

PROCEEDINGS OF THE

58th Annual

SCIENTIFIC MEETING

SOUTHEASTERN SOCIETY OF PLASTIC
AND RECONSTRUCTIVE SURGEONS



Creativity
FOR THE
FUTURE

JUNE 6-10, 2015

OMNI AMELIA ISLAND PLANTATION, AMELIA ISLAND, FL



PRESIDENTIAL WELCOME



I extend a warm greeting and welcome to the Omni Amelia Island Plantation Resort on behalf of the Southeastern Society of Plastic and Reconstructive Surgeons. You will find this meeting to be a great venue in which to hear and participate in a solid and innovative scientific program while at the same time having fun in the sun, surf, and many of Amelia Island's diverse paths and niches with family and friends. Walt Erhardt has prepared an outstanding educational program that takes us from hot topics to top tips to problems and pearls. The keynote speaker, Victoria Finn, will talk to us about how to face

the future with creative problem solving techniques. The named lectures, both Upchurch and Jurkiewicz, will be featured during the meeting along with several invited participants. We will, of course, have our own member and resident presentations including the Glancy Resident Competition and, again, this year the Residents' Jeopardy Bowl. Amelia Island has a number of different activities for people of all ages. Sports and outdoor activities include golf, tennis, and various forms of transportation like biking, kayaking, riding a Segway, and just plain walking. The theme dinner will be based on the Kentucky Derby with hats, racing, and plenty of mint juleps.

A welcome, once again, to all the members, guests, and their families to the 58th Annual Meeting of the Southeastern Society of Plastic and Reconstructive Surgeons. I hope you will enjoy the wide variety of experiences prepared for your education and pleasure.

Henry C. Vasconez, MD
President 2014-2015

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Omni Amelia Island Plantation
39 Beach Lagoon Road
Amelia Island, Florida
(904) 261-6161
June 6-10, 2015

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

WEEK AT A GLANCE

SATURDAY JUNE 6

8:00am
Board Meeting

3:00pm
Poster Session,
Evaluation

3:00pm
Early
Registration

4:00 pm
Hot Topics
Session (NO
CME)

6:00pm
Welcome
Reception

7pm
Past Presidents
Reception and
Dinner

SUNDAY JUNE 7

SCIENTIFIC SESSION

6:30am Registration Open -
Continental Breakfast

Visit Exhibits and Poster
Viewing

7:30am Welcome and Society
Reports

8:30am Resident Competition
Papers

9:15am Four Breaches & A
Funeral (HIPAA & You)

Michael Sacopulos, JD,
CEO, Medical Risk
Institute

10:00am Break – Visit Exhibits
and Poster Viewing

10:30am Keynote Presentation:
Victoria Finn,
Global Creative
Development Director,
Walt Disney Company
“The Habit of
Creativity”

11:30am Member Papers

12:15pm Resident Jeopardy
Bowl

SOCIAL EVENTS

8:00am Spouse Hospitality
Suite

1:30pm Tennis Tournament

7:00-
10:00pm Theme Dinner –
“Kentucky Derby”

MONDAY JUNE 8

SCIENTIFIC SESSION

6:15am Registration Open -
Continental Breakfast

Visit Exhibits and Poster
Viewing

7:15am Problems and Pearls

8:00am Resident Competition
Papers

8:45am Pricing Strategies and
Tactics
Karen Zupko, President,
KZ Associates

9:30am Perioperative &
Intraoperative Strategies
for Reducing
Complications, Jeffrey
Janis, MD

10:15am Break – Visit Exhibits and
Poster Viewing

10:45am Lightning Round Papers

11:15pm Jurkiewicz Lecture: The
Aging Surgeon: A View from
the Second Half - Grant
Carlson, MD

12:15pm Reputation Management &
Patient Communications:
Keeping it Legal – Mike
Sacopulos, JD

SOCIAL EVENTS

6:00am Fun Run

8:00am Spouse Hospitality Suite

10:00am Koffee With Karen (for
spouses who work in the
office, come hear Karen
discuss staffing issues)

1:30pm Golf Tournament

4:00pm Toast to Trudie

Dinner on your own

WEEK AT A GLANCE

TUESDAY JUNE 9

SCIENTIFIC SESSION

6:00am	Registration Open - Continental Breakfast
	Visit Exhibits and Poster Viewing
7:00am	MOC Accredited Course Sheri Slezak, MD
8:00am	Panel: Just The Facts
8:45am	Social Media Strategies That Won't Break the Bank – Karen Zupko
9:30am	Complex Abdominal Wall Reconstruction Jeffrey Janis, MD
10:15am	Break – Visit Exhibits and Poster Viewing
10:45am	Aesthetic Panel: Controversies in Lower Body Gluteal Contouring
11:30am	Upchurch Lecture: Chronic Pain: In the Heart, the Head or the Hand? Wyndell Merrit, MD
12:30pm	SESPRS Annual Business Meeting

SOCIAL EVENTS

8:00am	Spouse Hospitality Suite
12:30pm	Residents Luncheon
7:00pm	Black Tie Reception and Dinner

WEDNESDAY JUNE 10

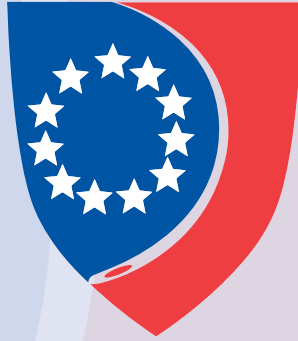
SCIENTIFIC SESSION

7:00am	Registration Open - Continental Breakfast
	Visit Exhibits and Poster Viewing
8:00am	Maxillofacial Trauma Panel
8:45am	Member & Lightning Round Papers
9:45am	Research Grant Award & Report
10:15am	Break – Visit Exhibits
10:45am	SESPRS Top Tips
11:30am	Patient Selection & Satisfaction Panel
12:00pm	Closing Remarks: Kevin Hagan, MD / Meeting Adjourns

SOCIAL EVENTS

12:30pm	Farewell Lunch – Falcon's Nest
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SOCIAL / RECREATIONAL / SPOUSE EVENTS

SOCIAL / RECREATIONAL / SPOUSE EVENTS

All paid meeting registrants, spouse, children and guests are eligible to attend all of the events below but **must be registered and will be required to present meal and/or event tickets**. Several events require additional registration fees. Our Black Tie event has an age restriction of 16 or older.

SATURDAY, JUNE 6

3:00 – 5:00 pm	Early Registration and Poster Session <i>Beverages will be served</i>	Amelia Foyer
6:00 – 8:00 pm	Welcome Reception	Amelia 1 & Amelia Foyer
7:00 – 10:00 pm	Past Presidents Reception and Dinner <i>By Invitation Only.</i>	Ibis Room & Verandah Restaurant

Dinner on your own. Reservations highly recommended

SUNDAY, JUNE 7

8:00 – 10:00 am	Breakfast Hospitality Suite Registered Spouse/family/guests welcome Meal Ticket Required	Oceanview Room & Terrace
10:30 - 11:30 am	Keynote Presentation: Victoria Finn, Global Creative Development Director, Walt Disney Company “ The Habit of Creativity ”	
12:00 – 1:00pm	Resident Jeopardy Bowl Please Register	Amelia 2-4
1:30 pm	Annual Tennis Tournament Registration is required. On property shuttle transportation should be taken to the Racquet Park. Additional fee applies.	Racquet Park
7:00 – 10:00 pm	Theme Dinner – “Kentucky Derby” Open to all paid registrants. Festive attire. Ladies wear your favorite Derby Hat and join in the Hat Contest! Children of all ages welcome! Transportation to Walker’s Landing will depart outside of the main lobby at 6:45 pm.	Walker’s Landing

SOCIAL / RECREATIONAL / SPOUSE EVENTS

MONDAY, JUNE 8

- 6:00 am **Annual Fun Run**
Registration preferred but not required. No Charge. Participants should meet in the lobby of the main hotel at 5:45 am.
- 8:00 – 10:00am **Breakfast Hospitality Suite** Oceanview Room & Terrace
Registered Spouse/family/guests welcome
Meal Ticket Required
- 10:00 – 11:00 am **Koffee with Karen** Talbot
Six Steps to Better Staffing
Registration preferred but not required.
Special session for spouses who work in the office
- 1:30 pm **Annual Golf Tournament** Ocean Links Course
Registration is Required – boxed lunch provided.
Transportation to and from the course will be provided. Registered golfers are responsible to make their way to the transportation area. Modified Shotgun start promptly at 1:30 pm. **Additional fee applies.**
- 4:00 – 5:30 pm **Toast to Trudie** Oceanview Room & Terrace
Reception for Women in Plastic Surgery
Registration preferred. Host: Ann Ford Reiley, MD

Dinner on your own. Reservations highly recommended

TUESDAY, JUNE 9

- 8:00 – 10:00 am **Breakfast Hospitality Suite** Oceanview Room & Terrace
Registered Spouse/family/guests welcome
Meal Ticket Required
- 12:00 pm **Resident Luncheon** Oceanview Room & Terrace
Registration Required.
Guest Speakers:
Jeffrey Janis, MD - "The First Full US Face Transplant: Never Give Up!"
Karen Zupko – "Years to Train, Minutes to Decide and Seconds to Sign"
Event/Meal Ticket Required

SOCIAL / RECREATIONAL / SPOUSE EVENTS

TUESDAY, JUNE 9 (CONTINUED)

7:00 – 11:00 pm **Black Tie Reception and Dinner** Amelia Foyer & 2-4
Open to paid registrants 16 and older. Separate registration required for exhibitors. Registrants MUST RSVP in advance of the meeting. Residents of the Glancy Award Competition are complimentary all other Residents and spouses a separate registration is required.
Event/Meal Ticket Required

WEDNESDAY, JUNE 10

12:30 – 2:30 pm **Farewell Luncheon** Falcon's Nest
Open to All paid registrants
Registration Required.
Event/Meal Ticket Required

*The Omni has many children's activities that may be arranged through the hotel directly.
Babysitting services are available through the Omni and are required in advance.*

The **SESPRS 58th Annual Scientific Meeting** is
Endorsed by
The American Society of Plastic Surgeons (ASPS)



AMERICAN SOCIETY OF
PLASTIC SURGEONS

PROGRAM OBJECTIVES

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

- Discuss the underlying theory and regulations of HIPAA, identify key factors that create potential risks to protection of patients' health information, and implement solutions to preventing security breaches.
- Utilize the education, best practice guidelines, and practice management tools provided by national plastic surgery organizations.
- Extend his/her creative talents beyond the practice of surgery into the other aspects of his/her life.
- Develop and incorporate into his/her medical practice best business management practices.
- Describe appropriate strategies for the reduction of complications.
- Recognize the effects of aging, both positive and negative, in the practice of plastic surgery.
- Evaluate the challenges to medical practices with regard to patient communications and practice reputation.
- Distinguish best evidence based practices for breast reduction surgery.
- Identify and describe best evidence (the "facts") regarding various pertinent factors encountered in the daily practice of plastic surgery.
- Discuss the latest advances in complex abdominal wall reconstruction
- Describe and discuss the aesthetics and best techniques to lower body and gluteal contouring.
- Distinguish techniques to treat maxillofacial trauma.
- Utilize effective patient selection techniques and how to deal with patient dissatisfaction.
- Discuss advances and new approaches incorporated by our members in a variety of areas including aesthetic, reconstructive and cosmetic breast surgery, and general reconstructive techniques.
- Apply new knowledge and/or strategies to enhance his/her practice of plastic surgery.

DISCLOSURE POLICIES & ACCREDITATION

SESPRS DISCLOSURE POLICY

As a provider accredited by the ACCME, SESPRS must ensure balance, independence, objectivity and scientific rigor in all it's individually sponsored or jointly sponsored educational activities. All planners, presenters and faculty members are required to disclose all relevant financial relationships with commercial interests 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 conflicts of interest are identified and managed in advance of the activity.

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 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.

COMMERCIAL SUPPORT DISCLOSURE

Contributions have been received from more than one company. Commercial contributors acknowledge that the Accredited Provider (SESPRS) will make all decisions regarding the disposition and disbursement of contributions and/or commercial support and that the funding received from each company will in no way affect; the identification of CME needs, determination of educational objectives,

selection and presentation of content, selection of all persons and organizations that will be in a position to control the content of the CME, selection of educational methods, or evaluation of the activity. Per the ACCME *Standards for Commercial Support*, the SESPRS will ensure that no contribution or commercial support will be used to pay for travel, honoraria, or personal expenses for non-teacher or non-author participants associated with the CME activity. The SESPRS will, as requested, provide documentation detailing the receipt and expenditure of the commercial support. Commercial contributors also agree that it will provide no other support of any type, whether financial, travel, speaker's bureau funding for a particular faculty member, or in kind support for any speaker at the meeting to which this agreement pertains. We plan to acknowledge fully the contribution from all commercial contributors in conference materials in conjunction with the meeting, and in other ways as applicable according to the guidelines of our program.

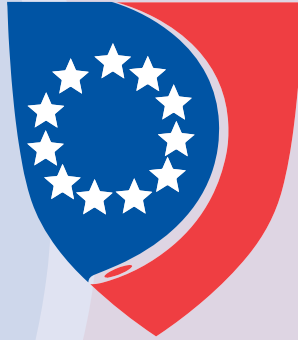
ACCREDITATION

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 20.75 CME CATEGORY 1 CREDITS** toward the AMA Physician's

Recognition Award. Physicians should claim only the credit commensurate with the extent of their participation in the live activity.

Of the 20.75 credits, 4.15 have been identified as applicable to patient safety. ▲ This symbol throughout the program identifies a safety credit.



SCIENTIFIC PROGRAM SCHEDULE

SATURDAY, JUNE 6

3:00 – 5:00 pm	Poster Session, Evaluation	Amelia Foyer
4:00 – 6:00 pm	Early Registration	Amelia Foyer

SCIENTIFIC PROGRAM

SATURDAY, JUNE 6

All general session, exhibits and poster facilities are located in the Conference Center in the Amelia Ballrooms and Foyer.

