PROCEEDINGS OF THE

66th ANNUAL SCIENTIFIC MEETING

SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

June 18-22, 2023 | SLS Hotel at Baha Mar | Nassau, Bahamas

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*Head-to-head in-person tabletop product comparison (MemoryGel Boost vs. Allergan Inspira Cohesive) with 297 respondents; In-person consumer survey with 452 respondents; Head-to-head form stability benchtop testing vs MemoryGel® Xtra and MemoryGel Breast Implants.

†Based on benchtop testing, when compared to Allergan and Sientra corresponding profiles and base widths. The third party trademarks used herein are the properties of their respective owners.

WARNING:

- Breast implants are not considered lifetime devices. The longer people have them, the greater the chances are that 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.

The sale and distribution of Mentor Breast Implant Devices are restricted to users and/or user facilities that provide information to patients about the risks and benefits of the device prior to its use in the form and manner specified in approved labeling to be provided by Mentor Worldwide LLC.

Important Safety Information: MENTOR® MemoryGel® Breast Implants are indicated for breast augmentation in women at least 22 years old or for breast reconstruction. Breast implant surgery should not be performed in women with active infection anywhere in their body with existing cancer or pre-cancer of their breast who have not received adequate treatment for those conditions or are pregnant or nursing. Breast implants are not lifetime devices and breast implantation is not necessarily a one-time surgery. The chance of developing complications increases over time. The most common complications with the MemoryGel® Breast Implants include reoperation, capsular contracture, asymmetry, and breast pain. A lower risk of complication is rupture. The health consequences of a ruptured silicone gel-filled breast implant have not been fully established. MRI screenings are recommended three years after initial implant surgery and then every two years after to detect silent rupture. Breast implants are also associated with the risk of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL), an uncommon type of lymphoma. An individual's risk of developing BIA-ALCL with MENTOR® Breast Implants is low based on the incidence of worldwide cases. Patients should receive a copy of Important Information for Augmentation Patients about MENTOR® MemoryGel® Silicone Gel-Filled Breast Implants or Important Information for Reconstruction Patients about MENTOR® MemoryGel® Silicone Gel-Filled Breast Implants. Your patient needs to read and understand the information regarding the risks and benefits of breast implants, with an opportunity to consult with you prior to deciding on surgery. For detailed indications, contraindications, warning and precautions associated with the use of MemoryGel® Breast Implants. Please refer to the Instructions for Use (IFU) provided with each product, or online at www.mentorwwllc.com.

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WEEK AT A GLANCE

SUNDAY, JUNE 18

7:30 am	Board Meeting
3:00 pm	Early Registration
4:00 pm	Resident Quick Shots

SOCIAL EVENTS

5:30 pm	Welcome Reception
6:30 pm	Program Chair Dinner *(invitation)*
6:30 pm	Past Presidents Dinner *(invitation)*

MONDAY, JUNE 19

SCIENTIFIC SESSION

6:45 am	Board Exam: What to Expect and & How to Prepare
7:35 am	Presidential Welcome
7:45 am	Challenges in Breast Surgery Panel
9:15 am	Perspectives from Our Societies
10:30 am	Round 1 Resident Glancy Competition
11:15 am	Keynote Speaker: Adrian Ballinger
12:30 pm	Mini-symposium on Craniofacial and Cleft Surgery

SOCIAL EVENTS

1:00 pm	Tennis Tournament
5:00 pm	Resident Jeopardy Bowl
7:00 pm	"Pirates of the Caribbean" Theme Dinner *(Badges Required)*

TUESDAY, JUNE 20

SCIENTIFIC SESSION

7:00 am	Grant & Fellowship Reports
7:30 am	Frontiers in Facial Rejuvenation Panel
9:00 am	Round 2 Resident Glancy Competition
10:15 am	Honorary Upchurch Lecture: L. Franklyn Elliott, MD
11:30 am	Safety Panel
12:00 pm	Member Papers

SOCIAL EVENTS

6:00 am	Fun Run
1:00 pm	Golf Tournament
1:00 pm	Toast to Trudie
2:30 pm	Resident & Medical Student Snorkel Scavenger Hunt

WEDNESDAY, JUNE 21

SCIENTIFIC SESSION

7:00 am	Just the Facts Panel
8:00 am	Challenges in Reconstruction & Extremity Salvage Panel
9:45 am	Honorary Jurkiewicz Lecture: Foad Nahai, MD
10:30 am	Member Papers
11:00 am	Looking Past The Horizon Panel
12:15 pm	Business Meeting *(Lunch to be served)*

SOCIAL EVENTS

7:00 pm	Black Tie Gala *(RSVP Required)*

THURSDAY, JUNE 22

SCIENTIFIC SESSION

8:30 am	Special Topics Panel
9:15 am	Innovation and Entrepreneurialism
10:00 am	Body Contouring & Gluteal Fat Grafting Updates
10:45 am	Closing Remarks: John T. Lindsey, MD

PRESIDENTIAL WELCOME

I am excited to welcome the Southeastern Society of Plastic and Reconstructive Surgeons membership to the 66th Annual Scientific Meeting at the SLS Baha Mar in Nassau, Bahamas. The annual meeting is the gem of our society and we all take pride in trying to make it as educational as possible while at the same time being fun and interactive for everyone.

The theme for the meeting this year is **Looking Past the Horizon**. Dr. Bruce Mast has put a very comprehensive program together that will provide educational opportunities for everyone. In addition to the outstanding student, resident, and member speakers we are pleased to welcome Drs. Steven Bernard, David Mathes, and Mindy Haws as well as our keynote speaker Mr. Adrian Ballinger. This year we are fortunate to have Dr. Foad Nahai as our Jurkiewicz Lecturer and Dr. Frank Elliott as our Upchurch Lecturer. They are both giants in the field and we are proud to call them Southeastern members. Also new this year is the mini-symposium on Monday afternoon with the topic this year being craniofacial surgery. We are very excited to welcome the craniofacial group to the meeting and hope that this breakout mini symposium becomes a new tradition.

The social experience is a Southeastern expectation and this years' program will not disappoint. The welcoming reception on Sunday evening is at the Sky Bar on the roof of the SLS hotel and the venue is a must see for everyone. Dress appropriately for the Pirates of the Caribbean theme event on Monday night with the beautiful backdrop being the Caribbean Ocean. We will have some theme drinks and traditional island food and all the fun and festivities that go along with the theme. The Black-Tie Dinner will be on Wednesday night at the Hyatt Hotel convention center. The Baha Mar Resort is a beautiful venue and has something to offer for everyone. The beaches, the water park, the shopping is amazing and there are various themed bars nestled through-out the resort. Be sure to make reservations early for the restaurants for Tuesday night, the free evening, and I hope you brought cash for the casino if you are feeling lucky.

This meeting is truly one of the highlights of my year and I look forward to learning, relaxing, reconnecting and meeting new friends and colleagues. I hope that it will similarly become a highlight and annual tradition of yours too. It has been an honor to serve as President of the Southeastern Society, and rest assured that looking past the horizon, this society is in excellent hands with the outstanding board and Executive team. Welcome and enjoy!

Albert Losken, MD
President

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EX-OFFICIO BOARD MEMBER
Kent K. Higdon, MD
Nashville, Tennessee

"Advancing professional excellence, quality education, and regional collegiality"

The Society By-laws and Policy Manual may be found online through our website: www.sesprs.org

SOCIAL, RECREATIONAL & SPOUSE EVENTS

See the SESPRS Registration Desk for details related to any events.

SUNDAY, JUNE 18

3:00–5:00 pm	**Early Registration**	*George Ballroom Foyer*
4:00–5:30 pm	**Resident Quick Shot Presentations**	*George Ballroom*
5:30–7:00 pm	**Welcome Reception**	*Sky Bar - 20th Floor SLS Hotel*
6:30 pm	**Past Presidents and Program Chair Dinners** *By Invitation Only. See Registration Desk for details.*	

Dinner on your own. Reservations highly recommended.

MONDAY, JUNE 19

6:45–7:30 am	**Board Exam: What to Expect and How to Prepare** Michael A. Harrington, MD, MPH	*George Ballroom*
6:30–7:45 am	**Attendee Breakfast and Visit Exhibits** *Name badge required.*	*George and Studio Foyer*
8:00–10:00 am	**Spouse/Guest Breakfast** Registered Spouse/family/guests only. *Name badge required*	*Fi'lia Restaurant*
1:00 pm	**Annual Tennis Tournament** *Registration is required.* Registered participants are responsible to make their way to the tennis facility by 1:00 pm - *Additional fees apply.*	*Baha Mar Tennis Courts*
5:00–6:00 pm	**Resident Jeopardy Bowl** *Support provided by Mentor*	*George Ballroom*
6:30–8:30 pm	**Theme Dinner - Pirates of the Caribbean** Open to all paid registrants. Children of all ages welcome! Dress, cool and comfortable. *See the Registration Desk for Details -* ***Name badge required***	*SLS Hotel Rooftop Pavilion 7th Floor*

TUESDAY, JUNE 20

6:00 am	**Annual Fun Run** *Registration prefered but not required*. Participants should meet in the lobby of the SLS Hotel by 5:45 am. *No Fee*	*Meet in Hotel Lobby*
6:30–7:30 am	**Attendee Breakfast and Visit Exhibits** *Name badge required.*	*George and Studio Foyer*
8:00–10:00 am	**Spouse/Guest Breakfast** Registered Spouse/family/guests only *Name badge required.*	*Fi'lia Restaurant*
1:00 pm	**Annual Golf Tournament** *Registration is Required.* Lunch provided. On property shuttles run every 15-20 minutes. Golfers are responsible to make their way to the shuttle and arrive at the course by 12:45 pm *Additional fees apply.*	*Royal Blue Golf Course*
1:00 pm	**Toast To Trudie** An Event for Women in plastic surgery Hosted by Holly C. Wall, MD, Ann Ford-Reilley, MD, Lynn A. Damitz, MD, Carmen Kavali, MD, Abigail E Chaffin, MD *Registration preferred. Support provided by Allergan*	*Cleo - Lobby Level SLS Hotel*
2:30 pm	**Resident & Medical Student Snorkel Scavenger Hunt on the Beach** Meet by the paddle board and kayak rentals	

Dinner on your own. Reservations highly recommended.

WEDNESDAY, JUNE 21

6:30–7:30 am	**Attendee Breakfast and Visit Exhibits** *Name badge required.*	*George and Studio Foyer*
8:00–10:00 am	**Spouse/Guest Breakfast** *Registered Spouse/family/guests only.* *Name badge required.*	*Fi'lia Restaurant*
7:00–10:00 pm	**Black Tie Dinner** ***Open to paid registrants 16 and older.*** Registrants **MUST RSVP** in advance of the meeting. Resident's of the Glancy Award Competition (and spouses) are complimentary, but MUST confirm prior to meeting. All other residents and spouses, a separate registration is required.	*Grand Hyatt Ballroom*

SOCIAL/RECREATIONAL/SPOUSE EVENTS

THURSDAY, JUNE 22

7:30–8:30 am	**Attendee Breakfast and Visit Exhibits** *Name badge required.*	*George and Studio Foyer*
8:00–10:00 am	**Spouse /Guest Breakfast** *Registered Spouse/family/guests only.* *Name badge required.*	*Fi'lia Restaurant*

2023 SPECIAL GUEST LECTURERS

Adrian Ballinger – Keynote Speaker

2023 SESPRS Keynote speaker, Adrian Ballinger, is a world class mountain athlete and business owner. As founder and head guide of the internationally acclaimed Alpenglow Expeditions, and the pioneer of Rapid Ascent™ expeditions, Adrian is held up as a thought leader in expedition innovation and responsible climbing practices.

Adrian is also a highly decorated alpinist and skier. He is the only American who has skied three 8,000 meter peaks, and in 2011 became the first person to summit three 8,000 meter peaks in only 3 weeks (Everest twice and Lhotse once). He has reached 17 summits of 8,000 meter peaks (including 8 summits of Mt. Everest), and in 2016 summited Everest without supplemental oxygen, as documented in the award-winning "Everest No Filter" social media program. 2019 brought another career milestone when he summited K2 without supplemental oxygen, a feat captured in the feature documentary "Breathtaking: K2".

As an experienced and polished speaker, Adrian leans into the experience he's gathered in a long career filled with remarkable personal accomplishments, and from leading countless others through difficult climbing challenges. Adrian is uniquely qualified to speak to the qualities that a world-class adventurer needs to have, such as risk management and preparation when the stakes are a matter of life or death, and to translate those themes to a wide variety of audiences.

L. Franklyn Elliott, MD – Honorary Upchurch Lecturer

2023 Honorary Upchurch Lecturer, L. Franklyn Elliott was born in Macon, Georgia and graduated from Princeton in 1972 majoring in history. He then graduated from Vanderbilt Medical School in 1976. After completing 5 years of general surgery at Vanderbilt and Tulane he came to Emory for plastic surgical training which he finished in 1983. His next 4 years was in private practice in New Orleans but also associated with the plastic surgery program at LSU in New Orleans. The opportunity came up to return to Atlanta and join Dr. Carl Hartrampf and Dr. Paul Black so he returned to Atlanta and joined Atlanta Plastic Surgery in 1987. He has been there ever since.

He ran the Atlanta Breast Symposium since 1988 and continued to be a part of the Symposium planning team after he became an emeritus chair in 2003.

He was president of the Southeastern Society of Plastic and Reconstructive Surgeons in 2000-2001.

He has been a member of the American Association of Plastic Surgeons , the American Society of Plastic Surgeons and the American Society of Aesthetic Plastic Surgeons.

Foad Nahai, MD – Honorary Jurkiewicz Lecturer

2023 Honorary Jurkiewicz Lecturer, Foad Nahai, is the former Maurice J. Jurkiewicz chair in Plastic Surgery and Professor of Surgery at Emory University in Atlanta, Georgia. He is the editor-in-chief of Aesthetic Surgery Journal and the past president of several organizations including the American Association for the Accreditation of Ambulatory Surgical Facilities, the American Society for Aesthetic Plastic Surgery, the International Society of Plastic Surgery and Chairman of the Plastic Surgery Research Council. Professor Nahai has published over 275 peer reviewed articles, edited or co-edited 14 textbooks, covering all aspects of reconstructive and aesthetic plastic surgery.

Professor Nahai is internationally recognized as an innovator in the field of plastic surgery, where he has developed and refined many aesthetic and reconstructive procedures.

Professor Nahai has been invited to lecture and demonstrate plastic surgical procedures all over the world. In addition to numerous professional honors and awards, he is listed in the “Best Doctors in America” and has been listed in W Magazine as one of the top plastic surgeons in the world.

Professor Nahai is certified by the American Board of Plastic Surgery and served 6 years as a Director of the Board. He is a fellow of the American College of Surgeons. He has been honored by numerous organizations worldwide including Honorary fellowship of the Royal College of Surgeons of England and Thailand.

2023 PRESENTERS

PROGRAM COMMITTEE, REVIEWERS, MODERATORS & SECRETARIES

Bruce A. Mast, MD - Program Chair

Christopher A. Campbell, MD
Anthony E. Capito, MD
Abigail E. Chaffin, MD
Harvey W. Chim, MD
Tae W. Chong, MD
Lynn A. Damitz, MD
Jared M. Davis, MD
Brent R. DeGeorge, Jr., MD, PhD
Felmont F. Eaves, MD
Harold I. Friedman, MD, PhD
Robert Garza, MD
Paul A. Ghareeb, MD
Michael S. Golinko, MD
Michael Hanemann, MD
Michael A. Harington, MD, MPH
Alexandra M. Hart, MD
Daniel F. Haynes, MD
Kent K. Higdon, MD
Scott T. Hollenbeck, MD
Ian C. Hoppe, MD
Adam J. Katz, MD
Carmen M. Kavali, MD
Ashley K. Lentz, MD
John T. Lindsey, MD
Albert Losken, MD
Bruce A. Mast, MD
Thomas C. McFadden, Jr. MD
Benjamin C. McIntyre, MD
Stephen E. Metzinger, MD
Kurtis E. Moyer, MD
Galen Perdikis, MD
Brett T. Phillips, MD
Kristin M. Rezak, MD
Brian D. Rinker, MD
Christopher M. Runyan, MD, PhD
Jack F. Scheuer, MD
James T. Thompson, MD
Peter W. Thompson, MD
Holly C. Wall, MD
Joseph K. Williams, MD
Timothy S. Wilson, MD
Jeyhan Wood, MD
Thomas J. Zaydon, Jr., MD

SPECIAL GUEST LECTURERS

Adrian Ballinger
Steven L. Bernard, MD
David W. Mathes, MD

SESPRS MEMBER AND RESIDENT MEMBER PRESENTERS

Jonathan S. Black, MD
Colin M. Brady, MD
Morgan S. Brgoch, MD
Ciara A. Brown, MD
David A. Brown, MD
Owen Brown, MD
Christina N. Canzoneri, MD
Harvey W. Chim, MD
Tae W. Chong, MD
Jesse Chou, MD
Lynn A. Damitz, MD
Jared M. Davis, MD
Robert DeVito, MD
Felmont F. Eaves, MD
L. Franklyn Elliott, MD
Heather R. Faulkner, MD, MPH
Thomas Fiala, MD
Laura I. Galarza, MD
Oni Garcia, MD
Patrick B. Garvey, MD
Michael S. Golinko, MD
James C. Grotting, MD
Melinda J. Haws, MD
Emily E. Hecox, MD
Miriam Henry, MD
Laura Humphries, MD
Scott T. Hollenbeck, MD
Ian C. Hoppe, MD
Salam A. Kassis, MD
Adam J. Katz, MD
Carmen M. Kavali, MD
Kevin Keller, MD
Lee H. Kilmer, MD
Samuel Kogan, MD, PhD
Nicole K. Le, MD, MPH
Paulina Le, MD
Michael Lebhar, MD
Howard Levinson, MD
Bruce A. Mast, MD
Thomas C. McFadden, Jr. MD
Gabriele Miotto, MD
Rene Myers, MD
Foad Nahai, MD
Gregory C. Neil, MD
Susi Orra, MD
Pat Pazmino, MD
Brett T. Phillips, MD
Nikitha Potturi, MD
Jason Pozner, MD
Salomon Puyana, MD
Christopher M. Runyan, MD, PhD
Harel G. Schwartzberg, MD
Amanda R. Sergesketter, MD
Ronnie L. Shammas, MD
Orr Shauly, MD
Peter M. Vonu, MD
D'Arcy Wainwright, MD
Holly C. Wall, MD
Joseph K. Williams, MD
S. Anthony Wolfe, MD
Blair A. Wormer, MD
Waylon Zeng, MD

NON-MEMBER PRESENTERS

Odette Abou Ghanem
Maxine Garcia, MD
Arian Ghanouni, MD
Delora Mount, MD
Sriya Nemani
Brendan Podszus, BS
Mariam Saad, MD
Alexis Tashima, MD
Michael Turgeon, MD
Jack C. Yu, MD

2023 EXHIBITORS

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To view exhibitor descriptions please scan

PROGRAM OBJECTIVES

Upon completion of this meeting, participants should be able to:

- Identify and analyze challenges in breast surgery to optimize outcomes,
- Review the organizational goals that help to guide the specialty of plastic surgery, as well as manage the professionalism and public interfaces,
- Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,
- Analyze how dreams and goals can enhance work and life balance,
- Review Craniofacial leaders past and future techniques and what affect they have had or may have going forward,
- Evaluate and consider techniques and technology to enhance surgical and non-surgical facial rejuvenation,
- Evaluate experiences through travel and mentorship and discuss tools and techniques that have influence on work and life,
- Identify and consider how complications arise and solutions that have been evaluated to provide better team and patient outcomes,
- Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery,
- Identify and analyze challenges in extremity salvage and reconstruction to optimize outcomes,
- Review components of life and leadership with the goal to inspire others as an outcome,
- Evaluate and discuss several areas in plastic surgery in regard to their present state and what they may look like in the future,
- Review special topics related to plastic surgery and potential applications,
- Describe the process of inventing, developing, and final product application providing plastic surgeons with the basic playbook for commercial innovation that could impact patient care,
- Review the safety and efficacy of body contouring and gluteal fat grafting to improve patient outcomes.

ACCREDITATION

The Southeastern Society of Plastic and Reconstructive Surgeons is accredited by the Accreditation Council for Continuing Medical Education in order to provide continuing medical education for physicians.

The Southeastern Society of Plastic and Reconstructive Surgeons designates this live activity for a maximum of *21.50 AMA PRA Category 1 Credit(s)™* . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the 21.50 credits, 3.75 (2.75 for main meeting and 1 for mini-craniofacial meeting) has been identified as applicable to patient safety.

Sign-in for the Mini-Symposium on Craniofacial and Cleft Surgery will be required.

This symbol throughout the program identifies a safety credit. ▲

Use calculations below to claim your credits after the meeting:

Sunday, June 18th: Quick Shot Presentations *1.5 AMA PRA Category 1 Credit(s)™*

Monday early morning, June 19th: *2.5 AMA PRA Category 1 Credit(s)™*

Monday mid-morning, June 19th: *1.5 AMA PRA Category 1 Credit(s)™*

Monday Craniofacial Symposium, June 19th: *4 AMA PRA Category 1 Credit(s)™*

Tuesday early morning: June 20th: *2.5 AMA PRA Category 1 Credit(s)™*

Tuesday mid-morning, June 20th: *2.25 AMA PRA Category 1 Credit(s)™*

Wednesday early morning, June 21st: *2.25 AMA PRA Category 1 Credit(s)™*

Wednesday mid-morning, June 21st: *2.5 AMA PRA Category 1 Credit(s)™*

Thursday morning, June 22nd: *2.5 AMA PRA Category 1 Credit(s)™*

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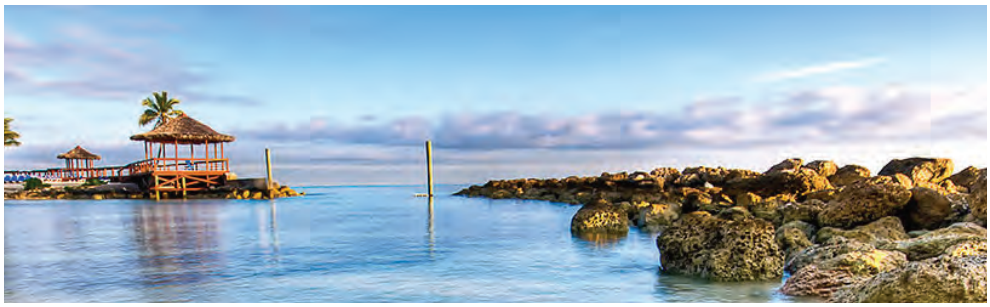
ENDORSED PROGRAM
2023



SESPRS DISCLOSURE POLICY

As a provider accredited by the ACCME, SESPRS must ensure balance, independence, objectivity and scientific rigor in all sponsored educational activities. All planners, presenters and faculty members are required to disclose all relevant financial relationships with ineligible companies in advance of the activity. All individuals responsible for the content of any SESPRS educational activity must disclose. Anyone who refuses to disclose will be removed. All disclosures are reviewed by the SESPRS ACCME Committee, and mitigated in advance of the activity if required.

Management takes place either through recusal, limiting participation, peer review, or divestment of the relationship.

All planners, presenters and faculty members' disclosures will be provided to the audience in advance of the activity in the program 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 faculty member/participant is required to disclose that the product is either investigational or it is not labeled for the usage being discussed. SESPRS shall convey any information disclosed by the faculty member/participant to the CME program audience prior to the activity.

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2023 ANNUAL MEETING DISCLOSURES

Odette Abou Ghanem. . . . . .Nothing to disclose

Adrian Ballinger. . . . . .Nothing to disclose

Steven L. Bernard, MD . . . . . .Nothing to disclose

Jonathan S. Black, MD . . . . . .Consultant with Stryker – receives consulting fees

Colin M. Brady, MD. . . . . Nothing to disclose

Morgan S. Brgoch, MD. . . . . .Nothing to disclose

Ciara A. Brown, MD. . . . . .Nothing to disclose

David A. Brown, MD . . . . . .Consultant with Checkpoint Surgical - receives consulting fees

Owen Brown, MD. . . . . .Nothing to disclose

Christopher A. Campbell, MD*. . .Consultant with Mentor - receives consulting fees; Investigator with AbbVie and LifeNet Health - receives research funds; Advisory board member with Integra Life Sciences - no financial payment

Christina N. Canzoneri, MD. . . . . .Nothing to disclose

Anthony E. Capito, MD*. . . . . .Nothing to disclose

Abigail E. Chaffin, MD* . . . . . .Consultant with Aroa and Urgo Medical - receives consulting fees

Harvey W. Chim, MD* . . . . . .Previous speaker with Axogen; Consultant with Integra Life Sciences - receives consulting fees; Institutional grants received from Integra and Neurptive Therapeutics

Tae W. Chong, MD*. . . . . .Consultant with Genentech - receives consulting fees

Jesse Chou, MD. . . . . .Nothing to disclose

Lynn A. Damitz, MD*. . . . . .Nothing to disclose

Brent R. DeGeorge, Jr., MD, PhD* Nothing to disclose

Robert DeVito, MD . . . . . .Nothing to disclose

Felmont F. Eaves, MD . . . . . .Owner Brijjit Medical - paid employee

L. Franklyn Elliott, MD . . . . . .Nothing to disclose

Heather R. Faulkner, MD, MPH. . .Nothing to disclose

Thomas Fiala, MD . . . . . .Advisory Board for Dominion Aesthetics - non compensated advisor; Dominion Aesthetics - research support as PI, stock options

Harold I. Friedman, MD, PhD* . . .Nothing to disclose

Laura I. Galarza, MD . . . . . .Nothing to disclose

Maxine Garcia, MD . . . . . .Nothing to disclose

Onelio Garcia, MD . . . . . .Consultant with Mentor, BD, Solta Medical, MTF - receives consulting fees; Springer Publishers – royalties

Patrick B. Garvey, MD . . . . . .Nothing to disclose

Robert Garza, MD* . . . . . .Nothing to disclose

Arian Ghanouni, MD . . . . . .Nothing to disclose

Paul A. Ghareeb, MD* . . . . . .Nothing to disclose

Michael S. Golinko, MD* . . . . . .Nothing to disclose

James C. Grotting, MD. . . . . .Aesthetic Surgeons Financial Group (CosmetAssure) - owner; Advisor with Premier Aesthetic Solutions - no compensation; Stock Holder with Ideal Implant, Stingray, LLC, Brijjit, LLC, Engage Media; Theime and Elsevier - receives royalties

Michael Hanemann, MD* . . . . . .Nothing to disclose

Michael A. Harrington, MD, MPH* Nothing to disclose

Alexandra M. Hart, MD* . . . . . .Nothing to disclose

Melinda Haws, MD . . . . . .Consultant with Revance, Strathspey Crown - receives consulting fees; Advisory board member and consultant with Sientra and Allergan. Relationships with Revance, Sientra, & Allergan have ended in the past 24 months

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Nicole K. Le, MD, MPH . . . . . .Nothing to disclose

Paulina Le, MD . . . . . .Nothing to disclose

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Galen Perdikis, MD* . . . . . .Axogen - national registry participant, university receives funds for data collection; Brijjit - stock options, divested of equity shares within past 24 months

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Salomon Puyana, MD*. . . . . .Nothing to disclose

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Waylon Zeng, MD . . . . . .Nothing to disclose

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SCIENTIFIC PROGRAM

SUNDAY, JUNE 18

4:00–5:30 pm **Resident Quick Shots** *George Ballroom*
Moderator: Benjamin C. McIntyre, MD
Secretary: Vincent Naman, MD

4:00–4:03 **#1 Complication Rates after Outpatient Distal Radius Fracture Fixation: Comparison of Two Different Treatment Facility Types** (p. 34)
Ciara A. Brown, MD - Emory University

4:04–4:07 **#2. Predictors of Autologous Fat Grafting in Immediate, Implant-Based Breast Reconstruction** (p. 36)
Owen Brown, MD – Emory University

4:08–4:11 **#3 Aesthetic Outcomes of Primary Cleft Lip Repair Utilizing 2-octyl Cyanoacrylate Liquid and a Self-adhesive Polyester Mesh** (p. 38)
Christina N. Canzoneri, MD – Virginia Tech University

4:12–4:15 **#4 Social Determinants of Health Associated with Prolonged Time to Treatment for Non-Traumatic Upper Extremity Conditions** (p. 39)
Jesse Chou, MD – University of Virginia

4:16–4:19 **#5 The Use of the Fisher Anatomical Subunit Approach for Cleft Lip Revision: An Evolution and Case Series** (p. 40)
Laura I. Galarza, MD – University of Mississippi

4:20–4:30 **Discussion**

4:31–4:34 **#6 Barriers to Remote Burn Care Delivery: An Analysis of Burn Center Proximity and Access to Critical Telehealth Infrastructure** (p. 42)
Emily E. Hecox, MD - University of Mississippi

4:35–4:38 **#7 Early Experience with Threaded Intramedullary Nail Fixation in the Treatment of Hand Fractures: The Move Away from Pins and Plates** (p. 45)
Miriam Henry, MD – University of Kentucky

4:39–4:42 **#8 Oncoplastic Breast Reduction Surgery Decreases Rates of Re-operation after Breast Conservation** (p. 47)
Lee H. Kilmer, MD – University of Virginia

4:43–4:46 **#9 Impact of Immediate Lymphatic Reconstruction Anastomotic Technique on Prevention of Breast Cancer Related Lymphedema** (p. 48)
Nicole K. Le, MD, MPH – University of South Florida

4:47–4:50 **#10 Craniometric and Volumetric Analyses of Normocephalic and Scaphocephalic Patients with Nonsyndromic Single-Suture Sagittal Craniosynostosis** (p. 49)
Michael Lebhar, MD – University of Mississippi

4:51–5:00 **Discussion**

5:01–5:04 **#11 Air or Saline? A Propensity Score-Matched Analysis on the Effect of Tissue Expander Fill on Complications in Immediate Breast Reconstruction** (p. 50)
Amanda R. Sergesketter, MD – Duke University

5:05–5:08 **#12 A Multi-Institutional Analysis of a Textbook Outcome Among Patients Undergoing Microvascular Breast Reconstruction** (p. 52)
Ronnie L. Shammas, MD – Duke University

5:09–5:12 **#13 ASPS Direct-to-Implant vs. Immediate Autologous Tissue Transfer: A Systematic Review and Meta-analysis of Patient Reported Outcomes after Immediate Breast Reconstruction** (p. 54)
Orr Shauly, MD – Emory Univeristy

5:13–5:16 **#14 ASPS Member Reported Risk Stratification and Elective Breast Surgery Specimen Labeling Practices** (p. 55)
Peter M. Vonu, MD – University of Florida

5:17–5:20 **#15 Virtual Loupes: A Pilot Study of the Use of Mixed Reality in Plastic Surgery** (p. 58)
Waylon Zeng, MD – Virginia Tech

5:21–5:30 **Discussion**

Objective: Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice.

