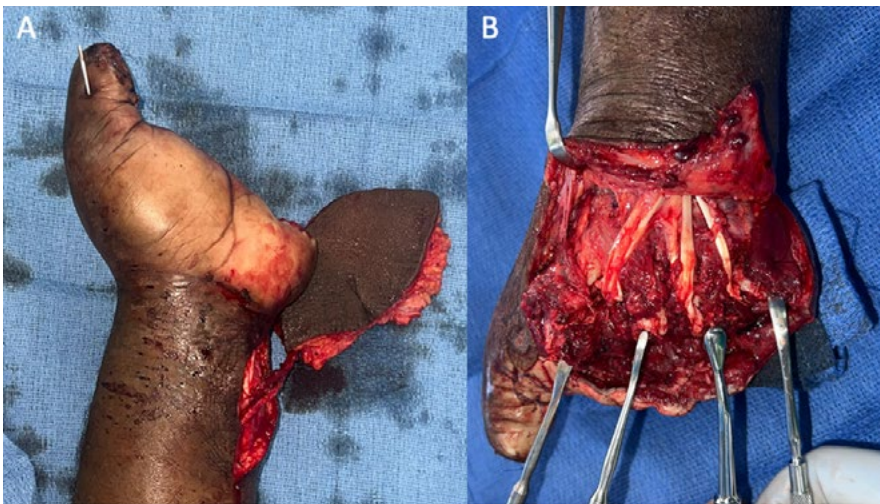
**Conclusions:** We have demonstrated the feasibility and success of a combined free SCIP flap and Starfish Procedure for trans-metacarpal hand reconstruction. The patient is able to use a myoelectric prosthesis with individual digital control without associated stump pain.



**Figure 1:** Initial presentation of left hand trans-metacarpal amputation, demonstrating avulsive nature of injury and gross contamination.



**Figure 2:** Post-operative x-ray of the amputated hand after washout, demonstrating the level of metacarpal injury.



**Figure 3:** Intra-operative photos of the (A) free SCIP flap and (B) transposed dorsal interossei muscles overlying the remaining metacarpals.





**Figure 4:** The patient in a well-fitted hand prosthesis with individual digital control.

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3. Denduluri SKR, A.; Nord, K. M.; Loeffler, B. J.; Gaston, R. G. The Starfish Procedure for Independent Digital Control of a Myoelectric Prosthesis. *Techniques in Hand & Upper Extremity Surgery.* 2023;27(1):61-67.

## **Revision Surgeries after Proton Versus Photon Post-Mastectomy Radiation Therapy in Pre-Pectoral Implant-Based Breast Reconstruction**

**Authors:** Anshumi Desai MD 1, Rohan Mangal Msc 2, Carolina Padilla MD 3, Kate McClintock BS 2, Seraphina Choi MD2, Juan R. Mella-Catinchi MD MPH1, John C. Oeltjen MD PhD1, Devinder P. Singh MD1, Cristiane Takita MD MBA FASTRO 4, Wrood Kassira MD1

**Disclosure and Conflict of Interest:** Devinder P. Singh MD is a consultant to IC and Solventum. All remaining authors have declared no disclosures.

**Introduction:** Postmastectomy radiation therapy (PMRT) improves disease-free survival in breast cancer but reduces aesthetic satisfaction. Proton PMRT has gained popularity due to fewer systemic complications. There is a lack of data regarding revision surgeries for pre-pectoral implant-based breast reconstruction (PP-IBBR) following radiation. We aimed to compare the revision surgeries in PP-IBBR with photon versus proton PMRT.

**Methods:** A single-institution retrospective cohort study included breast cancer patients undergoing mastectomy and PP-IBBR with PMRT (January 2020-October 2022). The mean follow-up duration for the cohort was 1056.4 days (2.89 years). Revision surgeries evaluated were fat grafting, conversion to autologous flaps, implant replacement, implant removal, capsulectomy, and scar revision.