4:00 - 5:30 pm Hot Topics Session (7 minutes each - Non CME) Amelia 2-4
Moderators: C. Scott Hultman, MD, William Lineaweaver, MD

#1 "Use of a 2-D Template in Facilitating Direct to Implant ("DTI") Immediate Breast Reconstruction: Evolution of Technique"

(Page 25)

Ram Kalus, MD

#2 "Characterization of Adipose Tissue-derived Stromal Vascular Fraction (SVF) Cells Isolated with a Novel Disposable, Closed-system Device" (Page 26)

Adam Katz, MD

#3 "Fat Grafting for Chronic Pain After Severe Burns" (Page 27)

Rafi Fredman, MD

#4 "Direct TAP Blocks with Exparel During Abdominoplasty" (Page 28)

Adam Oppenheimer, MD

#5 "Outcome of Dupuytren's Disease Contractures After Clostridium Histolyticum Collagenase Injection - A Single Institution Experience" (Page 29)

Yin Kan Hwee, MD

#6 "DuodermBra for Nipple Sparing Mastectomy" (Page 30)

Rose Trotta, MD

#7 "Procedural Portfolio Planning: Strategic Changes in Clinical Practice to Increase Physician Revenue, Improve Operative Throughput, and Maintain Patient Satisfaction" (Page 31)

C. Scott Hultman, MD

#8 "Autologous Upper Pole Augmentation Mammoplasty with Lower Pole Parenchymal Flap and Seri Mesh Fixation" (Page 33)

Yoav Barnavon, MD

SCIENTIFIC PROGRAM

SUNDAY, JUNE 7

SUNDAY

6:30 am	Registration Open	Amelia Foyer
6:30 – 7:30 am	Continental Breakfast Visit Exhibits and Poster Viewing	Amelia 1 & Foyer
7:30 – 7:40 am	Welcoming Remarks: Henry Vasconez, MD	Amelia 2-4
7:40 - 8:30 am	Town Hall Meeting with ASPS/ASAPS/ABPS Moderator: Henry Vasconez, MD ASPS Scott Glasberg, MD ASAPS James Grotting, MD ABPS Barry Noone, MD	Amelia 2-4
8:30 – 9:15 am	Resident Competition Papers Moderator: Harold I. Friedman, MD, PhD Secretary: John Lindsey, MD #1 “Outcomes of Breast Reconstruction after Mastectomy Using Tissue Expander and Implant Reconstruction: Bigger is Better” (Page 35) Katherine M. Huber, MD – University of South Florida Morsani College of Medicine #2 “Are the Transverse Cervical Vessels a Suitable Recipient Site in Complex Head and Neck Reconstruction after Radiation Therapy and Lymphadenectomy?” (Page 38) Daniel Womac, MD - Louisiana State University #3 “The Effects of Body Mass Index on Adipose-Derived Stem Cells” (Page 39) Michael P. Lynch, MD – University of Kentucky College of Medicine #4 “Primary Treatment of Hidradenitis Suppurativa Using Nd: YAG Laser” (Page 40) Brian Boland, MD – Cleveland Clinic Florida	Amelia 2-4
9:15 – 10:00 am	Special Guest Lecture “Four Breaches and a Funeral (HIPAA & You)”  Michael Sacopulos, JD	Amelia 2-4
10:00 – 10:30 am	Break – Visit Exhibits and Poster Viewing	Amelia 1 & Foyer

SCIENTIFIC PROGRAM

SUNDAY, JUNE 7 (CONTINUED)

10:30 – 11:30 am	Keynote Speaker: Victoria Finn “The Habit of Creativity”	Amelia 2-4
11:30 – 12:15 pm	Member Papers (5 minutes each)  Moderator: David Drake, MD Secretary: Timothy Wilson, MD #1 “Assessing Mastectomy Flap Viability in Skin-Sparing Mastectomy and Immediate Reconstruction: A Prospective Cohort Study” (Page 41) Brian Rinker, MD #2 “Nipple Pathology in Total Skin-sparing Mastectomy: Implications for Immediate Reconstruction” (Page 43) Lesley Wong, MD #3 “Risk Factor Analysis for Post-Mastectomy Skin Flap Necrosis: Implications for Intraoperative Vascular Analysis” (Page 44) Bruce Mast, MD #4 “Comparison of Reconstructive Outcomes Between Implant Sparing Mastectomy and Tissue Expander Reconstruction in Breast Cancer Patients with Pre-existing Subpectoral Implants” (Page 45) Sangeetha Prabhakaran, MD #5 “Vertical Mastectomy Incision in Implant Breast Reconstruction after Skin Sparing Mastectomy: Advantages and Outcomes” (Page 47) Deniz Dayicioglu, MD	Amelia 2-4
12:15 – 1:00 pm	Resident Jeopardy Bowl Moderator: Bert Losken, MD <i>Please Register</i>	Amelia 2-4

SUNDAY

SCIENTIFIC PROGRAM

MONDAY, JUNE 8

6:00 am	Registration Open	Amelia Foyer
6:15 – 7:15 am	Continental Breakfast Visit Exhibits and Poster Viewing	Amelia 1 & Foyer
7:15 – 8:00 am	Problems and Pearls  Moderator: C. Scott Hultman, MD	Amelia 2-4
8:00 - 8:45 am	Resident Competition Papers  Moderator: James Grotting, MD Secretary: Brian Rinker, MD #5 “A Prospective Randomized Trial of the Efficacy of Fibrin Glue and Triamcinolone Acetonide in Seroma Prevention After Latissimus Dorsi Breast Reconstruction” (Page 49) Alexandra Hart, MD – Emory University #6 “In Situ Vascular Bypass for Salvage of Chronic Hand Ischemia” (Page 51) Agustin Cornejo, MD – Duke University #7 “Reducing Infectious Complications in Implant Based Breast Reconstruction: Impact of Early Expansion and Prolonged Drain Use” (Page 53) Kassandra Hanna, MD – University of Virginia #8 “Lack of Validity of the ACS-NSQIP Database for Alloplastic Post-mastectomy Reconstruction” (Page 55) Charles A. Pierce, MD – University of Tennessee Health Science Center	Amelia 2-4
8:45 – 9:30 am	Special Guest Lecture “Pricing Strategies & Tactics” Karen Zupko	Amelia 2-4
9:30 – 10:15 am	Special Guest Lecture “Perioperative & Intraoperative Strategies for Reducing Complications”  Jeffrey Janis, MD – EF Visiting Professor	Amelia 2-4

MONDAY

SCIENTIFIC PROGRAM

10:15 – 10:45 am Break – Visit Exhibits and Poster Viewing Amelia 1 & Foyer

10:45 – 11:15 am Lightning Round Papers (2 min. 45 seconds each)  Amelia 2-4

Moderator: Kevin Hagan, MD

Secretary: Peter Haines, MD

#1 “Mesenchymal Cell Harvest From P188 Washed Fat” (Page 57)
Sherry Collawn, MD

#2 “Nasal Airway Dysfunction in Children with Cleft Lip and/or Palate: A Statewide Epidemiologic Survey” (Page 59)
Danielle Sobol, BS

#3 “The Effect of BMI on Outcomes following Complex Abdominal Wall Reconstructions” (Page 61)
Karan Desai, MD

#4 “Hair Restoration in Facial Scars by Follicular Unit Reconstruction” (Page 62)
Ovunc Akdemir, MD

#5 “The Affect of Financial Conflicts of Interest in Plastic Surgery Research” (Page 63)
Bruce Mast, MD

#6 “Enhancing Early Dependency Safety Following Microsurgical Reconstruction of the Lower Extremity” (Page 64)
Manny Trujillo, Jr., MD

11:15 – 12:15 pm Jurkiewicz Lecture Amelia 2-4

“The Aging Surgeon: A View From the Second Half “

Grant Carlson, MD

12:15 – 1:00 pm Special Guest Lecture Amelia 2-4

“Reputation Management & Patient Communications: Keeping it Legal” 

Michael Sacopulos, JD

MONDAY

SCIENTIFIC PROGRAM

TUESDAY, JUNE 9

6:00 am	Registration Open	Amelia Foyer
6:00 – 7:00 am	Continental Breakfast Visit Exhibits and Poster Viewing	Amelia 1 & Foyer
7:00 – 8:00 am	MOC Accredited Course  “Breast Reduction: Eight Clinical Questions” Sheri Slezak, MD	Amelia 2-4
8:00 – 8:45 am	Just the Facts Panel Moderator: Bruce Mast, MD Panel Members: Ashley Lentz, MD, Kent Higdon, MD, Duncan Hughes, MD, Jennifer Rhodes, MD, Brian Rinker, MD	Amelia 2-4
8:45 – 9:30 am	Special Guest Lecture “Social Media Strategies That Won’t Break the Bank” Karen Zupko	Amelia 2-4
9:30 – 10:15 am	Special Guest Lecture “Advanced Techniques in Optimizing Outcomes in Abdominal Wall Reconstruction” Jeffrey Janis, MD – EF Visiting Professor	Amelia 2-4
10:15 – 10:45 am	Break – Visit Exhibits and Poster Viewing	Amelia 1 & Foyer
10:45 – 11:30 am	Aesthetic Panel  “Controversies in Lower Body and Gluteal Contouring “ Moderator: Jim Grotting, MD Panel Members: Onelio Garcia, MD, Simeon Wall, MD Mindy Haws, MD, Sheri Slezak, MD	Amelia 2-4
11:30 – 12:30 pm	Upchurch Lecture “Chronic Pain: In the Heart, the Head or the Hand?” Wyndell Merritt, MD	Amelia 2-4
12:30 pm	SESPRS Annual Business Meeting	Amelia 2-4

Please Register – Lunch will be served

TUESDAY

SCIENTIFIC PROGRAM

TUESDAY, JUNE 9 (CONTINUED)

12:30 – 2:30 pm	Resident Luncheon Special Guest Lectures Jeffrey Janis, MD – “The First Full US Face Transplant: Never Give Up!” Karen Zupko – “Years to Train, Minutes to Decide & Seconds to Sign”	Oceanview Room & Terrace
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TUESDAY

SCIENTIFIC PROGRAM

WEDNESDAY, JUNE 10

7:00 am	Registration Open	Amelia Foyer
7:00 – 8:00 am	Continental Breakfast Visit Exhibits	Amelia 1 & Foyer
8:00 – 8:45 am	Maxillofacial Trauma Panel Moderator: Larry Sargent, MD Panel Members: Kevin Kelly, MD, Hugo St. Hilaire, MD	Amelia 2-4
8:45 – 9:30 am	Member Papers (5 minutes each)  .10 Moderator: Galen Perdakis, MD Secretary: John Sparrow, MD #6 “A Clinical and in Vitro Comparison of Irrisept® and Triple Antibiotic for Breast Irrigation” (Page 66) Daniel Haynes, MD #7 “Sculpted Pillar Vertical Reduction Mammoplasty in 317 Patients: The Impact of Pedicle, Scar Pattern and Payor Source on Long-Term Complication Rate and Patient-Reported BREAST-Q Outcomes” (Page 68) Brian Derby, MD #8 “Refinements in the Techniques of Two-Stage Breast Reconstruction” (Page 70) Rahul Vemula, MD #9 “Two Year Follow-Up Autologous Fat Grafting With Laser-Assisted Facelifts” (Page 71) Cristiano Boneti, MD #10 “Abdominoplasty with Scarpa Fascia Preservation” (Page 73) Antonio Costa-Ferreira, MD	Amelia 2-4
9:30 – 9:45 am	Lightning Round Papers (2 min. 45 seconds each)  .05 #7 “Distance to a Plastic Surgeon is Inversely Proportional to Rates of Post-Mastectomy Breast Reconstruction” (Page 74) Paul Diegidio, MD #8 “Outcomes of Breast Reconstruction After Mastectomy Using Deep Inferior Epigastric Perforator (DIEP) Flap Following Massive Weight Loss” (Page 76) Deniz Dayicioglu, MD	Amelia 2-4

SCIENTIFIC PROGRAM

WEDNESDAY, JUNE 10 (CONTINUED)

#9 “Relationship of Reduction Weight and Body Surface Area as Predictors of Complications after Breast Reduction Surgery”
(Page 79)
Anna Pavlov, MD

9:45 – 10:15 am Research Grant Award and Report Amelia 2-4
Moderator: Bruce Mast, MD
2014 Research Grant Report – Brent R. DeGeorge, MD
“Effect of Tissue Processing on ADM Revascularization”

10:15 – 10:45 am Break – Visit Exhibits Amelia 1 & Foyer

10:45 – 11:30 am SESPRS Top Tips (3 minutes each)
Amelia 2-4
Moderator: Walter Erhardt, MD

#1 “The Obicularis Oculi Graft, an Option for Tear Trough Correction”
Braun Graham, MD

#2 “Callus Cushion Nipple Protector”
Henry Wilson, MD

#3 “Biotenodesis Screw for CMC Arthroplasty”
David Drake, MD

#4 “Skin Expansion Technique to Close Wounds that Would Need Skin Graft”
Carl Lentz, MD

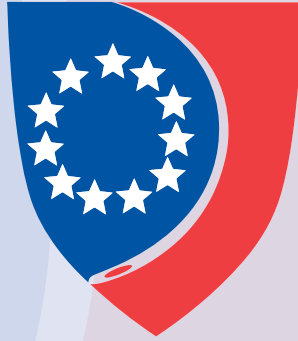
#5 “Use the Admix Needle, a Convenient Tool for Facial Fat Grafting”
Braun Graham, MD

11:30 – 12:00 pm Patient Selection & Satisfaction Panel  Amelia 2-4
Galen Perdakis, MD, Walter Erhardt, MD

12:00 pm Closing Remarks
Kevin Hagan, MD

Meeting Adjourns

WEDNESDAY



ABSTRACTS

HOT TOPIC SESSION 4:00-5:30pm

#1 Use of a 2-D Template in Facilitating Direct to Implant (“DTI”) Immediate Breast Reconstruction: Evolution of Technique.

Ram Kalus MD

Plastic Surgery of the Carolinas, PA
Charleston, SC

Since the introduction in 2006 by Salzberg et al of the technique of immediate breast reconstruction with the final implant (“DTI”) using acellular dermal matrix, the technique has become gradually more accepted, yet not fully embraced by plastic surgeons due primarily to safety concerns and perceived technical challenges, as well as a reluctance to depart from the comfort zone of the more predictable two stage expander/implant reconstruction. Once it has been determined that the vascularity of the mastectomy skin flaps will accept the insertion of a permanent prosthesis, one of the most critical technical steps is determining the proper suture line for inseting the acellular dermal matrix to define the inframammary and lateral mammary folds. Toward that end a sterile 2-D flexible yet form stable sterilizable template corresponding to the circumference of the intended final implant has been developed to precisely delineate the ADM inset suture line.