5:30–6:30 pm **Welcome Reception** *Sky Bar - 20 Floor SLS Hotel*

MONDAY, JUNE 19

6:30–7:45 am	**Attendee Breakfast and Visit Exhibits**	*George and Studio Ballroom Foyer*
6:45–7:30 am	**Board Exam: What to Expect and How to Prepare** Michael A. Harrington, MD, MPH	*George Ballroom*
7:35–7:45 am	**Presidential Welcome** Albert Losken, MD	*George Ballroom*
7:45–9:15 am	**Challenges in Breast Surgery Panel** Moderator: Abigail E. Chaffin, MD	*George Ballroom*
7:45–8:00	**Tuberous Breast** James C. Grotting, MD	
8:00–8:15	**Free Flap or No Free Flap** Steven L. Bernard, MD	
8:15–8:30	**Managing the Failed Reconstruction** ▲ Scott T. Hollenbeck, MD	
8:30–8:45	**Downsizing the Over-Augmented Breast** Holly C. Wall, MD	

8:45–9:00	**Aesthetic Breast Surgery in the Age of BII and Capsule Malignancies** Melinda Haws, MD	
9:00–9:15	**Discussion** **Objective:** Identify and analyze challenges in breast surgery to optimize outcomes	
9:15–10:00 am	**Perspectives from Our Societies** Moderator: Albert Losken, MD **The Aesthetic Society** Melinda Haws, MD **ASPS** Howard Levinson, MD **Objective**: Review the organizational goals that help to guide the specialty of plastic surgery, as well as manage the professionalism and public interfaces.	*George Ballroom*
10:00–10:30 am	**Break and Visit Exhibits**	*George and Studio Ballroom Foyer*
10:30–11:15 am	**Glancy Resident Papers 1 -5** Moderator: Brian D. Rinker, MD, Secretary Christopher M. Runyan, MD, PhD	
10:30–10:37	**#1 The Modified Fragility Index Predicts Major Complications in Oncoplastic Reduction Mammoplasty (OCR) (p.61)** Ciara A. Brown, MD - Emory University	
10:37–10:44	**#2 Gender-Affirming Surgery Improves Mental Health Outcomes and Decreases Anti-Depressant Use in Patients with Gender Dysphoria (p.62)** Jesse Chou, MD – University of Virginia	
10:44–10:51	**#3 Implementation of an Enhanced Recovery After Surgery Protocol for Cleft Palate Repair (p.63)** Laura I. Galarza, MD – University of Mississippi	
10:51–10:58	**#4 Cranial Defect Reconstruction with Custom 3D-Printed Hydroxyapatite Scaffolds: A Large Pre-Clinical Model (p.64)** Samuel Kogan, MD, PhD – Atrium Health Wake Forest Baptist	
10:58– 11:05	**#5 Improving the Care and Cost of Treating Community-Acquired Stage 3 and 4 Decubitus Ulcers (p.65)** Paulina Le, MD – University of South Carolina, Prisma Health	
11:05–11:15	**Discussion** **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice.	
11:15–12:00 pm	**Keynote Speaker - Adrian Ballinger - K2 no O_2** Moderator: Bruce A. Mast, MD **Objective:** Analyze how dreams and goals can enhance work and life balance	*George Ballroom*

12:30–4:45 pm SESPRS MINI-SYMPOSIUM ON CRANIOFACIAL AND CLEFT SURGERY

Planning Committee:

Joseph K. Williams, MD – CHOA Emory, Chair
Colin M. Brady, MD – CHOA/Emory
Michael S. Golinko, MD- Vanderbilt University
Ian C. Hoppe, MD – University of Mississippi
Rene Myers, MD – University of Alabama, Birmingham
Christopher M. Runyan, MD, PhD - Wake Forest

12:30–1:30 pm	**Lunch and Special Lectures** Moderator: Joseph K. Williams, MD	*George Ballroom*
12:30–1:00	**A Tale of Two Teachers** S. Anthony Wolfe, MD	
1:00– 1:30	**Craniofacial Surgery - What's our Future** Jack C. Yu, MD **Objectives:** Review Craniofacial leaders' past and future techniques and what affect they have had or may have going forward,	
1:30–2:00 pm	**Special Topics Panel: Management of Complex Craniofacial Trauma: Case Studies** ▲ Moderator: Ian C. Hoppe, MD Panelists: Michael S. Golinko, MD, Laura Humphries, MD, Christopher M. Runyan, MD, PhD	*George Ballroom*
2:00–2:40 pm	**Abstract Presentations**	*George Ballroom*
2:00–2:05	**#1 Feeding Outcomes after Mandibular Distraction for Airway Obstruction in Infants (p. 67)** Jonathan S. Black, MD	
2:05–2:10	**#2 Early Strip Craniectomy with Cranial Orthosis: An Effective Alternative for Multi-suture Craniosynostosis? (p. 68)** Odette Abou Ghanem	
2:10–2:15	**#3 Case and Review: Isolated Duplication of Oral Stoma with Osseous and Odontogenic Components (p. 69)** Miriam Henry, MD	
2:15–2:20	**#4 Helmets for Plagiocephaly – A Review of Crowdsource Funding: A National and Southeastern Regional Analysis (p. 71)** Brendan Podszus, BS	
2:20–2:25	**#5 Creation and Implementation of Regional Measure in Sagittal Craniosynostosis (p. 73)** Christopher M. Runyan, MD, PhD	
2:25–2:30	**#6 Considerations in the Management of the Recalcitrant Cleft Maxilla at Skeletal Maturity (p. 75)** Danielle Sobol, MD	

2:30–2:40	**Discussion** **Objectives:** Discuss presenter's research projects, the results, and the potential application to cleft and craniofacial,	
2:40–3:10 pm	**Special Topics Panel: Pediatric Microsurgery and its Role in Craniofacial Armamentarium** ▲ Moderator: Colin M. Brady, MD Panelists: Colin M. Brady, MD, Rene Myers, MD, Alexis Tashima, MD	*George Ballroom*
3:10–3:25	**Break**	
3:25–4:05 pm	**Abstract Presentations**	*George Ballroom*
3:25–3:30	**#7 Does Age at Time of Speech Surgery for Velopharyngeal Insufficiency Effect Need for Revision Surgery? (p. 76)** Danielle Sobol, MD	
3:30–3:35	**#8 Craniometric and Volumetric Analyses of Normocephalic and Scaphocephalic Patients with Nonsyndromic Single-Suture Sagittal Craniosynostosis (p. 77)** Michael Lebhar, MD	
3:35–3:40	**#9 Improving Access to ACPA Cleft Teams in Mississippi: A Cost Analysis (p. 78)** Emily E. Hecox, MD	
3:40–3:45	**#10 Perioperative Management of Obstructive Sleep Apnea in Patients with Syndromic Craniosynostosis Undergoing LeFort III Osteotomy with Distraction: A Case Series(p. 80)** Laura I. Galarza, MD	
3:45–3:50	**#11 Posterior Cranial Vault Distraction Osteogenesis in the Immunocompromised Patient (p. 82)** Michael Lebhar, MD	
3:50–3:55	**#12 Aesthetic Outcomes of Primary Cleft Lip Repair Utilizing 2-octyl Cyanoacrylate Liquid and a Self-adhesive Polyester Mesh (p. 83)** Christina N. Canzoneri, MD	
3:55–4:05	**Discussion** **Objectives:** Discuss presenter's research projects, the results, and the potential application to cleft and craniofacial,	
4:05–4:35 pm	**Special Topics Panel: The Future of Craniofacial Surgery: Our Model of Fellowship Training and Relevance to the Future** Moderator: Joseph K. Williams, MD Panelists: Joseph K. Williams, MD, Delora L. Mount, MD, Jack C. Yu, MD	*George Ballroom*
	S. Anthony Wolfe Best Craniofacial Abstract *(to be awarded at the Wednesday Evening Black Tie Gala)*	

5:00–6:00 pm	**Resident Jeopardy Bowl** Moderator: Kent K. Higdon, MD	*George Ballroom*
1:00 pm	**Tennis Tournament**	*Baha Mar Tennis Courts*
6:30–8:30 pm	**Theme Dinner "Pirates of the Caribbean"**	*Roof Top Pavilion 7th Floor*

TUESDAY, JUNE 20

6:30–7:30 am	**Attendee Breakfast and Visit Exhibits**	*George and Studio Ballroom Foyer*
7:00–7:30 am	**Grant and Fellowship Reports** Moderator: Adam J. Katz, MD	*George Ballroom*
7:00–7:15	**Long Term Efficacy of Immediate Lymphovenous Bypass at the Time of Axillary Lymph Node Dissection in the Prevention of Breast Cancer Related Lymphedema** D'Arcy Wainwright, MD	
7:15–7:30	**Mark A. Codner Aesthetic and Breast Fellowship Presentation** **The Gliding Browlift: A Single Surgeon's Long Term Outcomes and Maintenance of Lift** Susan Orra, MD	
7:30–9:00 am	**Frontiers In Facial Rejuvenation Panel** Moderator: Thomas C. McFadden, Jr., MD	*George Ballroom*
7:30–7:45	**Microcoring, Thermal Delivery and Minimally Invasive Suture Suspension** Jason Pozner, MD	
7:45–8:00	**Advanced Surgical Neck Refinements** James C. Grotting, MD	
8:00–8:15	**Improving the Neck Without a Submental Incision: Tweaks to a Classic Technique** Thomas Fiala, MD	
8:15–8:30	**Injectable and Surgery for Total Facial Rejuvenation** Gabriele Miotto, MD	
8:30–8:45	**The Mandatory Need for Tissue Quality Improvement Procedures in Various Facial Surgery Techniques** Thomas C. McFadden, Jr., MD	
8:45– 9:00	**Discussion** **Objective:** Evaluate and consider techniques and technology to enhance surgical and non-surgical facial rejuvenation,	

9:00–9:45 am	**Resident Glancy Papers 6-10** Moderator: Brent R. DeGeorge Jr., MD, PhD Secretary: Lynn A. Damitz, MD	*George Ballroom*
9:00–9:07	**#6 The Utility of Thermal Imaging in Perforator Identification and Flap Planning (p. 84)** Nikitha Potturi, MD – Virginia Tech	
9:07–9:14	**#7 The Outcomes of Local Infiltration Anesthesia vs Ultrasound-guided Pectoralis (PEC1) + Serratus Anterior Plane (SAP) Blocks on Post Anesthetic Care Unit (PACU) Pain Control in Patients Undergoing Primary Submuscular Augmentation Mammoplasty (p. 85)** Salomon Puyana, MD – Tulane University	
9:14–9:21	**#8 Increased Time Intervals in Postoperative Flap Monitoring After Autologous Breast Reconstruction (p. 86)** Harel G. Schwartzberg, MD – Louisiana State University	
9:21–9:28	**#9 Targeted Muscle Reinnervation: Factors Predisposing to Successful Pain Score Reduction (p. 88)** Peter M. Vonu, MD – University of Florida	
9:28–9:35	**#10 The Impact of Obesity On Success of Immediate Lymphatic Reconstruction For Prevention of Breast Cancer Related Lymphedema (p. 90)** D'Arcy Wainwright, MD – University of South Florida	
9:35–9:45	**Discussion** **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,	
9:45–10:15 am	**Break and Visit Exhibits**	*George and Studio Ballroom Foyer*
10:15–11:30 am	**Upchurch Lecture: My Travel Through Plastic Surgery - L. Franklyn Elliott, MD** Moderator: Albert Losken, MD **Objective:** Evaluate experiences through travel and mentorship and discuss tools and techniques that have influence on work and life,	*George Ballroom*
11:30–12:00 pm	**Safety Panel** ▲ Moderator: Galen Perdikis, MD	*George Ballroom*
11:30–11:42	**Complications With and Without Residents** Steven L. Bernard, MD	
11:42–11:54	**Complications: What I Learned** Bruce A. Mast, MD	
11:54–12:00	**Discussion**	

11:54–12:00	**Objective:** Identify and consider how complications arise and solutions that have been evaluated to provide better team and patient outcomes	
12:00–12:30 pm	**Member Papers 1-5** Moderator: Christopher A. Campbell, MD Secretary: Ashley K. Lentz, MD	*George Ballroom*
12:00–12:05	**#1 Early Sensory Recovery Following Polyethylene Glycol-Assisted Nerve Coaptation (p. 92)** Sriya Nemani	
12:05–12:10	**#2 Monitoring for Breast Cancer Recurrence Following Goldilocks Breast Reconstruction (p. 93)** Arian Ghanouni, MD	
12:10–12:15	**#3 Outcomes in Fibula Free Flap Reconstruction for Treatment of Mandibular Osteonecrosis (p. 95)** Patrick B. Garvey, MD	
12:15–12:20	**#4 The Financial Impact of a Co-surgeon in Breast Microsurgery (p. 96)** Robert DeVito, MD	
12:20–12:25	**#5 Prophylactic Muscle Flaps as an Adjunct to Complex Spine Surgery: Experience from Over 500 Spinoplastics Cases (p. 97)** David A. Brown, MD	
12:25–12:30	**Discussion** **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,	

6:00 am	**Fun Run**	
1:00 pm	**Golf Tournament**	*Royal Blue Golf Course*
1:00 pm	**Toast to Trudie**	*Cleo - SLS Hotel*
	Free Evening	

WEDNESDAY, JUNE 21

6:30–7:30 am	**Attendee Breakfast and Visit Exhibits**	*George and Studio Ballroom Foyer*
7:00–8:00 am	**Just the Facts Panel** Moderator: Brian D. Rinker, MD	*George Ballroom*
7:00–7:10	**Prepectoral Breast Reconstruction: Fad or Here to Stay?** Heather R. Faulkner, MD, MPH - Emory University	
7:10–7:20	**Does ADM Resist Infection in Abdominal Wall Reconstruction?** David A. Brown, MD - Duke University	
7:20–7:30	**Does Migraine Surgery Work?** Salam Al Kassis, MD - Vanderbilt University	
7:30–7:40	**Is Suspension Necessary in Trapezial Resection Arthoplasty?** Morgan S. Brgoch, MD - University of Kentucky	
7:40–7:50	**Does Innervation of DIEPs Improve Outcomes?** Blair A. Wormer, MD - Charlotte	
7:50–8:00	**Discussion**	
	Objective: Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery,	
8:00–9:15 am	**Challenges in Reconstruction and Extremity Salvage Panel** ▲ Moderator: Tae W. Chong, MD	*George Ballroom*
8:00–8:15	**Hand and Upper Extremity Salvage** Harvey W. Chim, MD	
8:15–8:30	**Novel Solutions for Trunk Defects** Tae W. Chong, MD	
8:30–8:45	**Lower Extremity Salvage and Reconstruction** Jared M. Davis, MD	
8:45–9:00	**Complex Defets of the Chest and Thorax** David W. Mathes, MD	
9:00–9:15	**Discussion**	
	Objective: Identify and analyze challenges in extremity salvage and reconstruction to optimize outcomes	
9:15–9:45 am	**Break and Visit Exhibits**	*George and Studio Ballroom Foyer*

9:45–10:30 am	**Jurkiewicz Lecture - On Leadership and Leadership Style - Foad Nahai, MD** Moderator: Bruce A. Mast, MD **Objective:** Review components of life and leadership with the goal to inspire others as an outcome,	*George Ballroom*
10:30–11:00 am	**Member Papers 6-10** Moderator: Daniel F. Haynes, MD Secretary: Jack F. Scheuer, MD	*George Ballroom*
10:30–10:35	**#6 Outcomes of Migraine and Chronic Headache Surgery at One-Year Evaluation (p. 98)** Mariam Saad, MD	
10:35–10:40	**#7 Non-Surgical Aesthetic Treatment Conversion to Surgery: Implications for Patient Selection and Practice Modeling (p. 99)** Bruce A. Mast, MD	
10:40–10:45	**#8 Outcomes of Skin-sparing Mastectomy with Free Nipple Areolar Graft and De-epithelialized Mastectomy Flap Breast Reconstruction (p. 101)** Maxine Garcia, MD	
10:45–10:50	**#9 Impact of Reconstruction on Oncologic Outcomes for Patients with Melanoma after Wide Local Excision: A High-Volume, Quaternary-Referral Center Experience (p. 103)** Michael Turgeon, MD	
10:50–10:55	**#10 Foot Fracture May Predict Poor Patient Reported Functional Outcomes in Lower Extremity Reconstruction of the Traumatically Injured Lower Extremity: A Case-control Study (p. 104)** Orr Shauly, MD	
10:55–11:00	**Discussion** **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,	
11:00–12:15 pm	**Looking Past The Horizon Panel** Moderator: Bruce A. Mast, MD	*George Ballroom*
11:00–11:15	**VCA Transplantation Now and In the Future** Steven L. Bernard, MD	
11:15–11:30	**Will Plastic Surgery Lose Breast Surgery?** Lynn A. Damitz, MD	
11:30–11:45	**Is It More Than Fat?** Adam J. Katz, MD	

11:45–12:00	**Is the Reconstructive Ladder Still Relevant?** David W. Mathes, MD	
12:00–12:15	**Discussion** **Objective:** Evaluate and discuss several areas in plastic surgery in regard to their present state and what they may look like in the future,	
12:15–1:00 pm	**SESPRS Business Meeting**	*George Ballroom*
7:00– 10:00 pm	**Black Tie Gala**	*Grand Hyatt Ballroom*

THURSDAY, JUNE 22

7:30–8:30 am	**Attendee Breakfast and Visit Exhibits**	*George and Studio Ballroom Foyer*
8:30–9:30 am	**Special Topics Panel** Moderator: Holly C. Wall, MD	*George Ballroom*
8:30–8:45	**Outcome Measures: Why, How, When?** Brett T. Phillips, MD	
8:45–9:00	**Plastic Surgery in The Bahamas** Gregory C. Neil, MD	
9:00–9:15	**Cybersecurity: Averting Disaster** Carmen M. Kavali, MD	
9:15–9:30	**Discussion** **Objective:** Review special topics related to plastic surgery and potential applications,	
9:30–10:15 am	**Special Topic: Innovation and Entrepreneurialism** Moderator: Felmont Eaves, MD Panelists: Howard Levinson, MD, Felmont Eaves, MD, Adam J. Katz, MD, Kevin Keller, MD **Objective:** Describe the process of inventing, developing, and final product application providing plastic surgeons with the basic playbook for commercial innovation that could impact patient care,	*George Ballroom*
10:15–11:00 am	**Body Contouring and Gluteal Fat Grafting Updates** ▲ Moderator: Benjamin C. McIntyre, MD Panelists: Pat Pazmino, MD, Oni Garcia, MD **Objective:** Review the safety and efficacy of body contouring and gluteal fat grafting to improve patient outcomes.	*George Ballroom*
11:00 am	**Closing Remarks** John T. Lindsey, MD	*George Ballroom*


ABSTRACTS

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

1 Complication Rates After Outpatient Distal Radius Fracture Fixation: Comparison of Two Different Treatment Facility Types

Ciara A Brown, MD, Ambika Menon, Tobi Somoron, Adam Whitsett, Evan D. Woodar, Paul A Ghareeb, MD

Introduction: Distal radius fractures (DRF) are common fractures treated by hand surgeons. While some are appropriately treated with closed reduction and casting, many DRFs require open reduction and internal fixation (ORIF). Complications after DRF surgery were compared between two hospital systems serving the same metropolitan region: 1) Safety-net hospital/ level-1 Trauma center and 2) University tertiary care center. We hypothesized an increased rate of complications within the safety-net hospital system.

Methods: All patients who underwent outpatient surgical fixation of DRFs from January 2017 to June 2021 at two separate institutions were retrospectively reviewed. Our primary outcome measure was the incidence of overall complications between the groups. Secondary outcomes included the rate of specific complication types.

Results: The safety-net cohort included 189 patients, while the university cohort included 257 patients. Table 1 depicts patient demographics, fracture characteristics, treatment methods and complication profiles. There was no difference in the overall rate of surgical complications between the two hospital systems: 4.3% (safety-net) verses 7.8% (university hospital) (p=0.13). Symptomatic hardware/hardware malposition was the most common complication requiring an unplanned return to the operating room in the university cohort, whereas infection was the most common complication in the safety-net cohort.

Conclusion: DRFs are commonly treated with surgery and have a favorable complication profile. There were no differences in complications based upon treatment facility. It is well understood that dorsal spanning techniques require hardware removal following bony healing. However, volar techniques may require hardware removal if malposed or symptomatic. This is important to include in preoperative counseling.

Table 1: Patient Characteristics, Fracture Etiology, Surgical Characteristics and Outcomes

	Safety-Net Hospital n (%)	Tertiary Care University Hospital n (%)	P-value
Demographics			
- Female	91 (48.1)	192 (74.7)	- <.0001 **
- Male	98 (51.9)	65 (25.3)	
- Age <65 (years)	181 (95.8)	193 (75.1)	- <0.001 **
- Age ≥65 (years)	8 (4.2)	64 (24.9)	
- ASA Score	41.4	53.5	- 0.007 **
Fracture Characteristics			
- Intra-articular	150 (79.4)	207 (80.5)	- 0.758
- Extra-articular	39 (20.1)	50 (19.5)	
-Mechanism of Injury			
High Energy	77 (41)	20 (7.8)	- <0.001 **
Low Energy	111 (59)	237 (92.2)	
Surgical Characteristics			
- Days to Surgery	16.7	10.1	- p < 0.001 **
- Fixation Method			
VLP	240 (93.4)	159 (85)	
Dorsal spanning	17 (6.6)	22 (11.8)	
Other	0 (0)	6 (3.2)	
Major Complication	8 (4.2)	20 (7.8)	- 0.13
- Infection	5 (0.03)	0 (0)	
- Hardware malposition	3 (0.02)	18 (7.0)	
- Post- traumatic carpal tunnel syndrome	0	2 (0.78)	

** Indicates statistical significance

Table 2: Complication Risk Based Upon Patient and Injury Factors

	Safety-Net Hospital P-value	Tertiary Care center P-value
Age	0.65	0.396
Gender	0.005 **	0.397
ASA score	0.224	0.54
Tobacco Usage	0.59	0.293
Mechanism of Injury (high verses low energy)	0.573	0.057
Articular Involvement	.481	0.212
Time to Surgery	0.57	0.327

** Indicates Statistical significance

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

2 Predictors of Autologous Fat Grafting in Immediate, Implant-Based Breast Reconstruction

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Background: Autologous fat grafting (AFG) is a common adjunct to implant-based breast reconstruction (IBBR). Patients frequently need or desire fat grafting to improve common issues such as implant visibility and contour deformity, often done as a second, staged procedure following immediate reconstruction. This study aimed to identify which patient factors and reconstructive techniques predict the need for revision with AFG after IBBR.

Methods: Patients who underwent IBBR with either tissue expanders or implants following mastectomy from 2017 to 2021 were identified. Demographics, comorbidities, and the postoperative course were reviewed. The primary outcome variable was AFG after the initial reconstruction. Univariate and regression analyses were performed to identify factors predictive of AFG.

Results: Five-hundred twenty-nine patients were included in our analysis, with 43% having AFG. The grafting cohort was younger (P<.0001) and less likely to have undergone radiation therapy (p=.0457). Mean implant size was larger in the AFG cohort (p=.0375). Univariate regression displayed single-stage reconstruction (OR=0.53, 95% 0.37-0.75) and previous radiation (OR 0.59, 95% 0.35-0.99) negatively predicted the need for AFG, while bilateral breast reconstruction (BBR) was a predictor (OR 2.32, 95% 1.58-3.4). On multivariate analysis, decreasing age and BBR remained predictive of AFG. The odds of AFG decreased by 3% for every one-unit increase in age (95% CI [0.96, 0.99]). Interestingly, neither pre-pectoral breast reconstruction nor specimen weight:implant ratio was associated with increased need for AFG on univariate/multivariate analysis.

Conclusions: Patients requiring AFG were likely younger and had undergone BBR with tissue expanders. Plane of implant did not appear to affect need for AFG. Knowledge of predictive factors may help plastic surgeons in preoperative counseling before implant-based breast reconstruction.