**Results:** 116 PP-IBBR were divided into two cohorts: photon (75, 64.66%) and proton (41, 35.34%) radiation cohorts. Overall corrective surgeries were higher with photon (27.5% overall; 32.4% photon vs 19.5% proton,  $p=0.132$ ). The odds of any revision surgery were nearly double with photon ( $OR=1.98$ ), and the conversion to an autologous flap was significantly more likely with photon ( $OR=4.55$ ,  $p=0.025$ ). Multivariable analysis showed an increased tendency for photon therapy patients to require any revision surgeries ( $OR=1.62$ ,  $p=0.359$ ), autologous flaps ( $OR=5.97$ ,  $p=0.049$ ), fat grafting ( $OR=1.52$ ,  $p=0.664$ ) and scar revision ( $OR=4.51$ ,  $p=0.273$ ).

**Conclusions:** Compared to proton therapy, traditional photon therapy has a higher conversion rate to autologous flaps with PP-IBBR. Photon therapy had higher rates of overall revision surgeries, however not statistically significant. Proton therapy is safer, with fewer revision surgeries, warranting larger studies and broader utilization.

**Table 1: Comparison of demographic and treatment characteristics between photon and proton PMRT**

Characteristic	Photon n (%)	Proton n (%)	p value
Total 116 PP-IBBR in 114 patients <sup>+</sup>	75 (100)	41 (100)	--
Age (years) Mean [SD] (Range)	51.1 [10.76] (29 – 82)	42.6 [11.55] (25 – 67)	<b>&lt;0.0001</b>
BMI (kg/m <sup>2</sup> ) Mean [SD] [(Range)	28.9 [5.93] (18.5 – 46.7)	27.2 [5.71] (17.7 – 44.5)	0.141
<b>Race</b>			
White	67 (89.3)	31 (75.6)	0.051
African American	8 (10.7)	10 (24.4)	--
Asian	0(0)	0(0)	
<b>Ethnicity</b>			
Hispanic	63 (84)	27 (65.9)	<b>0.025</b>
Non-Hispanic	12 (16)	14 (34.1)	--
<b>Current smoker</b>	3 (4)	0 (0)	0.551
<b>Number of Comorbidities</b>			
0	22 (29.3)	19 (46.3)	0.134
1	28 (37.3)	14 (34.1)	--
2+	25 (33.3)	8 (19.5)	--
<b>Implant type</b>			
DTI	31 (41.3)	23 (56.1)	0.128
TE	44 (58.7)	18 (43.9)	--
<b>Fill Volume of Tissue Expander/Implant (cc) Mean [SD]</b>	506.2 (171.9)	474.9 (120.8)	0.473
<b>Incision type</b>			
SSM (Peri-areolar/Elliptical)	69 (92)	27 (65.9)	<b>0.002</b>
SSM (Wise pattern)	2 (2.7)	4 (9.8)	--
NSM	4 (5.3)	10 (24.4)	--
<b>Stage</b>			
DCIS	4 (5.3)	0 (0)	0.322
Stage I	11 (14.7)	4 (9.8)	--
Stage II	34 (45.3)	16 (39)	--
Stage III	25 (33.3)	20 (48.8)	--
Stage IV	1 (1.3)	1 (2.4)	--
<b>Occurrence any complications</b>	23 (30.7)	3 (7.3)	<b>0.002</b>
<b>Time from Surgery to Revision Surgery (days) Mean [SD]</b>	542.0 [258.0]	578.6 [553.2]	0.893
<b>Occurrence of any capsular contracture</b>	32 (42.7)	17 (41.5)	0.902
<b>Time from Surgery to Radiation (days) Mean [SD]</b>	144.1 [118.8]	143.3 [138.1]	0.977

<sup>+</sup> 2 patients had Bilateral cancer, reconstruction, and radiation.