This presentation reviews this solo plastic surgeon’s experience with 129 Direct to Implant breast reconstructions in 68 patients between 2006 and 2015, with a review of the evolution of the technique that now incorporates the routine intra-operative use of a 2-D template (patent pending) which confers a greater degree of control of the subpectoral/ADM implant pocket dimensions, precision in defining the aesthetically critical IMF and LMF landmarks, and has resulted in reduced revision rates and higher levels of patient satisfaction.

HOT TOPIC SESSION 4:00–5:30pm

#2 Characterization of Adipose Tissue-derived Stromal Vascular Fraction (SVF) Cells Isolated with a Novel Disposable, Closed-system Device.

Adam J. Katz, MD, Hulan Shang, MS, Ning Yang, PhD, Akane Yu, MD, and Ying Li, MD, PhD

BACKGROUND: Adipose-derived cells lend themselves to a variety of translational strategies. It is particularly suited to autologous “point-of-care” (PoC) strategies using uncultured cells. *The purpose of this study was to characterize the identity, purity and reproducibility of adipose-derived stromal vascular fraction (SVF) cells isolated using a novel, scalable closed system PoC disposable device.*

METHODS: Liposuctioned adipose tissue was obtained under IRB approval. The tissue was subjected to enzymatic digestion to isolate and concentrate SVF cells. Cell identity was evaluated by measuring cell yield, % viability, and cell surface phenotype using flow cytometry. Purity was evaluated by assays of endotoxin, gram stain and residual collagenase.

Results: Tissue was harvested from a total of 23 patients, with an average age of 44, an average BMI of 28, and an average sample weight of 252 grams. The average initial (raw) yield of viable nucleated cells was 9.55×10^5 cells per gram of dry tissue processed, with an average viability of 81.5%. WBCs constituted approximately 14% of total viable nucleated cells and nearly 10% of cells stain with markers that are suggestive of endothelial cells/*progenitor* cells. An average of 16% of cells stain positive for CD34, marking the putative adipose stem/progenitor cell. All isolates but one were negative for endotoxin and final residual collagenase levels were minimal in the final cell suspension.

CONCLUSION: We show that the isolation of SVF cells using a novel disposable ‘point-of-care’ device and standardized methods is safe, yielding a viable but mixed population of cells that are free of microbial contaminants.

HOT TOPIC SESSION 4:00–5:30pm

#3 Fat Grafting for Chronic Pain After Severe Burns

Rafi S. Fredman, MD; Scott C. Hultman, MD, MBA, FACS

BACKGROUND: Chronic burn pain is a significant clinical problem that affects many burned patients. Hypothesized to be neuropathic in origin, chronic burn pain is a challenge for plastic surgeons, who have yet to discover a solution. Fat grafting has recently gained acceptance as a useful regenerative medium for problematic scars. In this study, the possible role of lipotransfer in treating chronically painful burn scars is examined.

METHODS: The cases of six patients with chronically painful burn scars that had failed conservative management and underwent lipotransfer were retrospectively reviewed. Burns occurred one to three years prior to fat grafting. All of the patients complained of extremely painful and lifestyle limiting burn scars, allodynia, pruritus, and five patients exhibited Tinel's sign on exam. Previous conservative management and laser therapy failed to significantly improve the symptoms. Each patient received two sessions of fat grafting, spaced two months apart. Harvested fat was injected in a radial pattern, directly beneath the scar.

RESULTS: Three months after lipotransfer, significant clinical and subjective improvement was seen. All six patients expressed an improvement in pain and pruritus, and in four of five patients, Tinel's sign was no longer present. Scars appeared more supple, with improved color, texture, and contour. Donor site seroma in a single patient was the only complication among the cases.

CONCLUSION: Fat grafting improved chronic burn pain in these patients and may play an important role in the management of painful burn scars. Further scientific and clinical research is necessary to elucidate its mechanism and effectiveness.

HOT TOPIC SESSION 4:00-5:30pm

#4 Direct TAP Blocks with Exparel During Abdominoplasty

Adam J. Oppenheimer, M.D.

Karen Lu, B.S.

Pain control following abdominoplasty is a major source of concern for the patient and surgeon alike. Pain pumps and opiate medications are currently the frontline therapies. With the following technique, Exparel (liposomal bupivacaine, 72 hour duration of action) has been used for transversus abdominis plane (TAP) blocks *under direct visualization* during abdominoplasty. Traditionally, the TAP block has required an anesthesiologist for ultrasound-guided, transcutaneous injection of local anesthetic. Twenty patients have been treated with the direct, fascial-splitting technique to reach the TAP plane. Primary and secondary endpoints of total narcotic use and patient reported pain scores will be discussed, with a focus on surgical technique.

This represents an exciting opportunity to decrease postoperative pain following abdominoplasty.

HOT TOPIC SESSION 4:00-5:30pm

#5 Outcome of Dupuytren's Contractures After Clostridium Histolyticum Collagenase Injection – A Single Institution Experience

Yin Kan Hwee, Marisa Vinas, Christopher Litts, David Friedman

BACKGROUND: The success of surgical and non-surgical treatment for Dupuytren's disease (DD) of the hand is reported to vary widely between 25-80%. This study presents the outcome of patients with DD contractures treated with *Clostridium histolyticum* collagenase (CHC) injections.

METHODS: A retrospective study was conducted of patients with DD of the hand treated with CHC injections from February 2010 to October 2014. Data at follow-up on post-op day 1, 7 and 30 and up to 4 years for patients who return seeking further therapy for recurrent symptoms were reviewed.

RESULTS: Ninety-five patients with 117 joint contractures were treated with CHC injections. All patients underwent joint manipulation on post-op day 1. Successful CHC therapy was observed in 75% of treated joints, defined by <5 degrees contraction after treatment. Partial correction occurred in 22% of treated joints. 13 joints (11%) had contracture recurrences prompting patients to return to the clinic seeking additional evaluation. 8 joints (7%) experienced recurrent contractures within 1 year of therapy, 2 joints (2%) recurred within 2 years, 1 joint (0.8%) recurred within 3 years, and 2 joints (2%) recurred within 4 years. There were no tendon ruptures or nerve injuries.

DISCUSSIONS: Our four-year outcome of CHC injections for DD contractures revealed full correction in 75% and partial correction in 22% of treated joints. The self-reported recurrence rate in our study group was 11% of the total joints treated. These results are comparable to current surgical treatment modalities and demonstrate CHC injections as an important non-surgical treatment alternative for DD contractures.

HOT TOPIC SESSION 4:00-5:30pm

#6 DuodermBra for Nipple Sparing Mastectomy

Rose Trotta, Deniz Dayicioglu

BACKGROUND: The leading method in nipple sparing mastectomy (NSM) reconstruction to improve precision of nipple placement is the use of high intraoperative fill volumes. High fill volume produces a more natural breast mound appearance post-operatively, however, it is more likely to lead to ischemia and loss of the nipple-areolar complex. Low intraoperative fill rates are conducive to enhanced tissue circulation and viability, however, they may lead to poor skin envelope draping and incorrect nipple placement. We have found good results using a hydrocolloid dressing and no acellular dermal matrix (ADM) or initial fill volume to hold the nipple in a high position during healing while allowing the skin to stay well perfused and protected.

METHODS: DuodermBra dressing is initially placed over the breast after NSM with a hole cut out to leave the nipple free. As the tissue expanders are filled over time, Duoderm covering is applied on either side of the nipple to hold it in the correct place as the breast tissue expands.

RESULTS: Out of 30 patients treated using Duoderm hydrocolloid dressing, no ADM, and no fill, patients were 75% less likely to have incorrect nipple positioning after reconstruction (nipple not at point of maximal breast projection on lateral view), and 19% less likely to have a complication after surgery than those treated with traditional fill volume and dressings.

DISCUSSION: DuodermBra dressing after NSM with no ADM and no intraoperative fill is an efficient method to achieve precise nipple placement while protecting the viability of overlying tissue.

HOT TOPIC SESSION 4:00-5:30pm

#7 Procedural Portfolio Planning: Strategic Changes in Clinical Practice to Increase Physician Revenue, Improve Operative Throughput, and Maintain Patient Satisfaction

C. Scott Hultman, MD, MBA, FACS

Chief and Program Director, University of North Carolina at Chapel Hill

PURPOSE: Portfolio planning in health care represents the strategic prioritization of services that permits an organization to better achieve its goals of margin and mission. Because of recent volatility in the economy, declining reimbursement, and rising costs of providing care, such strategic planning has become increasingly important, if physicians want to remain leaders in health care. This project assesses the financial impact of procedural portfolio planning on an academic plastic surgery practice.

METHODS: We tracked the top 50 procedures, defined as total charges per CPT code, that were performed in our baseline year, for 6 providers in a stable plastic surgery practice. At the end of the first year, we implemented 3 types of strategic changes: growth of areas with high contribution margin (laser resurfacing of burn scars), curtailment of high-risk procedures with negative contribution margin (panniculectomy in smokers), and improved efficiency of mission-critical services with high resource consumption (free-flap breast reconstruction). During the 2-year study period, we had no turnover in faculty, did not pursue any formal marketing, did not change our surgical fees or billing system, provided care independent of payer mix, and maintained our commitment to indigent care. Outcome measures included procedural charges and revenue, collection rates, work RVUs, OR room times, idle times (room time less case time), receipts/minute in OR, uncompensated charity care, and patient satisfaction (Press-Gainey scores). Prior to the study period, annual incremental growth in our practice was 1-2%, in terms of charges and receipts.

RESULTS: After implementation of the portfolio planning project, the financial position of our division improved significantly, with patient satisfaction rates increasing from 85.5% to 94.1% and charity care remaining constant at \$400K/year. Encounters, wRVUs, charges, and receipts all increased by 16-27%, with receipts/minute increasing from \$5.60/minute to \$7.28/minute. Interestingly, but not surprisingly, highest

margin cases did not correspond with highest volume or highest revenue cases; portfolio analysis helped us to align these parameters, without sacrificing patient satisfaction or commitment to indigent care. The highest receipt/minute procedure was laser ablation of vascular lesions (\$23.87), whereas one of the lowest receipt/minute cases was muscle free flap (\$3.07).

CONCLUSION: Procedural portfolio analysis is a powerful tool that can guide strategy and positively impact the financial position and clinical value of the services provided by an academic plastic surgery practice. Identifying high margin procedures allows the surgeon to focus marketing efforts, target areas of future growth, and optimize the blend of margin and mission.

HOT TOPIC SESSION 4:00-5:30pm

#8 Autologous Upper Pole Augmentation Mammoplasty with Lower Pole Parenchymal Flap and Seri Mesh Fixation

Yoav Barnavon, Yin Kan Hwee

BACKGROUND: Augmentation of the upper pole of the breast with lower pole parenchymal flap has been described by many authors. Controversy exists regarding the best way to secure the parenchymal flap to maintain upper pole fullness. We used mesh fixation as an alternative to sub-pectoral loop or suture fixation in patients undergoing reduction mammoplasties and mastopexies.

METHODS: A retrospective study of patients undergoing autologous augmentation with Seri mesh fixation between July 2014 and March 2015 was conducted. Charts and peri-operative photographs were reviewed.

RESULTS: Fourteen patients underwent surgery on 20 breasts using Seri mesh fixation. 14 breasts underwent concomitant reduction by an average of 826 grams (range 75-2315 grams). There were no major complications. One patient had a subsequent procedure for breast contour revision. Photographs reveal improvement in upper pole aesthetics of nearly all patients. Maintenance of upper pole fullness was confirmed in all patients who were followed for over 6 months (Figures 1-3).

CONCLUSIONS: Seri mesh is a safe and effective fixation method for autologous upper pole augmentation. Maintenance of upper pole fullness is seen at 6 months follow-up.

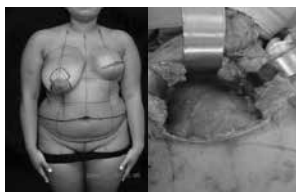


Figure 1a: Right reduction mammoplasty (120g) with Seri mesh fixation and left expander exchange for TRAM flap.



Figure 1b: 6 months post-op (right).



Figure 2a: Right auto-augmentation mastopexy with Seri mesh fixation and left mastopexy with fat grafting.



Figure 2b: 6 months post-op (right).



Figure 3: Bilateral breast reduction (L 2,060 g; R 2,315 g) with Seri mesh upper pole fixation, 6 month post-op (right).

RESIDENT COMPETITION 8:30-9:15AM

#1 Outcomes of Breast Reconstruction After Mastectomy Using Tissue Expander and Implant Reconstruction: Bigger is Better.

Katherine M. Huber, MD¹, Kristen L. Zemina, BS², Bugra Tugertimur, MS², Sequoya R. Killebrew, BS², Augustine R. Wilson, BS², Johnathon V. DallaRosa, BS², Deniz Dayicioglu, MD¹.

¹Division of Plastic Surgery, University of South Florida Morsani College of Medicine

²University of South Florida Morsani College of Medicine

OBJECTIVE: Considerable attention has been given to patient-reported outcomes in breast reconstruction. The objective of this study is to evaluate the effect of post-reconstruction change in breast volume on validated patient satisfaction survey scores.

METHODS: Patients undergoing skin-sparing mastectomy followed by tissue expander/implant (TE/I) reconstruction between July 2010 and July 2014 by a single surgeon were given post-operative patient-reported satisfaction surveys (BREAST-Q[®]). Retrospective chart review of patients with completed surveys was undertaken to record patient characteristics and compare pre-operative breast volume (extrapolated from mastectomy mass) with post-operative implant volume, and percent change in volume was calculated. Regressions were utilized to correlate percent change ratio with satisfaction in each category.

RESULTS: A total of 160 patient surveys were included. Sixty-five percent of breasts analyzed had increased volume after reconstruction, while 35% had decreased volume. The increased volume group had significantly lower BMI ($p=0.0001$), and was significantly younger ($p=0.009$) than the decreased volume group. Patients who experienced increase in breast volume reported statistically greater satisfaction with breasts ($p=0.019$), overall outcome ($p=0.012$), sexual well-being ($p=0.002$) and information ($p=0.042$) compared to the decreased volume group. Moreover, linear regression revealed that as change ratio increased, so did satisfaction with outcome ($p=0.02$), sexual well-being ($p=0.005$), information ($p=0.018$), and surgeon ($p=0.036$). Notably, there was not a significant difference in complication rate between the groups ($p=0.146$).