	AFG [*N* (% or IQR)	No AFG [*N* (% or IQR)	Combined	p-value
Oncologic Details				
Unilateral	54 (10.2)	126 (23.8)	180 (34.0)	**<0.0001***
Bilateral	174 (32.9)	175 (33.1)	349 (66.0)	
NSM	121 (26.1)	138 (22.9)	259 (49.0)	0.19*
SSM	99 (18.7)	146 (27.6)	245 (46.3)	
SRM	8 (1.51)	17 (3.2)	25 (4.73)	
Median mastectomy specimen weight (g)	441.8 (276-638.5)	438 (280.5-688.0)	440.5 (227.5-657.5)	0.84^
Reconstructive Details				
Direct-to-Implant	116 (21.9)	199 (37.6)	315 (59.6)	**0.0004***
Tissue Expander	112 (21.2)	102 (19.3)	214 (40.5)	
Pre-pectoral	134 (25.3)	191 (36.1)	325 (61.4)	0.27*
Sub-pectoral	94 (17.8)	110 (20.8)	204 (38.6)	
Average Implant Size (cc) ± SD	444.6 ± 136.8	419.7 ± 135.0	430.4 ± 136.2	0.038*
Specimen weight (g) to implant ratio	0.99 (0.75-1.37)	1.06 (0.76-1.43)	1.03 (0.76-1.40)	0.19^

Table 1. Oncologic and reconstruction characteristics
*Pearson chi-square test
^Wilcoxon test

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

3 Aesthetic Outcomes of PrimaryCleft Lip Repair Utilizing 2-octyl Cyanoacrylate Liquid and a Self-adhesive Polyester Mesh

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Background: The method of epidermal closure during cleft lip repair is important to consider, as it may affect complication rates, cosmetic outcomes, and patient comfort. The purpose of this study is to compare the outcomes between 2-octyl cyanoacrylate liquid with a self-adhesive polyester mesh (Dermabond Prineo) and typical suture closure techniques, which to our knowledge has never previously been investigated.

Methods: In nine consecutive cleft lip repairs, the epidermal closure was performed with permanent suture, and in the subsequent nine consecutive cleft lip repairs, the epidermal closure was performed with Dermabond Prineo. Complication rates were compared between the groups. Aesthetic scar outcomes were investigated via post-operative photograph analysis utilizing the Manchester Scar Scale. Statistical significance was determined with Fischer Exact Tests and Wilcoxon Rank-Sum tests. Subsequently, the scar scores for cleft lip repairs performed with Dermabond Prineo in our practice were compared to previously reported scores in the literature for cleft lip repairs performed with typical suture technique.

Results: Three patients in the permanent suture group had documented scar-related complications and one patient in the Dermabond Prineo group had documented scar-related complications. No statistically significant difference was found in complication rates between the two groups. No statistically significant difference was found in aesthetic scar scores between the two different closure techniques either within our practice or in comparison to reports in the literature.

Conclusions: Overall, the use of Dermabond Prineo offers comparable aesthetic outcomes and complication rates to the use of permanent suture in epidermal closure of cleft lip repairs.

POSTER QUICK SHOTS..... 4:00 – 5:30 PM

4 Social Determinants of Health Associated with Prolonged Time to Treatment for Non-Traumatic Upper Extremity Conditions

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Objective: To examine whether social determinants of health (SDH) factors are associated with time to treatment in common non-traumatic upper extremity conditions.

Methods: A national insurance claims–based database with patient records from the Centers for Medicare and Medicaid Services was used for data collection. Patients with diagnoses of wrist arthritis, carpal tunnel syndrome, cubital tunnel syndrome, stenosing tenosynovitis, Dupuytren's contracture, De Quervain's Tenosynovitis, medial epicondylitis, lateral epicondylitis, and thumb basal joint arthritis between 2005 and 2014 were identified. Primary outcomes included average time to treatment. Secondary outcomes included demographic variables and social determinants including education, employment, and other social factors.

Results: We identified 7,535,621 patients with non-traumatic upper extremity conditions. 437, 093 patients had associated social determinants of health (SDH). SDH patients had higher rates of COPD, obesity, substance use, and depression. Patients with non-traumatic upper extremity conditions and social determinants of health were more likely to experience increased average time to treatment.

Conclusions: In patients with non-traumatic upper extremity conditions, social determinants of health are associated with higher times to treatment.

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

5 The Use of the Fisher Anatomical Subunit Approach for Cleft Lip Revision: An Evolution and Case Series

Galarza, Laura I., MD; Sudduth, Jack D., MD, MS Humphries, Laura S., MD; Hoppe, Ian C., MD.

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Purpose: Many techniques exist to reapproximate a cleft lip but can leave unsatisfactory results with non-anatomic scars and a short upper lip. Because of this, the need for cleft lip revision often arises years after the initial repair. Many revisions focus on adjacent tissue transfers and realignment of landmarks, but in the senior surgeons' experience, entirely re-creating the defect and utilizing the Fisher repair for revision has led to aesthetically pleasing results and less noticeable scars.

Methods: A database was collected that included all cleft lip revisions performed at a large, comprehensive children's hospital from October 2018 to July 2021. Inclusion criteria included any cleft patient with a cleft lip revision performed by two craniofacial surgeons regardless of previous repair history. Data collected included sex, characteristics of the cleft lip (laterality and complete or incomplete defect), age at initial repair, type of initial repair, any previous revisions, age at index revision, type of revision with any additional tissue rearrangement, and any nose repair.

Results: Sixty-five patients met inclusion criteria, 75.4% of patients previously underwent repair of a unilateral cleft lip and 24.6% of a bilateral cleft lip. The type of initial repair is known in sixty-four cases (98.5%), with the majority being a Millard repair. Twenty-two of the total subset of patients (33.8%) had a previous revision prior to their index revision with the senior surgeons. Most revisions took place between the ages of three and twenty-four; the average revision age is 9.6 years, ranging from three to twenty-four years. Sixty patients (92.3%) underwent the Fisher repair technique for their index revision and forty-six (70.7%) underwent some form of nasal revision. In follow-up, all patients demonstrated an improvement in lip aesthetics.

Conclusion: The necessity for cleft lip revision derives from suboptimal results of initial treatment. Here we have demonstrated a large subset of patients that have undergone cleft lip revision using the Fisher technique. In the senior surgeons' experience, the Fisher repair technique in the setting of cleft lip revision is an ideal way to address the shortcomings of historical repair techniques.

Figure 1A; 1. *Midline of columellar base,* 2-3. *height of philtral columns,* 4. *lip midline,* 5-6. *peak of Cupid's bow,* 7-8. *cutaneous roll on bilateral Cupid's bow* 9. *proposed cutaneous back cut* 10-12. *wet-dry border on vermillion* 13-14. *Noordhoff's point and white roll* 15-16. Cutaneous isosceles triangle 17-18. *Bilateral subalare* 19-20. *Junction of the lateral crura and the nasal sill are marked* 21. *Height of the lip at site of proposed closure* 21-22. *Transposed triangle for scar excision and nasal sill inset* 23-25. *Proposed back cut and inset for wet-dry lip inset* **B.** *Final markings.*

Table 1. Patient Demographics

		Total (%)
No.	65	
Sex		
Male	43	66.2%
Female	22	33.8%
Laterality		
Left	31	47.7%
Right	18	27.7%
Bilateral	16	24.6%
Degree		
Known	60	92.3%
Complete	*43*	66.2%
Incomplete	*17*	26.2%
Unknown	5	7.7%
Age at Initial Repair *(mos)*		
Range	2-18	
Mean	3.8	
Standard Deviation	2.5	
Age at Index Revision *(yrs)*		
Range	3-24	
Mean	9.6	
Standard Deviation	5.3	

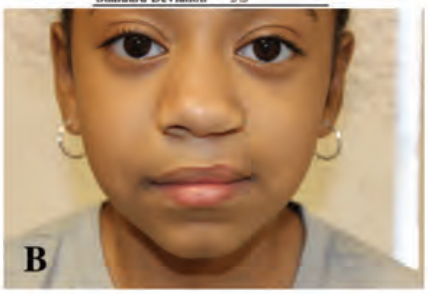

Figure 2A. Preoperative evolution of cleft lip demonstrating hypertrophic scar, lip asymmetry and lip notching **B.** 1-year postoperative result after Fisher revision technique

6 Barriers to Remote Burn Care Delivery: An Analysis of Burn Center Proximity and Access to Critical Telehealth Infrastructure

Shelley R. Edwards BS, Gabrielle Chamoun BS, Emily E. Hecox MD, Ian Hoppe MD, Laura S. Humphries MD

University of Mississippi Medical Center, Division of Plastic and Reconstructive Surgery

Mounting evidence supports the use of telehealth to improve access and efficiency in burn care. However, significant barriers to telehealth use remain throughout the US and may disproportionately affect specific populations such as rural and non-English speaking patients. The present study analyzes the association between physical proximity to burn care and determinants of telehealth access.

The relationship of telehealth-associated measures and proximity to burn care was analyzed with Linear regression analysis. County-level data was sourced from the Agency for Healthcare Research and Quality's Social Determinants of Health Database (2020) and the American Community Survey (2021). County-level distances to the nearest ABA-verified burn center were calculated based on verified centers listed in the ABA burn center directory (n=59). A subsequent analysis was performed on income-stratified datasets available for subset counties.

Distance was negatively correlated with household access to a smartphone ($P<0.0001$), broadband internet($P<0.0001$), and cellular data plan ($P<0.0001$) and positively correlated with percent of households with no computing device ($p<0.0001$) and no internet access ($p<0.0001$). Analysis of income-stratified data revealed comparable results. However, the slope of the regressions differed between groups. The percent population not speaking English well ($p<0.0001$), at all ($p=0.0009$), and the proportion of limited English-speaking households ($p=0.0001$) decreased as a function of distance.

Those living furthest from a verified burn center are less likely to have adequate access to critical telehealth infrastructure. However, income impacts overall access and the degree to which access changes with proximity. Conversely, language-associated access barriers decrease as a function of proximity

Data Below for Context:

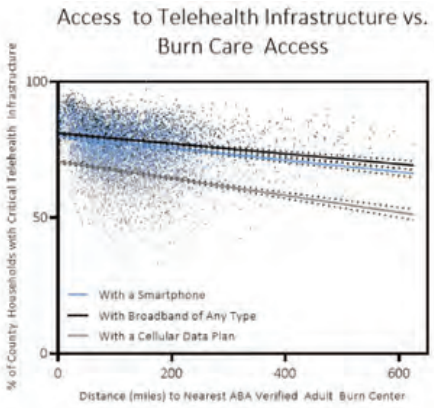

Figure 1. Distance to the nearest verified burn center negatively correlates with the presence of critical pieces of telehealth infrastructure including broadband (F (1,3106) =134.2, p<0.0001) (black), cellular data plan (F (1,3106) =242.4, p<0.0001) (grey), and smart phone (F (1,3106) =227.4, p<0.0001) (blue). The slope of the regression lines differs significantly (F=14.43, p<0.0001) between infrastructure items.

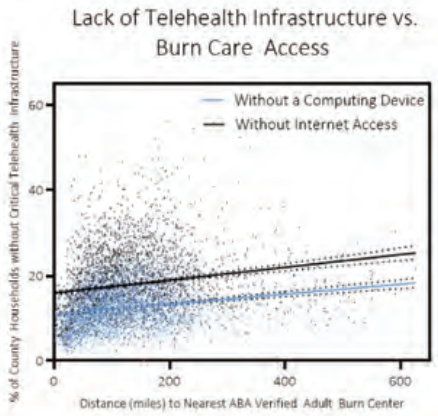

Figure 2. without a computing device (F (1,3106) = 96.56, p<0.0001) (grey) without internet access (F (1,3106) = 108.9, p <0.0001) (blue) The slope of the regression lines in not significantly different (p=0.0779).

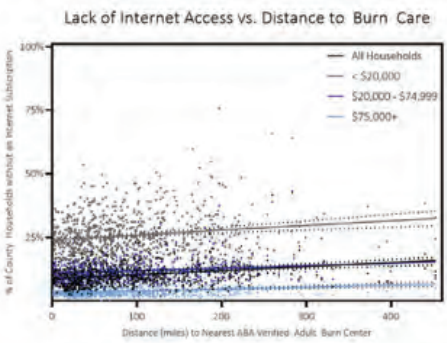

Figure 3. Linear regression analysis revealed a significant negative correlation between the distance to burn care and the proportion of households with no internet subscription (F (1,821) = 58.31, P<0.0001) (black). When individually analyzing data stratified by annual household income (adjusted for inflation), differences were noted among household income cohorts. <$20,000 (grey) (F (1,801) = 20.08, P<0.0001) vs. $20,000-$75,000 (dark blue) (F (1,801) = 24.39 P<0.0001) vs. $75,000+ (light blue) (F (1,801) = 42.08, P<0.0001). Slopes of the income-stratified regression lines differed significantly (F= 3.628 p=0.0121). 95% confidence intervals are represented by dashed lines.

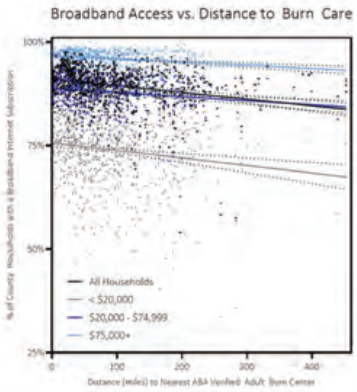

Figure 4 Linear regression analysis revealed a significant negative correlation between the distance to burn care and the proportion of households with broadband access (F (1,821) = 57.90, P<0.0001) (black). When individually analyzing data stratified by annual household income (adjusted for inflation), broadband access differences were noted between households with an income of <$20,000 (grey) (F (1,801) = 19.81, P<0.0001) vs. $20,000-$75,000 (dark blue) (F (1,801) = 23.32 P<0.0001) vs. $75,000+ (light blue) (F (1,801) = 42.06, P<0.0001). While a significant correlation was observed for all income groups, the slope of the regression lines varied significantly (F=3.629 (p=0.0125). 95% confidence intervals are represented by dashed lines.

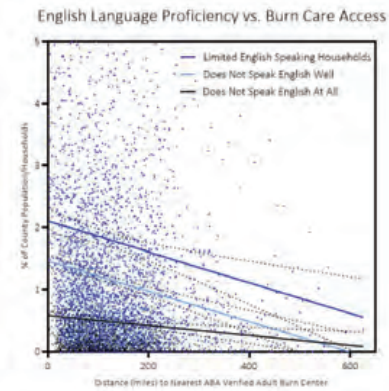

Figure 5 Percent of the county population (over age 5) not speaking English at all (F (1,3106) = 11.11, P=0.0009) (black) and not speaking English well (F (1,3106) = 55.03, P<0.0001) (light blue) were negatively correlated with distance to burn care. The percent of county households considered limited English speak was similarly correlated (F (1,3106) = 15.36, P<0.0001) (dark blue). The slopes of the regression lines varied significantly from each other (F=4.882, P=0.0076). Black dashed lines represent 95% confidence intervals. Individual data points have been omitted from this graphic to better visualize regression lines. However, all datapoints were considered in data analysis.

POSTER QUICK SHOTS ..... 4:00 – 5:30 PM

7 Early Experience with Threaded Intramedullary Nail Fixation in the Treatment of Hand Fractures: The Move Away from Pins and Plates

Chris Kubajak, Miriam Henry, Jayson Johnson, Chase Kluemper, Maureen O'Shaughnessy, Morgan Brgoch, David Drake. Presenter: Miriam Henry

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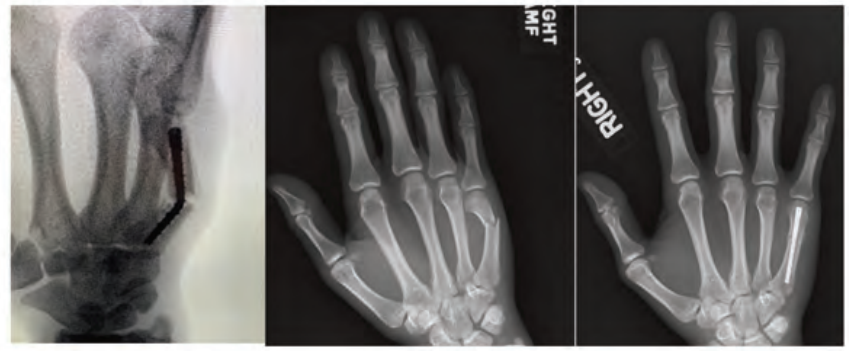
Introduction: Hand fractures constitute 40% of upper extremity fractures in the United States. Upper extremity injuries account for more than 16 million off-work days and 90 million days of restricted activity. Threaded intramedullary nail fixation has emerged as an alternative to other methods of fracture reduction including Kirschner wire fixation, dorsal plating, and lag screws. The authors present their early outcomes utilizing threaded intramedullary nail fixation for metacarpal and phalangeal fractures.

Methods: This is a retrospective cohort review of patients treated with threaded intramedullary nail fixation for metacarpal and phalangeal fractures from January 2021 to January 2023. Demographics, fracture patterns, post-operative DASH score, and complications were reviewed.

Results: 33 patients identified (38 fractures). Mean age 32.8 years. 22 patients (67%) were men. Mean follow-up 1.5 months. Mean tourniquet time 30.5 minutes. Mean qDASH 54.8. 1 case of hardware failure. 2 patients required revision and hardware replacement. No cases of nonunion. 1 patient required tenolysis. There were 36 metacarpal fractures (95%), 1 proximal phalangeal 3%, 1 middle phalangeal 3%, and no distal phalangeal fractures.

Conclusions: Intramedullary nail fixation is a viable alternative in the treatment of metacarpal and phalangeal fractures. Potential for reduction in operative time and initiation of active range of motion. Obviates need for extensive periosteal stripping seen in dorsal plating. Noted difficulty in cases with severe comminution, delayed presentation, spiral pattern, and those involving short segments of the metacarpal or phalangeal head. Surgeons should not defer open reduction prior to nail placement if unable to achieve adequate closed reduction.

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM



POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

8 Oncoplastic Breast Reduction Surgery Decreases Rates of Re-operation after Breast Conservation

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2. University of Virginia School of Medicine,

Introduction: Oncoplastic breast reduction surgery (OBRS) involves tumor resection with immediate plastic surgery reconstruction to ensure a cosmetically pleasing outcome. Prior studies have found comparable oncologic safety to lumpectomy alone, with some studies showing increased risk of subsequent mastectomy1. The purpose of this study is to compare the oncologic and surgical outcomes of lumpectomy versus oncoplastic breast reduction on a national scale.

Methods: A commercially available national insurance-based database (Pearldiver) was queried using CPT codes to identify patients who underwent lumpectomy with or without a same day breast reduction. Patients who underwent lumpectomy or OBRS were matched by obesity, BMI, age, region, and receipt of neoadjuvant chemotherapy. Safety outcomes were compared, and a multiple logistic regression was conducted to identify factors associated with repeat lumpectomy or mastectomy procedures.

Results: There were 421,455 patients in the lumpectomy group and 15,909 patients in the OBRS group. After matching, 15,134 patients were identified in each group. Repeat lumpectomy or subsequent mastectomy was more common in the lumpectomy group (15.2% vs. 12.2%, $p<0.001$). Patients in the OBRS group had higher rates of 90-day surgical complications including dehiscence, infection, fat necrosis, breast abscesses, antibiotic prescription, and any surgical complication ($p<0.001$). Meanwhile, any medical complication was less common in the OBRS group (3.7% vs. 4.5%, $p=0.001$). Logistic regression revealed that OBRS was associated with decreased odds of repeat lumpectomy (OR = 0.71, 95% CI 0.66-0.77, $p<0.001$) with no significant increased odds of subsequent mastectomy (OR = 1.01, 95% CI 0.91-1.11, $p=0.914$), and an overall decreased odds of reoperation (OR = 0.80, 95% CI 0.76-0.86, $p<0.001$). In addition, neoadjuvant chemotherapy was found to be associated with decreased odds of reoperation (OR = 0.69, 95% CI 0.61-0.78, $p<0.001$).

Conclusions: OBRS is associated with decreased risk for repeat operation in the form of lumpectomy without significant increased likelihood of subsequent mastectomy. Although OBRS was associated with increased wound complications, overall medical complications were found to occur less frequently compared to the lumpectomy alone cohort. The results of this study endorse increased consideration of OBRS in situations where either lumpectomy or oncoplastic breast reduction surgery are appropriate.

References:

1. Losken A, Dugal CS, Styblo TM, Carlson GW. A meta-analysis comparing breast conservation therapy alone to the oncoplastic technique. Ann Plast Surg. 2014 Feb;72(2):145-9. doi: 10.1097/SAP.0b013e3182605598. PMID: 23503430.

2. PearlDiver. Colorado Springs, CO 80918, USA. Available at: https://pearldiverinc.com/about-us/. Accessed February 2023.

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

9 Impact of Immediate Lymphatic Reconstruction Anastomotic Technique on Prevention of Breast Cancer Related Lymphedema

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Introduction: Immediate lymphatic reconstruction (ILR) is an emerging technique for the prevention of breast cancer related lymphedema (BCRL). We've demonstrated the use of end-to-end and arborized anastomoses for ILR in prior studies. However, no studies have investigated the difference between the type of anastomoses in efficacy for reduction in BCRL rates. We aimed to compare the incidence of BCRL between end-to-end and multi-lymphatic anastomoses.

Methods: A prospective cohort study was conducted including patients who underwent ILR between 2018-2020 with at least 2 years of follow up. Patients either had end-to-end anastomoses (1 lymphatic vessel intussuscepted into 1 venule), arborized anastomosis (multiple lymphatics intussuscepted into 1 venule), or a combination or both. Descriptive statistics, t tests, and Pearson's $\chi 2$ test were used. Multivariable logistic regressions were performed to assess the association between BCRL and type of anastomosis used. A loose age-matched subsample was created for sub-analysis.

Results: 172 patients were included in this study (28 patients had end-to-end anastomoses, 122 had arborized anastomoses, and 22 had both). Patients had an average age of 52 ± 12 years and mean BMI of 28.4 ± 6.9 kg/m2. The incidence of BCRL was higher in the end-to-end cohort than the arborized cohort, 28.6% vs. 10.7%, respectively ($p = 0.01$). The arborized anastomosis was associated with lower odds of developing BCRL (OR 0.3 [0.1 – 0.8], $p = 0.02$).

Conclusions: Arborized anastomoses were associated with a lower incidence of BCRL.

10 Craniometric and Volumetric Analyses of Normocephalic and Scaphocephalic Patients with Nonsyndromic Single-Suture Sagittal Craniosynostosis

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Purpose: Non-syndromic single-suture sagittal craniosynostosis (NSSSC) presentation spans scaphocephalic and normocephalic head shapes. Herein we studied craniometric differences between scaphocephalic and normocephalic patients with NSSSC.

Methods: Head CT scans of 20 scaphocephalic and 20 normocephalic NSSSC patients and their age- and sex-matched controls were analyzed, including cranial base angles, distances-from-midline, and intracranial volumes. Two-tailed t-tests compared groups.

Results: Cranial Index was lower for cases than controls in both the scaphocephalic and normocephalic groups ($p = <0.001$, respectively).

Right external acoustic meatus angle (EAMA) was significantly larger in scaphocephalic ($p = <0.001$) and left EAMA was significantly smaller in normocephalic patients ($p = 0.002$) when compared with controls. Midline angular analysis showed that bifrontal angle was significantly decreased amongst scaphocephalic patients but insignificant amongst the normocephalic group along with decreases in interoccipital angle ($p=<0.001$) in both scaphocephalic and normocephalic groups.

Cranial base distances-from-midline were longer to the right and left internal acoustic meatus and shorter to the euryon-to-zygomaticofrontal suture for both groups of cases than controls ($p<0.05$).

Scaphocephalics had a larger anterior cranial volume ratio than controls (18% vs 13%, $p=<0.001$). Normocephalics had larger posterior volume ratios than controls (42% vs 33%, $p=<0.001$). Scaphocephalics had larger anterior volume ratios than normocephalics (1.69 vs 1.16, $p=0.016$), but smaller posterior compartment volume ratios (0.9 vs 1.53, $p=<0.001$).

Conclusion: NSSSC scaphocephalic and normocephalic patients have significant craniometric and volumetric differences than their controls and each other. Some of the craniometric differences among the sagittal craniosynostosis patients are in common, despite cranial morphology, while others are different. Specifically, both normocephalic and scaphocephalic patients had a longer-than-wide head ratio (cranial index) than their controls, and wider anterior cranial base angle (IOA) than controls. However, both scaphocephalic and normocephalic patients demonstrated rightward lateralization of cranial base angles and distances compared to controls but not to the same extent. This data shows craniometric evidence that although normocephalic and scaphocephalic sagittal craniosynostosis patients have some overlapping cranial morphologic characteristics, they also differ in their cranial base lateralization and their intracranial volume distributions. This may have implications for underlying pathophysiology, diagnostic timing, and treatment of NSSSC.

11 Air or Saline? A Propensity Score-Matched Analysis on the Effect of Tissue Expander Fill on Complications in Immediate Breast Reconstruction

Amanda R. Sergesketter, MD;[1] William W. Tian, BS;[2] Hannah C. Langdell, MD;[1] Ronnie L. Shammas, MD;[1] Yisong Geng, MD, PhD, MBA;[3] Rebecca Knackstedt, MD;[1] Kristen Rezak, MD;[1] Geoffroy C. Sisk, MD;[1] Brett T. Phillips, MD, MBA[1]

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2. Duke University School of Medicine, Durham, NC
3. Calc LLC, Wilton, CT

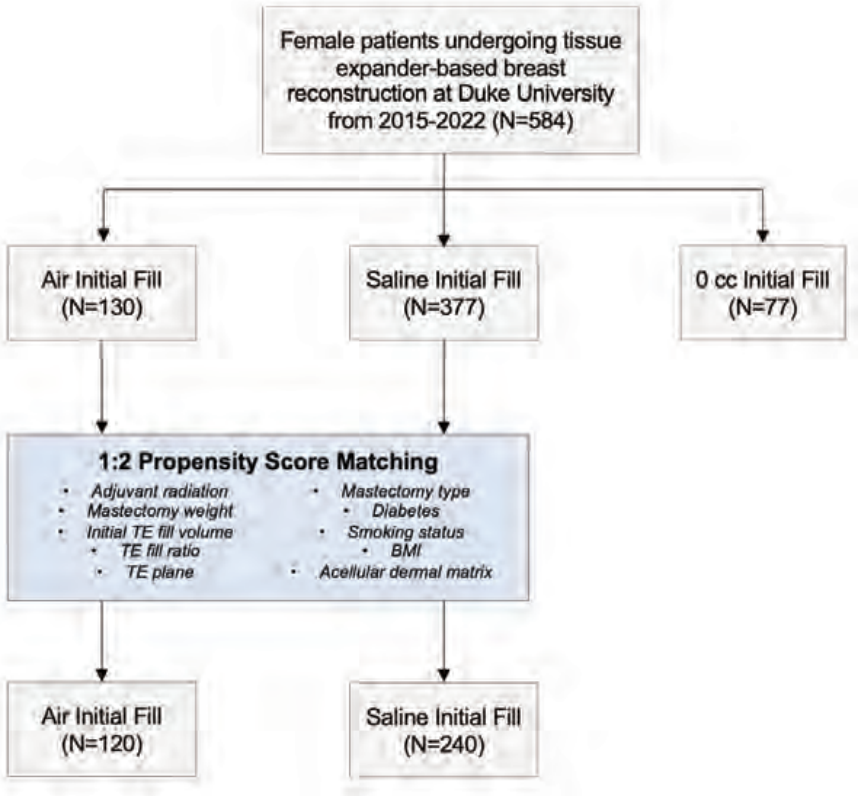
Background: Tissue expander fill medium and volume have implications for the pressure exerted on mastectomy skin flaps. This study evaluated the influence of initial fill medium (air versus saline) on complications in immediate breast reconstruction.