PP-IBBR, Pre-pectoral Implant Based Breast Reconstruction; BMI, Body Mass Index; DTI, Direct to Implant; TE, Tissue Expander, SSM Skin Sparing Mastectomy; NSM, Nipple Sparing Mastectomy; DCIS, Ductal carcinoma in situ

**Table 2: Comparison of the revision procedure rates between photon and proton PMRT**

Characteristics	Photon n (%)	Proton n (%)	p-value	Odds Ratio (photon vs proton)	Confidence Interval (Lower limit, Upper limit)
Any revision surgery	24 (32.4)	8 (19.5)	0.132	1.98	[0.79, 4.93]
Fat grafting	6 (8.1)	2 (4.9)	0.503	1.72	[0.33, 8.94]
Conversion to autologous flap	14 (18.9)	2 (4.9)	0.025*	4.55	[1.01, 21.1]
Implant Removal with capsulectomy	2 (2.7)	3 (7.3)	0.258	0.35	[0.06, 2.20]
Implant replacement with capsulectomy	1 (1.4)	2 (4.9)	0.269	0.27	[0.02, 3.04]
Scar revision	5 (6.8)	1 (2.4)	0.291	2.90	[0.33, 25.69]
Capsulectomy Only	1 (1.4)	0 (0)	0.346	n/a	n/a

\*Statistically significant

Total n will not equal to sum of n and % will not be 100% as each patient might have had more than one cosmetic procedure

**Table 3: Multivariable logistic regression for overall revision surgeries and individual surgeries**

Characteristics	p value +	OR (photon vs proton)	Confidence (Lower limit, Upper limit) Interval
Any revision surgery	0.359	1.62	[0.58, 4.57]
Fat grafting	0.664	1.52	[0.23, 10.28]
Conversion to autologous flap	0.049*	5.97	[1.00, 35.3]
Implant Removal with capsulectomy	0.055	0.14	[0.02, 1.05]
Implant replacement with capsulectomy	0.135	0.13	[0.01, 1.88]
Scar revision	0.273	4.51	[0.31, 65.99]
Capsulectomy Only	n/a	n/a	n/a

+Controlling for age, occurrence of any complication, incision type, race, and ethnicity

## Comparing direct to implant with staged tissue expanders in prepectoral breast reconstruction

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**Introduction:** Prepectoral implant based reconstruction has been shown to reduce rates of animation deformity, implant malposition, and overall complications when compared with subpectoral reconstruction. Prepectoral direct to implant reconstruction (DTI) has gained favor over staged tissue expander reconstruction (TE). Our study aimed to assess our institutional outcomes with prepectoral DTI compared to TE reconstruction.

**Methods:** A retrospective cohort study was performed to assess patients who underwent either DTI or TE between 2018 and 2023 at our institution. Descriptive statistics, chi-square tests, Wilcoxon signed-rank tests, logistic regressions, and linear regressions were utilized to assess patient demographics, surgical and oncologic characteristics, complications, and patient reported outcomes.

**Results:** A total of 482 patients (882 breasts) were included in the study. There were 573 breasts that were reconstructed with DTI reconstruction and 309 breasts with TE. Mean age was  $51 \pm 13$  years and average BMI was  $27.1 \pm 7.7$  kg/m<sup>2</sup>. DTI resulted in significantly reduced total number of surgeries for complete reconstruction (2.0 vs. 3.1 surgeries,  $p < 0.01$ ). TE was associated with higher odds of complications compared to DTI (1.6 [1.2 – 2.2],  $p < 0.01$ ). When comparing DTI to TE, satisfaction with breasts was 72.4 vs 66.2 ( $p = 0.24$ ), psychosocial wellbeing was 73.8 vs 71.2 ( $p = 0.33$ ), sexual wellbeing was 56.8 vs 45.6 ( $p = 0.02$ ), and physical wellbeing of the chest was 71.2 vs 67.8 ( $p = 0.23$ ).

**Conclusions:** Given the introduction of acellular dermal matrixes and surgical meshes, DTI reconstruction has become more feasible with lower complications and improved patient reported outcomes.