CONCLUSION: Patients who undergo TE/I breast reconstruction with final implants that are larger in volume than their native breasts have increased patient satisfaction scores in several categories without increase in complication rate.

SUPPORTING DATA

Equation 1: Percent Change Calculation

$$\text{Percent change} = \left(\frac{\text{Native breast volume (mL)} - \text{Final implant volume (mL)}}{\text{Native breast volume (mL)}} \right) \times 100$$

Table 1: Patient Characteristics

		Increase n=177		Decrease n=94		P value
Age		50.01 ± 10.66		54.19 ± 12.57		0.009
BMI		24.67 ± 3.83		27.87 ± 4.46		0.0001
Tumor Margins total (cm)		1.43 ± 2.21		1.46 ± 0.99		0.914
Later- ality	Bilateral	143/222	64.41%	79/222	35.59%	
	Right	16/24	66.67%	8/24	33.33%	
	Left	18/25	72.00%	7/25	28.00%	
Unilateral w/ implant for symmetry		25/27	65.79%	2/27	12.50%	0.0001
Unilateral w/o contralateral implant for symmetry		13/27	34.21%	14/27	87.50%	
Complication Rate		27/177	15.3%	21/94	22.3%	0.146

Increased volume group was significantly younger in age than the decreased volume group ($p=0.009$). BMI was significantly lower in the increased volume group ($p=0.0001$). Tumor margins were not significantly different between the two groups ($p=0.914$).

Table 2: Breast-Q Scores

	Increase n=177	Decrease n=94	p
Satisfaction with Breasts	67.46 ± 21.73	56.03 ± 22.02	0.019
Satisfaction with Outcome	75.23 ± 25.24	60.42 ± 28.06	0.012
Psychosocial Well-Being	72.82 ± 19.99	67.36 ± 28.38	0.289
Sexual Well-Being	55.02 ± 18.27	39.72 ± 24.78	0.002
Physical Well-Being: Chest	67.09 ± 19.72	73.33 ± 19.59	0.150
Satisfaction with Nipples	63.07 ± 32.68	68.5 ± 27.3	0.578
Satisfaction with Information	73.11 ± 23.30	62.35 ± 23.49	0.042
Satisfaction with Surgeon	82.56 ± 27.67	69.64 ± 35.57	0.058
Satisfaction with Medical Staff	93.21 ± 18.74	90.52 ± 20.67	0.528
Satisfaction with Office Staff	94.05 ± 16.33	90.45 ± 20.12	0.358

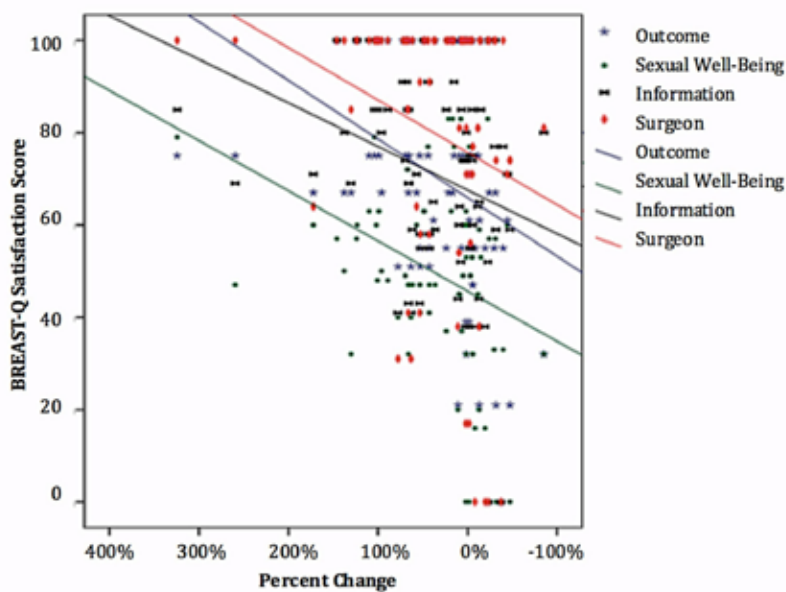
Increased volume group had significantly higher scores when compared to the decreased volume group in satisfaction with breasts ($p=0.019$), satisfaction with outcome ($p=0.012$), sexual well-being ($p=0.002$), and satisfaction with information (0.042).

Table 3: Correlation Between Percent Change and Satisfaction Scores

	Change Ratio	p
Satisfaction with Breasts	-0.187	0.061
Satisfaction with Outcome	-0.231	0.02
Psychosocial Well-Being	-0.094	0.351
Sexual Well-Being	-0.284	0.005
Physical Well-Being: Chest	0.035	0.726
Satisfaction with Nipples	0.018	0.899
Satisfaction with Information	-0.237	0.018
Satisfaction with Surgeon	-0.209	0.036
Satisfaction with Medical Staff	-0.059	0.555
Satisfaction with Office Staff	-0.076	0.452

There was a statistically significant positive correlation between breast volume percent change ratio and satisfaction with outcome ($r=-0.231$ $p=0.02$), sexual well-being ($r=-0.284$, $p=0.005$), information ($r=-0.237$, $p=0.018$), and surgeon ($r=-0.209$, $p=0.036$). As the percent change ratio increased, satisfaction increased in each category. See Graph 1.

Graph 1: Scatter Plot and Linear Regression of Percent Change versus Satisfaction



#2 Are the Transverse Cervical Vessels a Suitable Recipient Site in Complex Head and Neck Reconstruction after Radiation Therapy and Lymphadenectomy?

Daniel Womac MD, Mirko Gilardino MD, Tassos Dionisopoulos MD, Hugo St. Hilaire MD, Oren Tessler MD.

PURPOSE: Recipient vessels for free tissue transfer in head and neck cancer patients with prior surgery and radiation treatment may be of poor quality or nonexistent. In attempt to avoid vein grafting, the transverse cervical vessels (TCVs) were used. We describe our experience applying the TCVs in cases of difficult head and neck reconstruction.

METHODS & MATERIALS: A total of 19 patients were treated using the transverse cervical arteries (TCAs) as the recipient site. The transverse cervical veins were used in 13 cases, and the jugular vein in 6. All patients had undergone prior neck dissection and sixteen of 19 patients (84%) had received radiation therapy. Free flap reconstruction was accomplished using a TRAM flap (6), radial forearm flap (5), rectus flap (4), anterior lateral thigh flap (2) jejunum flap (1), and latissimus dorsi flap (1).

RESULTS: There were no flap failures in any of the patients. The TCA was found to be free of fibrosis and atherosclerosis in patients that had received previous radiation. Vein grafts were required in one (95%).

DISCUSSION: The location of TCVs is highly predictable and provides a usable pedicle length and diameter. By avoiding the use of vein grafts in these microsurgical reconstructions, operative time and potential rates of thrombosis can be reduced.

CONCLUSION: The TCVs are dependable recipients and obviate the need for vein grafts in difficult head and neck microsurgical reconstructions.

RESIDENT COMPETITION 8:30-9:15AM

#3 The Effects of Body Mass Index on Adipose-Derived Stem Cells

Michael P. Lynch, M.D.¹, Krishna S. Vyas, M.D.¹, Henry C. Vasconez, M.D.¹

¹ Division of Plastic Surgery, Department of Surgery, University of Kentucky College of Medicine

BACKGROUND: The growing interest in adipose-derived stem cells (ASCs) for cell-based therapies such as soft tissue augmentation with autologous fat grafting has led to questions about donor physiological conditions on ASC functionality, including effects on viability and differentiation. The effects of obesity on the intrinsic cellular properties of ASCs are still largely unknown. Our objective is to elucidate molecular mechanisms by which ASC functionality is affected by BMI.

METHODS: ASCs were isolated and cultured from the lipoaspirate of female patients with a BMI<26 (lean) or a BMI>32 (obese) who were undergoing autologous fat grafting at the time of secondary breast reconstruction. Cell morphology was examined using phase contrast microscopy. Capacity for multi-lineage differentiation of ASCs will be compared *in vitro*. Adipogenic differentiation was assessed at 1 week of differentiation with Oil Red O staining and photometric quantification. Early osteogenic differentiation was assessed at 1 week of differentiation with alkaline phosphatase staining and quantification. Late osteogenic differentiation was assessed at 2 weeks of differentiation with Alizarin Red staining with photometric quantification and quantification of calcium content. Clinical correlation was also studied using preoperative and postoperative photos of breast reconstruction patients undergoing fat grafting.

RESULTS: ASCs derived from obese donors exhibited altered cell morphology, immunophenotype and growth factor expression, and compromised abilities to proliferate, differentiate, and form colonies *in vitro* when compared to ASCs derived from non-obese subjects.

CONCLUSION: The specific stimuli that contribute to ASC impairment should be investigated in order to optimize the use of ASCs for cell-based therapies.

**#4 Primary Treatment of Hidradenitis Suppurativa
Using Nd:YAG Laser**

Brian N. Boland, MD

Nathan Eberle, MD, DDS

Alex Zuriarrain, MD

Eric J. Stelnicki, MD

BACKGROUND: Hidradenitis suppurativa is a chronic, inflammatory skin disease often resulting in wide local excision with extreme morbidity. Although initially thought as a disease of the apocrine glands, hidradenitis has recently been shown to center on the hair follicle unit, resulting in follicular occlusion and inflammation. The purpose of this study was to determine the effectiveness of Nd:YAG laser therapy as primary treatment for hidradenitis.

METHODS: The surgical database was queried for all patients with hidradenitis treated with Nd:YAG laser from January 2012-December 2014. Data points included age, gender, skin type, operative site, Hurley stage, duration of symptoms, number of laser treatments, post-treatment flare-ups, pathology results, and photographs. A telephone survey was then conducted to assess patient satisfaction using a standardized questionnaire and likert scale.

RESULTS Eight patients with hidradenitis were treated during the time period. All patients were female; average age was 17 years old. 63% of patients were Fitzpatrick skin type 5 or 6. Most common operative site was axilla (88%). All patients were either Hurley stage 2 (87%) or Hurley stage 3 (13%). Average duration of symptoms was 2.4 years. Average number of laser treatments was 4.6. Success of treatment was noted in 100% of patients with an average patient satisfaction score of 4.75 out of 5.

CONCLUSION: This study demonstrates successful primary treatment of hidradenitis suppurativa with Nd:YAG laser therapy in 100% of patients, therefore avoiding the devastating morbidity of wide local excision. Given the limitations of this study, further prospective studies will prove useful to validate these results.

MEMBER PAPERS 11:30-12:15pm

#1 Assessing Mastectomy Flap Viability in Skin-Sparing Mastectomy and Immediate Reconstruction: A Prospective Cohort Study

Brian Rinker, MD, FACS
University of Kentucky Division of Plastic Surgery
Lexington, KY

PURPOSE: A prospective cohort study was undertaken to evaluate three methods of assessing mastectomy flap viability following skin-sparing mastectomy (SSM) and immediate reconstruction to determine which is most effective in reducing mastectomy flap necrosis.

METHODS: The study group consisted of 60 consecutive patients (99 breasts) undergoing SSM and immediate reconstruction with either tissue expanders (n=39) or TRAM flaps (n=21). In 20 patients, mastectomy flap viability was assessed visually, in 20 patients fluorescein dye and Wood's lamp imaging was employed, and 20 patients underwent indocyanine green (ICG) angiography. Variation across groups was analyzed using ANOVA for continuous variables and chi-square test for dichotomous variables.

RESULTS: Mean follow up was 10 months. The group did not show significant differences in mean age, BMI, medical history, smoking history, pathologic diagnosis, chemotherapy, or reconstruction type. Mastectomy flap necrosis was observed in 8 of 30 breasts in the direct visualization group (27%), compared to 14% in the ICG angiography group, and 3% in the fluorescein group (p=0.03). The reoperation rate in the direct visualization group was 20%, compared to 15% in the ICG angiography group, and 0% in the fluorescein group.

CONCLUSIONS: ICG angiography was associated with a reduced rate of mastectomy flap necrosis compared to direct visualization, but fluorescein dye was associated with the lowest complication rates. Routine imaging of mastectomy flap perfusion seems to be beneficial in SSM, but intravenous fluorescein may be as effective as more expensive modalities.

	Direct Visualization	Fluoroscein / Wood's Lamp	ICG Angiography	P-value
No. of Patients	20	20	20	
Age, mean y (SD)	50.4 (7.6)	50.5 (11.4)	47.2 (7.7)	.432
BMI, mean kg/m ² (SD)	31.4 (9.4)	28.6 (6.0)	32.2 (6.3)	.282
Breasts w/ MFN	8 (27%)	1 (3%)	5 (14%)	.025
Reoperation, %	20	0	15	.122
Seroma, %	5	10	25	.153
Infection, %	15	5	20	.364

MEMBER PAPERS 11:30-12:15pm

#2 Nipple Pathology in Total Skin-sparing Mastectomy: Implications for Immediate Reconstruction

Lesley Wong, MD, Ryan Wilson, MD, W. Kelsey Snapp, BA, Raevti Boli, BA,
Division of Plastic Surgery, University of Kentucky

PURPOSE: The management of occult tumor involvement of the nipple during total skin-sparing mastectomy (TSSM) and immediate reconstruction is not well addressed in the literature. We reviewed our experience with positive nipple core biopsies, comparing outcomes of different management options.

METHODS: Mastectomy and Implant/expander reconstructions over a five year period were reviewed. Patient characteristics, type of mastectomy and complications were analyzed. Patients were grouped by type of mastectomy/immediate reconstruction and delayed reconstruction to compare outcomes. Positive intraoperative core nipple biopsy cases formed a subset of the TSSM group.

RESULTS: 41/240 (17%) cases were total skin-sparing mastectomies (TSSM) performed through inferolateral incisions. All were reconstructed immediately, 19 with tissue expanders and 22 with implants. Major complications (necrosis, infection, seroma) were significantly lower than for skin-sparing mastectomies, but higher than delayed reconstruction. One case of full thickness nipple necrosis occurred. Seven of the TSSM group had positive core nipple biopsies (17%). Three of these patients underwent nipple excision and tissue expander placement at the initial surgery, of which two developed subsequent mastectomy skin flap necrosis requiring explantation. A third patient underwent staged nipple excision without complication. The remaining three patients underwent delayed nipple resection at the time of tissue expander replacement without complication. Pathology in the nipple core was Invasive ductal carcinoma and DICS. No TSSM patients have developed local recurrence.