Methods: Patients undergoing immediate tissue expander-based breast reconstruction with initial intra-operative fill with air were propensity matched 1:2 to those with an initial fill of saline based on patient and tissue expander characteristics, Figure. Incidence of overall and ischemic complications were compared by fill medium (air versus saline).

Results: A total of 584 patients were included, including 130 (22.2%) with initial fill with air, 377 (64.6%) with initial fill with saline, and 77 (13.2%) with 0 cc of initial fill. Higher intra-operative fill volume was associated with increased risk of mastectomy skin flap necrosis [Regression Coefficient (RC) 14.3; p=0.049]. Propensity-score matching was then conducted among 360 patients (Air: 120 patients vs. Saline: 240 patients). After propensity score matching, there were no significant differences in the incidences of skin flap necrosis, extrusion, reoperation, or readmission between the air and saline cohorts (all p>0.05). However, initial fill with air was associated with lower incidence of infection requiring oral antibiotics (p=0.003), seroma (p=0.004), and nipple necrosis (p=0.03).

Conclusions: Within a propensity score-matched cohort accounting for patient and tissue expander characteristics, initial fill with air was associated with a lower incidence of complications, including ischemic complications after nipple-sparing mastectomy. Initial fill with air and lower intra-operative fill volumes may be strategies to reduce ischemic complications among high-risk patients.

Figure 1. Consort diagram illustrating patient selection and propensity score matching.



12 A Multi-Institutional Analysis of a Textbook Outcome Among Patients Undergoing Microvascular Breast Reconstruction

Ronnie L. Shammas, M.D.; [1] Abbas M. Hassan, MD; [2] Amanda R. Sergesketter, M.D.;[1] Nicholas L. Berlin, M.D., MPH., MS;[3] Humza N. Mirza, MS; [3] Natalie M. Guzman, BA; [3] Hani I. Naga, M.D.;[1] Perri Vingan, B.S;[4] Janhavi G. Govande, BS;[2] Max L. Silverstein, M.D.; [5] Arash Momeni, M.D.; [5] Geoffroy C. Sisk, M.D.; [1] Anaeze C. Offodile 2nd, M.D., MPH; [2] Rene D. Largo, M.D.;[2] Adeyiza O. Momoh, M.D.;[3] Jonas A. Nelson, M.D., MPH;[4] Evan Matros, M.D., MMSc, MPH.;[4] Brett T. Phillips, M.D., MBA[1]

1. Division of Plastic, Maxillofacial, and Oral Surgery, Duke University, Durham, NC
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3. Department of Surgery, Section of Plastic Surgery, University of Michigan, Ann Arbor, MI, USA
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Background: A textbook outcome (TO) is a composite measure that may be superior to individual metrics when assessing hospital performance and quality of care. We investigated the prevalence and predictors of TOs in a multi-institutional cohort of patients who underwent breast reconstruction with deep inferior epigastric artery perforator (DIEP) flaps.

Methods: A TO was previously defined using a Delphi process, and is comprised of eight individual metrics related to DIEP flap reconstruction. A multi-institutional cohort of 1000 (200 per institution) consecutive DIEP flap patients at five major institutions was reviewed. Multivariate regression investigated associations between patient characteristics and achieving a TO.

Results: Out of 1000 patients, 732 (73.2%) achieved a TO. The most common reasons for not achieving a TO were re-operation (9.6%), prolonged operative time (9.5%) and prolonged LOS (9.2%) (Figure 1). Women who were smokers, obese, widowed/divorced, had a contralateral prophylactic mastectomy, or bilateral reconstruction demonstrated a lower proportion of TOs ($p<0.05$). Mean operative time (448±115 vs. 591±175 minutes) and LOS (3.1±0.8 vs. 4.6±1.6 days) were shorter in the TO group ($p<0.001$) (Table 1). On multivariate analysis, prophylactic mastectomy and hormonal therapy were associated with a higher likelihood of TOs; increased BMI displayed a lower likelihood.

Conclusions: In this multicenter study of 1000 women undergoing DIEP flap reconstruction, most (>70%) experienced a textbook outcome. Future studies should investigate how this metric may be used in comprehensive performance evaluation, and in reporting patient-level hospital performance and variation, leading to collaborative quality improvement efforts in reconstructive surgery.

Figure 1. Textbook outcome distribution by parameters. For each outcome, the percentage of patients for whom that specific outcome and all previous outcome indicators were realized was calculated.

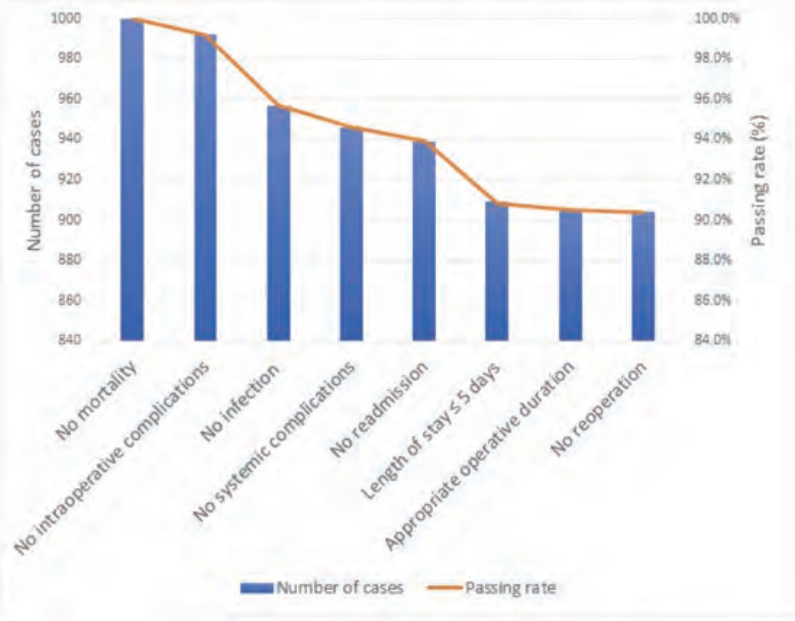


Table 1. Surgical outcomes for the overall cohort according to a textbook outcome definition

		Textbook Outcome		
Variable	**All**	**No**	**Yes**	**P-value**
Patients, n (%)	1000 (100)	268 (26.8)	732 (73.2)	
Intraoperative blood transfusion, n (%)	5 (0.5)	5 (1.9)	0 (0.0)	**<0.001**
Intraoperative complication, n (%)	6 (0.6)	6 (2.2)	0 (0.0)	**<0.001**
Operative Duration, minutes, mean±SD	486.1±148.2	591.0±175.0	448.0±115.0	**<0.001**
Length of stay, days, mean±SD	3.5±1.2	4.6±1.6	3.1±0.8	**<0.001**
Complication requiring reoperation, n (%)	96 (9.6)	96 (35.8)	0 (0.0)	**<0.001**
Partial flap loss	11 (1.1)	11 (4.1)	0 (0.0)	**<0.001**
Total flap loss	7 (0.7)	7 (2.6)	0 (0.0)	**<0.001**
Seroma	18 (1.8)	18 (6.7)	0 (0.0)	**<0.001**
Hematoma	41 (4.1)	41 (15.3)	0 (0.0)	**<0.001**
Infection	39 (3.9)	39 (14.6)	0 (0.0)	**<0.001**
Wound dehiscence	36 (3.6)	36 (13.4)	0 (0.0)	**<0.001**
Microvascular complication	76 (7.6)	76 (28.4)	0 (0.0)	**<0.001**
30-day readmission, n (%)	61 (6.1)	61 (22.8)	0 (0.0)	**<0.001**
Any medical complication, n (%)	54 (5.4)	54 (20.2)	0 (0.0)	**<0.001**
Deep venous thrombosis	6 (0.6)	6 (2.2)	0 (0.0)	**<0.001**
Pulmonary embolism	4 (0.4)	4 (1.5)	0 (0.0)	**0.001**
Myocardial infarction	1 (0.1)	1 (0.4)	0 (0.0)	0.268
Stroke	0 (0.0)	0 (0.0)	0 (0.0)	1.000
Acute kidney injury	4 (0.4)	4 (1.5)	0 (0.0)	**0.001**
Pneumonia	6 (0.6)	6 (2.2)	0 (0.0)	**0.021**
Urinary tract infection	10 (1.0)	10 (3.7)	0 (0.0)	**<0.001**
Blood transfusion	32 (3.2)	32 (11.9)	0 (0.0)	**<0.001**

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

13 Direct-to-Implant vs. Immediate Autologous Tissue Transfer: A systematic review and meta-analysis of patient reported outcomes after immediate breast reconstruction.

Orr Shauly, MD, Troy Marxen, BS, Albert Losken, MD

Background: The effect of immediate implant and autologous breast reconstruction on patient complication rates has been studied extensively, but patient-reported outcomes for these procedures during immediate, one-stage reconstruction has yet to be comprehensively investigated. This study compares patient-reported outcomes for immediate implant reconstruction with immediate autologous reconstruction to determine advantages and disadvantages for each surgical modality from the patient's perspective.

Methods: A literature search of PubMed between 2010 and 2021 was performed, and 21 studies containing patient-reported outcomes were selected for analysis. Meta-analysis of patient-reported outcome scores was performed separately for immediate breast reconstruction using autologous tissue transfer and synthetic implants.

Results: Data was collected on 831 patients in the immediate reconstruction group and 511 in the delayed group, with a minimum of 3-month follow-up. The pooled mean of patients' satisfaction with their breasts was 70.7±1.3 after immediate autologous reconstruction and 68.5±1.4 after immediate implant reconstruction, showing a statistically significant difference in outcome ($p<0.05$). The pooled mean of patients' sexual well-being was 59.3±1.5 after immediate autologous reconstruction and 62.8±2.0 after immediate implant reconstruction ($p<0.01$). The pooled mean of patients' satisfaction with their outcome was 78.8±2.6 after immediate autologous reconstruction and 82.3±1.8 after immediate implant reconstruction ($p<0.05$). The results of each meta-analysis were summarized on forest plots depicting the distribution of patient-reported outcome scores from each study.

Conclusions: Immediate reconstruction with implants may have a similar or greater capacity to achieve patient satisfaction and improve QoL compared to immediate reconstruction with autologous tissue transfer when both procedures are an option.

POSTER QUICK SHOTS..... 4:00 – 5:30 PM

14 ASPS Member Reported Risk Stratification and Elective Breast Surgery Specimen Labeling Practices

Peter M. Vonu, MD; Elizabeth Cox, MD; Jaimie Bryan, BS; Lisa Spiguel, MD; Rachel Safeek, MD; Sarah Sorice-Virk, MD

Department of Surgery, Division of Plastic and Reconstructive Surgery
University of Florida College of Medicine, Gainesville, FL

Introduction: The average life-time risk of developing breast cancer is approximately 13% in US women,1 and approximately 575,000 breast surgeries were performed in the US in 2020.2 The incidence of unexpected malignancy in breast reduction specimen ranges from .06 to 4.5%.3 Without specimen orientation, the default oncologic treatment unfortunately necessitates mastectomy. The purpose of this study is to report intraoperative specimen collection practices among plastic surgeons during elective breast surgery.

Methods: From November 2021 to January 2022, an anonymous survey was administered to all members of the American Society of Plastic Surgery (ASPS). The survey included 30 single and multiple response questions summarizing both breast cancer risk stratification practices and intraoperative specimen collection practices. Questions regarding respondent demographics, surgical training, and length of practice were also included.

Results: One-hundred and fifty-six respondents were included in this study. While 80.8% of respondents routinely sent breast specimen to pathology for review, only 22.3% oriented or marked specimen margins (Figure 1). Those who had encountered atypical ductal/lobular hyperplasia during elective breast surgery were more likely to routinely send breast specimen to pathology for review ($p = 0.01$). Respondents who had more experience (≥15 years) were more likely than those who had less experience (<15 years) to orient their specimen or mark the specimen margins ($p = 0.02$).

Conclusions: The findings from this study indicate the potential for standardization of breast specimen labeling practices among plastic surgeons, and potentially more formal education of the possible oncologic ramifications of such in plastic surgery residency training curricula.

Figure 1: Breast Cancer Risk Stratification Survey Responses

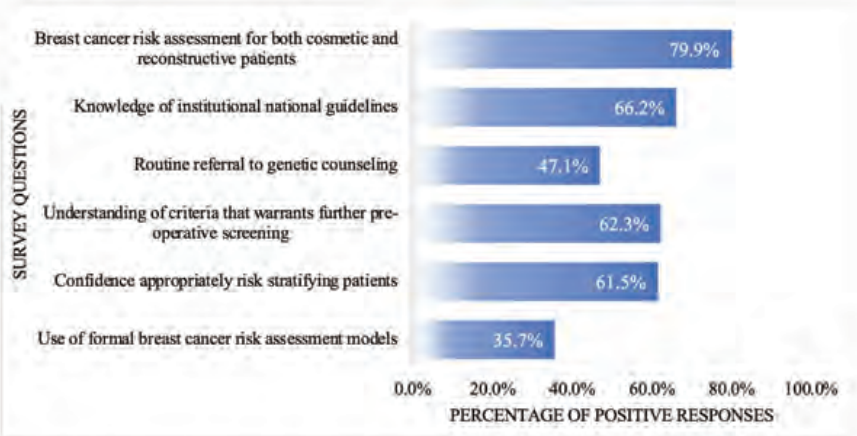


Figure 2. Intraoperative Experiences and Specimen Collection Practices Among ASPS Members During Elective Breast Surgery

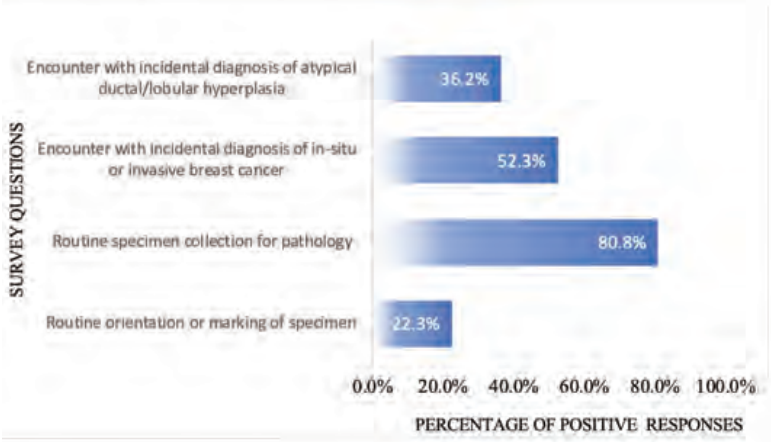


Table 1. ASPS Breast Cancer Risk Stratification and Intraoperative Specimen Collection Practices by Percentage Breast Surgery Practice

Questions	≤ 50%	> 50%	*P*
Routine referral to genetic counseling	17 (34.7)	50 (53.8)	*0.035
Use of standardized risk assessment models	18 (36.0)	32 (35.6)	1.000
Understanding of criteria that warrants further preoperative screening	20 (44.4)	61 (71.8)	*0.004
Confidence appropriately risk stratifying patients	22 (48.9)	58 (68.2)	*0.038
Routine specimen collection for pathology review	34 (75.6)	71 (83.5)	0.350
Routine orientation or marking of specimen	8 (17.8)	21 (24.7)	0.507

Data presented as N (%)
*Denotes statistical significance

Table 2. ASPS Specimen Collection Practices by History of Encounter with Incidental Atypical or Malignant Diagnosis During Routine Breast Surgery

Outcome	Encounter with atypical dx	No encounter with atypical tissue	*P*	Encounter with malignant dx	No encounter with malignant dx	*P*
Routine specimen collection for pathology review	73 (88.0)	32 (68.1)	*0.010	58 (85.3)	47 (75.8)	0.188
Routine orientation or marking of specimen	15 (18.1)	14 (29.8)	0.132	15 (22.1)	14 (22.6)	1.000

Data presented as N (%). Abbreviations and Definitions: Atypical tissue, incidental diagnosis of atypical ductal or lobular hyperplasia; Dx, diagnosis; Malignant tissue, incidental diagnosis of in-situ or invasive breast cancer.
*Denotes statistical significance

References:

1.Breast cancer statistics: How common is breast cancer? American Cancer Society. https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html. Accessed March 1, 2022.

2. 2020 Plastic Surgery Statistics Report. American Society of Plastic Surgeons. https://www.plasticsurgery.org/documents/News/Statistics/2020/plastic-surgery-statistics-full-report-2020.pdf/. Published 2021. Accessed March 15, 2022.

3. Vande Walle K, Yang DY, Stankowski-Drengler TJ, Livingston-Rosanoff D, Fernandes-Taylor S, Schumacher JR, Wilke LG, Greenberg CC, Neuman HB. Breast Cancer Found Incidentally After Reduction Mammaplasty in Young Insured Women. Ann Surg Oncol. 2019 Dec;26(13):4310-4316. doi: 10.1245/s10434-019-07726-9. Epub 2019 Sep 19. PMID: 31538286; PMCID: PMC7486797.

POSTER QUICK SHOTS. . . . . 4:00 – 5:30 PM

15 Virtual Loupes: A Pilot Study of the Use of Mixed Reality in Plastic Surgery

Waylon Zeng MD[1], Cory Ilo MS[2], Douglas Bowman PhD[2], James Thompson MD[1]

1. Virginia Tech Carilion
2. Virginia Tech University

Background: Traditionally, plastic surgeons have used loupes or operative microscope for visual magnification to aid in tissue dissection and anastomosis of structures. These devices have their own limitations, including fixed or lower magnification, bulkiness, narrow field of view and depth, cost, and set-up time.

Current uses of augmented and virtual reality technology in surgery have been limited to pre-operative planning and simulation. We present a proof of concept that utilizes AR and VR, known as mixed reality, to address the limitations of loupes and microscopes to augment visualization.

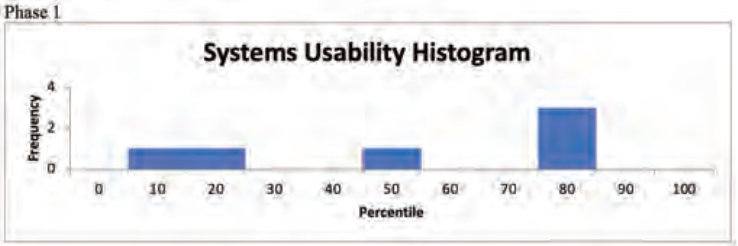
Methods: We first evaluated methods of gaze-based eye tracking to enable digital magnification. Using an industry-ready head-mounted display (HMD), we compared discrete zoom through a displayed interface versus continuous zoom through eye squinting. Participants completed a survey and interview following the activity.

Next we assessed the performance and limitations of MR digital magnification. Participants were asked to complete anastomotic suturing tasks with progressively finer polypropylene suture. Participants completed a similar survey and interview.

Findings: All participants felt the discrete zoom was easier to use. Participants had difficulty determining depth and visualizing the suture as it became finer regardless of the magnification level. Using Wilcoxon rank sum test to examine differences in system usability scale, the second stage user experience had significant difference in percentile distribution (p 0.0390).

Conclusion: These findings suggest that virtual loupes may be a valuable tool for plastic surgeons, offering potential for variable magnification and advanced visualization. Further development is needed to address the limitations of existing devices.

Phase 1



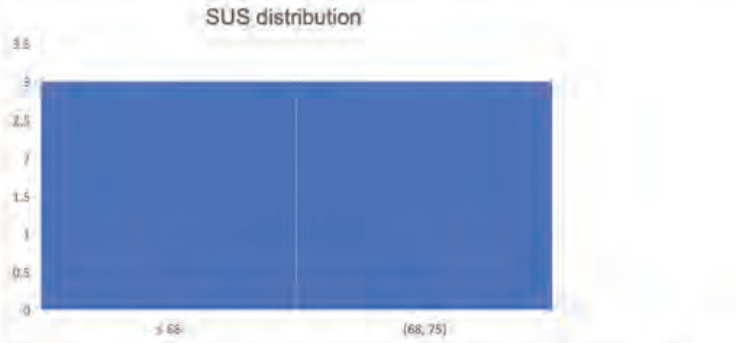
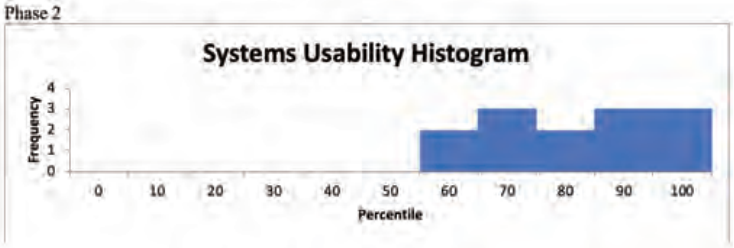


Table 1: Histogram of the participants' survey responses using the validated Systems Usability Scale. Distribution of 6 participants.

Table 2: Distribution histogram of the participants' SUS responses. Scores with <68th percentile indicates a poor usability score. Scores >68th percentile indicates acceptable or above.

Phase 2



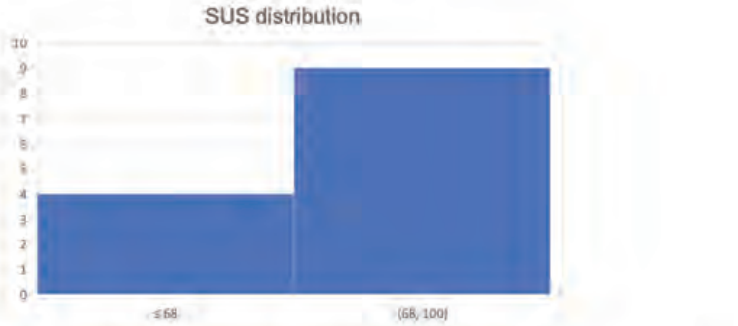


Table 3: Histogram of the participants' survey responses using the validated Systems Usability Scale. Distribution of 13 participants.

Table 4: Distribution histogram of the participants' SUS responses. Scores with <68th percentile indicates a poor usability score. Scores >68th percentile indicates acceptable or above.

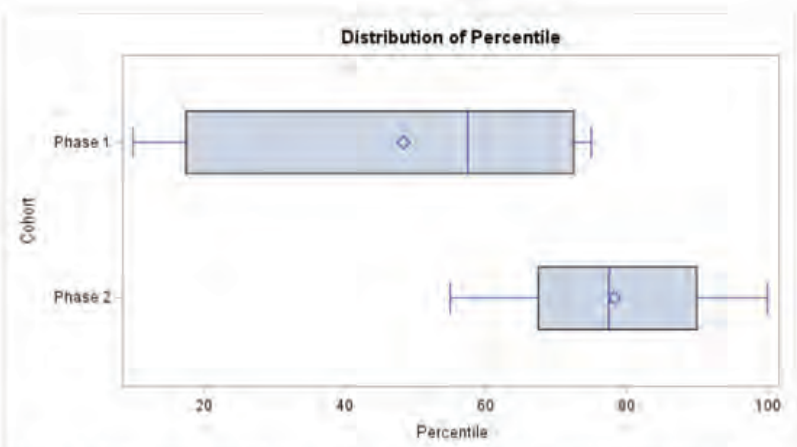


Table 5: Wilcoxon rank sum test was used to examine the differences in percentile distributions. Distribution of phase 1 percentiles is statistically different than phase 2 percentiles (p=0.0390). Observing the medians and interquartile ranges, we can descriptively interpret that phase 2, 77.50 [67.50, 90.00], reported significantly greater percentiles than phase 1, 57.50 [17.50, 72.50].

1 The Modified Fragility Index Predicts Major Complications in Oncoplastic Reduction Mammoplasty (OCR)

Ciara A Brown, MD[1], Makenna Ash[2], Grant Carlson, MD[1], Albert Losken, MD[1]

1. Emory University, Division of Plastic and Reconstructive Surgery
2. Emory University School of Medicine

Background: An important component of preoperative counseling and patient selection involves surgical risk- stratification. There are many tools developed to predict surgical complications. The Modified Fragility Index (mFI) calculates risk based on the following five elements: hypertension, COPD, CHF, DM and functional status. Recent literature demonstrates the efficacy of the mFI across multiple surgical disciplines. We elected to investigate its utility in oncoplastic reductions (OCR).

Methods: A retrospective review of all patients with breast cancer who underwent OCR from 1998 to 2020 were queried from a prospectively maintained database. Patient demographics, comorbidities, and surgical details were reviewed. The mFI was computed for each patient. The primary clinical outcome was the development of complications.

Results: 547 patients were included in the study cohort. The average age was 55 and the average BMI was 33.5. The overall complication rate was 19% (n=105) and the major complication rate was 9% (n=49). Higher fragility scores were significantly associated with the development of major complications (p=0.028). mFI scores of 0 had a major complication rate of 5.7%; scores of 1, 13%; and scores of 2, 15.1% (Table 1). The relative risk of a major complication in patients with elevated mFI (>0) was 2.2. Age, BMI and resection weights were not associated with complications (p=0.15, p=0.87 and p= 0.30 respectively).

Conclusion: The mFI predicts surgical risk in patient who are undergoing oncoplastic reduction. Benefits of this risk assessment tool include its ease of calculation. Our study is the first to demonstrate its utility in OCR.

Table 1: Modified Fragility Index and Major Complications

Calculated mFI	Number	Major complications N (%)
• 0	• 314	• 18 (5.7%)
• 1	• 178	• 23 (13%)
• 2	• 53	• 8 (15.1%)
• 3	• 2	• 0 (0)
• 4	• 0	• 0 (0)
• 5	• 0	• 0 (0)

2 Gender-Affirming Surgery Improves Mental Health Outcomes and Decreases Anti-Depressant Use in Patients with Gender Dysphoria

Lee H. Kilmer MD, Christopher A. Campbell MD, Brent R. DeGeorge MD PhD, John T. Stranix MD
Presenter: Jesse Chou, MD

University of Virginia

Background: Patients with gender dysphoria face significant health disparities and barriers to care. Transition-related care includes hormonal therapy, mental healthcare, and gender-affirming surgeries. Studies have described favorable surgical outcomes and patient satisfaction, however the degree to which these procedures impact mental health conditions is not fully understood. The purpose of this study was to evaluate the effect of gender affirming plastic surgery on mental health and substance abuse in the transgender population.

Methods: A national insurance claims-based database was used for data collection. Patients with a diagnosis of gender dysphoria were propensity score-matched for likelihood of undergoing gender affirming surgery (no surgery being the control cohort), based on comorbidities, age, and listed sex. Primary outcomes included post-operative antidepressant use and prevalence of mental health conditions.

Results: A total of 3,134 patients with gender dysphoria were included in each cohort. Patients in the surgery group had overall lower rates of mental health conditions, substance abuse and SSRI/SNRI use. Among patients that underwent surgery, the majority of which were female to male procedures (74.7), with chest masculinization the most common (71.2%). There was an absolute decrease of 8.8% in SSRI or SNRI prescription after gender affirming plastic surgery ($p<0.001$), and significant decreases in post-operative depression (7.7%), anxiety (1.6%), suicidal ideation (5.2%) and attempts (2.3%), alcohol abuse (2.1%), and drug abuse (1.9%).

Conclusion: Gender-affirming surgery in appropriately selected gender dysphoric patients is associated with decreased postoperative rates of SSRI or SNRIs use and improved mental health

3 Implementation of an Enhanced Recovery After Surgery Protocol for Cleft Palate Repair

Laura I Galarza, MD; Kathryn W. Brown, MD; Colton Fernstrum, MD ; Samuel Hopper, BS; Laura S. Humphries, MD; Ian C Hoppe, MD

University of Mississippi Medical Center

Background: As trends in healthcare focus on decreased hospital stays and improved patient outcomes it is important to provide protocols that address both. Enhanced recovery after surgery (ERAS) protocols have been implemented across surgical disciplines, including cleft surgery. The authors aim to describe the implementation of an ERAS protocol for cleft palate repair at a tertiary care hospital.