# Alligator Assault: A Systematic Literature Review and Case Series at a Florida Level 1 Trauma Center

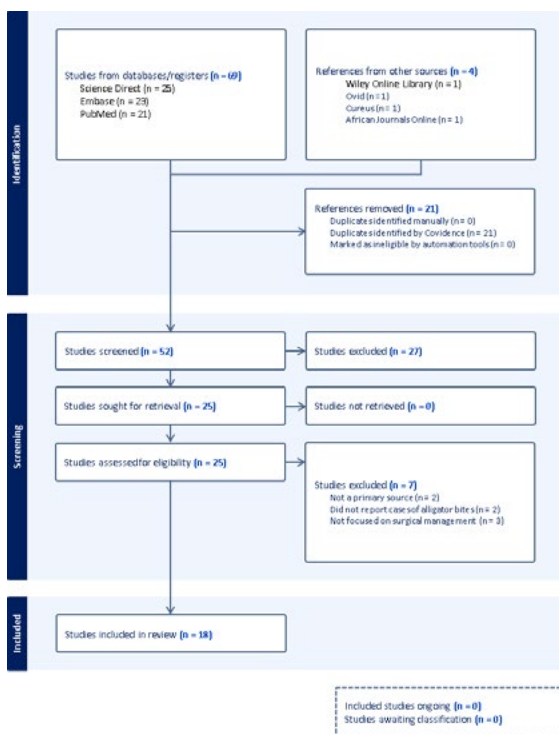
**Authors:** Bilal Koussayer, B.S., Sarah Moffitt, B.S., Kristina Buller, DO, Meredith G Moore, MD, Mariel McLaughlin, MD, Jenna Stoehr, MD, Riley Schlub, MD, Michael Doarn, MD, Jared Troy, MD

**Introduction:** Alligator bites represent a rare occurrence. This report details existing literature on injurious human-alligator interactions, and cases of alligator bite-related wounds with characteristic extensive tissue damage and subsequent reconstruction.

**Methods:** We present a systematic literature review on alligator bite-related sequelae and care. We also present a case series of three patients wounded by alligators presenting to a large tertiary academic center on Florida's west coast.

**Results:** Early debridement, prophylactic antibiotics for an alligator's polymicrobial oral microbiome, soft tissue reconstruction, and interdisciplinary care are the main tenets of care for alligator bite victims. Case 1 is a 53-year-old male with a left upper extremity bite with significant neurovascular damage and near trans-radial amputation who underwent emergent revascularization. After multiple attempts at limb salvage, the patient underwent formal trans-radial amputation. Case 2 is a 77-year-old female with bites to her left upper/lower extremities, with concern for lower extremity Morel-Lavallee lesion. The lower extremity wound was reconstructed with lateral gastrocnemius muscular and fibularis longus musculocutaneous flaps and split thickness grafting. The devascularized upper extremity ultimately underwent trans-radial amputation.. Case 3 was a 34-year-old male with a facial injury and skull fracture. After initial operative repair of the facial nerve and soft tissue lacerations, the patient required later revision with cranioplasty and temporalis coverage due to a draining wound. All three patients survived their severe injuries.

**Conclusions:** This represents a unique set of patients maimed by alligators and subsequent surgical management. We also review the literature on caring for this specific population.





**Case 1**

Figure 1: Initial ED Presentation, note torsion of soft tissues.

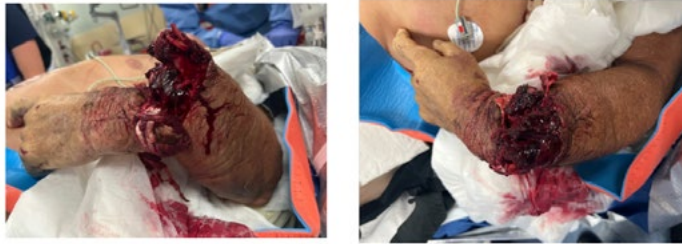


Figure 2: a) Initial X- Ray of the left Arm b) Intraoperative X- Ray of the left arm after ORIF