CONCLUSION: Concurrent excision of the nipple and an inferolateral incision increases the incidence of skin flap necrosis. Delaying nipple excision may prove to be a safer option.

#3 Risk Factor Analysis for Post-Mastectomy Skin Flap Necrosis: Implications for Intraoperative Vascular Analysis

Christian Reintgen BS, Adam Leavitt, BS, Elizabeth Pace BS, Justine Molas-Pierson MS, Bruce A. Mast, MD

INTRODUCTION: Skin flap necrosis after mastectomy can be a devastating complication with potentials for increased morbidity, failed reconstruction, delayed adjuvant therapy, and increased costs. Routine vascular analysis of mastectomy skin flaps in all patients is not cost effective. The aim of this study was to identify causative risk factors for post-mastectomy skin flap necrosis and thereby target intraoperative vascular assessment.

METHODS: This is a retrospective study approved by our institutional IRB. All patients from 2007 to 2013 that underwent mastectomy related to breast cancer were analyzed. Standard data mining was done. Postoperative skin necrosis was defined as that which required return to the OR. Patients with necrosis were then compared to non-necrosis patients for determination of causative factors. During this time, intraoperative vascular screening was not done.

RESULTS: 616 mastectomies were done of which 57 had necrosis (9.25%). Fourteen potential causative factors were evaluated including age, BMI, smoking, prior irradiation, CAD, COPD, HTN, history of lumpectomy, breast reduction or augmentation. Analyses via Student t tests, univariate analyses, chi-square testing and logistic regression showed that PREVIOUS LUMPECTOMY was the ONLY patient factor associated with necrosis $p<0.05$.

CONCLUSION: Previous lumpectomy proved to be the only characteristic/co-morbidity that had a statistically significant association with post-mastectomy skin necrosis. As such, we recommend that ALL patients with such a history undergo intraoperative vascular evaluation prior to reconstruction and/or closure. Furthermore, financial data specific to these select patients can provide cost/benefit analysis for expensive technology such as SPY angiography.

MEMBER PAPERS 11:30-12:15pm

#4 Comparison of Reconstructive Outcomes between Implant Sparing Mastectomy and Tissue Expander Reconstruction in Breast Cancer Patients with Pre-existing Subpectoral Implants

Sangeetha Prabhakaran, MD¹; Megan Melody²; Rose Trotta²; Amina Lleshi¹; Nazanin Khakpour, MD¹ and Deniz Dayicioglu, MD³

1. Department of Women's Oncology, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL
2. University of South Florida Morsani College of Medicine, Tampa, FL
3. Department of Surgery and Division of Plastic Surgery, University of South Florida Morsani College of Medicine, Tampa, FL.

BACKGROUND: Women who have undergone prior augmentation mammoplasty represent a unique subset of breast cancer patients with several options available for breast reconstruction. We performed a single institution review of surgical outcomes of breast reconstruction performed in patients with breast cancer with prior history of breast augmentation.

METHODS: IRB approved retrospective review was conducted among patients with above criteria treated at our institution between 2000 and 2014. We grouped the reconstructions performed into immediate tissue expander placement (Group 1) or implant sparing mastectomy followed by delayed implant exchange (Group 2). We reviewed demographics, tumor features and reconstruction outcomes of these groups.

Results: 64 patients were included with 79 mastectomies performed. These included 63(79.7%) breasts with pre-existing subpectoral implants. There were 18(28.6%) breast reconstructions in Group 1 vs. 45(71.4%) in Group 2. The groups were comparable based on cancer type, tumor grade, tumor stage at presentation, hormonal receptor status, tumor margins and subsequent recurrence. No significant differences were noted between age, body mass index, breast weight, removed implant volume, or volume of implant placed during reconstruction. Rates of complications were significantly higher in Group 1 vs. Group 2, 7(38.9%) vs. 4(8.9%) (P = 0.005).

Conclusions: Implant sparing mastectomy with delayed implant exchange in patients with pre-existing subpectoral implants is safe and has fewer complications compared to tissue expander placement.

Table 1: Differences between Tissue Expander Placement vs. Delayed Implant Exchange groups.

	Group 1	Group 2	P value
Age at reconstruction (years)	53.9±9.6	48.8±10.5	0.081
BMI	24.8±5.1	23.3±3.7	0.218
Time from initial augmentation to mastectomy (years)	18.2±12.5	11.1±8.1	0.011
Time from mastectomy to final implant placement (months)	7.9±5.9	8.5±9	0.811
R Breast weight (grams)	496.6±287.6	392.8±255.5	0.196
L Breast weight (grams)	521.8±380.2	437.4±261.9	0.340
R Implant volume removed (ml)	356.6±83.9	351.6±117.6	0.883
L Implant volume removed (ml)	328.3±120.3	353±102.1	0.469
R Implant volume placed at reconstruction (ml)	581.5±142.8	531.9±130.1	0.259
L Implant volume placed at reconstruction (ml)	540.8±153.3	558.8±114.2	0.667
R Breast %	249.1±283.3	175±198.8	0.383
L Breast %	294.8±453.3	185.3±229.3	0.318
R+L Breast Weight (grams)	509.2±332.2	416.6±258.1	0.119
R+L Implant volume removed (ml)	342.9±102.3	352.3±108.7	0.693
R+L Implant volume placed at reconstruction (ml)	562±146.3	545.6±122.2	0.585
R+L Breast %	269.7±359.6	181.1±215.4	0.195

BMI - body mass index, R - right, L- left, ml - milliliters

MEMBER PAPERS 11:30-12:15pm

#5 Vertical Mastectomy Incision in Implant Breast Reconstruction after Skin Sparing Mastectomy: Advantages and Outcomes

Deniz Dayicioglu, MD, Bugra Tugertimur, MD, Kristen Zemina, MD, Jonathan Dallarosa, MD, Nazanin Khakpour, MD

BACKGROUND: The type of since skin-sparing mastectomy (SSM) incision directly impacts the final aesthetic and functional results of reconstruction. Different incisions are used for SSM depending on tumor location, previous biopsy scars, breast weight, and ptosis degree.

A vertical scar is less visible to the patient, reminiscent of a mastopexy, and patients may not have the stigma of mastectomy. This study investigates complication rates, patient reported outcomes, and plastic surgeon evaluations to compare vertical incision mastectomy to others.

METHODS: A total population of 167 patients that underwent mastectomy with tissue expander reconstruction was separated into vertical incision and non-vertical incision mastectomy groups consisting of 38 and 129 patients, respectively. After IRB approval, the medical records of these patients were retrospectively reviewed. Patient demographics, complications, tumor margins, staging, breast weight, and breast implant volume were recorded. BREAST-Q™ Survey analysis was conducted using patient reported outcomes from the patient’s perspective. Aesthetic evaluations of postoperative photos were systematically scored by plastic surgeons to obtain data from the plastic surgeon’s perspective.

RESULTS: Vertical incision orientation did not increase surgical complication rates, mastectomy skin necrosis or interfere with obtaining adequate tumor margins (p=0.142, p=0.907).

There was no statistical difference for patient satisfaction or plastic surgeon aesthetic evaluation however there were trends of superior results for vertical scar in the statistical analysis.

CONCLUSION: The use of vertical incision may improve cosmetic outcome without increasing complication rates. Larger scale studies are necessary for wider acceptance of vertical scar for mastectomy.

	<u>Non-Vertical incision n: 129</u>	<u>Vertical n: 38</u>	<u>p</u>
Age	53.75 ± 11.9	54.16 ± 13.03	0.857
BMI	26.06 ± 4.95	25.81 ± 4.04	0.773
Left Breast Weight (g)	616.14 ± 320.14	521.61 ± 216.67	0.106
Right Breast Weight (g)	614.66 ± 348.79	553.16 ± 212.35	0.347
Left Implant Volume (ml)	611.81 ± 172.34	638 ± 151.07	0.421
Right Implant Volume (ml)	583.83 ± 198.15	583.89 ± 209.96	0.999
Tumor Margins Total (cm)	1.36 ± 1.7	1.32 ± 1.14	0.907

Table 1: Comparison of patient and breast characteristics between non-vertical and vertical incision groups.

	<u>Non-Vertical incision (n= 128)</u>		<u>Vertical (n=38)</u>		<u>p</u>
Complications (-)	101	78.90%	34	89.50%	
Complications (+)	27	21.10%	4	10.50%	0.142

Table 2: Comparison of complications between non-vertical and vertical incision groups.



Figure 1: Preop image of a patient before bilateral vertical scar mastectomy

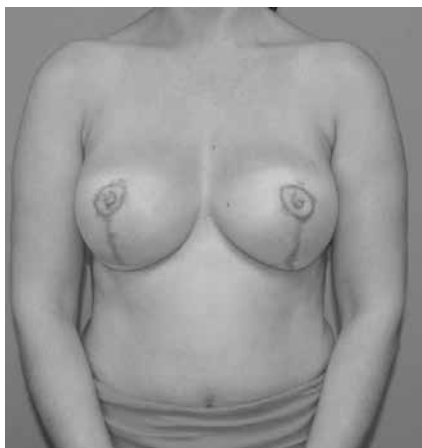


Figure 2: Postop image of a patient after bilateral vertical scar mastectomy

#5 A Prospective Randomized Trial of the Efficacy of Fibrin Glue and Triamcinolone Acetonide in Seroma Prevention After Latissimus Dorsi Breast Reconstruction

Alexandra Hart, M.D., Clarie Duggal, M.D., Ximena Pinell-White, M.D., Albert Losken, M.D.

Purpose: Donor site seroma is the most common complication following latissimus dorsi flap (LDF) breast reconstruction. Various agents have been sprayed into the donor site at the time of closure in an attempt to minimize seroma formation. The purpose of this study was to evaluate and compare the efficacy of different products at seroma prevention.

Methods: This is a single-center, double-blinded, randomized, control trial of a consecutive series of breast cancer patients (n=76) receiving LDF breast reconstruction by a single surgeon. Patients were randomized to receive 1) fibrin glue [TISSEEL® (Baxter Health Corporation)] (n= 23), 2) steroid [Kenalog© (triamcinolone acetonide)] (n= 26), or 3) normal saline (control, n= 27) sprayed into the donor site prior to skin closure. Outcomes of interest include: seroma, aspiration history, daily drain output, and days to last drain removal. Comparisons were made between the three groups. Drain removal was standardized at <30 cc/day.

Results: The 3 groups were evenly matched with no differences in risk, procedures, and complications. The overall seroma rate was 38% (n=29). The steroid group had significantly less output for the first week postoperatively, but there was not a significant difference in other outcomes among groups (Table1).

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MONDAY

Table 1. Comparison of Outcomes Among the Three Treatment Groups

	Control	Fibrin	Steroid	p-value
	(n= 27)	(n=23)	(n=26)	
Seromas (%)	10 (34.5)	8 (27.6)	11 (37.9)	0.854
Aspirations (No.)	1.30	2.25	2.58	0.118
Days until last drain removed	35.52	39.50	37.40	0.856
Drain output per day, mean (cc)	95.6	93.5	84.6	0.895
Drain output total per week, mean (cc)				
Week 1	1421 (22)	1373 (17)	1067 (19)	0.036*
Week 2	562 (15)	718 (16)	554 (14)	0.277
Week 3	537 (14)	539 (9)	532 (8)	0.998
Week 4	439 (13)	470 (8)	644 (8)	0.103

Conclusion: Fibrin and steroid spray into the latissimus donor site is no better than saline at minimizing donor site seroma formation.

#6 *In Situ* Vascular Bypass for Salvage of Chronic Hand Ischemia

Agustin Cornejo, Keith Neaman, Suhail K. Mithani, Howard Levinson, William C. Pederson.

BACKGROUND: Chronic ischemia of the hand in the setting of arteriosclerotic disease is a challenging problem with limited options for salvage. Often patients require serial amputations and are at risk for superinfection. Salvage using an *in situ* venous bypass has been described previously. *In situ* veins confer a good size match for anastomosis at the wrist or palmar arch. Due to the rarity of the condition, there is a paucity of data regarding the efficacy of this technique.

STUDY DESIGN: We retrospectively reviewed twenty-three consecutive patients with chronic arterial disease who underwent 25 *in situ* vein grafts over a 16-year period. Eighteen were men and five were women with a mean age of 61 years (Table 1). Target vessels at the wrist or palmar arch were identified on preoperative vascular imaging.

RESULTS: The cephalic vein (n=19, 76%) was most commonly used followed by the basilic vein (n=6, 24%). Overall patency rate at a mean follow-up period of 12.1 months was 92%. Improvement was reported in 18 (72%) patients as evidenced by resolution of symptoms or lack of recurrent ulceration after revision amputation at the time of index procedure (Table 2). Twelve patients (48%) developed postoperative complications. Six patients (24%) had progression of ischemia. In three cases (12%) a hand amputation was ultimately required.

CONCLUSIONS: Our study demonstrates *in-situ* vein grafts in the upper extremity offer good short-term patency rates and can be employed for salvage of chronic hand ischemia.

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Table 1. Demographic characteristics

Characteristic	Mean (SD) or n (%)	
Age	60.6 (11.5)	
Male	18 (78.3)	
Female	5 (22.7)	
End stage renal disease	18 (78.2)	
Diabetes	17 (73.9)	
Hypertension	17 (73.9)	
Coronary artery disease	16 (69.5)	
Hyperlipidemia	13(56.5)	
Kidney transplant recipient	8 (34.7)	
Buerger's disease	1 (4.3)	
Collagen vascular disease	1 (4.3)	
Active Smoking	6 (26.1)	
Calcium channel blocker use	9 (39.1)	
Steroid use	7 (30.4)	
ASA rating	2	1 (4.3)
	3	18(78.3)
	4	4 (17.3)

Table 2. In situ bypass operative details, outcomes and length of follow up.