Methods: Institutional review board approval was received. All patients undergoing repair of a cleft palate at the authors' institution over a 10-year period were collected (n=242). Patient and cleft demographics were collected as well as operative details. Primary outcomes measures were hospital length of stay (LOS) and narcotic usage. Secondary outcome measures were development of a fistula and need for speech surgery. Chi square tests and independent t-tests were utilized to determine significance. A significance value of 0.05 was utilized.

Results: During the time period examined, there were 290 cleft palate repairs performed at the authors' institution, 242 patients had enough data for analysis. Infiltration of the surgical field with bupivacaine was associated with decreased initial 24-hour morphine equivalent usage ($p < 0.01$) and decreased hospital LOS ($p < 0.01$). Utilization of the Furlow palatoplasty was associated with a decreased hospital LOS ($p < 0.01$). Patients using the ERAS protocol experienced a shorter LOS ($p < 0.01$). The development of a fistula was associated with increased 24-hour morphine equivalent usage ($p < 0.01$). The need for speech surgery was associated with an increased 24-hour morphine equivalent usage ($p < 0.01$) and an increased hospital length of stay ($p < 0.05$).

Conclusion: This study reiterates the benefit of developing and implementing an ERAS protocol for patients undergoing cleft palate repair. The protocol resulted in an overall decreased LOS and a decrease in narcotic use. The finding regarding fistula formation and need for speech surgery requiring increased narcotics may indicate that the initial postoperative period is vital to adequate wound healing and subsequent outcomes. This has implications for ways to maximize hospital reimbursement for these procedures, as well as potentially improve outcomes.

RESIDENT GLANCY COMPETITON . . . . . 10:30 – 11:15 AM

4 Cranial Defect Reconstruction with Custom 3D-Printed Hydroxyapatite Scaffolds: A Large Pre-Clinical Model

Samuel Kogan MD/PhD[1], Griffin Bins MD[1], Heather Burkhart DVM[1], Lukasz Witek M.Sci/PhD[2], Christopher Runyan MD/PhD[1]

1. Atrium Health Wake Forest Baptist, Department of Plastic and Reconstructive Surgery
2. Biomaterials Division - New York University College of Dentistry

Introduction: When considering critical bone defect reconstruction, cranial reconstruction via cranioplasty is an attractive target due to the presence of adjacent, vascularized tissue and the relative lack of load bearing. This study seeks to demonstrate clinical readiness of a bone tissue engineering approach for critical cranial defects in an adult non-human primate model.

Methods: 5-cm vertex guided-craniotomies were created in 12 rhesus macaques. Three treatment groups were tested to examine the contributions of osteogenic factors to scaffolds: naked scaffold, rhBMP-2, and dipyridamole. CT scans were obtained until 12 months following implantation, at which time micro-CT scan, histology and nano-indentation testing were performed.

Results: No bone formation was identified in unrepaired craniotomies. Bridging analysis demonstrated complete fusion of the BMP-2 treated scaffolds at 2 months while dipyridamole and naked scaffold groups had significantly less bridging (78.4% and 64.6% vs 100%). Micro-CT analysis demonstrated a greater volume of bone formation in the BMP-2 treated scaffolds (7621 ± 145 mm3) compared with the dipyridamole- (6466 ± 693 mm3, p=0.033) and naked scaffold (6348 ± 663 mm3, p=0.021) at 12 months. Histologic analysis found increased integration with 64% of BMP-2 scaffolds pore volume occupied by bone (dipyridamole, 39%; NS, 27%). Nanoindentation demonstrated BMP-2 scaffolds had a larger Young's Modulus and Hardness than NS and dipyridamole scaffolds ($p<0.05$).

Conclusion: Reconstruction of critical cranial defects was successful with large, custom 3D-printed hydroxyapatite cranioplasty implants with a one year follow up. Bony ingrowth and bridging were most prevalent in scaffolds pre-treated with BMP-2. These findings demonstrate successful incorporation of large hydroxyapatite cranial scaffolds, and suggest an alternative approach to alloplastic materials for surgical cranioplasty.

5 Improving the Care and Cost of Treating Community-Acquired Stage 3 and 4 Decubitus Ulcers

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1. Prisma Health-Midlands/University of South Carolina School of Medicine
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Introduction: The healthcare costs for treatment of community-acquired decubitus ulcers accounts for $11.6 billion in the United States annually.1 Patients with stage 3 and 4 decubitus ulcers are often treated inefficiently prior to reconstructive surgery while physicians attempt to optimize their condition, including debridements, fecal and urinary diversion, physical therapy, nutrition, and obtaining durable medical goods. We hypothesized that hospital costs and reimbursements result in massive financial losses to hospital and that transitioning optimization to an outpatient setting might greatly reduce hospital expenditures for these patients. In this study, we analyzed and compared the financial expenditures of optimizing patients with decubitus ulcers in an inpatient setting versus maximizing outpatient utilization of resources prior to reconstruction.

Methods: Encounters of patients with stage 3 or 4 decubitus ulcers over a five-year period were investigated. Admissions were divided into five groups as depicted in Table 1. Financial charges and reimbursements for each admission were compared among the groups

Results: Ninety-six encounters met inclusion criteria. Group 4 (outpatient optimization group) had the lowest average total hospital charges ($133,598), while Group 2 (inpatient optimization group) had the highest ($523,827) with the longest average length of stay. However, the average amount reimbursed to the hospital per admission across all encounters was only $38,647. Estimated outpatient optimization cost is $7,686.74 monthly (Table 2). Combining this with group 4's total hospital charges equates to $141,284.74, which represents total expenditures for optimization and planned admission for reconstruction.

Conclusion: Hospital charges can be reduced by an average of $382,542.26 per admission, and subsequently hospital costs can be also significantly reduced by transitioning optimization of patients with stage 3 and 4 decubitus ulcers to an outpatient setting.

References: 1.Russo CA, Steiner C, Spector W. Hospitalizations Related to Pressure Ulcers Among Adults 18 Years and Older, 2006. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Rockville (MD): Agency for Healthcare Research and Quality (US); December 2008.

Measure	1. Recommend No Closure; debrided only	2. Optimized inpatient, reconstruction performed	3. Recommend No Closure: not reconstruction candidate	4. Optimized outpatient, admitted for reconstruction	5. Reconstruction candidate, but admitted for problem other than optimization	p-value
Number of Patients	18	17	9	28	24	
Length of Stay (days), mean	29.6	70.2	25.3	21.7	20.0	<0.001
Charges, mean	$256,359	$523,827	$184,077	$133,598	$136,243	<0.001
Adjustments, mean	$53,626	$68,002	$29,300	$30,342	$26,249	<0.001
Hospital Cost, mean	$202,324	$455,595	$154,653	$105,305	$109,855	0.005

Table 1. Comparison of hospital costs among the patient groups. Group 1: Not a candidate for closure, wound debridement performed only. Group 2: Optimized inpatient, then undergoes reconstructive procedure for closure. Group 3: Not candidate for closure, no debridement performed. Group 4: Optimized outpatient, then admitted for reconstructive procedure. Group 5: Candidate for reconstructive procedure, but the ulcer was an ancillary problem during that admission.

Outpatient Item	Estimated Monthly Cost
3 Wound Care Center Clinic Visits	$459.12
Outpatient Wound Care Center Debridement	$447.62
Home Health Nursing	$660
Negative-pressure therapy supplies and care	$3,800
Physical Therapy	$2,200
Nutrition Supplements	$120
Total	**$7,686.74**

Table 2. Itemized list of estimated outpatient optimization costs per month.

1 Feeding Outcomes after Mandibular Distraction for Airway Obstruction in Infants

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Departments of 1Plastic Surgery and 2Otolaryngology

Abstract: Robin Sequence is a congenital issue resulting in airway obstruction, difficulty feeding, and failure to thrive. Mandibular Distraction Osteogenesis (MDO) is used to improve airway obstruction in these patients, but little data exists characterizing feeding outcomes following surgery. This study aims to evaluate feeding outcomes and weight gain following mandibular distraction for airway correction in infants. A single center retrospective chart review was conducted on patients under 12 months old who underwent mandibular distraction between December 2015 and July 2021. The presence of cleft palate, distance of distraction, and polysomnography results were recorded. The primary outcomes were length of distraction, need for NGT or G-tube at discharge, time lapsed to achieve full oral feeds, and weight gain (kg). 10 patients met criteria. Of those patients, 4 were syndromic, 7 had a cleft palate, and 4 had a congenital cardiac diagnosis. The average length of stay post-surgery was 28 days. 8 patients achieved full oral feeds in an average of 65.6 days. 5 patients required NGT or G-tube at discharge with 3 of these patients later transitioning to full oral feeds. All patients gained weight 3 months post-surgery with an average of 0.521 kg/month. Patients who achieved full oral feeds gained an average of 0.549 kg/month. Patients with supplementation gained an average of 0.454 kg/month. All patients demonstrated improvement of airway obstruction with an average postoperative apnea hypopnea index (AHI) of 1.64. Further investigation is necessary to identify challenges seen in feeding after MDO and improve care.

2 Early Strip Craniectomy with Cranial Orthosis: An Effective Alternative for Multi-suture Craniosynostosis?

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Vanderbilt University Medical Center

Objective: In this case series, the authors aim to present the use of early treatment of multi suture craniosynostosis(mCS) in both syndromic and non-syndromic infants with strip craniectomies followed by helmet therapy.

Methods: Five patients with mCS, two with Apert syndrome, were treated with strip craniectomies and helmet therapy between 2020-2022. All patients are actively being followed. Four patients were females; one was male. Age ranged from 8-14 weeks. Weight ranged between 4.3- 5.7 kg. 12 sutures were treated. Three patients had two suture fusion; all were bicoronal. Two patients had three suture fusion, involving the coronal and lambdoid.

Results: All patients are still being followed with the longest follow-up being 27 months. Two graduated helmet therapy. Estimated blood loss ranged from 15-75 ml (mean 33). One patient received transfusion. Procedure time ranged between 35 -70 minutes (mean 54). Length of hospital stay ranged from 1-2 days (mean 1.4). There were no deaths. Head shapes became more normocephalic with increased intracranial volume and cranial bone thickness in all cases. One patient thus far had a fronto-orbito advancement for severe exorbitism.

Conclusion: Early strip craniectomies and cranial orthosis in cases of mCS may be an effective alternative to posterior vault distraction or later age cranial vault remodeling. Despite the potential of reoperation, this approach increases intracranial volume, improves head shape and cranial bone thickness with lower rates of blood loss and transfusion, shorter procedure times and hospital stay.

3 Case and Review: Isolated Duplication of Oral Stoma with Osseous and Odontogenic Components

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University of Kentucky, Department of Surgery, Division of Plastic and Reconstructive Surgery

Introduction: Duplication of craniofacial structures, otherwise known as diprosopus, is a rare congenital anomaly. Proposed etiologies are branchial arch duplications, fetal absorption, or neural crest migration. As of 2020, approximately 36 cases have been reported since 1900. Diprosopus can be an isolated finding or in conjunction with craniofacial syndromes. Here we present our experience with an isolated duplication of oral stoma with underlying odontogenic and osseous elements.

Case: A newborn female found to have a left lower facial lesion at birth. Physical exam consistent with duplicated oral stoma with underlying bony protrusion (Figure 1). The duplicated stoma did not communicate with primary oral opening (Figure 2). CT scan showed mandibular ossified mass containing teeth (Figure 3). She continued to grow and feed without difficulty and at 13 months of age the decision was made to excise the mass.

She underwent excision of stoma, mucosa glandular tissues, accessory teeth, and bone (Figure 4). The mandibular interruption was then bone grafted with iliac crest donor site. Adjacent tissue transfer was performed, and closure was achieved (Figure 5). Pathology was consistent with benign skin, salivary glands, bone, and odontogenic epithelium. Post operatively she healed without issue. Scar revision with further debulking may be pursued as she matures (Figure 6).

Discussion: Diprosopus is a rare congenital anomaly we observed in our patient as an isolated oral duplication. Few reports exist in the literature and treatment varies depending on elements observed and severity of presentation. Excision with reconstruction of defect remains the standard of care. Delaying surgery until further dental maturity to prevent damage to native teeth remains an important consideration, however stigma of this anomaly relieved with removal is of equal importance in surgical timing.

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

Figure 6

4 Helmets for Plagiocephaly – A Review of Crowdsource Funding: A National and Southeastern Regional Analysis

Podszus, Brendan BS[1], Pham, Jason BS[1], Dopson, Erika BS[1], Trivedi, Shikha MS[1], & Guo, Yifan MD[2]

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Background: Plagiocephaly and other forms of skull deformation are commonly seen in the postnatal period, and frequently treated with a custom helmet. However, not all insurance covers this cost, creating a significant financial burden that presses some to utilize crowdsourcing. To date, no studies have elucidated the results and statistics of US crowdsourcing for this therapy.

Method: GoFundMe campaign data from 2011 to 2022 were collected querying terms such as "plagiocephaly" and "helmet therapy". These data, including demographics, story themes, and unique characteristics, were analyzed by two independent reviewers. Using logistic regression, each variable's impact on success, defined as attaining ≥75% of a campaign's goal, was determined. Statistical significance was set at $p \leq 0.05$.

Results: Overall, 413 campaigns were analyzed, on average raising $2,005 (range: $0-$7,799) and requesting $3,151 (range: $160-$30,000). Among these, 72 (17%) resided in the Southeast, 228 (54%) achieved success, 167 (40%) met their goal, and 35 (8%) raised no funds. The mean reported age was 6 months (range: 2-17m). In total, campaigns raised $828,256 of a requested $1,301,317 (overall 64%, range: 0%-206%). Significant factors associated with success were military affiliation, providing multiple images, including a quoted cost, campaign updates, indicating a sense of urgency, stating torticollis diagnosis, and mentioning possible complications without treatment. Raising additional funds for physical therapy and unrelated medical costs lowered success. Campaigns in the Southeast performed similarly to the remainder of the Nation.

Conclusion: This study may aid families struggling with financial stress from helmet therapy to successfully navigate the complexities of crowdfunding.

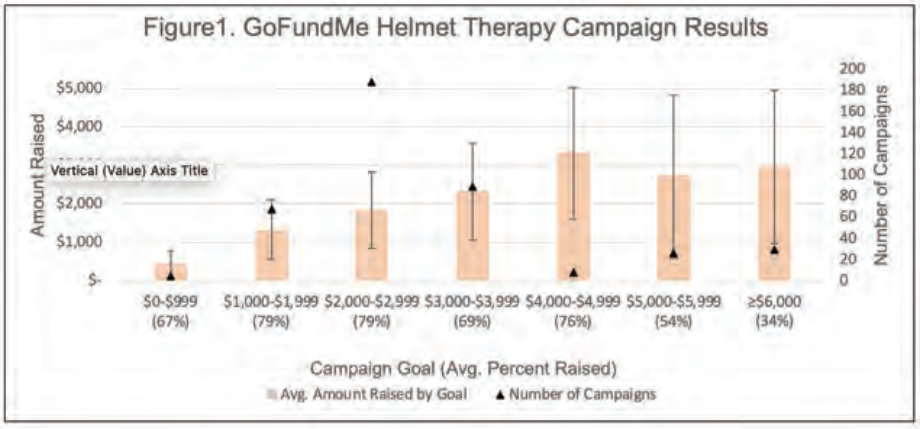


Table 1. Univariate Logistic Regression Analysis of Factors Associated With Success (≥75%)				
Predictors	**N (%)**	**Z**	**Odds Ratio**	**p-value**
Age in Months (Reference: 0 to 3)				
4 to 6	102 (24.7)	-0.782	0.649	0.434
≥7	75 (18.2)	-0.667	0.686	0.505
Anonymous	220 (53.3)	-0.443	0.789	0.658
Patient Sex (Reference: Female)				
Male	259 (62.7)	0.617	1.13	0.537
Patient Race (Reference: White)				
Asian	4 (1)	0.021	3.77E+06	0.983
Black*	22 (5.3)	-2.504	0.306	0.012
Hispanic*	87 (21.1)	-2.923	0.485	0.003
Anonymous	7 (1.7)	-0.919	0.492	0.358
Photo Characteristics				
Photos with Family	70 (16.9)	0.094	1.03	0.925
Patient Smiling	247 (59.8)	1.74	1.422	0.082
Multiple Photos Provided*	204 (49.4)	2.836	1.764	0.005
Medical Imaging Included	95 (23)	0.365	1.09	0.715
Story Elements				
Plagiocephaly Diagnosis	282 (68.3)	0.068	1.01	0.946
Brachycephaly Diagnosis	85 (20.6)	0.996	1.28	0.319
Sense of Urgency*	157 (38)	2.1	1.54	0.036
Prematurity	57 (13.8)	1.01	1.34	0.312
Complications without Treament Mentioned*	180 (43.6)	2.908	1.803	0.004
ICU Stay	50 (12.1)	-0.486	0.863	0.627
Physical Therapy Treatment	94 (22.8)	-1.62	0.683	0.105
Other Major Medical Issues	62 (15)	-0.34	0.91	0.734
For Multiple Children	10 (2.4)	-0.964	0.533	0.335
Torticollis Diagnosis*	126 (30.5)	2.022	1.56	0.043
Military Affiliation*	49 (11.9)	2.67	2.48	0.008
Quoted Price for Helmet Included*	162 (39.2)	3.535	2.09	< .001
Relationship of Beneficiary to Crowdfunder (Reference: Family)				
Child	339 (82.1)	0.347	1.133	0.728
Foster	7 (1.7)	0.883	2.222	0.377
Friend	21 (5.1)	-1.067	0.547	0.286
Anonymous	12 (2.9)	0.322	1.244	0.747
Additional Funding Purposes				
Beyond Helmet Coverage	373 (90.3)	1.028	1.409	0.304
Travel Expenses	22 (5.3)	-0.504	0.802	0.614
Physical Therapy*	22 (5.3)	-2.09	0.376	0.037
Unrelated Medical Expenses*	29 (7)	-2.61	0.339	0.009
For Multiple Helmets*	13 (3.1)	-2.19	0.233	0.029
Miscellaneous				
Update(s) to Campaign*	238 (57.6)	2.03	1.07	0.042
Southeastern States vs Rest of US	72 (17.4)	-0.716	0.83	0.474
* denotes statistically significant (p≤0.05)				

5 Creation and Implementation of Regional Measure in Sagittal Craniosynostosis

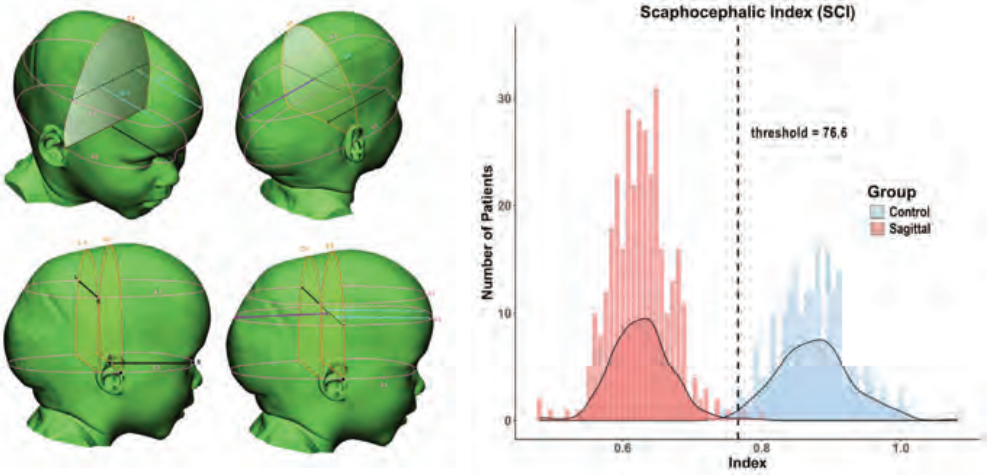
Christopher Runyon, MD

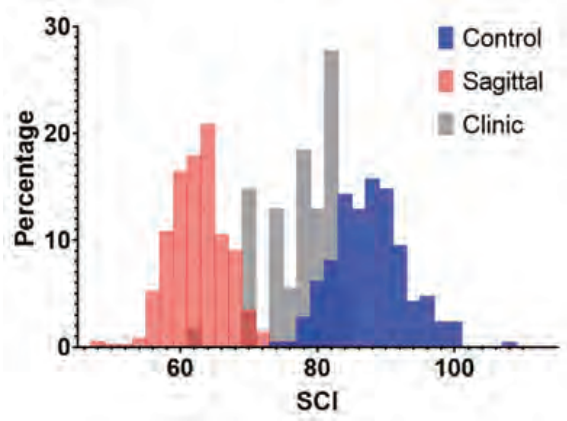
Introduction: Currently a lack of objective regional metrics leaves surgeons without tools able to adequately assist in diagnosis, operative planning, and post-operatively assessment of patients with sagittal craniosynostosis (SC).

Methods: CT imaging and 3D-photography of 360 individuals with SC and 210 control patients were used to create tailored objective tools which maximize the measurement of frontal bossing (FBI), occipital bulleting (OBI), vertex narrowing (VNI), and global severity (SCI). To evaluate the ability of 3D-photography to act as a primary screening tool, these metrics were used to evaluate 62 individuals without craniosynostosis who were referred by craniofacial surgeons for rule-out CT imaging. To better understand long-term outcomes, these tools were applied to 788 postoperative 3D-photographs of 223 individuals whose SC was treated by either spring surgery or cranial vault remodeling.

Results: Metric performance had sensitivity and specificity >99% relative to normal controls. When applied to the more clinically relevant population, screening with 3D photography could prevent unnecessary CT imaging in 85% of those without SC. Post-operative analysis found both interventions to improve frontal bossing and occipital bulleting overtime while vertex narrowing regressed following initial improvement in both groups. Globally, spring patients trended toward superior shape (p=0.087) despite those with CVR having less severe preoperative morphology (p<0.05).

Conclusions: These tools allow for more effective use of 3D-photography which can prevent unnecessary use of CT imaging. In post-operative study, these metrics indicate that spring surgery maintains the growth potential of the skull, while CVR potentially impairs long-term growth.

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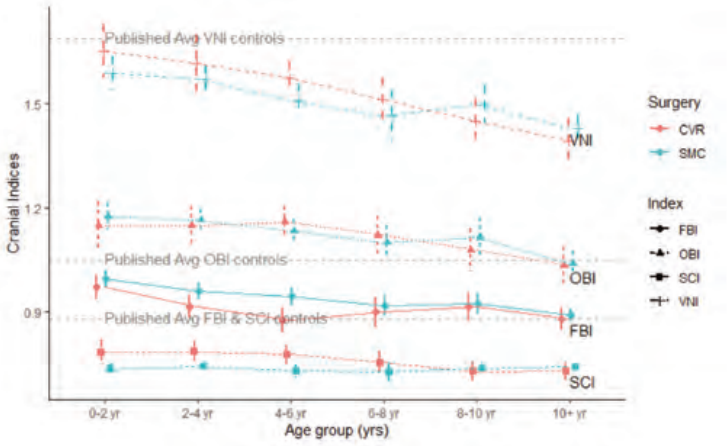
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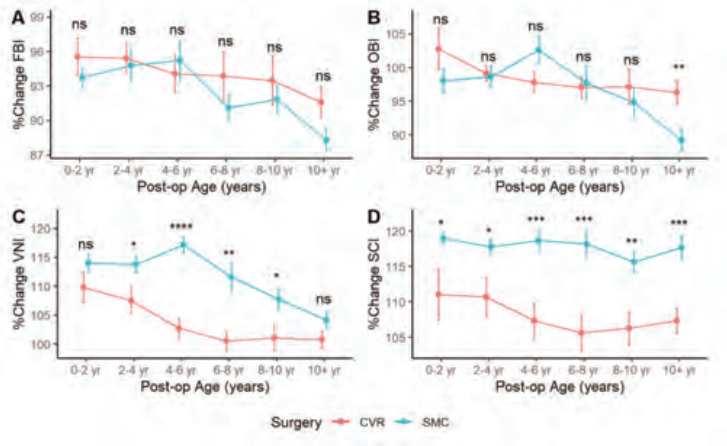
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6 Considerations in the Management of the Recalcitrant Cleft Maxilla at Skeletal Maturity

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Children's Healthcare of Atlanta

Background: We define the recalcitrant cleft maxilla as a maxillary arch at skeletal maturity which despite traditional cleft-reconstructive efforts does not meet the skeletal and soft tissue requirements for definitive dental rehabilitation. There is no consensus as to the management of the maxilla in this rare but difficult patient population. The authors present lessons learned with completion maxillectomy/edentulation and total vascularized maxillary reconstruction as a bridge to dental rehabilitation.

Methods: Patients meeting criteria for a recalcitrant maxilla were retrospectively reviewed. All patients had failed reconstructive efforts via the traditional cleft surgical paradigm and presented at skeletal maturity with severe 3-dimensional maxillary deficiency and poor-quality intraoral soft tissues. Lessons learned in the surgical decision-making, virtual planning, and execution of a total maxillary reconstruction are elucidated.

Results: Between 2019 and 2022, 4 patients (3 with diagnosis of bilateral cleft lip and plate, 1 with isolated cleft palate) met the criteria of a recalcitrant maxilla. All patients had severe transverse and sagittal maxillary deficiency, a discontiguous maxillary arch, and deficient alveolar soft tissue. All patients were treated with completion maxillectomy and immediate reconstruction with a multisegmented osteocutaneous free fibula flap to set them up for dental rehabilitation. Pearls and pitfalls are detailed.

Conclusion: We contend that in the rare setting of the recalcitrant cleft maxilla at skeletal maturity, completion maxillectomy/edentulation with concomitant total vascularized maxillary reconstruction is a viable option to achieve the ideal bimaxillary relationship for definitive dental rehabilitation.

7 Does Age at Time of Speech Surgery for Velopharyngeal Insufficiency Effect Need for Revision Surgery?

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Joseph K Williams, MD[1]

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2. University of Virginia

Introduction: Velopharyngeal insufficiency (VPI) in patients with cleft palate affects speech intelligibility and quality of life. A pharyngeal flap (PF) and sphincter pharyngoplasty (SP) are accepted interventions, though the exact size of the pharyngeal ports, sphincter size, and palatal movement cannot be guaranteed. In considering early intervention to avoid maladaptive speech, we investigated VPI surgical outcomes by age.

Methods: A retrospective review was completed for patients who underwent superiorly-based pharyngeal flap or sphincter pharyngoplasty between 2015-2021. Inclusion criteria included cleft palate diagnosis, age <18 years old, and 5-18 months post-operative speech evaluation. Pre-operative and post-operative functional speech outcomes were compared. Need for revision surgery within the 18 month study period was evaluated.

Results: 125 patients met inclusion criteria; 62 PF and 63 SP. Average age was 7.6 years for PF group and 6.7 years for SP group. In the < 3 year old age group, 2 patients (7.7%) required revision. In the 4-7 year old group, 7 patients (12.1%) underwent revision. 5 patients (12.2%) required revision in the >8 year old age group. The breakdown between pharyngeal flap and sphincter outcomes per age group is displayed in Figure 1. Overall, the PF group had a lower revision rate, 4.8% vs. 17.5% SP which was significant, p=0.006. Obstruction requiring revision was more frequent in the SP group vs PF group, p < 0.001; 63.6% of SP revisions. No significant differences were seen in post-operative VP function and hypernasality between the PF and SP groups, p=0.395 and p=0.433 respectively.

Conclusion: The overall revision rate for pediatric patients undergoing cleft VPI surgery was 11.2%; 4.8% PF vs. 17.5% SP. Early intervention (< 3 years of age) did not show a higher complication rate. Functional outcomes were comparable.