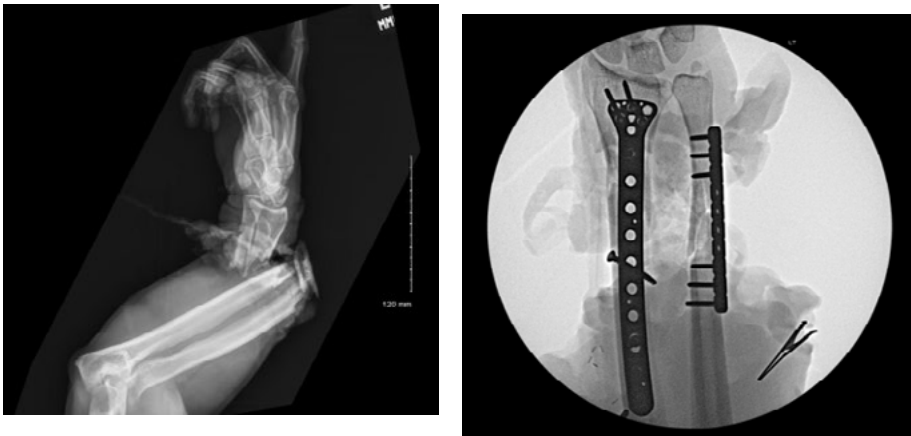


Figure 3: Hospital day 2 blistering and darkening of digits



Figure 4: Hospital day 6 Intraoperative photos



Figure 5: Two month follow up



**Case 2**

Figure 1: Initial ED presentation of LUE

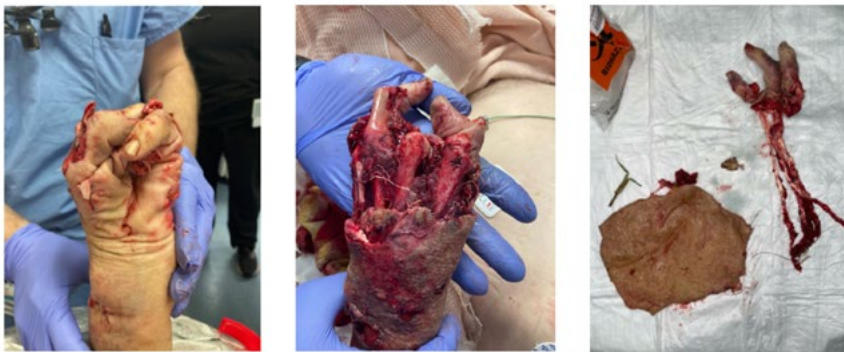


Figure 2: Initial ED presentation of LLE

Figure 3: X-ray of left hand



Figure 4: CT showing alligator bite to the lower leg on the left and on the right showing Morel-Lavallee lesion to the upper thigh.



Figure 5: Left lower extremity wound intra-operative flap procedure



### Case 3

Figure 1: Initial Presentation to the ED



Figure 2: A) Axial Plane Head Computerized Tomography (CT) B) 3D Bone Reconstruction of CT C) Coronal Plane CT