Case	Inflow	Outflow	In situ Vein	Improvement	Patency	Follow Up (months)
1	Brachial	Radial at snuffbox	Cephalic	Y	Y	4
2	Radial	Radial at snuffbox	Cephalic	Y	Y	1.3
3	Brachial	Radial at snuffbox	Cephalic	Y	Y	11.2
4	Brachial	Radial at snuffbox	Cephalic	N	Y	41
5	Brachial	Radial at snuffbox	Cephalic	Y	Y	8.9
6	Brachial	Radial at snuffbox	Cephalic	Y	Y	2.8
7	Brachial	Ulnar beyond wrist	Basilic	Y	Y	5.2
8	Brachial	Radial at snuffbox	Cephalic	Y	Y	18.5
9	Brachial	Radial distal forearm	Cephalic	N	N	3.8
10	Ulnar	Radial at snuffbox	Basilic	N	Y	8.4
11	Brachial	Radial at snuffbox	Cephalic	Y	Y	7.1
12	Brachial	Radial distal forearm	Cephalic	N	N	24.3
13	Brachial	Radial at snuffbox	Cephalic	Y	Y	23.1
14	Brachial	Radial at snuffbox	Cephalic	N	Y	1.6
15	Brachial	Radial at snuffbox	Cephalic	N	Y	5.1
16	Brachial	Deep palmar arch	Cephalic	Y	Y	2.2
17	Ulnar	Ulnar beyond wrist	Basilic	Y	Y	1.7
18	Brachial	Radial at snuffbox	Cephalic	Y	Y	0.3
19	Brachial	Radial at snuffbox	Cephalic	Y	Y	5.4
20	Brachial	Radial at snuffbox	Cephalic	Y	Y	4.6
21	Radial	Radial at snuffbox	Cephalic	Y	Y	25.8
22	Radial	Radial at snuffbox	Basilic	Y	Y	37.4
23	Brachial	Radial at wrist	Basilic	Y	Y	1.8
24	Brachial	Radial at wrist	Cephalic	Y	Y	8
25	Brachial	Radial at wrist	Basilic	N	Y	50.6

#7 Reducing Infectious Complications in Implant Based Breast Reconstruction: Impact Of Early Expansion and Prolonged Drain Use

Kasandra R Hanna, MD, Michael Holland, BS, Alexandra Tilt, BS, David Colen, MD, Madeline Stovall, BS, David Drake, MD, Kant Lin, MD, Christopher Campbell, MD

University of Virginia Health System, Department of Plastic Surgery

INTRODUCTION: Risk factors such as radiation, obesity and smoking have been associated with surgical complications after implant-based breast reconstruction. We hypothesized that prolonged drain use may likewise be associated with postoperative complications and that early postoperative expansion may allow for earlier drain removal and improved outcomes.

METHODS: A retrospective chart review was performed to identify all immediate, tissue-expander-based breast reconstruction patients using acellular dermal matrix (ADM). Time to first expansion, post-operative day (POD) of drain removal, and complication data were collected. Early expansion was defined as occurring prior to POD14, and prolonged drain duration as removal after POD21. Logistic regression was used to identify risk factors for complications. Fisher’s exact test and Pearson’s correlation were used to define the relationship of early expansion and drain duration.

RESULTS: 195 breast reconstructions met inclusion criteria. Logistic regression revealed prolonged drain use as an independent risk factor for infection ($p=0.009$, Table 1). Earlier expansion was correlated with earlier POD drain removal ($r= 0.147$, $p=0.04$) with fewer early expansion patients (3.4%) requiring prolonged drain use than those undergoing late expansion (16.2%) ($p=0.016$, Figure 1). Obesity and smoking were also associated with increased complications (Table 1).

CONCLUSION: Prolonged drain use was associated with post-operative infection and may represent an independent source of infection or may be an indicator of delayed healing. Early tissue expansion was associated with earlier drain removal and so may help avoid infectious complications and improve outcomes.

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Table 1. Logistic regression analysis identifying risk factors for complications in patients who underwent immediate tissue expander reconstruction.

	Obesity	Smoking	Diabetes	Pre-op Radiation	Expansion prior to POD 14	Drain duration longer than POD 21
n = 195 breasts, 95% CI	OR (p value)	OR (p value)	OR (p value)	OR (p value)	OR (p value)	OR (p value)
Infection	2.64 (0.075)	2.68 (0.130)	0.00 (0.999)	2.11 (0.174)	5.11 (0.049)	4.31 (0.009)*
Seroma	7.98 (0.020)*	1.35 (0.810)	0.00 (0.999)	5.73 (0.051)	0.42 (0.370)	0.00 (0.998)
Skin necrosis	1.72 (0.411)	5.60 (0.008)*	0.00 (0.999)	0.58 (0.490)	0.00 (0.999)	4.61 (0.018)*
Wound separation	1.81 (0.435)	3.77 (0.050)*	1.35 (0.808)	0.95 (0.947)	1.30 (0.768)	0.81 (0.844)

Figure 1. Early expansion is associated with a decreased rate of prolonged drain requirement

#8 Lack of Validity of the ACS-NSQIP Database for Alloplastic Post-mastectomy Reconstruction

Charles A. Pierce, DO, MPH; Edward A. Luce, MD
University of Tennessee Health Science Center, Memphis, TN, USA

PURPOSE: The ACS-NSQIP is an outcomes-based program with the objective to improve the quality of surgical care. Attracted by size and validity, the ACS-NSQIP database has been mined by both general and plastic surgery clinical researchers to provide information for possible risk reduction strategies and patient counseling. Yet, the 30-day window of the ACS-NSQIP database may be inappropriately brief in documentation of complications for some operative procedures. Conclusions drawn from the database have been utilized to calculate risk (BRA score)¹ associated with tissue expander breast reconstruction. The hypothesis was the ACS-NSQIP database under estimates complications in alloplastic reconstruction, in particular, prosthesis loss.

METHODS: A cohort was reviewed by the first author (CAP), identifying patients who underwent immediate post-mastectomy reconstruction with tissue expanders. The hiatus between implantation and prosthesis loss, or explantation, was recorded. Means and standard deviations were calculated and Fisher’s exact test used where appropriate.

RESULTS: Of 511 breasts reconstructed with immediate placement of tissue expanders, 55 were explanted due to infection and/or exposure. Of the total, 19 were explanted in 30 days or less, 36 afterward, a mean of 62.1 and median of 43 days (Figure 1).

CONCLUSION: The ACS-NSQIP database, originally developed for application to general and vascular surgery, may not be appropriate for analysis of post-mastectomy alloplastic breast reconstruction complications.

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1. Kim JY, Mlodinow A, Khavanin N et al. Development of a Breast Reconstruction Risk Assessment (BRA) Score: An individualized risk calculator for complication using the NSQIP and TOPS databases. *Plast Reconstr Surg.* 2014 Apr;133(4 Suppl):997.

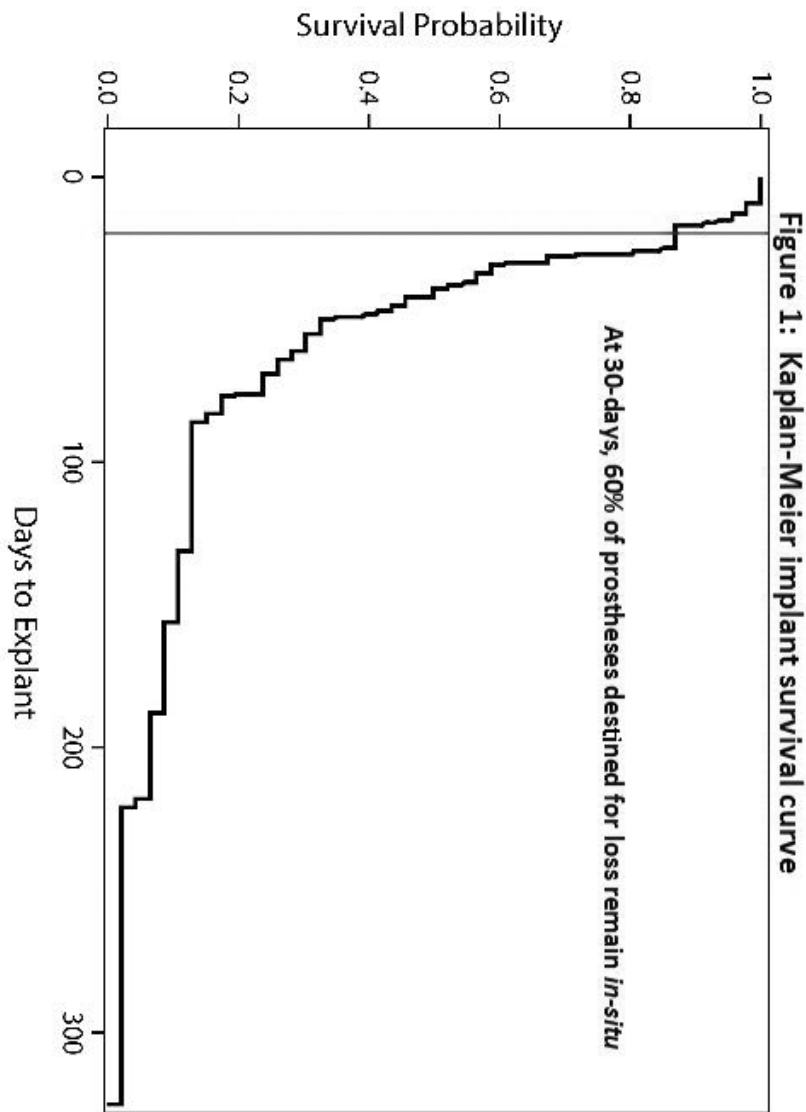


Figure 1: Kaplan-Meier implant survival curve

LIGHTNING ROUNDS 10:45-11:15am

#1 Mesenchymal Cell Harvest from P188 Washed Fat

Sherry S. Collawn, M.D.,Ph.D.

BACKGROUND: Nano fat grafting has been used for the injection of fine lines in the face. Mesenchymal cell harvest from these cells has been described [1]. The surfactant P188 [2] has been used as a wash for fat. This study will show that the P188 wash prior to cell harvesting does not interfere with mesenchymal cell harvest or activity.

METHODS: Discarded fat is obtained after abdominal liposuction performed with toomey syringe cell harvest with a 3.0mm cannula. IRB approval has been obtained. Fat is allowed to separate by gravity and the fluid portion removed. Fat is washed with p188 in a strainer, placed on telfa and then emulsified x 30 in syringes. The fat is digested with 1% collagenase, centrifuged, and the pellet plated. The mesenchymal cells produce conditioned media that is used in cell migration assays.

RESULTS: Mesenchymal cell yield after P188 washing of the adipose tissue is not decreased and in cell migration assays the conditioned media from the P188 treated fat accelerates wound healing. Figure 1 below demonstrates at 48 hours the measurement of cell migration in microns after scratch injury in fibroblast monolayer cell culture in controls (Control), in conditioned media (CM) from non-washed fat, or conditioned media from P188 treated fat (P188). Statistics was performed with a one-way ANOVA and $p<0.05$ was obtained. Standard deviations are shown.

CONCLUSIONS: The use of P188 washes does not interfere with mesenchymal cell yield or activity.

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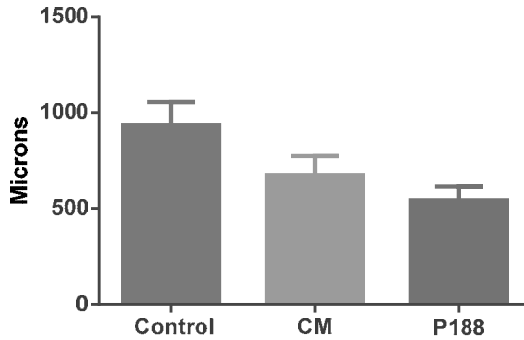


Figure 1. Cell migration in monolayer cultures is accelerated with the addition of conditioned media (CM). Fat washed in P188 also produces mesenchymal cells (P188) that produce accelerated migration. Statistics was performed with a one-way ANOVA and $p < 0.05$ was obtained. Standard deviations are shown.

1. Tonnard P, Verpaele A, Peeters G, Hamdi M, Cornelissen M, et al. (2013) Nanofat grafting: basic research and clinical applications. *Plast Reconstr Surg* 132: 1017-1026.
2. Medina MA, 3rd, Nguyen JT, Kirkham JC, Lee JH, McCormack MC, et al. (2011) Polymer therapy: a novel treatment to improve fat graft viability. *Plast Reconstr Surg* 127: 2270-2282.

LIGHTNING ROUNDS 10:45-11:15am

#2 Nasal Airway Dysfunction in Children with Cleft Lip and/or Palate: A Statewide Epidemiologic Survey

Danielle L. Sobol, BS¹, Alexander C. Allori, MD, MPH², Anna R. Carlson, MD², Irene J. Pien, BS¹, Stephanie Watkins, PhD, MSPH³, Arthur S. Aylsworth, MD⁴, Robert Meyer, PhD, MPH⁵, Luiz Pimenta, DDS, PhD³, Ronald Strauss, DMD, PhD³, Barry Ramsey, BS⁶, Jeffrey R. Marcus, MD²

¹Duke University School of Medicine; Durham, NC

²Division of Plastic, Maxillofacial & Oral Surgery, Duke Children's Hospital; Durham, NC

³Department of Dental Ecology, University of North Carolina; Chapel Hill, NC

⁴Department of Genetics and Department of Pediatrics, University of North Carolina; Chapel Hill, NC

⁵State Center for Health Statistics, Department of Health and Human Services; Raleigh, NC

⁶Center for Health Promotion and Disease Prevention, University of North Carolina; Chapel Hill, NC

BACKGROUND: Nasal airway obstruction is a widely encountered and often underappreciated problem for patients with cleft lip and/or palate (CL/P). Careful history, examination, and validated patient-reported outcome measures may reveal moderate-to-severe nasal airway dysfunction. This may help identify children in need of functional rhinoplasty. This study aims to assess the prevalence and severity of nasal obstructive symptoms in CL/P.

METHODS: Children with isolated, nonsyndromic CL/P and controls born 1997-2003 were identified through the North Carolina Birth Defects Monitoring Program and birth certificates, respectively. A parental survey was designed based upon the validated Nasal Obstruction Symptom Evaluation (NOSE) scale. The survey was completed by 176 children with CL/P and 333 controls. Frequency distributions and chi square statistics were used to compare responses.

RESULTS: Nasal functional symptoms were significantly more predominant in cleft lip and palate (CL+P) compared with controls ($p<0.0001$); unilateral CL+P was more significantly affected ($p<0.0001$). Cleft lip only (CL) and cleft palate only (CP) were not statistically different from controls. Compared with controls, CL+P reported significantly more nasal

congestion/stuffiness (80.5% vs. 59.8%, $p<0.0001$), nasal blockage (47.4% vs. 21.1%, $p<0.0001$), trouble breathing through the nose (57.1% vs. 26.7%, $p<0.0001$), trouble sleeping (41.6% vs. 25.2%, $p=0.0001$), and difficulty with nasal breathing during exercise (39.5% vs. 10.5%, $p<0.0001$) (figure 1).