Figure 1: Rates of revision and post-operative residual VPI by age group and surgery type

	≤ 3 Years old age group			4 - 7 years old age group			≥ 8 years old age group		
	Participants, N	Revisions, N (%)	Residual VPI (%)	Participants, N	Revisions, N (%)	Residual VPI (%)	Participants, N	Revisions, N (%)	Residual VPI (%)
Pharyngeal flap	13	1 (7.7%)	2 (15.4%)	29	1 (3.4%)	1 (3.4%)	20	1 (5.0%)	4(20.0%)
Sphincter pharyngoplasty	13	1 (7.7%)	0 (0.0%)	29	6 (20.7%)	3 (10.3%)	21	4 (19.0%)	0 (0.0%)
Total: both VPI surgeries	26	2 (7.7%)	2 (7.7%)	58	7 (12.1%)	4 (6.9%)	41	5 (12.2%)	4 (10.0%)

8 Craniometric and Volumetric Analyses of Normocephalic and Scaphocephalic Patients with Nonsyndromic Single-Suture Sagittal Craniosynostosis

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Purpose: Non-syndromic single-suture sagittal craniosynostosis (NSSSC) presentation spans scaphocephalic and normocephalic head shapes. Herein we studied craniometric differences between scaphocephalic and normocephalic patients with NSSS.

Methods: Head CT scans of 20 scaphocephalic and 20 normocephalic NSSSC patients and their age- and sex-matched controls were analyzed, including cranial base angles, distances-from-midline, and intracranial volumes. Two-tailed t-tests compared groups.

Results: Cranial Index was lower for cases than controls in both the scaphocephalic and normocephalic groups (p = <0.001, respectively).

Right external acoustic meatus angle (EAMA) was significantly larger in scaphocephalic (p = <0.001) and left EAMA was significantly smaller in normocephalic patients (p = 0.002) when compared with controls. Midline angular analysis showed that bifrontal angle was significantly decreased amongst scaphocephalic patients but insignificant amongst the normocephalic group along with decreases in interoccipital angle (p=<0.001) in both scaphocephalic and normocephalic groups.

Cranial base distances-from-midline were longer to the right and left internal acoustic meatus and shorter to the euryon-to-zygomaticofrontal suture for both groups of cases than controls (p<0.05).

Scaphocephalics had a larger anterior cranial volume ratio than controls (18% vs 13%, p=<0.001). Normocephalics had larger posterior volume ratios than controls (42% vs 33%, p=<0.001). Scaphocephalics had larger anterior volume ratios than normocephalics (1.69 vs 1.16, p=0.016), but smaller posterior compartment volume ratios (0.9 vs 1.53, p=<0.001).

Conclusion: NSSSC scaphocephalic and normocephalic patients have significant craniometric and cranial volumetric differences than their controls and each other. Some of the craniometric differences among the sagittal craniosynostosis patients are in common, despite cranial morphology, while others are different. Specifically, both normocephalic and scaphocephalic patients had a longer-than-wide head ratio (cranial index) than their controls, and wider anterior cranial base angle (IOA) than controls. However, both scaphocephalic and normocephalic patients demonstrated rightward lateralization of cranial base angles and distances compared to controls but not to the same extent. These data show craniometric evidence that although normocephalic and scaphocephalic sagittal craniosynostosis patients have some overlapping cranial morphologic characteristics, they also differ in their cranial base lateralization and their intracranial volume distributions. This may have implications for underlying pathophysiology, diagnosis timing and treatment of NSSSC.

9 Improving Access to ACPA Cleft Teams in Mississippi: A Cost Analysis

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University of Mississippi Medical Center, Division of Plastic and Reconstructive Surgery

Purpose: Access to American Cleft Palate-Craniofacial Association (ACPA)-approved teams is difficult for patients with orofacial clefts or craniosynostosis in rural communities. We studied the impact of pediatric plastic surgery outreach clinics on travel-time and cost savings for patients in Mississippi.

Methods: Mean travel-times from Mississippi counties to the main pediatric hospital was created using an isochrone map. Mean travel-times after the addition of 2 outreach clinics were calculated for our cleft and craniosynostosis patients. Travel-time differences between counties based on mean income were calculated. Cost-savings analysis for travel to specialized care was calculated.

Results: After outreach clinic addition, mean travel-times significantly decreased for cleft and craniosynostosis patients across Mississippi counties (1.81 vs 1.46 hours, p<.001) (Figure 1). The second lowest income group of counties was most impacted (2.12 vs 1.69 hrs, p<.001). Significant travel savings were observed after the addition of outreach clinics for pandemic-low gas prices ($15.27 vs 9.80, p<.001) and high prices two years later ($36.52 vs 23.43, p<.001).

Conclusion: The addition of outreach clinics allows cleft and craniofacial patients improved access to specialized healthcare in Mississippi. We anticipate a positive impact of outreach clinics in rural states, like ours, that improves care for patients with orofacial clefts and craniosynostosis. Future studies can address whether follow up rates and surgical outcomes were improved by the addition of the outreach clinics.

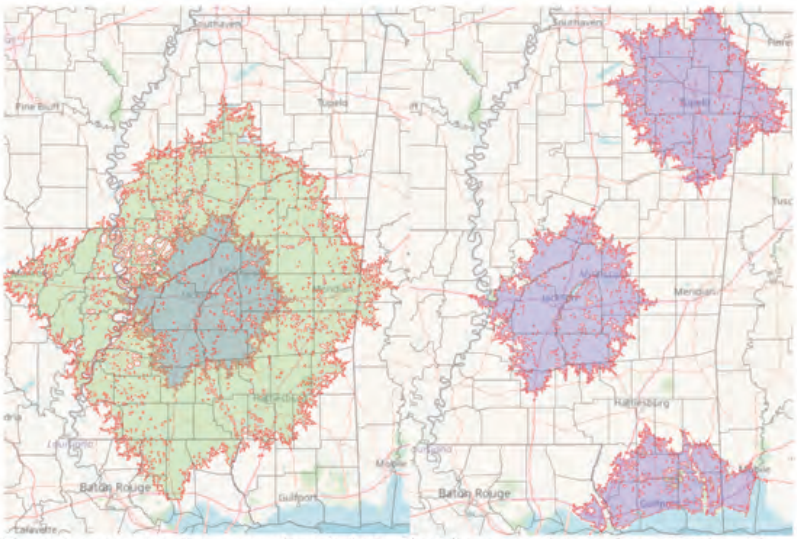

Figure 1a: <1 and 1-2 hour areas from Jackson ,**1b** <1 hour areas from Jackson, Tupelo, and Biloxi

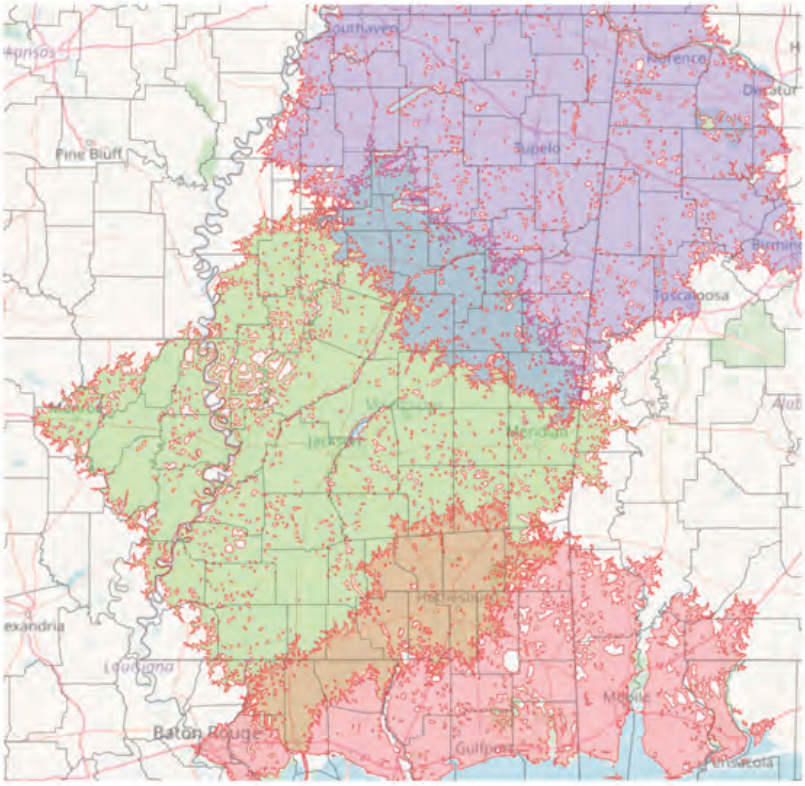

Figure 2: 2-hour catchment areas for main campus and two outreach clinics.

County Earnings	31-34k	34-39k	39-45k	45-68k
Total	44 (7.9%)	125 (22.5%)	281 (50.5%)	106 (19.1%)
Pre-outreach				
<1 hr	35 (79.5%)	18 (14.4%)	87 (31.0%)	90 (84.9%)
1-2 hrs	6 (13.6%)	76 (60.8%)	133 (47.3%)	
2-3 hrs	3 (6.8%)	29 (23.2%)	56 (19.9%)	7 (6.6%)
3-4 hrs		2 (1.6%)	5 (1.8%)	9 (8.5%)
Post-outreach				
<1 hr	35 (79.5%)	39 (31.2%)	131 (46.6%)	102 (96.2%)
1-2 hrs	9 (20.5%)	86 (68.8%)	144 (51.2%)	4 (3.8%)
2-3 hrs			6 (2.1%)	
Driving time saved in hours	.07 (P=.08)	.44 (P<.001)	.37 (P<.001)	.36 (P<.001)

Table 2: patients in counties separated by mean income pre and post-outreach clinic

	Mileage	High Fuel Cost	Low Fuel Cost
Pre-outreach	202.0	36.52	15.27
Post-outreach	129.59 (P<.001)	23.43	9.80
Cost-savings		13.09 (P<.001)	5.47 (P<.001)

Table 3: cost savings analysis for pre and post-outreach clinic for high and low fuel cost

10 Perioperative Management of Obstructive Sleep Apnea in Patients with Syndromic Craniosynostosis Undergoing LeFort III Osteotomy with Distraction: a Case Series

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Purpose: The purpose of this publication is to address the absence of literature detailing respiratory management in patients with syndromic craniosynostosis and obstructive sleep apnea during the immediate postoperative interval following Le Fort III advancement with placement of distraction hardware but prior to sufficient midface advancement.

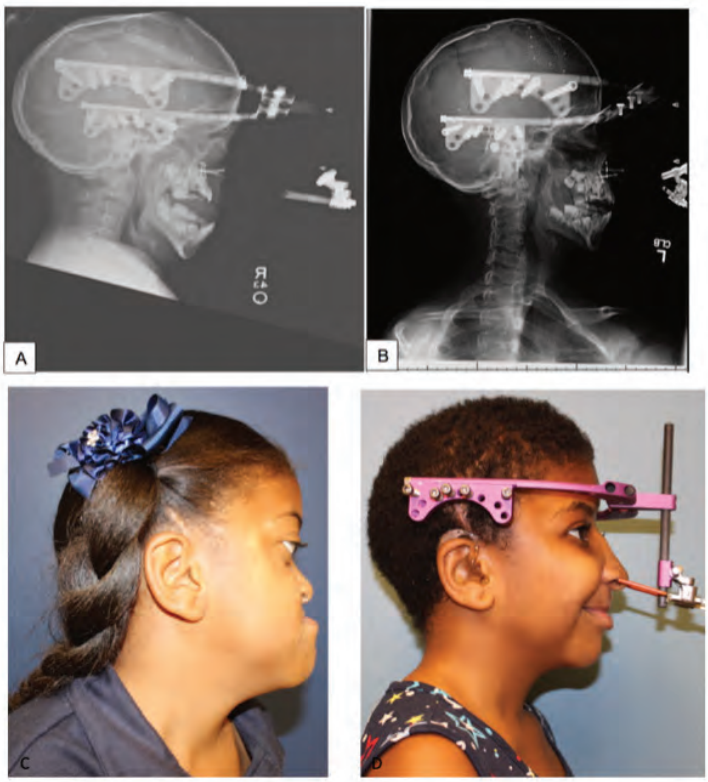
Methods: After IRB approval, the investigators retrospectively selected candidates for inclusion in this case series. The sample was composed of four patients ranging from 10 to 19 years of age undergoing Le Fort III midface advancement during a one-year span at a single tertiary care center. All operations were performed by a single surgeon. Three of the selected patients suffered significant obstructive sleep apnea necessitating the operation, as determined by polysomnography. One patient experienced persistent apnea postoperatively requiring prolonged ICU level care.

Results: Three of the four patients had severe OSA diagnosed by polysomnography with a median AHI of 28.3. Two of the three patients with preoperative OSA experienced no untoward respiratory compromise in the immediate postoperative period; one required nightly oxygen tent and the other required no supplemental oxygen. Patient 1 experienced significant postoperative respiratory distress with nightly apneic episodes and desaturations requiring supplemental oxygen and frequent stimulation.

Conclusion: The present study suggests that early involvement of sleep medicine and management of patient expectations is vital. Extremely close postoperative monitoring in the ICU is necessary. Future studies are needed to protocolize perioperative management of obstructive sleep apnea in patients undergoing Le Fort III osteotomy prior to initiation and completion of midface advancement.

Patient	Preoperative diagnosis	Preoperative AHI, OSA management	Perioperative management	Postoperative AHI
1. 10 year old female	Pfeiffer syndrome, severe OSA	AHI 12.2 Nightly BiPAP	Multiple nightly desaturations requiring frequent stimulation and oxygen tent. Prolonged ICU stay and hospital course. Discharged on POD11 with supplemental oxygen and continuous pulse oximetry	AHI 5.8
2. 17 year old female	Crouzon's syndrome, severe OSA	AHI 28.5 Nightly BiPAP	Required no postoperative oxygen supplementation, remained stable on room air, transferred to the floor on POD2, discharged on POD4	AHI 2.8
3. 12 year old male	Crouzon's syndrome	AHI 1.2	Required no postoperative oxygen supplementation, remained stable on room air, transferred to the floor on POD3, distraction begun and discharged on POD5	Not applicable
4. 19 year old female	Familial Crouzon's syndrome, severe OSA	AHI 28.3 Nightly CPAP	PaO_2 kept >90 with use of nightly oxygen tent, transferred to the floor on POD2 and no longer required supplemental oxygen, distraction begun POD4 and discharged POD5	AHI 3.5

Table 1: Summary of Patients 1 - 4



11 Posterior Cranial Vault Distraction Osteogenesis in the Immunocompromised Patient

John M Sullivan III, Alicia E Snider, Jeffrey Farrington, Micheal Lebhar, J Mason Shiflett, Kristin J Weaver, Laura S Humphries, Ian C Hoppe

The University of Mississippi Medical Center, Jackson

Purpose: The treatment of patients with multisuture craniosynostosis is complex and patient-dependent. Cranial distraction osteogenesis is a relatively new procedure for treatment of these patients, with its use increasing in many centers. With this increased use comes an expanding range of indications. Surgical management of multisuture craniosynostosis in therapeutically immunosuppressed patients following a solid organ transplant presents unique challenges. We describe our experience with posterior cranial vault distraction in two patients with multisuture craniosynostosis that had previously undergone organ transplantation.

Methods: Two solid-organ transplant recipient patients with multisuture craniosynostosis were identified. A detailed examination of their medical/transplant history and perioperative details were recorded.

Results: The first patient was a 3-year-old girl who received a kidney transplantation in infancy and subsequently presented with a symptomatic Chiari malformation and papilledema. Imaging revealed pansynostosis. She underwent posterior cranial vault distraction extending into a Chiari decompression. Her postoperative course was complicated by distractor site infection at the beginning of consolidation, necessitating early removal of distractors. The second patient was a 2-year-old boy who received a heart transplantation at the age of 3 months and subsequently presented with head shape concerns. Imaging revealed bicoronal and sagittal craniosynostosis. He underwent a posterior cranial vault distraction without complication. Following removal of the distractors, he developed an infection at one of the distractor sites with associated fever and leukocytosis, necessitating washout and drain placement. Both patients achieved successful cranial vault expansion with distraction osteogenesis and at a 2-year follow-up do not have evidence of elevated intracranial pressure.

Conclusions: Immunosuppressive therapy has the potential to inhibit wound healing and place patients at risk for wound infection. Although we have demonstrated successful cranial vault expansion with distraction in two immunosuppressed children, extra care must be taken with these patients when placing semi-buried hardware. Specifically, prompt identification and proactive management of potential infectious complications is critical to applying this technique safely in these patients.

12 Aesthetic Outcomes of Primary Cleft Lip Repair Utilizing 2-octyl Cyanoacrylate Liquid and a Self-adhesive Polyester Mesh

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Background: The method of epidermal closure during cleft lip repair is important to consider, as it may affect complication rates, cosmetic outcomes, and patient comfort. The purpose of this study is to compare the outcomes between 2-octyl cyanoacrylate liquid with a self-adhesive polyester mesh (Dermabond Prineo) and typical suture closure techniques, which to our knowledge has never previously been investigated.

Methods: In nine consecutive cleft lip repairs, the epidermal closure was performed with permanent suture, and in the subsequent nine consecutive cleft lip repairs, the epidermal closure was performed with Dermabond Prineo. Complication rates were compared between the groups. Aesthetic scar outcomes were investigated via post-operative photograph analysis utilizing the Manchester Scar Scale. Statistical significance was determined with Fischer Exact Tests and Wilcoxon Rank-Sum tests. Subsequently, the scar scores for cleft lip repairs performed with Dermabond Prineo in our practice were compared to previously reported scores in the literature for cleft lip repairs performed with typical suture technique.

Results: Three patients in the permanent suture group had documented scar-related complications and one patient in the Dermabond Prineo group had documented scar-related complications. No statistically significant difference was found in complication rates between the two groups. No statistically significant difference was found in aesthetic scar scores between the two different closure techniques either within our practice or in comparison to reports in the literature.

Conclusions: Overall, the use of Dermabond Prineo offers comparable aesthetic outcomes and complication rates to the use of permanent suture in epidermal closure of cleft lip repairs.

6 The Utility of Thermal Imaging in Perforator Identification and Flap Plannings

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1. Virginia Tech Carilion School of Medicine, Roanoke, VA
2. Department of Surgery, Section of Plastic and Reconstructive Surgery, Carilion Clinic, Roanoke, VA

Background: Precise identification of perforators is vital for perforator flap planning and success. Various imaging modalities are currently utilized. Doppler is the peri-operative modality of choice for perforator detection but is time consuming and operator dependent. Thermal imaging is an affordable, easy-to-use adjunct for perforator mapping. This study aims to compare the sensitivity and speed of thermal imaging to doppler in perforator identification.

Methods: 21 participants (42 thighs) were studied. A circle with a 5cm radius at the midpoint between the ASIS and lateral patella was marked. Two investigators independently utilized either doppler or thermal imaging to identify perforators within the marked territory. Thermal hotspots were marked with UV ink to blind the other investigator. Concordance between modalities was determined under UV-A light if perforator markings aligned within 1cm. Any non-concordant thermal hotspots were re-scanned with doppler. Time, number of perforators, rate of concordance, and presence/absence of doppler signal at thermal hotspot were recorded.

Results: Average time to identify perforators using doppler was 3.57 minutes and 1.06 minutes using thermal imaging ($p<0.001$). Among 42 ALT flap territories, 143 perforators were identified by doppler and 142 by thermal imaging with a mean difference of 0.02 ($p=0.858$) per thigh. When tested independently, there was 72.7% concordance between modalities in identifying the same perforators. Of 142 thermal hotspots, 132 (93.0%) had perforators confirmed with doppler.

Conclusions: Thermal imaging is a useful adjunct for flap planning to more quickly identify perforators and to unmask perforators missed by doppler.

7 The Outcomes of Local Infiltration Anesthesia vs Ultrasound-guided Pectoralis (PEC1) + Serratus Anterior Plane (SAP) Blocks on Post Anesthetic Care Unit (PACU) Pain Control in Patients Undergoing Primary Submuscular Augmentation Mammoplasty

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1. Division of Plastic and Reconstructive Surgery Tulane University School of Medicine
2. Tulane University School of Medicine
3. Garnet Health Medical Center

Background: Ultrasound-guided regional field blocks are not widely used in outpatient plastic surgery. The efficacy of truncal blocks (PEC1+SAP) has not been established in plastic surgery. The purpose of this study is to analyze outcomes of these newer anesthetic techniques compared to traditional blind local anesthetic infiltration in patients undergoing breast augmentation.

Methods: This is a retrospective IRB-approved study comparing the outcomes of the different practices of two plastic surgeons at the same accredited outpatient surgery center between 2018 and 2022. Group 1 received intraoperative blind local infiltration anesthetic with lidocaine and bupivacaine. Group 2 received surgeon-led, intraoperative ultrasound-guided PEC1+SAP blocks with liposomal bupivacaine and bupivacaine. Patients receiving any procedure other than primary submuscular augmentation mammoplasty were excluded. Outcomes measured included operative time, opioid utilization in morphine milligram equivalents (MME), pain level at discharge and time spent in PACU.

Results: 60 patients met the inclusion criteria in each group for a total of 120 patients. The study groups were similar (Table 1). Patients receiving PEC1+SAP blocks (group 2) had significantly lower average MME requirements in the PACU (3.04 MME vs. 4.52 MME, p=0.041) and required shorter average PACU stay (70.13 minutes vs. 80.38 minutes, p=0.008). There were no significant differences in pain level at discharge, operative time, nor implant size between the two groups (Table 1).

Conclusion: Surgeon-led, intraoperative, ultrasound-guided PEC1+SAP blocks significantly decreased opioid utilization in the PACU by 33% and patient time in PACU by 13% while achieving similar patient pain scores and operating times.

Table 1. Local vs. PEC1 + SAP Blocks

	Breast Augmentation		
	Local	PEC1 + SAP	*P*-value
No. patients	60	60	-
Age (yrs)	33.48 (19 - 55)	32.11 (20 - 71)	0.422
Weight (lbs)	130.97 (95 - 190)	131.06 (73 - 198)	0.98
BMI (kg/m^2)	22.19 (18 - 28.3)	22.7 (13.85 - 33.74)	0.4
Implant Size (cc)	354 (210 - 520)	360 (250 - 650)	0.645
Smoker	0	0	-
Diabetic	0	0	-
Pain level at discharge (0 – 10)	1.63	1.35	0.373
Morphine Milligram Equivalents (MME)	4.52	3.04	0.041
OR Time (Mins)	56.4	54.08	0.196
Time in PACU (Mins)	80.38	70.13	0.008

8 Increased Time Intervals in Postoperative Flap Monitoring After Autologous Breast Reconstruction

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Louisiana State University Health Science Center, New Orleans

Background: Hourly flap checks are the most common means of flap monitoring immediately following autologous breast reconstruction (ABR). This practice often requires intensive care unit (ICU) admission which is a known driver of healthcare costs. This study addresses this issue by demonstrating the safety and decreased cost of a 4-hour interval between flap checks during the first 24 hours following ABR.

Methods: This is a retrospective review of ABRs performed by multiple surgeons from 2017 to 2020. Two cohorts were examined, patients that initially underwent flap checks every hour in the ICU (Q1 cohort) and patients that initially underwent flap checks every four hours on the hospital floor (Q4 cohort). Primary outcome measures were LOS, flap takebacks (FT), flap loss (FL), and encounter cost (EC).

Results: FT and FL rates were 11.8% and 1.21% for the Q4 cohort. This was compared with FT and FL rates in the Q1 cohort which were 17.4% and 2.86%. Neither endpoint was significantly different between cohorts (pFT=0.18, pFL=0.21). The Q4 cohort's average LOS was shorter than the Q1 cohort (p=0.002). The Q4 cohort's average EC was also $25,554.80 less than the Q1 cohort (p<0.001). Cost savings persisted after controlling for LOS, takeback, timing and laterality of reconstruction, and flap configuration (HR=0.65, p=.0007).

Conclusion: This study demonstrates the benefits of increased flap check intervals following ABR. These intervals decrease the cost of ABR while also maintaining a consistent rate of success and safety.

Table 1. Comparison of patient demographic and medical history characteristics by Q1 and Q4 flap monitoring status.

Characteristics	All n = 282 (100%)		Cohort Q1 n = 115 (40.4%)		Cohort Q4 n = 170 (59.7%)		*p-value*
Age (yrs)	52 ± 10.51		51.89 ± 10.08		52.08 ± 10.82		0.878
BMI	29.92 ± 5.28		29.90 ± 5.12		29.94 ± 5.40		0.957
ASA	2.22 ± 0.49		2.21 ± 0.50		2.23 ± 0.47		0.725
Comorbidities							
Diabetes Mellites, type II	32	(11.2)	11	(9.6)	21	(12.4)	0.465
Hypertension	108	(37.9)	40	(34.8)	68	(40.0)	0.372
Hyperlipidemia	64	(22.5)	24	(20.9)	40	(23.5)	0.598
Coronary Artery Disease	4	(1.4)	2	(1.7)	2	(1.2)	0.999
Pulmonary Disease	37	(13.0)	14	(12.2)	23	(13.5)	0.738
Health Behaviors							
Ever Smoker	72	(25.3)	35	(30.4)	37	(21.8)	0.098
Current Smoker	5	(1.8)	3	(2.6)	2	(1.2)	0.396
Any alcohol use	158	(55.4)	56	(48.7)	102	(60.0)	0.060
Illicit drug use	5	(1.8)	1	(0.9)	4	(2.4)	0.651
Prior chemotherapy	15	(5.3)	3	(2.6)	12	(7.1)	0.113

Table 2. Breast level oncologic history and surgical characteristics were compared by Q1 and Q4 flap monitoring status.

Characteristics	All n = 282 (100%)	Cohort Q1 n = 115 (40.4%)	Cohort Q4 n = 170 (59.7%)	*p-value*
Age (yrs)	52 ± 10.51	51.89 ± 10.08	52.08 ± 10.82	0.878
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Prior chemotherapy	15 (5.3)	3 (2.6)	12 (7.1)	0.113

Table 3. Comparison of complications and cost outcomes compared between cohorts as previously described (Table 3)

Outcome	All	Cohort Q1	Cohort Q4	*p-value*
Takeback	40 (14.04%)	20 (17.4%)	20 (11.8%)	0.180
Flap failure	11 (1.91%)	7 (2.86%)	4 (1.21%)	0.218
Length of stay (days)	3.85 ±1.11	4.10 ±1.16	3.68 ±1.04	0.002
Encounter cost ($)	100308.8 ±39186.6	115660.3 ±48655.6	90105.2 ±27039.9	<0.001

Figure 1. Odds ratio of OR takeback by monitoring cohort and comorbidity status.

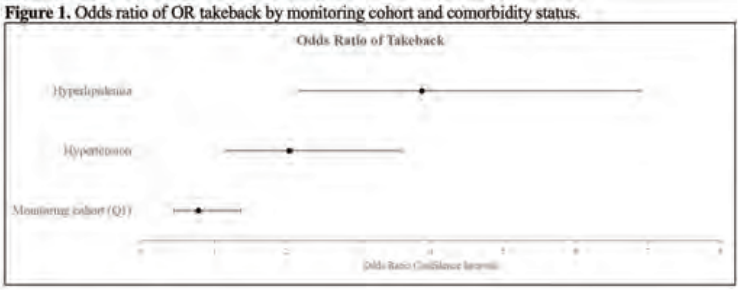
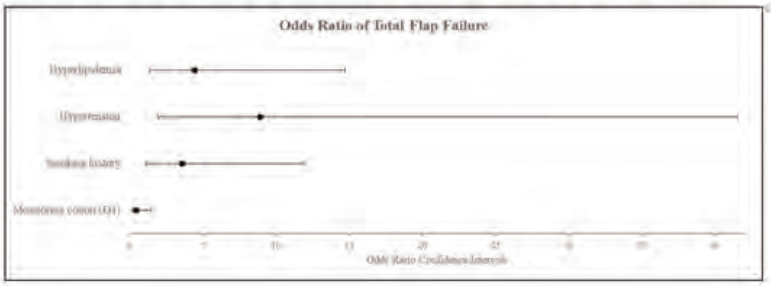


Figure 2. Odds ratio of OR takeback by monitoring cohort, smoking history, and comorbidity status.