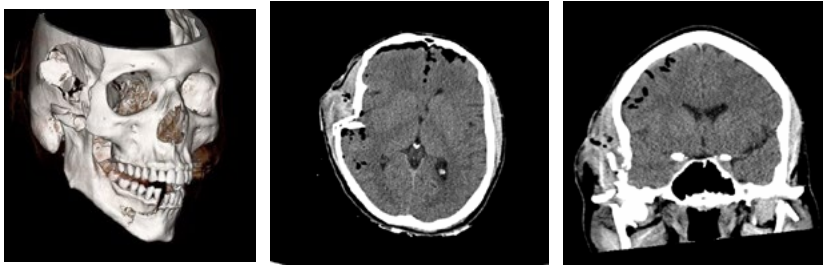


Figure 3: Surgical site infection





Figure 4: MRI when presenting with purulent discharge A) Axial B) Coronal

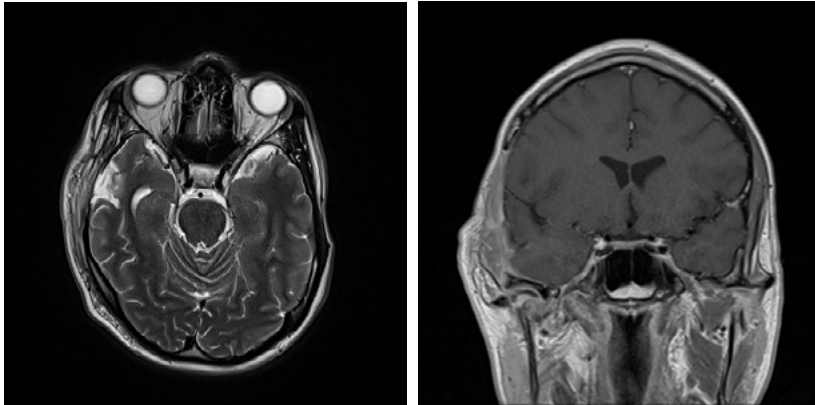


Figure 5: Post cranioplasty





## Institutional Experience with Change of Plane in Implant-Based Breast Reconstruction

**Authors:** Kinsey Rice, MD; Nicole K. Le, MD, MPH; Sarah Moffitt, BS; Bilal Koussayer, BS; Logan Ziegler, MS; Tim Nehila, BA; Nicholas Alford, BS; Kristina Buller, DO, MS; Jenna Stoeher, MD; Kristen Whalen, MD; Deniz Dayicioglu, MD; Nicholas Panetta, MD; Jared Troy, MD; Paul D. Smith, MD; Lauren Kuykendall, MD

**Objective:** Pre-pectoral implant-based breast reconstruction is increasing in popularity due to its benefits over sub-pectoral reconstruction, which include decreasing the likelihood of animation deformity, pain, and lateralization of the implant. Patients who have previously undergone sub-pectoral reconstruction can undergo change of plane to exchange the implant from a sub-pectoral to pre-pectoral position. This study aimed to assess our institutional experience with change of plane in breast reconstruction.

**Methods:** Patients between 2020 and 2024 who had change of plane revision of their breast reconstruction at our institution were included in the study. Descriptive statistics and t-tests were performed assessing patient demographics and surgical and oncologic characteristics. The BREAST-Q questionnaire was used to assess the Satisfaction with Breasts, Psychosocial Well-being, Sexual Well-being, and Physical Chest Well-being domains.

**Results:** 87 patients (154 breasts) were included in this study. The mean age was  $57 \pm 10$  and average body mass index was  $26.8 \pm 4.9$ . Total complication rate was 16.2% with only 5.2% experiencing a major complication. A reduction in animation deformity was noted from 79.9% to 1.9%, and a reduction of preoperative pain was seen from 37% to 7.1% of breasts after change of plane. The Satisfaction with Breasts domain of the BREAST-Q was significantly higher for change of plane than normative data,  $81 \pm 14$  vs.  $58 \pm 18$  ( $p < 0.01$ ), respectively.

**Conclusions:** Change of plane is a safe and effective procedure to improve cosmesis and decrease implant-associated pain and animation deformity in breast reconstruction patients.

## Addressing the Aging Neck with Direct Excision

**Authors:** Colton Riley, MD; Sarvam Terkonda MD

**Introduction:** Direct excision cervicoplasty is an aesthetic operation allowing for excision of redundant skin, neck contouring, and youthful neck rejuvenation. Since 1950, there have been 23 publications discussing direct excision with the vast majority involving technique papers describing different excision patterns. Very few have discussed patient satisfaction, outcomes, and complications encountered.

**Methods:** After IRB approval, we retrospectively reviewed the aesthetic plastic surgery databases at three larger tertiary referral hospitals (Mayo Clinic Arizona, Florida, Rochester) from 1999–2019. Inclusion criteria included patients aged 18 years or older who underwent direct excision cervicoplasty. Patients were excluded if neck rejuvenation was performed through a submental incision or rhytidectomy. Cervicomental angle was measured from patients pre- and post-operative photos. Complications were identified by a retrospective review of the electronic medical record.