CONCLUSIONS: This is the first population-based study to demonstrate the high prevalence and severity of nasal obstructive symptoms in children with CL/P. Unilateral CL+P patients were most severely affected. The NOSE questionnaire is useful to help determine the need for functional rhinoplasty.

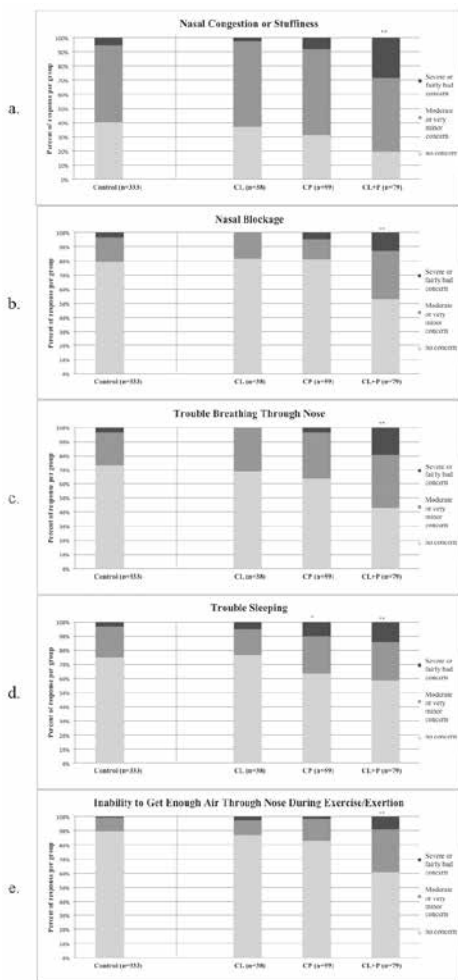


Figure 1: Results of NOSE questionnaire by groups: CL, CP, and CL+P compared with controls. Proportion of reported symptom severities of (a.) nasal congestion or stuffiness (b.) nasal blockage (c.) trouble breathing through the nose (d.) trouble sleeping (e.) nasal dysfunction during exertion. Darker shades represent increased concern. ** $p<0.01$, * $p<0.05$

#3 The Effect of BMI on Outcomes Following Complex Abdominal Wall Reconstructions

Desai K, Razavi A, Hart A, Losken A
Emory University Division of Plastic Surgery

BACKGROUND: The management of complex abdominal wall defects continues to be a challenging process secondary to patient morbidity associated with high rates of wound healing issues and ventral hernia recurrences. High body mass indices (BMI) have been linked to higher rates of complications among various types of surgeries. We hypothesize that higher BMIs result in higher rates of postoperative complications in complex abdominal wall reconstructions (CAWR).

STUDY DESIGN: We retrospectively reviewed all patients who underwent CAWR at Emory University Hospital over a 14-year period. Patients were divided into four cohorts based on BMI (15-24.9, 25-29.9, 30-34.9, 35+). Complication rates among the four groups were evaluated as the primary outcome using Pearson chi-square analysis. Further analysis was done on specific complications including mesh exposure, skin necrosis, delayed healing, rate of fistula formation, seroma, hematoma, infection, rate of recurrence, and rate of re-operation.

RESULTS: We included 313 patients with a mean follow up of 15.6 months. The rate of overall complications between the four BMI groups 15-24.9, 25-29.9, 30-34.9, 35+, was not statistically significant (31.7%, 35.0%, 47.6%, 48.3%, $p = 0.079$, respectively). The rate of skin necrosis was significantly increased in the higher BMI groups (1.7%, 1.3%, 9.5%, 13.5% $p = 0.004$). The rate of ventral hernia recurrence was significantly increased in the higher BMI groups (8.3%, 12.5%, 29.8%, 27.0% $p = 0.002$). Rates of re-operation were also statistically increased in the higher BMI groups (25.0%, 22.5%, 41.7%, 34.8% $p = 0.035$). Rates of mesh exposure, delayed healing, fistula formation, seroma, hematoma, and infection were not statistically significant among the four BMI groups.

CONCLUSIONS: Patient undergoing CAWR with BMIs over 30 have significantly higher rates of skin necrosis, hernia recurrence and re-operation compared to subgroups of lower BMI. Rates of overall complications among all BMI groups are similar, although trended up with BMI. Surgeons should weight the risk and benefits of CAWR in patients with higher BMIs to reduce specific postoperative complications.

MONDAY

LIGHTNING ROUNDS 10:45-11:15am

#4 Hair Restoration in Facial Scars by Follicular Unit Reconstruction

Ovunc Akdemir, M.D., Levent Acar, M.D., **William Lineaweaver, M.D., FACS
SESPRS member: WCL

* Department of Plastic, Aesthetic and Reconstruction Surgery, Kemerburgaz University, Istanbul, Turkey

**JMS Burn and Reconstruction Center, Merit Central Hospital, Jackson, MS,USA

INTRODUCTION: Follicular unit extraction(FUE) is a hair restoration technique in which single hair follicles are transplanted to reconstruction sites. The technique includes minimal donor sites and highly specific hair follicle placement and matching. We applied this technique to facial scar alopecia in burn patients.

MATERIALS AND METHODS: Between 2010 and 2014, 23 patients underwent FUE restoration. These cases were reviewed for objective and patient satisfaction data.

RESULTS: 19(92.5 %) patients were male, 4 (7.5%) were female, and the mean age was 28.8 years (range 19-38). Recipient sites included scalp (11, 47.8%), beard and mustache (9, 39.2%), and eyebrows (3,13%). The mean number of grafts was 752 ± 553 . A single session was used for all patients. No complication were noted except for transient local edema. The survival of the grafts was 82%. Mean patient satisfaction score was 8.6 (scale 1-10, 10 = satisfied).

CONCLUSION: FUE offered satisfactory hair restoration to scalp, eyebrow, and beard/mustache scars.

LIGHTNING ROUNDS 10:45-11:15am

#5 The Affect of Financial Conflicts of Interest in Plastic Surgery Research

Adam Leavitt BS, Elizabeth Pace BS, Christian Reintgen BS, Bruce Mast MD

INTRODUCTION: Medical research has a long history of joint venture between commercial entities and non-industry researchers. Significant concern exists amongst accrediting bodies for medical education and federal granting agencies that conflicts of interests (COI) exist that affect the validity of the research. This study evaluates the legitimacy of this concern.

METHODS: All clinical breast and cosmetic articles in *Plastic and Reconstructive Surgery* and *Annals of Plastic Surgery* were reviewed for calendar year 2013. If a financial disclosure was present the article was then reviewed to determine if the subject/findings were in favor of the commercial conflict, and if so, was the study valid. To assess plastic surgery versus other specialties, articles from *Dermatology* and *Journal of Bone and Joint Surgery* were similarly reviewed from January to April of 2013.

RESULTS: 272 clinical manuscripts were reviewed. Only 15 (5.5%) had a true conflict of interest: the article’s findings favored the commercial interest of at least one author. For each journal:

	PRS	Annals	Dermatology	JBJS
Articles reviewed	112	61	46	53
COI	8	2	1	4
% with COI	7.7%	3.3%	2.2%	7.5%

COIs were not statistically significant between pooled articles of Plastic Surgery versus Dermatology/Orthopedics. However, COI was statistically greater (p=0.05) in *PRS* compared to *Annals* and *Dermatology*

CONCLUSIONS: Despite public and regulatory concerns, this assessment demonstrates that the peer review process of leading journals polices true conflicts of interest. Published manuscripts provide sound research despite presumed COIs. As such, the integrity and validity of published research remains high.

#6 Enhancing Safety of Early Dependency Protocols Following Microsurgical Reconstruction of the Lower Extremity

Michael J. Orseck, MD; Shawn Birchenough, MD; Manny G. Trujillo, Jr., MD

BACKGROUND: Successful outcomes following microsurgical reconstruction of the lower extremity include timely return to ambulation. Flap monitoring in the early postoperative period consists of multiple clinical assessments of flap viability. The ViOptix system has shown promise in increasing sensitivity of current flap monitoring. We have incorporated this system into our postoperative monitoring protocol in an effort to initiate earlier dependency protocols.

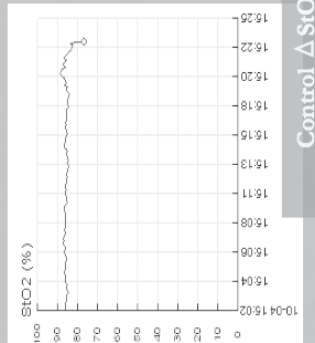
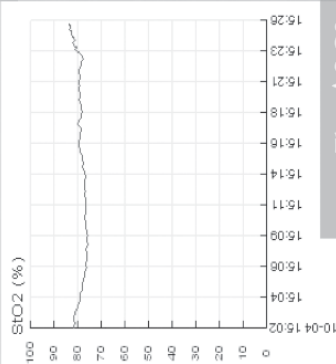
METHODS: A prospective analysis of twelve consecutive ALT and radial forearm flaps for lower extremity reconstruction between was performed. The ViOptix oximeter was placed on each flap postoperatively, as well as the contralateral leg as a control. Depending on weight-bearing status, the reconstructed legs were placed either in the standing or dependent position on POD#2 for 20 minutes. The maximum drop (ΔStO_2) and the lowest absolute StO_2 were recorded.

RESULTS: 11 of 12 flaps tolerated early dependency without clinical compromise with an average ΔStO_2 of -11%. One flap requiring delay of dependency demonstrated a ΔStO_2 of -37% that was accompanied by clinical venous congestion. After re-elevation and return to baseline, the dependency protocol was successfully implemented on POD#7. All flaps went on to successful healing.

CONCLUSION: A significant percentage of lower extremity free flaps can tolerate early dependency. ViOptix can be used reliably as an adjunct to increase the sensitivity of detecting poorly performing flaps during the postoperative progression of dependency. We demonstrate in a small group of patients that early ambulation after lower extremity free flap reconstruction can be safely undertaken with close monitoring and sound clinical judgment.

Patient	Defect Type	Flap	Size (cm ²)	Flap Δ StO ₂	Control Δ StO ₂	Lowest Absolute StO ₂
1	Trauma	ALT	88	-18%	-3%	72%
2	Trauma	ALT	63	-3%	-6%	85%
3	Trauma	ALT	45	-15%	-13%	68%
4	Trauma	RF	40	-3%	-2%	87%
5	Oncologic	RF	42	-18%	-13%	61%
6	Trauma	ALT	70	-5%	-5%	76%
7	Chronic Wound	ALT	65	-11%	-3%	79%
8	Trauma	ALT	77	-4%	-6%	85%
9	Chronic Wound	ALT	60	-19%	-16%	59%
10	Oncologic	RF	50	-12%	-10%	72%
11	Trauma	ALT	75	-15%	-17%	67%
12	Trauma	ALT	85	-37%	-19%	39%

PATIENT 6



#6 A Clinical and in Vitro Comparison of Irrisept® and Triple Antibiotic for Bretast Irrigation

Daniel F Haynes, MD
Christopher L Pritchett, PhD
East Tennessee State University

BACKGROUND: Infection around breast implants and expanders can result in additional surgeries, delays in reconstruction, and is implicated in the long-term development of capsular contracture. Multiple irrigation regimens have been used, including triple antibiotic and povidone-iodine, with the recent addition of dilute chlorhexidine (Irrisept®) as a pre-mixed, FDA approved surgical irrigant.

PATIENTS AND METHODS: A retrospective review was performed of breast reconstruction surgeries (both tissue expander and permanent implant placement) performed by a single surgeon over a 3.5 year period, encompassing 386 patients and 656 breasts. Breast pockets were irrigated with triple antibiotic alone, Irrisept alone, or a combination of the two, in three sequential time periods. An in vitro study was performed comparing chlorhexidine and triple antibiotic irrigation (cefazolin, gentamicin, and bacitracin) for activity against four common organisms (*E. coli*, *S. epidermidis*, *S. aureus*, and *P. aeruginosa*).

RESULTS: Two hundred and seventy five expanders were placed, and 381 permanent implants. Chlorhexidine and triple antibiotic irrigation had similar rates of both infection and implant loss (Table 1). A combination of chlorhexidine and triple antibiotic had the lowest rate of infection, and no implant loss, but did not reach statistical significance. The in vitro study showed chlorhexidine to have better activity against gram negative organisms compared to triple antibiotic.

CONCLUSIONS: Chlorhexidine and triple antibiotic have similar in vivo efficacy in breast reconstruction surgery. Based on this study, the combination of chlorhexidine and triple antibiotic may provide the best protection against implant loss.

Table 1.

Triple Antibiotic Irriga-
tion

patients

breasts

infections

implant loss

177

289

16

8

5.5%

2.8%

Irrisept

patients

breasts

infections

implant loss

158

280

15

5

5.4%

1.8%

Triple Antibiotic +
Irrisept

patients

breasts

infections

implant loss

51

87

3

0

3.4%

0.0%

**#7 Sculpted Pillar Vertical Breast Reduction
Mammaplasty in 317 Patients: The Impact of Pedicle,
Scar Pattern and Payor Source on Complication Rates
and BREAST-Q Outcomes**

Brian M. Derby MD (Presenting Author), James C. Grotting MD FACS
Grotting and Cohn Plastic Surgery
Birmingham, AL

BACKGROUND: The senior author has described the sculpted pillar vertical breast reduction. To compare this technique's safety profile to other established techniques, complication rate reporting is necessary. Few studies have utilized the BREAST-Q for long-term outcomes reporting in bilateral reduction mammaplasty patients. BREAST-Q outcomes data comparisons, between cosmetic and insurance-based breast reduction cohorts, have not been previously performed.

PATIENTS AND METHODS: A retrospective chart review was undertaken to include patients who underwent reduction mammaplasty over the last twelve years in the senior author's practice. Three hundred and seventeen (317) patients of 386 met inclusion criteria. Demographic, operative, and complication data were extracted. The BREAST-Q postoperative reduction mammaplasty module was administered. Complication rates and outcomes data were tabulated and analyzed between patient cohorts distinguished by pedicle (superior or superomedial), scar pattern (inverted T, vertical, J- or L-shaped) and payor population (cosmetic or insurance-based). Statistically significant differences were set at $p < 0.05$.

RESULTS: Compared to the superior pedicle, use of the superomedial pedicle statistically increases rates of postoperative fat necrosis. Complication rates did not differ among the scar patterns utilized, but use of a J, L-shaped, or short-T scar decreased the need for secondary/ revisional surgery. Cosmetic and insurance-based outcomes did not differ in any domain of the postoperative reduction mammaplasty BREAST-Q module.