9 Targeted Muscle Reinnervation: Factors Predisposing to Successful Pain Score Reduction

Peter M Vonu, MD; Ramin Shekouhi, MD; Harvey Chim, MD

University of Florida Department of Surgery, Division of Plastic and Reconstructive Surgery, Gainesville, Fl

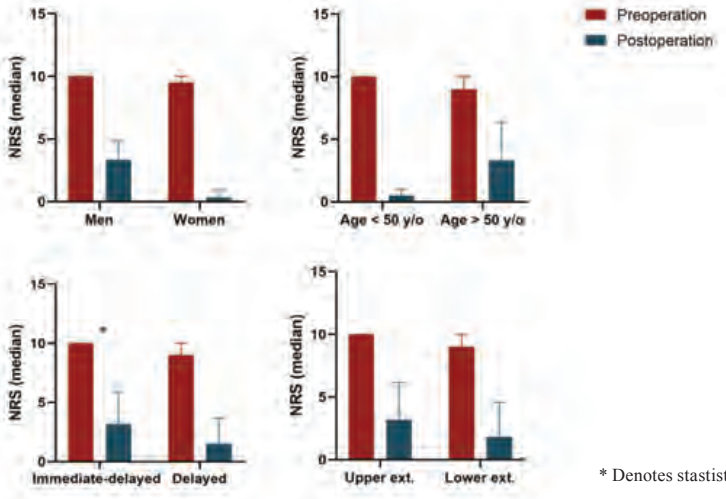
Introduction: Targeted muscle reinnervation (TMR) has demonstrated efficacy in reducing neuroma and phantom limb pain.1-4 Here we investigated postoperative outcomes in our patient cohort, with a focus on the role of nonmodifiable factors such as patient age and gender.

Methods: Patients who had extremity TMR from April 2018 to October 2022 were reviewed. Outcomes of interest included patient age, gender, cause and type of amputation, delayed vs immediate TMR, as well as postoperative improvement in pain as assessed by numerical rating score (NRS).

Results: A total of 39 patients underwent 46 TMR surgery with a mean age of 45.9 ± 17.2 years. Delayed TMR (27, 58.7%) was most commonly performed, followed by immediate and delayed-immediate at 10 (21.7%) and 9 (19.6%), respectively. Amputation level was most commonly above-knee in 20 (43.5%) patients, followed by below-knee (11, 23.9%), transhumeral (9, 19.6%), and transradial (6, 13.0%). The median time interval between amputation and TMR was 12 months. The median preoperative NRS score for patients that underwent delayed TMR was 10. At the last follow-up, 33 (71.7%) patients had more than 50% resolution of pain. The median postoperative NRS for all patients was 0 (IQR25-75: 0-4) and significantly improved compared to preoperative NRS (P <0.001). There was a significant difference in median postoperative NRS by gender (3.5 in men and 0 in women) (P<0.05). Postoperative median NRS also favored younger patients (0, <50 yrs; 4, >50 yrs; P<0.05).

Conclusion: TMR showed high efficacy in our cohort, with improved outcomes in women and younger patients.

Figure 1. Pain Scores According to Patient Characteristics and Surgery Type



* Denotes statistical insignificance

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ABSTRACTS - TUESDAY

Table 1.

Comparative analysis of pre/post-TMR NRS scores in different patient groups			
Variable (median)	**Preoperative NRS** (median, IQR^{25-75})	**Postoperative NRS** (median, IQR^{25-75})	**P-value**[1]
Study population	10 (7-10)	0 (0-4)	**<0.001**
Men	10 (7-10)	3 (0-5)	**<0.001**
Women	9.5 (7-10)	0 (0)	**0.001**
Age>50	9 (7-10)	4 (0-6)	**0.003**
Age<50	10 (7-10)	0 (0-1)	**0.001**
Immediate-delayed TMR	10 (8-10)	4.5 (0-5)	0.066
Delayed TMR	9 (7-10)	0 (0-4)	**<0.001**
Upper extremity	10 (7-10)	3.5 (0-6)	**0.005**
Lower extremity	9 (7-10)	0 (0-5)	**<0.001**
Differences in postoperative NRS scores between groups			
Postoperative NRS	Variables [median (IQR^{25-75})]		**P-value**[2]
	Men [3 (0-5)]	**Women** 0 (0)	**0.031**
	Age>50 [4 (0-6)]	**Age<50** [0 (0-1)]	**0.026**
	Immediate-delayed TMR [4.5 (3-5)]	**Delayed TMR** [0 (0-4)]	0.141
	Upper extremity [3.5 (0-6)]	**Lower extremity** [0 (0-5)]	0.68

[1] Related samples Wilcoxon ranked test
[2] Mann Whitney U test

References:

1. Cheesborough JE, Smith LH, Kuiken TA, et al. Targeted muscle reinnervation and advanced prosthetic arms. Semin Plast Surg 2015;29(1):62-72. doi:10.1055/s-0035-1544166.

2. Chappell AG, Jordan SW, Dumanian GA. Targeted Muscle Reinnervation for Treatment of Neuropathic Pain. Clin Plast Surg 2020;47(2):285-293. doi: 10.1016/j.cps.2020.01.002.

3. Hijjawi JB, Kuiken TA, Lipschutz RD, et al. Improved myoelectric prosthesis control accomplished using multiple nerve transfers. Plast Reconstr Surg 2006;118(7):1573-1578. doi: 10.1097/01.prs.0000242487.62487.fb.

4. Di Valerio E, Lautenslager L, Vonu P, Mustafa C, Chim H, Satteson E. Efficacy of targeted muscle reinnervation for treating and preventing postamputation pain-a systematic review. Plastic and Aesthetic Research. 2022 Dec 28;9:62.

10 The Impact of Obesity On Success of Immediate Lymphatic Reconstruction For Prevention of Breast Cancer Related Lymphedema

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2. Department of Surgery, Moffitt Cancer Center, Tampa, Florida

Background: Breast cancer related lymphedema (BRCL) is a potential sequelae of high risk breast cancer treatment1. Preventative treatment with immediate lymphatic reconstruction (ILR) at the time of axillary lymph node dissection(ALND) has emerged as the standard of care 2,3, however there is relatively little known about factors that may contribute to procedural failure4,5.

Methods: A retrospectively maintained, IRB approved study followed patients who underwent ILR at the time of ALND at our tertiary care center between May 2018 to January 2023. Patients who presented for at least one follow up visit in our multidisciplinary lymphedema clinic met criteria for inclusion. Patients who developed lymphedema despite ILR and contributing factors were further explored.

Results: 327 patients underwent ILR at our institution between May 2018 and January 2023. 313 of these patients have presented for follow up in our multidisciplinary lymphedema clinic.

31 (9.9%) patients developed lymphedema despite ILR. This cohort was older (55.9 ± 9.5 v 51.6 ± 12.3, p=0.04), with a significantly higher BMI (32.8 ± 7.3 v 28.1± 6.5, p<0.01). Multivariate logistic regression demonstrates increased odds of procedural failure in patients with a BMI ≥35 (OR 2.81 (1.26-6.26), p=0.01).

Conclusion: This data comment upon our institutions outcomes following ILR. Patients who develop lymphedema despite ILR tend to be older with higher BMI, with a significantly increased risk in patients with a BMI of 35 or greater. Consideration of this data is critical for preprocedural counseling and may support a BMI cutoff when considering candidacy for ILR going forward as well as when optimizing failures for secondary lymphedema procedures.

1. Gillespie R SH, Brunelle C, Danielle K, Taghian A. Breast cancer-related lymphedema: risk factors, precautionary measures, and treatments. Gland Surgery 2018;7(4):379-403

2. Boccardo F CF, De Cian F, Friedman D, et al. Lymphatic microsurgical preventing healing approach (LYMPHA) for primary surgical prevention of breast cancer-related lymphedema: over 4 years follow-up. Microsurgery 2014;34(6):421-24

3. Coriddi M MB, Skoracki R, Singhal D, Dayan J. Immediate lymphatic reconstruction: Technical points and literature review. PRS Global Open 2021:1-8

4. Johnson AR, Fleishman A, Granoff MD et al. Evaluating the impact of immediate lymphatic reconstruction for the surgical prevention of lymphedema. Plastic and Reconstructive Surgery 2021: 147(3): 373-81.

5. Chun MJ, Saeg F, Meade A et al. Immediate lymphatic reconstruction for prevention of secondary lymphedema: A meta-analysis. Journal of Plastic, Reconstructive & Aesthetic Surgery 2022: 75: 1130-1141.

Variable	Lymphedema	No Lymphedema	Overall	p-value
BMI (kg/m²)	32.8 ± 7.3	28.1 ± 6.5	28.6 ± 6.7	**< 0.01**
Weight (kg)	88.9 ± 20.2	74.8 ± 17.9	76.2 ± 18.6	**< 0.01**
Obesity (BMI ≥35)	11 (35.5)	46 (16.4)	57 (18.3)	**< 0.01**
Age (years)	55.9 ± 9.5	51.6 ± 12.3	52.0 ± 12.1	**0.04**

Table 1: Characteristics of patients who develop lymphedema compared to those who do not following ILR

1 Early Sensory Recovery Following Polyethylene Glycol-Assisted Nerve Coaptation

Sriya Nemani[1], Sara Chaker, BS[1], Helene Ismail, MSc[1], Julia Yao, RN[1], Hakmook Kang, PhD[2], Brian Drolet, MD[1], Brinkley Sandvall, MD[3], John B. Hill, MD[1], Wesley Thayer, MD, PhD[1]

1. Department of Plastic Surgery, Vanderbilt University Medical Center, Nashville, TN
2. Department of Biostatistics, Vanderbilt University Medical Center, Nashville, TN
3. Department of Plastic Surgery, Baylor College of Medicine, Waco, TX

Background: Peripheral nerve repair is limited by Wallerian degeneration coupled with the slow and inconsistent rates of nerve regrowth. In more proximal injuries, delayed nerve regeneration can cause debilitating muscle atrophy. Topical application of polyethylene glycol (PEG) during neurorrhaphy facilitates the fusion of severed axonal membranes, restoring morphological continuity and the immediate conduction of action potentials across the coaptation site. In preclinical animal models and human case studies, PEG-fusion resulted in remarkable early functional recovery.

Methods: This is the first randomized clinical trial comparing functional outcomes between PEG-fusion and standard neurorrhaphy. Participants with peripheral nerve transections in the upper extremities were followed up at 2 weeks, 1 month, and 3 months postoperatively. The primary outcome was assessed using the Medical Research Council Classification (MRCC) rating for sensory recovery at each timepoint. Semmes-Weinstein monofilaments and static two-point discrimination determined MRCC ratings. Postoperative quality of life was measured using the Michigan Hand Questionnaire (MHQ).

Results: Thirty-six transected digital nerves (16 control, 20 PEG) across sixteen patients were analyzed. Nerves treated with PEG demonstrated significantly higher MRCC scores at 2 weeks ($p = 0.008$) and 1 month ($p = 0.0136$) postoperatively compared to controls. Participants in the PEG cohort also had significantly higher average MHQ scores at 2 weeks ($p = 0.0406$) compared to control patients. Demographic and surgical characteristics did not significantly differ between groups. No participants had adverse events related to the study drug.

Conclusion: PEG-fusion promotes early sensory recovery and improved patient well-being following peripheral nerve repair of digital nerves.

2 Monitoring for Breast Cancer Recurrence Following Goldilocks Breast Reconstruction

Arian Ghanouni MD[1], Jennifer Wang BS[2], Albert Losken MD[3], Peter Thompson MD[3]

1: Department of Surgery, Emory University School of Medicine, Atlanta, GA
2: Emory University School of Medicine, Atlanta, GA
3: Division of Plastic Surgery, Emory University School of Medicine, Atlanta, GA

Background: The Goldilocks breast reconstruction utilizes redundant mastectomy skin flaps to fashion a breast mound; however, imbrication of these skin flaps may predispose to fat necrosis and make detection of local breast cancer recurrence more difficult. Goldilocks patients follow a traditional post-mastectomy screening pathway that includes clinical examination for locoregional recurrence,1,2 but it is unclear if this is sufficient. We evaluate our Goldilocks reconstruction case series to determine rates of diagnostic imaging, biopsy, locoregional and distant recurrence.

Methods: Sixty-six patients (94 breasts) undergoing Goldilocks breast reconstruction were retrospectively reviewed. Any diagnostic post-operative imaging/biopsies performed and confirmed local or distant breast cancer recurrence were noted.

Results: Average time of follow up was 45 months. Most patients in this cohort had Stage 0 (28.1%) or Stage I (42.2%) breast cancer. There were a total of 8 (8.5%) concerning breast masses identified, all in ipsilateral postoperative breasts. Five (5.3%) masses were biopsied, of which 3 were benign and 2 were invasive cancer recurrence. Three masses (3.2%) underwent diagnostic imaging only, all with benign findings. Five patients in this series were found to have either distant disease or a second primary cancer in the non-operative contralateral breast.

Conclusions: Rates of local recurrence following Goldilocks are not higher than expected after other types of post-mastectomy reconstruction4. Clinical monitoring successfully detected local recurrence in all affected patients in this series. More definite guidelines around the routine screening of Goldilocks mastectomy patients may aid in early detection of local breast cancer recurrence.

Overall Cohort Staging	# of Patients (%)
0 or Prophylactic Surgery	18 (28.1%)
Stage I	27 (42.2%)
Stage II	17 (6.3%)
Stage III	4 (28.1%)

	Biopsy	Imaging
Stage 0	0	0
Stage I	2	1
Stage II	3	2
Stage III	0	0
Total	5	3

Sources:

1) Trop I. Is There a Role for Imaging Surveillance after Mastectomy and Autologous Breast Reconstruction? Radiology. 2018;289(1):49-50.

2) Freyvogel, Mary et al. "Screening mammography following autologous breast reconstruction: an unnecessary effort." Annals of surgical oncology vol. 21,10 (2014): 3256-60. doi:10.1245/s10434-014-3913-1

3) van la Parra RFD, Liao K, Smith BD, Yang WT, Leung JWT, Giordano SH, Kuerer HM. Incidence and Outcome of Breast Biopsy Procedures During Follow-up After Treatment for Breast Cancer. JAMA Surg. 2018 Jun 1;153(6):559-568. doi: 10.1001/jamasurg.2017.5572. PMID: 29387884; PMCID: PMC5875371.

4) Joo JH, Ki Y, Kim W, Nam J, Kim D, Park J, Kim HY, Jung YJ, Choo KS, Nam KJ, Nam SB. Pattern of local recurrence after mastectomy and reconstruction in breast cancer patients: a systematic review. Gland Surg. 2021 Jun;10(6):2037-2046. doi: 10.21037/gs-21-15. PMID: 34268088; PMCID: PMC8258883.

3 Outcomes in Fibula Free Flap Reconstruction for Treatment of Mandibular Osteonecrosis

Z-Hye Lee, MD[1], John W. Shuck MD[1], Rene D. Largo, MD [1], Peirong Yu MD[1], Patrick B. Garvey, MD[1]

The University of Texas MD Anderson Cancer Center, Department of Plastic and Reconstructive Surgery, Houston, Texas

Introduction: Osteoradionecrosis (ORN) of the mandible is an unfortunate possible sequela of radiotherapy for head and neck cancer. In advanced cases of ORN, mandibulectomy and free fibula flap reconstruction is required. We hypothesized that patients undergoing fibula free flap reconstruction of ORN mandibulectomy pose unique challenges and experience more complications than patients undergoing fibula free flaps after oncologic mandibulectomy.

Methods: After IRB approval, we created a database of all free fibula flaps for mandible reconstruction from April 2005 through October 2019. Medical records were retrospectively reviewed for patient and surgical characteristics and post-operative outcomes.

Results: 549 patients met inclusion criteria (173 ORN versus 376 non-ORN patients). Average age was 61.8±13.7 years. Mean follow-up was 35.0±29.5 months. ORN patients received more double-skin-island fibula flaps compared to non-OR patients (21.4% vs. 5.9%, p<0.001). Recipient artery other than the facial artery was utilized more commonly in ORN patients (41.0% vs. 19.1%, p <0.001). ORN patients had higher rates of delayed wound healing (27.2% vs. 17.3%, p=0.006) and surgical site infections (22.0% vs. 16.0%, p=0.058). Rates of flap loss, return to operating room, hematoma, operative time, and length of stay were similar between the groups.

Conclusion: Mandibular reconstruction with fibula flaps for osteoradionecrosis is a more complicated procedure, often requiring two skin islands for both intraoral and extraoral resurfacing as well as utilization of unconventional recipient vessels due to previous history of neck dissection and radiotherapy. ORN patients also experience more complications such as delayed wound healing and infection compared to non-ORN patients.

4 The Financial Impact of a Co-surgeon in Breast Microsurgery

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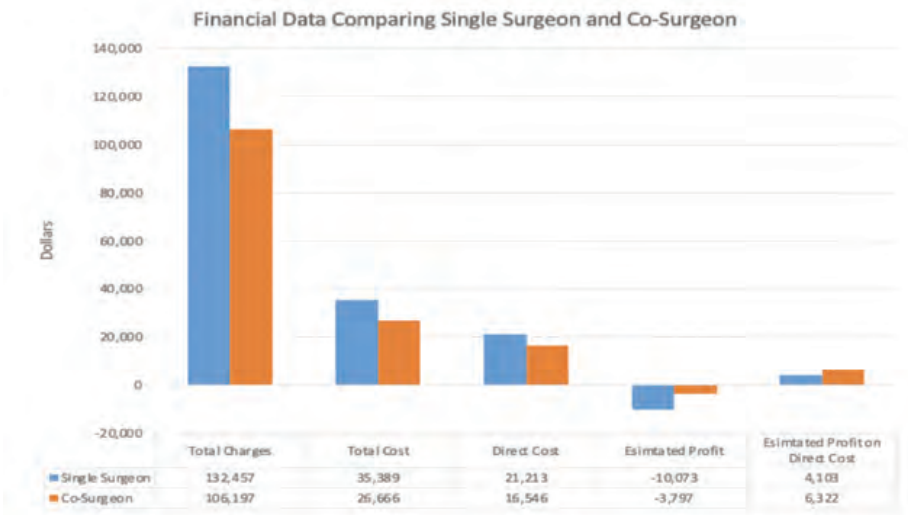
Department of Plastic Surgery, University of Virginia Health System, Charlottesville, Virginia, USA

Purpose: Co-surgeon approaches for autologous breast reconstruction have demonstrated improvements in operative efficiency. The health system financial impact, however, warrants further investigation.

Methods: Retrospective review of consecutive autologous reconstructions between 2018-2021. Primary outcome measures: length of stay (LOS), operative time, and financial metrics. Cases were stratified by co-surgeon presence, timing, and laterality.

Results: 125 cases met inclusion criteria: 49 co-surgeon, 76 single surgeon. Cosurgeon cases demonstrated decreased LOS (2.7 vs. 3.6 days; p = 0.012), operative time in unilateral (317 vs. 423 minutes; p<0.01) and bilateral cases (470 minutes vs. 615 minutes; p<0.01), total charges ($106,197 vs. $132,457; p<0.01), total cost ($26,666 vs. $35,389; p<0.01), direct cost ($16,546 vs. $21,213; p<0.01), and increased estimated profit averaging $6,276 (p=0.023).

Conclusion: Cosurgeon breast microsurgery not only improves operative efficiency, but also translates to improved financial metrics. As we transition to value-based care models, this is particularly relevant to health systems offering microsurgical breast reconstruction. Analyses of downstream benefits including optimized patient throughput and surgeon opportunity cost warrant investigation.



5 Prophylactic Muscle Flaps as an Adjunct to Complex Spine Surgery: Experience from Over 500 Spinoplastics Cases

David A. Brown, MD, PhD

Duke University

Purpose: Complex spine operations are often plagued by wound healing complications such as dehiscence, seroma, and surgical site infection. A growing body of literature supports the use of prophylactic muscle flaps at the time of back closure to reduce these complications, despite the additional dissection and operative time. The author reports his experience with over 500 back closures utilizing local muscle flaps, including paraspinal, trapezius, rhomboid, splenius capitis, and latissimus muscles.

Methods and Results: Three-year reviews were conducted for two cohorts of patients undergoing combined spine surgery and prophylactic muscle flap closure at the author's institution. In an oncologic patient population (n=83), 6% of patients undergoing muscle flap closure developed wound complications, compared to 17% patients undergoing traditional closure (p=0.028). Multivariate logistic analysis suggested that non-flap closures were the strongest predictor of wound healing complications in this cohort (OR=9.80, p=0.007). In a cohort of patients undergoing cervical or cervicothoracic spine surgery (n=72), 1.4% of patients undergoing muscle flap closure developed wound infection versus 6.3% of patients undergoing traditional closure (p=0.123).

Conclusions: The author's experience supports other studies suggesting that muscle flap closures significantly reduce complication rates after spine surgery. Building a partnership with spine surgeons is an effective means to improve outcomes in this population while offering a high value to the plastic surgeon in terms of productivity and time commitment.

6 Outcomes of Migraine and Chronic Headache Surgery at One-Year Evaluation

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Vanderbilt University Medical Center, Nashville, Tennessee

Background: Headache surgery has been proven to be an effective treatment modality for migraine and chronic headache in a subset of patients who fail standard medical therapy. In this study, we present patient reported outcomes after undergoing headache surgery at our institution.

Methods: Patients completed a prospective headache questionnaire preoperatively and at one-year postoperatively. A migraine headache index (MHI) was calculated for each patient by multiplying headache duration, intensity, and frequency. Surgery was considered successful if there was at least 50% improvement in MHI. Outcomes were further compared by trigger site.

Results: Fifty-four patients completed the survey and were included in this analysis. 74% had at least 80% improvement in their MHI, 20% had a MHI improvement between 50% and 80%, and 6% had a MHI improvement of less than 50%. Improvement was significant in headache duration, intensity, and frequency from baseline. There was a variation in symptom improvement based on trigger site, where patients with occipital site (n=36) surgery had significant improvement in all headache symptoms, while patients with frontal trigger site (n=7) intervention reported a significant decrease in MHI and in headache duration, but no statistically significant decrease in headache frequency and intensity.

Conclusion: Surgical management of migraine and chronic headaches can considerably improve patient outcomes and decrease headache frequency, duration, and intensity. The magnitude of improvement could differ by trigger site, yet larger prospective data is needed to confirm this variation.

All patients (n=54)	Preoperative	Postoperative	Mean improvement	95% CI	p-value
MH frequency (days)	18.2 ± 8.9	9.4 ± 9.3	8.8 ± 9.7	[6.2-11.3]	<0.0001
MH duration (hour)	17.8 ± 10.7	4.7 ± 6.1	13.1 ± 10.9	[10.1-16.1]	<0.0001
MH pain (scale 1-10)	7.0 ± 1.8	5.8 ± 2.6	1.2 ± 2.6	[0.5-1.9]	0.001
MHI total score	96.5 ± 77.6	12.0 ± 25.5	84.5 ± 71.9	[64.9-104.1]	<0.0001

Table 1. Patient Headache Frequency, Duration, Pain, and Migraine Headache Index

7 Non-Surgical Aesthetic Treatment Conversion to Surgery: Implications for Patient Selection and Practice Modeling

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2. Department of Surgery, Division of Plastic and Reconstructive Surgery, University of Florida, Gainesville, Florida, USA

Introduction: Non-surgical treatment for facial aging is a mainstay in plastic surgical practices most commonly employing chemomodulation with botulinum toxin and/or use of dermal fillers. Good objective data indicating the transition from non-surgery to surgery treatment does not exist. The purpose of this study is to identify surgical conversion from non-surgical care which will guide overall care of these patients.

Methods: An IRB-approved retrospective chart review was conducted analyzing patients treated with either Botox® or fillers in a single plastic surgery office. All treatments were provided by two experienced physician assistants. The end-point of surgical treatment with the same practice was comparatively analyzed.

Results: 737 patients were treated of which 612 had no previous aesthetic surgery, and 104 had previous surgery. 604 patients were treated with Botox, 385 with filler (304 had both). Patients had an average of 5.4 office visits for Botox treatments and 2 visits for filler treatment. Only 39 patients had surgical procedures (5.3%; Figure 1). The conversion from non-surgical to surgical treatment was significantly higher in patients with prior aesthetic surgery (12.5% vs 4.1%, $p<0.001$) (Table 1).

Conclusions: The conversion from non-surgical to surgical care was only 5.3%. However, patients with a previous history of aesthetic surgery have a higher conversion rate, indicating a targeted patient demographic for early plastic surgeon involvement. These findings provide objective data that patients undergoing nonsurgical care are unlikely to convert to surgical care. This supports a practice model in which physician extenders provide Botox and fillers.

Figure 1. Thirty-nine patients underwent a total of 82 surgical procedures after undergoing non-surgical office-based procedures at our institution.

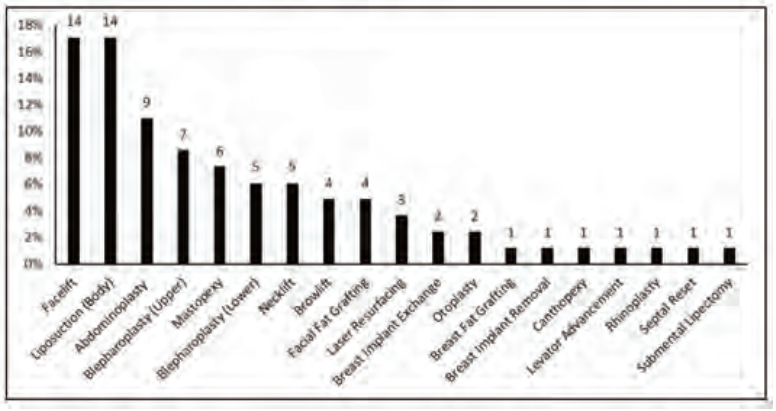

Table 1

Demographic Characteristic	All patients (N=737)	No prior aesthetic surgery (N=633)	Prior aesthetic surgery (N=104)	p-value
Sex, N (%)				
Female	715 (97)	612 (96.7)	103 (99)	0.19
Male	22 (3)	21 (3.3)	1 (1)	0.19
Race, N (%)				
American Indian	2 (0.3)	2 (0.3)	0 (0)	0.33
Asian	20 (2.7)	19 (3)	1 (1)	0.24
Black	15 (2)	12 (1.9)	3 (2.9)	0.51
Other	58 (7.9)	52 (8.2)	6 (5.8)	0.73
White	642 (87.1)	548 (86.6%)	94 (90.4)	0.28
Ethnicity, N (%)				
Hispanic	39 (5.3)	34 (5.4)	5 (4.8)	0.81
Non-Hispanic	698 (94.7)	599 (94.6)	99 (95.2)	0.81
Botulinum Toxin visits				
Patients receiving, N (%)	646 (87.7)	554 (87.5)	92 (88.5)	0.79
Botulinum toxin visits, mean (SD)[range]	5.4 (6.3) [0-41]	5.3 (6.3) [0-41]	6.3 (6.5) [0-25]	0.1609
Age at first botulinum toxin visit, mean (SD)	47.6 (13.2)	47.5 (13.3)	48.2 (12.7)	0.6382
Filler visits				
Patients receiving, N (%)	395 (53.6)	320 (50.6)	75 (72.1)	0.0001
Filler visits, mean (SD)[range]	2 (3.1) [0-22]	2.7 (3.1) [0-22]	2.7 (3.2) [0-16]	1
Age at first filler visit, mean (SD)	51.9 (14.1)	52.1 (14.3)	50.7 (13.3)	0.44
Botulinum Toxin & Fillers				
Patients receiving both treatments, N (%)	304 (41.2)	241 (38.1)	63 (60.6)	0.0001
Prior aesthetic surgeries, mean (SD)[range]	n/a	n/a	1.2 (0.9) [1-7]	
Cosmetic surgery at our center, N (%)	39 (5.3)	26 (4.1)	13 (12.5)	0.0004
Conversion rate	5.3%	4.1%	12.5%	0.0004

8 Outcomes of Skin-sparing Mastectomy with Free Nipple Areolar Graft and De-epithelialized Mastectomy Flap Breast Reconstruction

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Memorial Healthcare System

Introduction: Patients with significant breast ptosis are not considered good candidates for nipple-sparing mastectomy. One approach in patients with advanced ptosis is skin-sparing mastectomy (SSM) with immediate reconstruction using free nipple areolar grafts (FNG) and de-epithelialized mastectomy skin flaps (DEF).