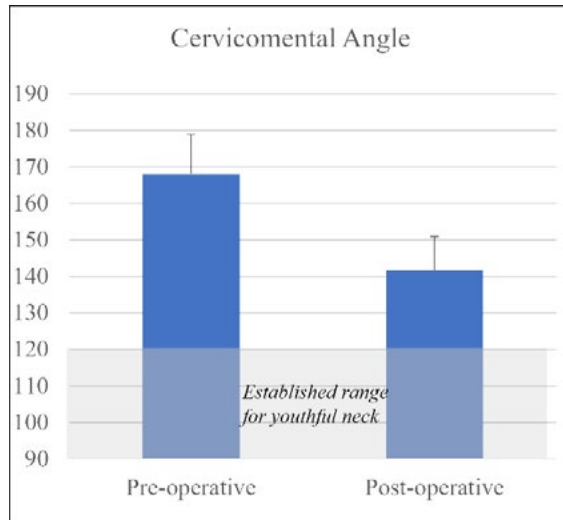
**Results:** Following review of our aesthetic plastic surgery database, a total of 54 patients met aforementioned inclusion criteria. The cohort included 20 females and 34 males. All patients exhibited redundant skin in the central/anterior region of the neck. Cervicomental angle decreased by a mean of  $31.5^\circ$  from preoperative ( $168^\circ$ ) to post-operative ( $141^\circ$ ) assessment. Postoperative complications included: hypertrophic scarring (17%), hematoma (2%), and seroma (2%). Postoperative revisions performed were 20% and included submental re-excision (11%), scar revision (4%), and additional liposuction (5%). Of all 54 patients, 1 patient was not satisfied due to scarring. Both patients were concerned with areas of hypertrophic scarring. All wound healing complications resolved with conservative wound care and close outpatient follow-up.

**Conclusions:** To our best knowledge, this cohort represents the most extensive examination of direct excision cervicoplasty and its satisfaction as well as complications and risks. From this data, we conclude that direct excision cervicoplasty is an option to maximize skin reduction, minimize risk, and achieve high patient satisfaction.

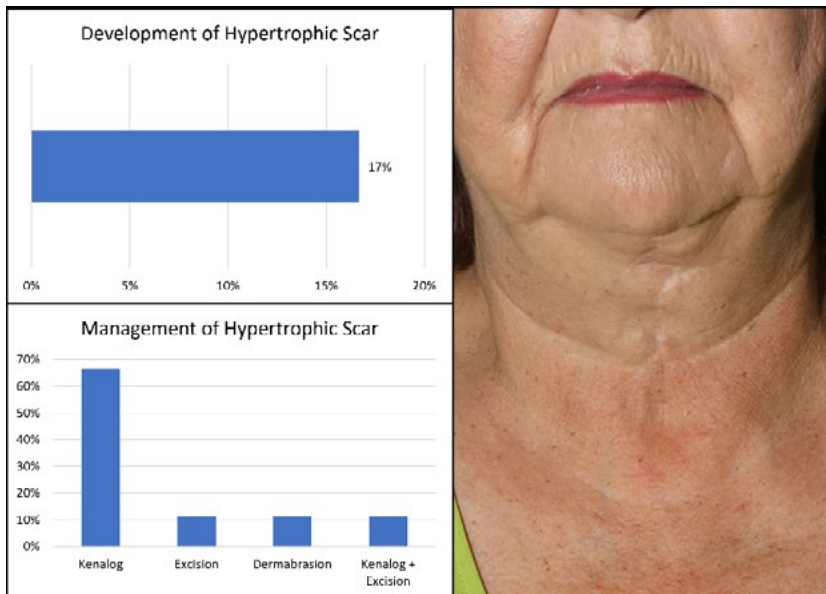
**Figure 1**



**Figure 2**



**Figure 3**



## **The Extended Scapular Fasciocutaneous Flap: An Alternative to the Anterolateral Thigh Flap for Lower Extremity Reconstruction**

**Authors:** Kristen Whalen, MD, Sarah Moffitt, MD, D'Arcy Wainwright, MD, Nicole Le, MD, Jared Troy, MD

**Introduction:** The anterolateral thigh (ALT) flap is a workhorse flap for reconstruction of traumatic lower extremity defects, but can result in donor site morbidity including hematoma, dehiscence, and the need for skin grafting. The extended scapular (ES) flap is a valuable alternative with an inconspicuous donor site that can be closed primarily. This study aims to compare the outcomes in patients undergoing ALT and ES flaps for lower extremity reconstruction.