Methods: To evaluate the safety and reliability of SSM with FNG and DEF reconstruction, we performed a retrospective chart review of patients between September 2020 to January 2023. 19 patients that met inclusion criteria were identified. Patients with FNG and DEF were stratified into: direct-to-implant (DTI), tissue expander, or autologous reconstruction groups. Outcomes were evaluated with pre- and post-operative photographs. Complications were recorded per patient and breasts by specifically identifying hematoma, seroma, infection, and NAC/flap necrosis.

Results: There were a total number of 36 reconstructed breasts. 25 breasts healed uneventfully. Of the 9 breasts that suffered complications, flap necrosis (66.7%) and post-operative breast infection (77.8%) were the most common. Irradiated breasts had the highest complication rate (66.7%). 7 of the 9 breasts that suffered complications were salvaged with autologous reconstruction.

Conclusion: The use of FNG with DEF may provide patients with grade III ptosis an option for SSM with immediate reconstruction. SSM with FNG and DEF reconstruction can be a safe and reliable procedure. Caution must be used in patients undergoing radiation therapy, as the risk of post-operative complications increases. Despite this, the majority of patients are able to achieve final stage reconstruction with satisfactory outcomes.


Case 1
51 yo, 40.68 BMI, and grade III ptosis with right breast invasive ductal carcinoma.
Following bilateral skin-sparing mastectomies with FNG and DEF reconstruction with pre-pectoral expanders.
6 months following bilateral exchange of expanders for permanent implants with fat grafting.
Case 2
33 yo, 29.05 BMI, and grade III ptosis with left breast invasive ductal carcinoma.
Following left skin-sparing mastectomy with FNG and DEF reconstruction with pre-pectoral expander.
16 months following left expander exchange to permanent implant with fat grafting and right reduction mammoplasty.
Case 3
55 yo, 37.8 BMI, and grade III ptosis with left breast ductal carcinoma in situ.
Following bilateral skin-sparing mastectomies with FNG and DEF reconstruction complicated by left breast infection and capsular contracture.
3 months following bilateral exchange of expanders to autologous muscle-sparing latissimus dorsi de-epithelialized myocutaneous flaps.

9 Impact of Reconstruction on Oncologic Outcomes for Patients with Melanoma after Wide Local Excision: A High-Volume, Quaternary-Referral Center Experience

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3. Winship Cancer Institute, Division of Surgical Oncology, Emory University Department of Surgery, Atlanta, GA
4. Division of Plastic and Reconstructive Surgery, Emory University Department of Surgery, Atlanta, GA

Background: There are limited data on the impact of reconstructive surgery on oncologic outcomes in patients with melanoma who undergo wide local excision (WLE). We sought to evaluate the association of reconstruction with recurrence patterns and recurrence-free survival (RFS).

Methods: A retrospective review of patients with stage I-III melanoma (AJCC 8th edition) who underwent WLE and reconstruction 2014-2020 at a single, quaternary-referral center were included. Primary outcomes were disease recurrence and 5-year RFS.

Results: Of 1,127 patients, 7.5% (n=84) underwent reconstruction after WLE. Reconstructive techniques included complex closure (10%, n=8), locoregional flaps (63%, n=52), skin grafts (26%, n=21), and dermal substitutes (1%, n=1). The majority of melanomas requiring reconstruction were located on the face (68%, n=57). Median melanoma thickness was 1.2mm(IQR 0.80-2.5). Increased depth of invasion was a predictor for reconstruction after WLE (OR 1.08, 95% CI 1.01-1.15, p=0.02). Reconstruction after WLE was associated with decreased odds of positive margins (OR 0.21, 95% CI 0.51-0.88, p=0.03). Recurrence rates were 10.5% and 8.3% for patients undergoing reconstruction and WLE alone, respectively (p=0.44). Reconstruction was not associated with disease recurrence (OR 1.33, 95% CI 0.64-2.75, p=0.44) or worse RFS. Among local recurrences, 44% (n=4) were on the scalp. Median follow-up was 46 months(IQR 27-107).

Conclusions: For patients with melanoma, reconstruction after WLE serves as an oncologically safe approach with the potential for improved rates of achieving a negative margin resection without increasing the risk of disease recurrence. Reconstruction should be a consideration in the treatment algorithm for patients

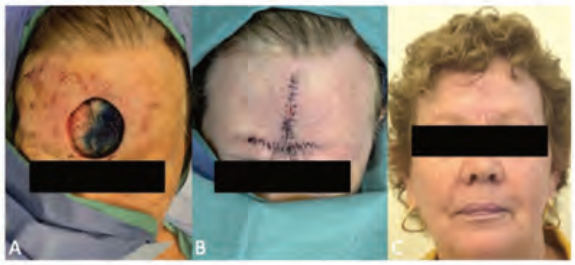

Figure 1
Forehead defect after 1cm margin excision (Panel A); reconstruction with an O-to-T flap (Panel B); patient shown 6 months post-operatively (Panel C)

10 Foot Fracture May Predict Poor Patient Reported Functional Outcomes in Lower Extremity Reconstruction of the Traumatically Injured Lower Extremity: A Case-control Study.

Orr Shauly, MD, Karen Burtt MD, Troy Marxen, BS, Daniel J. Gould, MD, PhD, Anna Howell, MD
Ido Badash, MD, Alexis Rounds, MD, Hyuma Leland, MD, Ketan M. Patel, MD, Joseph N. Carey, MD

Background: A paucity of evidence currently exists regarding factors affecting the success of lower extremity reconstruction at restoring a functional limb. We aim to determine the effect of foot fracture on outcome measures of ambulatory success after lower extremity salvage in a trauma population.

Methods: A retrospective chart review was performed on 63 patients presenting to an urban level 1 trauma center between 01/2007 and 01/2015 who received soft tissue coverage of a lower extremity traumatic wound. Patients were administered the Lower Extremity Functional Scale (LEFS) questionnaire.

Results: A total of 21/63 patients completed the LEFS questionnaire, representing a 33% response rate. Responders to the surveys included 4 (19%) patients with foot fractures and 17 (81%) without foot fractures. Average total LEFS scores were significantly lower in patients with foot fractures (23.8±5.9) than in patients without (36.2±19.2) foot fractures ($p = 0.04$). With respect to the SF36 functional scale, patients with foot fractures paradoxically reported significantly higher measures of physical functioning (81±11) in comparison to those without a foot fracture (59±25) at a p-value of 0.02, and role limitation due to physical health (98±3) versus those with no foot fracture (74±37) at a p-value of 0.02.

Conclusion: Sustaining a foot fracture during severe traumatic injury that necessitates lower extremity reconstruction may result in significantly decreased ambulatory success scores. Fractures of the foot may predict poor patient reported functional outcomes and should be considered as a factor in the pre-operative reconstruction assessment of the mangled limb.


FOUNDERS
PAST PRESIDENTS
& ANNUAL MEETINGS

SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

APRIL 17, 1958

Seated (from left to right)

Dr. Beverly Douglas, Dr. Anthony Jerome, Dr. Thomas Zaydon, Dr. Henry Brobst, Dr. George Robertson, Dr James Hendrix, Dr. Greer Ricketson, Dr. Neal Ownn, Dr. McCarth DeMere, Dr. Lorenzo Adams, Dr. James Cox, Dr. Gertrude Waite, Dr. Richard Vincent, (Dr. Donald Kapetansky, guest)

Standing (from left to right)

Dr. Kirk Todd, Dr. John Hamilton, Dr. Bernard Morgan, Dr. Tony Marzoni, Dr. James Stucky, Dr. Grover Austin, Dr. Roberty Hagerty, Dr. Robert Meade, Dr. Cliff Snyder, Dr. John Lewis, Dr. Charles Horton, Dr. Claude Coleman

PAST PRESIDENTS & ANNUAL MEETINGS

JORGE DE LA TORRE
65th Annual Scientific Meeting
The Four Seasons, Orlando FL
June 11-15, 2022

DAVID B. DRAKE
64th Annual Scientific Meeting
The Westin, Hilton Head SC
June 13-17, 2021

MARK A. CODNER*
63rd Virtual Scientific Meeting
June 6-7, 2020

STEPHAN J. FINICAL
62nd Annual Scientific Meeting
June 8-12, 2019
Ritz-Carlton; Naples, FL

BRAUN H. GRAHAM
61st Annual Scientific Meeting
June 17-20, 2018
The Breakers; Palm Beach, FL

WALTER L. ERHARDT JR.
60th Annual Scientific Meeting
June 11-15, 2017
The Cloister; Sea Island, GA

KEVIN F. HAGAN
59th Annual Scientific Meeting
June 11-15, 2016
Disney Grand Floridian Resort and Spa; Lake Buena Vista, FL

HENRY C. VASCONEZ
58th Annual Scientific Meeting
June 6-10, 2015
Omni Amelia Island Plantation; Amelia Island, FL

HAROLD I. FRIEDMAN
57th Annual Scientific Meeting
June 8-12, 2014
Atlantis Resort; Paradise Island, Nassau, Bahamas

ANN FORD REILLEY
56th Annual Scientific Meeting
June 1-5, 2013
Hyatt Regency Coconut Point Resort and Spa; Bonita Springs, FL

W. BYRON BARBER
55th Annual Scientific Meeting
June 2-6, 2012
Ritz-Carlton; Amelia Island, FL

JAMES C. GROTTING
54th Annual Scientific Meeting
June 4-8, 2011
Naples Grand Beach & Resort; Naples, FL

JAMES MOORE
53rd Annual Scientific Meeting
June 12-16, 2010
The Breakers; Palm Beach, FL

JAMES W. WADE
52nd Annual Scientific Meeting
June 6-10, 2009
Wyndham Rio Mar Beach Resort & Spa; Puerto Rico

SUMAN K. DAS
51st Annual Scientific Meeting
June 7-11, 2008
Boca Raton Resort and Club; Boca Raton, FL

R. BRUCE SHACK
50th Annual Scientific Meeting
June 9-13, 2007
Sandestin Golf and Beach Resort; Destin, FL

ANTHONY J. PIZZO
49th Annual Scientific Meeting
June 4-8, 2006
The Cloister; Sea Island, GA

MICHAEL E. BEASLEY
48th Annual Scientific Meeting
June 4-8, 2005
The Atlantis; Paradise Island, Bahamas

WILLIAM H. WALLACE
47th Annual Scientific Meeting
June 5-9, 2004
The Homestead; Hot Springs, VA

RONALD J. JOHNSON
46th Annual Scientific Meeting
May 31 - June 3, 2003
The Breakers; Palm Beach, FL

ANDREW M. MOORE II
45th Annual Scientific Meeting
June 1-5, 2002
The Westin Resort; Hilton Head, SC

L. FRANKLYN ELLIOTT
44th Annual Scientific Meeting
June 9-13, 2001
Disney's Yacht & Beach Club Resort; Orlando, FL

R. COLE GOODMAN
43rd Annual Scientific Meeting
June 4-8, 2000
Southampton Princess; Bermuda

W. HOWARD KISNER
42nd Annual Scientific Meeting
June 5-9, 1999
Boca Raton Resort and Club; Boca Raton, FL

KENNA S. GIVEN
41st Annual Scientific Meeting
June 6-10, 1998
The Registry Resort; Naples, FL

J. BARRY BISHOP
40th Annual Scientific Meeting
June 7-11, 1997
The Lodge; Williamsburg, VA

THOMAS F. ORCUTT
39th Annual Scientific Meeting
June 1-5, 1996
The Breakers; Palm Beach, FL

WILLIAM F. MULLIS
38th Annual Scientific Meeting
June 3-7, 1995
Marriott at Sawgrass Resort; Ponte Verde Beach, FL

BENJAMIN H. WOODFORD
37th Annual Scientific Meeting
June 5-9, 1994
Boca Raton Resort and Club; Boca Raton, FL

EDWARD A. LUCE
36th Annual Scientific Meeting
June 6-10, 1993
Westin Resort; Hilton Head, SC

NORMAN M. COLE*
35th Annual Scientific Meeting
1992
Ritz-Carlton Amelia Island; Amelia Island, FL

ALLEN H. HUGHES
34th Annual Scientific Meeting
June 9-13, 1991
The Greenbrier; White Sulphur Springs, WV

W. MICHAEL BRYANT
33rd Annual Scientific Meeting
June 3-7, 1990
Kiawah Island Resort; South Carolina

JOHN H. HARTLEY JR.*
32nd Annual Scientific Meeting
June 18-22, 1989
Southampton Princess; Bermuda

**deceased*

JAMES H. CARRAWAY
31st Annual Scientific Meeting
June 5-9, 1988
Innisbrook Resort;
Tarpon Springs, FL

JOHN R. ROYER*
23th Annual Scientific Meeting
1987
The Grand Hotel, Point Clear, AL

JOHN R. REYNOLDS*
29th Annual Scientific Meeting
May 25-29, 1986
Boca Raton Hotel and Club;
Boca Raton, FL

ANDREW W. WALKER*
28th Annual Scientific Meeting
May 5-9, 1985
Disney World; Lake Buena Vista, FL

ROBERT C. REEDER*
27th Annual Scientific Meeting
April 29-May 3, 1984
Colonial Williasmburg Inn &
Lodge; Williamsburg, VA

JAMES H. FLEMING*
26th Annual Scientific Meeting
May 8-12, 1983
Amelia Island Plantation;
Amelia Island, FL

JOEL W. L. MATTISON*
25th Annual Scientific Meeting
June 20-24, 1982
Southhampton Princess; Bermuda

EUGENE F. WORTHEN*
24th Annual Scientific Meeting
May 30-June 4, 1981
The Cloister; Sea Island, GA

WILLIAM E. HUGER*
23rd Annual Scientific Meeting
May 25-29, 1980
The Greenbrier;
White Sulphur Springs, WV

GEORGE W. HOFFMAN*
22nd Annual Scientific Meeting
May 27-31, 1979
The Cloister; Sea Island, GA

BYRON E. GREEN
21st Annual Scientific Meeting
May 14-18, 1978
Boca Raton Hotel and Club;
Boca Raton, FL

JEROME E. ADAMSON
20th Annual Scientific Meeting
May 27-31, 1979
The Cloister; Sea Island, GA

JOHN M. HAMILTON*
19th Annual Scientific Meeting
April 25-29, 1976
Don Cesar Resort Hotel;
St. Petersburg, FL

HENRY T. BROBST*
18th Annual Scientific Meeting
May 25-29, 1975
The Grand Hotel; Point Clear, AL

WILLIAM M. BERKELEY*
17th Annual Scientific Meeting
March 10-14, 1974
The Marriott; Hilton Head, SC

JAMES B. COX*
16th Annual Scientific Meeting
1973
The Grand Hotel; Point Clear, AL

JAMES G. STUCKEY*
15th Annual Scientific Meeting
May 31-June 3, 1972
Williamsburg Lodge;
Williamsburg, VA

JOHN R. LEWIS*
14th Annual Scientific Meeting
May 30-June 3, 1971
The Cloister; Sea Island, GA

JAMES H. HENDRIX*
13th Annual Scientific Meeting
April 1-4, 1970
Royal Orleans; New Orleans, LA

CARTER P. MAGUIRE*
12th Annual Scientific Meeting
March 30-April 3, 1969
Velda Rosa Towers;
Hot Springs, AR

ANDREW M. MOORE*
11th Annual Scientific Meeting
May 29-June 1, 1968
Broadwater Beach Hotel;
Biloxi, MS

FRANCIS MARZONI*
10th Annual Scientific Meeting
1967
West End; Grand Bahama Island

CHARLES HORTON*
9th Annual Scientific Meeting
1966
The Marriott; Atlanta, GA

MCCARTHY DEMERE*
8th Annual Scientific Meeting
May 20-22, 1965
Grand Hotel; Point Clear, AL

SAMUEL E. UPCHURCH*
7th Annual Scientific Meeting
April: 1964
Imperial House Motel;
Lexington, KY

CLIFFORD C. SNYDER*
6th Annual Scientific Meeting
1963
The Peabody; Memphis, TN

LORENZO H. ADAMS*
5th Annual Scientific Meeting
1962
The Cloister; Sea Island, GA

ROBERT F. HAGERTY*
4th Annual Scientific Meeting
November 6-9, 1961
Colonial Williasmburg Inn &
Lodge; Dallas, TX

GREER RICKETSON*
3rd Annual Scientific Meeting
February 11-14, 1960
The Tides Hotel; St. Petersburg, FL

NEAL OWENS*
2nd Annual Scientific Meeting
March 20-21, 1959
Fort Sumter Hotel; Charleston,
SC

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1st Annual Scientific Meeting
April 17-18, 1958
International House;
New Orleans, LA

**deceased*

The inaugural Samuel E. Upchurch Memorial lecture was given on May 27, 1975 by Ian Jackson entitled, "Reconstruction of the Upper Limb in Rheumatoid Arthritis."

Ian Jackson 1975
Thomas Cronin 1977
Sal Castanares 1978
Kenneth Pickrell 1979
Robert Goldwyn 1980
Richard Stark 1981
William Hamm 1982
Red Dingman 1983
Clifford Snyder 1984
John Mustarde 1985
Fernando Ortiz-Monasterio 1986
Jack Sheen 1987
Jacques van der Meulen 1988
Thomas Rees 1989
Paul Weeks 1990
Frederick McCoy 1991
Simon Fredericks 1992
John Hoopes 1993
J.B. Lynch 1994
Maurice J. Jurkiewicz 1995
Milton T. Edgerton 1996
Carl R. Hartrampf 1997
John B. McCraw 1998
D. Ralph Millard 1999
Burton D. Brent 2000
Jacques Baudet 2001
Leonard Furlow 2002
Norman M. Cole 2003
Michael E. Jabaley 2004
P.G Arnold 2005
Luis O. Vasconez 2006
Edward A. Luce 2007
Wayne Morrison 2008
Gustavo Colon 2009
T. Roderick Hester 2010
William P. Magee, Jr. 2011
Thomas Biggs 2012
R. Bruce Shack 2013
Foad Nahai 2014
Wyndell Merritt 2015
Andrew Moore 2016
Kenna Given 2017
James C. Grotting 2018
Robert J. Allen 2019
William C. Lineaweaver 2021
Renato Saltz 2022

Maurice (Josh) Jurkiewicz, M.D. (1923–2011) was born on September 24, 1923 in Claremont, New Hampshire. He died on May 29, 2011. He was the second of five children born to his Polish immigrant parents who passed through Ellis Island before World War I. The family moved to Bellow's Falls, VT where they operated a family grocery store. After high school, Josh graduated magna cum laude with a D.D.S. from the University of Maryland in 1946. During a brief enlistment in the Navy, he became interested in surgery. After his discharge, he enrolled at Harvard Medical School completing his M.D. studies and stayed for residency training in general surgery.

He received his plastic surgery training at Barnes Hospital in St. Louis under Drs. Brown and Byars. After completing his surgical training in 1959, he was appointed chief of plastic surgery at the University of Florida. He did not take his plastic surgery board exam until 1963. Thus, formal plastic surgery resident training did not occur until 1965 at the University of Florida. In 1971, Dr. Jurkiewicz moved to Atlanta and became the chief of plastic surgery at Emory University. His surgical skills coupled with excellent faculty recruitment and training resulted in Emory's residency training program becoming renowned throughout the country. After years of national and international contributions to surgery, Dr. Jurkiewicz was selected as president of the American College of Surgeons in 1989. In 2001, the Jurkiewicz Society of Emory University honored him by providing funding for a biannual Jurkiewicz lecture to be presented on odd years during the annual SESPRS meeting. The first Jurkiewicz lecture was presented by Dr. Carl Hartrampf, Jr. on June 11, 2001 entitled "Plastic Surgery at Emory Before Jurkiewicz and Plastic Surgery at Emory, 1971–2001."

Carl R. Hartrampf 2001
Leonard T. Furlow 2003
Luis O. Vasconez 2005
T. Roderick Hester..... 2007
John McCraw..... 2009
John J. Coleman, III..... 2011
Jack Fisher.....2013
Grant Carlson 2015
Joseph Williams.....2017
Phillip G. Arnold.....2019
David A. Staffenberg 2021

FUTURE ANNUAL SCIENTIFIC MEETINGS

June 8–12, 2024	The Cloister, Sea Island, Georgia
June 15–19, 2025	The Breakers, Palm Beach, Florida

FUTURE ATLANTA BREAST SURGERY SYMPOSIUM

January 19–21, 2024	Intercontinental Hotel, Atlanta, Georgia
Jan 31 - Feb 2, 2025	Intercontinental Hotel, Atlanta, Georgia


AWARDS

SPECIAL ACHIEVEMENT AWARD

William J. Pitts 1977
Robert C. Reeder 1979
John R. Lewis 1981
Bernard L. Kaye 1982
Joel Mattison 1985
McCarthy DeMere 1987
Greer Ricketson 1994
Allen Hughes 1995
Richard Hagerty 1997
Erle Peacock 2001
S. Anthony Wolfe 2008
Andrew Moore, II 2010
Leonard Furlow 2019

FOUNDERS AWARD: The Founders Award initiated in 2011 honors the best presentation by a SESPRS Member from the preceding Annual Meeting with votes cast by those members attending.

Albert Losken 2012
Wyndell Merritt 2013
Adam Katz 2014
C. Scott Hultman 2015
Galen Perdikis 2015
Brian R. Rinker 2016
Bruce A. Mast 2017
Joseph K. Williams 2018
John T. Lindsey 2019
Grant W. Carlson 2020
Detlev Erdmann 2021
Bruce A. Mast 2022

PICKRELL AWARD

Kenneth L. Pickrell, M.D. (1910–1984) was born on June 6, 1910 in Reading, PA. He died on August 20, 1984 in Durham, NC. He completed his undergraduate studies at Franklin and Marshall College in 1931. He received his MD from Johns Hopkins University in 1935. He completed his general surgery and plastic surgery training under Dr. John Stage Davis (1872–1946) at Johns Hopkins from 1935–1943. He subsequently became Chief of the Division of Plastic Surgery at Duke University where he trained scores of talented plastic surgery residents. The SESPRS honored him posthumously by creating the Pickrell Award given meritoriously to a Southeastern member exemplifying outstanding teaching attributes in plastic surgery. The first recipient of the award was Dr. Andrew Moore from Lexington, KY in 1985.

Andrew M. Moore 1985
Charles E. Horton 1986
James W. Davis 1987
James H. Hendrix 1988
Maurice J. Jurkiewicz 1989
Carl R. Hartrampf 1990
Leonard T. Furlow 1992
Hal. G. Bingham 1993
Norman Cole 1994
John McCraw 1996
Robert F. Hagerty 1997
John B. Lynch 1998
Joel Mattison 1999
John Bostwick, III 2001
Milton T. Edgerton 2002
Luis Vasconez 2005
Michael E. Jabaley 2006
Wyndell Merritt 2012
Edward Luce 2015

GLANCY AWARD

General Alfred Robinson Glancy, a former vice president of General Motors Corporation, was appointed by Franklin Roosevelt in 1942 to become Brigadier General in charge of running the automotive combat division of Army Ordnance in Detroit. In 1944, General and Mrs. Glancy donated funds at the request of their daughter, Nora, to help build a hospital in Duluth, GA. The hospital was named the Joan Glancy Memorial Hospital in memory of their other daughter, Joan, who died of pneumonia as a child. While visiting Georgia long after his retirement, General Glancy had a successful surgical encounter with Southeastern member Dr. Billy Huger of Atlanta. When the General asked what he could do for Dr. Huger in gratitude for medical services rendered, he was politely asked to fund a residency competition award for the SESPRS. Hence, the Glancy Competition and the Glancy Award were founded. This award is given every year to the resident judged to have the best paper presented in the resident's competition. The winning resident's program director is allowed to retain the coveted Glancy Bowl and display it at their institution for the following year until a new resident winner is named. The first award was presented to Dr. Foad Nahai in 1977 for the paper "Facial Reconstruction with Microvascular Free Omental Transfer and Split Rib Grafts."

Foad Nahai, MD 1977
Emory University

H. Louis Hill, MD 1978
Emory University

E.D . Newton, MD 1979
University of Tennessee

Dan H. Shell, MD 1981
University of Tennessee

Donato Viggiano, MD 1982
University of Tennessee

Larry Nichter, MD 1983
University of Virginia

Leonard Miller, MD 1984
Emory University

Richard Sadove, MD 1985
Eastern Virginia Medical School

Mason Williams, MD 1986
Eastern Virginia Medical School

David Hurley, MD 1987
University of Virginia

J.D. Stuart, MD 1988
University of Virginia

James H. Schmidt, MD 1989
University of Florida

Paul A. Watterson, MD 1990
Emory University

Michael G. Kanosky, MD 1991
University of Mississippi

GLANCY AWARD

Joseph M. Woods, IV, MD.....1992
Vanderbilt University

David Brothers, MD.....1993
University of N.C. at Chapel Hill

Scott N. Oishi, MD.....1994
University of Kentucky

Gregory Mackay, MD.....1995
Emory University

R.C. High, MD.....1996
Bowman Gray School of Medicine

Henry F. Garazo, MD.....1997
Medical College of Georgia

Kim Edward Koger, MD.....1998
Duke University

J. Timothy Katzen, MD.....1999
Vanderbilt University

Richard Rosenblum, MD.....2000
Vanderbilt University

Colin Riordan, MD.....2001
Vanderbilt University

Julia MacRae, MD.....2002
University of Virginia

M.I. Okwueze, MD.....2004
Vanderbilt University

Robert E.H. Ferguson, MD.....2005
Kentucky Clinic

Dean DeRoberts, MD.....2006
Wake Forest

Howard Levinson, MD.....2007
Duke University

S. S. Tholpady, MD.....2008
University of Virginia

Scott Hollenbeck, MD.....2009
Duke University

Yvonne Pierpont, MD.....2010
University of South Florida

Anthony Capito, MD.....2011
University of Virginia

Matthew Blanton, MD.....2012
Duke University

Michael Lynch, MD.....2013
University of Kentucky

Brent R. DeGeorge, MD.....2014
University of Virginia

Michael Lynch, MD.....2015
University of Kentucky

William D. North, MD.....2016
University of Kentucky

Kristopher M. Day, MD.....2017
University of Tennessee, Chattanooga

Alexandra Marie Hart, MD.....2018
Emory University

Shepard P. Johnson, MD.....2019
Vanderbilt University

Ronnie L. Shammas, MD.....2020
Duke University

John Heinemann, MD, MHP.....2021
University of Virginia

Matthew E. Pontell, MD.....2022
Vanderbilt University