**Methods:** We performed a retrospective review of 48 consecutive patients who underwent lower extremity reconstruction with an ALT or ES flap by a single surgeon from 2020 to 2024.

**Results:** Thirty-four patients had ALT flaps and 14 had ES flaps performed. The average size of the ALT flap was 182cm<sup>2</sup> (range 30-405cm<sup>2</sup>) and 171 cm<sup>2</sup> (range 64- 266cm<sup>2</sup>) for the ES flap. All ES donor sites were closed primarily whereas 8.8% of the ALT donor sites required skin grafting. There were no donor site complications in the ES group, but 5.8% of patients had dehiscence and 14.7% had hematomas at the donor sites in the ALT group. No intra-operative position changes were required in the ALT or ES groups. There was one flap loss in each group.

**Conclusions:** The ES flap is a suitable alternative to the ALT flap in terms of size, tissue quality, and difficulty of dissection, but has less donor site morbidity. With careful pre-operative planning, it can be harvested and inset from a single position with primary closure of the donor site (Figures 1 and 2).

Figure 1

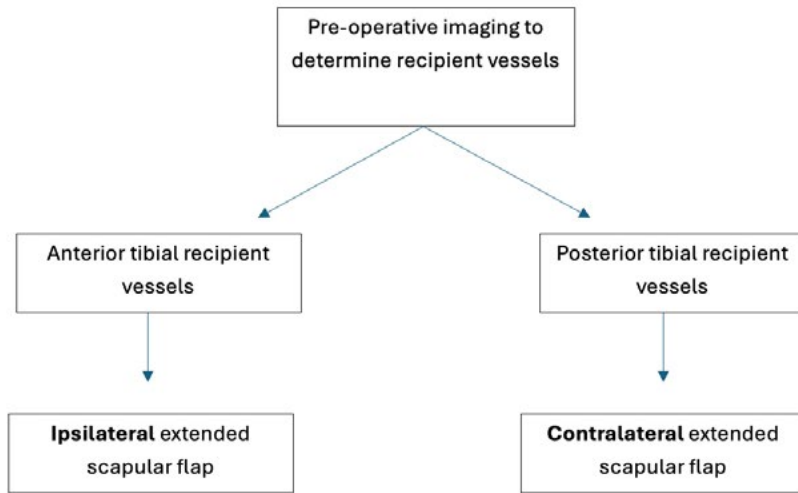
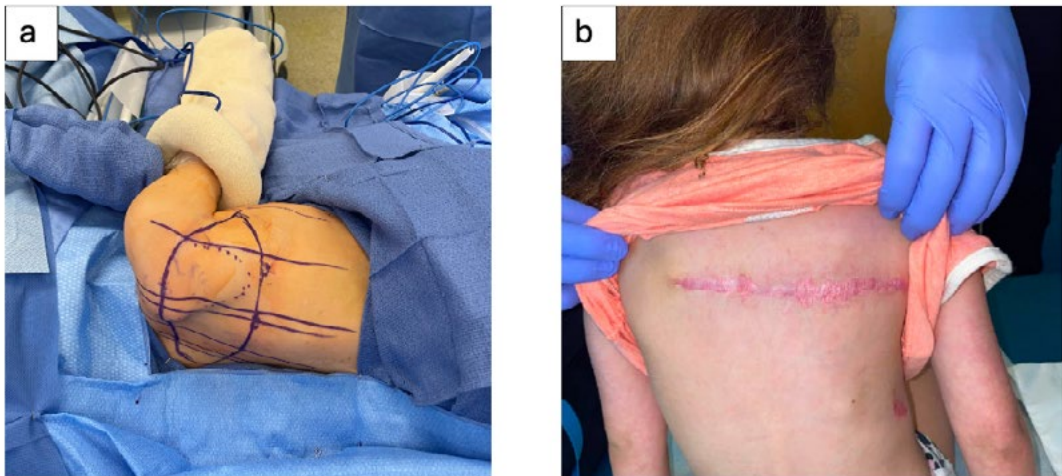


Figure 2





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