CONCLUSION: Complications data for the sculpted pillar vertical reduction mammaplasty were comparable to published results for other techniques.

Complication rates are unaffected by scar pattern. Superomedial pedicle selection and larger insurance-based reductions predispose to statistically significant increases in fat necrosis compared to use of the superior pedicle. Payor source neither affects the majority of complication rates, nor BREAST-Q satisfaction and quality of life domains. This information has been used in the context of practice based learning to improve management of expectations during the preoperative consultation process. Insurance-based criteria for coverage may require reappraisal.

#8 Refinements in the Techniques of Two-Stage Breast Reconstruction

Rahul Vemula, MD , Matthew Freeman, Rahul Rao, Abigail Chaffin, MD, John T. Lindsey, MD FACS, David A. Jansen, MD FACS

BACKGROUND: Two-stage breast reconstruction following mastectomy has undergone an evolution over the past decade. Initially, two-stage breast reconstruction placed a tissue expander with or without acellular dermal matrix (ADM), and then proceeded to final reconstruction with either autologous tissue or an implant. We will present technical refinements that allow for quicker, aesthetically superior, and more patient-friendly breast reconstruction.

METHODS: We retrospectively reviewed charts from the senior author’s private practice over a nine-year follow-up period. Inclusion criteria included all women who underwent mastectomy and had a tissue expander placed at the initial operation. These women were followed and the final outcomes of reconstruction, including complications, were reviewed.

RESULTS: A total of 129 women met inclusion criteria. Earlier in the study years, there was a propensity for the reconstructive surgeon to use an ADM for inferolateral support. Later during the study, there was a paradigm shift, and ADM was no longer utilized. We found no difference in initial fill volume, number of visits until final expansion, or number of days until implant exchange between women who had an ADM and those who did not. In addition, some women decided not to proceed with implant based reconstruction and decided to undergo autologous reconstruction.

CONCLUSION: This reconstructive algorithm focuses on patient education, surgical cooperation, and improved technique. This focus translates into improved tissue expansion outcomes, aesthetically pleasing results, and allows time for patient understanding and education.

WEDNESDAY

#9 Two Year Follow-Up Autologous Fat Grafting with Laser-Assisted Facelifts

Sherry S. Collawn, Cristiano Boneti, Tony L. Weaver, and Jorge de la Torre

BACKGROUND: *Skin* tightening and improved facial contouring can be achieved through a variety of methods including traditional facelifts, autologous fat injections and other fillers, laser resurfacing, radio frequency and ultrasound devices, and the use of laser liposuction fibers. In recent years, the use of laser-assisted liposuction fibers for skin tightening and facial contouring has increased. We will demonstrate in this two year follow-up study that lasers and fat grafting can improve and maintain good results.

METHODS: Facial contouring was achieved using a subcutaneous laser fiber with the wavelengths 1064nm and 1320nm. Following the laser treatment fat injections were performed with 1ml syringes and small 0.9mmTulip injection cannulas. Standard surgical facelifts with were then performed.

RESULTS: From 2011 through 2014 forty-three patients received facial fat injections with other surgical procedures. The patients shown in figures 1a and 2a underwent laser-assisted liposuction/contouring, standard facelifts, and fat injections. The patient in figure 1b maintained improvement in her cheeks, periorbital, and temple hollows at 21 months. The patient shown in figure 2b maintained improvement in her neck and perioral region at 12 months.

CONCLUSIONS: Overall, laser fiber contouring with autologous facial fat injections during facelifts is safe with satisfactory results maintained up to two years post operatively.



Figure 1a. Pre Treatment.



Figure 1b. 21 months Post Operative.



Figure 2a. Pre Treatment.



Figure 2b. 1 Year Post Operative.

#10 Abdominoplasty with Scarpa Fascia Preservation

António Costa-Ferreira; Marco Rebelo; Luis Vásconez; José Amarante

The plane of dissection used during a full abdominoplasty has been implicated on the seroma rate.

A randomized controlled study comparing classical abdominoplasty to abdominoplasty with Scarpa fascia preservation is presented. It involved 160 patients and was considered a level 1 study (PRS journal). This investigation demonstrated that using a more superficial plane of dissection (at Scarpa fascia level) had a beneficial effect on patient recovery by reducing: total drain output (66%), daily drain output (69% reduction on the first 6 days), time to drain removal (3 days), long periods with suction drains (longer than 6 days - from 26/80 patients to 1/80 patients), hematoma (80%), infection (83%), seroma (87%). The aesthetical result was not affected by this modification.

Controversy still exists on the manipulation of the deep fat compartment by liposuction or direct fat excision. No manipulation is another option which should be considered but it has been questioned due to the risk of aesthetic compromise. A morphometric study performed on the surgical specimens of 41 female patients submitted to a full abdominoplasty is presented. The quantitative distribution of fat between the superficial and deep fat compartments was evaluated along with its variation with adiposity. This study suggests that total preservation of the deep fat compartment on the lower abdomen does not compromise the aesthetical result.

Based on this evidence the authors recommend that surgeons consider performing abdominoplasties using a more superficial plane of dissection in the infra-umbilical area with total preservation of Scarpa fascia and the deep fat compartment.

#7 Distance to a Plastic Surgeon is Inversely Proportional to Rates of Post-Mastectomy Breast Reconstruction.

Paul Diegidio, Lei Zhou, Anne-Marie Meyer, Karyn B. Stitzenberg, Michelle C. Roughton.

Introduction: The psychosocial benefits of post-mastectomy breast reconstruction are well documented, however, socioeconomic and demographic barriers to reconstruction exist. We evaluated our state-wide patient population to characterize barriers to reconstruction.

Methods: A linked dataset combining North-Carolina-Central-Cancer-Registry (NC-CCR) with administrative claims from Medicare, Medicaid, and private insurance, identified women diagnosed with breast cancer from 2003-2006. Women were included if they received a mastectomy within 6-months of diagnosis, and had continuous insurance enrollment at least 2-years postoperatively (n=5,379). Multivariable logistic regression was used to model odds of receiving reconstruction, adjusting for patient demographics and tumor characteristics.

Results: As the distance to plastic surgeon increased, the likelihood of reconstruction decreased, independent of other previously identified predictors, including age, race, rural location, and lower household income (Table 1). Women with government-funded healthcare (i.e. Medicaid & Medicare) were also significantly less likely to receive reconstruction. Consistent with previous studies, advanced cancer stage, and receipt of radiation decreased the likelihood of reconstruction. Furthermore, when we compared immediate to delayed reconstruction, rural county of residence, chemotherapy, and radiation were significantly associated with delay. (Table2)

Conclusions: This is the first population-based study to demonstrate distance to care, and insurance plan as significant predictors of receipt of reconstruction. Additional research is needed to understand these healthcare barriers, and if the impact of distance to plastic surgeon can be mitigated by outreach programs, including telemedicine, and staged-immediate reconstruction. Current changes regarding coverage and

eligibility in the American insurance system, including widespread low-reimbursement coverage may significantly influence access to breast reconstruction.

Table 1: Receipt of any post-mastectomy breast reconstruction: n=5379, 21% (1130) with reconstruction, 79% (4,249) without

Variables	Category	Odds Ratio (95% CI)
Distance to plastic surgeon	<10 Miles	Referent
	10-20 Miles	0.77 (0.63-0.95)**
	>20 Miles	0.67 (0.53 -0.84)***
Healthcare Plan	Private Only	Referent
	Medicare or Medicare with Private	0.48 (0.37-0.62)***
	Any Medicaid	0.25 (0.19-0.32)***
Cancer Stage	Stage 0/I	Referent
	Stage II/III	0.76 (0.62-0.94)**
	Unknown	1.01 (0.38-2.72)
Rural County	No	Referent
	Yes	0.69 (0.57-0.84)***
Income quartile	1 st	0.71 (0.55-0.96)**
	2 nd	0.73 (0.57-0.94)**
	3 rd	0.87 (0.69-1.09)
	4 th	Referent
Race	Non-Hispanic White	Referent
	Other	0.49 (0.38-0.62)***
Radiation	No	Referent
	Yes	0.45 (0.36-0.57)***

* P<0.05
** P<0.01
***P<0.001

Table 2: Receipt of Delayed reconstruction (n=1130, 863 Immediate, and 267 Delayed❖)

Variables	Category	Odds Ratio (95% CI)
Rural County	No	Referent
	Yes	1.61 (1.1-2.36)*
Chemotherapy	No	Referent
	Yes	2.46 (1.61-3.69)***
Radiation	No	Referent
	Yes	1.56 (1.03-2.35)*

❖Delayed = greater than 4 months from mastectomy
* P<0.05
** P<0.01
***P<0.001

#8 Outcomes of Breast Reconstruction After Mastectomy Using Deep Inferior Epigastric Perforator

(DIEP) Flap Following Massive Weight Loss

Deniz Dayicioglu, MD, Bugra Tugertimur, MD, Kristen Zemina, MD, Sequoya Killebrew, MD, Augustine Wilson, MD, Jonathan Dallarosa, MD, Nazanin Khakpour, MD

BACKGROUND: Due to correlation of breast cancer and obesity, bariatric surgeons may encounter patients requiring breast reconstructive surgery. Deep inferior epigastric artery perforator flap (DIEP) that utilizes redundant abdominal skin for breast reconstruction in massive weight loss patient (MWL) has not been adequately studied in this population.

METHODS: After Institutional Review Board (IRB # Pro00014840) approval retrospective review was undertaken of 103 consecutive patients who underwent breast reconstruction, using 150 DIEP flaps, performed by the same plastic surgeon. Within this group, 9 DIEP flaps were performed on 6 massive weight loss patients. Parameters compared in MWL and non-weight loss patients (NWL) were demographics (age, Body Mass Index (BMI), co morbidities, total weight loss, methods of weight loss), breast cancer characteristics (immediate versus delayed reconstruction, history of radiation); DIEP flap characteristics (coupler size, additional venous anastomosis, need for re-exploration, flap loss), length of hospital stay; abdominal wound healing complication, and hernia or bulging.

RESULTS: There were no flap failures, bulging or hernias requiring surgery in MWL. There was no statistical difference in flap survival, abdominal complications (early or late), hospitalization days, operative time, or operative characteristics between two groups.

CONCLUSIONS: For breast reconstruction after mastectomy, DIEP can be used in MWL and NWL populations with equal flap success and abdominal donor site results. Immediate wound healing complications were significantly correlated with co-morbidities and not with weight loss history

Table 1: Patient characteristics of History of Massive Weight loss Patients undergoing DIEP

	Coupler size – left/right (mm)	Additional venous anastomosis	Ischemia Time – left/right (min)	Proc Length (hr)	Flap loss	POD at DC	Early Abdominal Wound	Late Abdominal Hernia or Bulging
Patient 1	3.5 / X	0	67	7.4	n/a	5	1	0
Patient 2	2.0 / 3.0	0	60 / 30	12.3	n/a	4	0	1
Patient 3	3 / 2.5	0	38 / 38	10.2	n/a	4	0	0
Patient 4	3.0 / 2.5	0	22 / 150	12.1	n/a	4	1	0
Patient 5	X / 3.0	0	X / 60	8.7	n/a	3	0	0
Patient 6	3.0	0	60	8.7	n/a	3	0	0

Table 2: DIEP flap characteristics of Massive Weight Loss (MWL) patients

		NWL n:141		MWL n:9		p
Age at Operation		51.9±10.0		57.6±7.1		0.038
Timing of reconstruction	Delayed	77	54.6%	6	66.7%	0.481
	Immediate	64	45.4%	3	33.3%	
Coupler size (mm)		2.6±0.4		2.8±0.4		0.188
Ischemia time (min)		51.4±20.0		55.6±38.6		0.661
Proc length (hours)		10.01±2.8		9.8±2.3		0.908
POD at DC		5.0±3.9		4.1±0.7		0.773
Additional Venous Anastomosis		15	10.6%	0	0.00%	0.302
DIEP flap loss		3	2%	0	0.00%	0.719
Re-exploration		8	5.7%	0	0.00%	0.463
History of smoking		29	33.7%	2	33.3%	0.985
History of co-morbidities		73	51.8%	6	66.7%	0.386
History of radiation		60	42.9%	3	33.3%	0.575

Table 3: Massive Weight Loss (MWL) and Non Weight Loss (NWL) patient and flap characteristics comparison



Figure 1: Preoperative image of a MWL patient



Figure 2: Postop image of a MWL patient after bilateral mastectomy and delayed DIEP reconstruction



Figure 3: Preoperative image of a MWL patient



Figure 4: Post operative image of a MWL patient after bilateral mastectomy and immediate DIEP reconstruction

#9 Relationship of Reduction Weight and Body Mass Index as Predictors of Complications After Breast Reduction Surgery

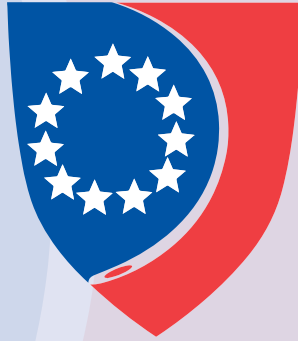
Authors: Anna K Pavlov, M.D., Somjade J Songcharoen, M.D., Samantha R Seals, Ph.D., Peter B Arnold, M.D., Ph.D.

INTRODUCTION: In Bilateral Breast Reduction (BBR) surgery, there is evidence that a patient's risk for post-operative complications increases with higher Body Mass Index (BMI). We hypothesize that the amount of tissue removed during surgery is more strongly associated with complications than BMI.

METHODS: In this retrospective study, we examined 81 women who underwent BBR for symptomatic macromastia by a single surgeon using an inferior pedicle approach. We focused on patient characteristics, which included BMI, average sternal notch-to-nipple distance (N2N), average inframmary fold-to-nipple distance (IMF), and total weight of tissue removed (TWR), and their relationship to the development of major and minor complications. These were compared using two-sample t-tests. Separate multivariable logistic regressions were used to model complication status and type of complication.

RESULTS: When comparing patients with and without complications, there were significant differences in BMI ($p=0.037$), N2N ($p=0.010$), and TWR ($p=0.005$). There were no significant differences in those with major vs. minor complications. After adjusting for N2N, IMF, and TWR, BMI was not a significant predictor of minor vs. major complications ($p=0.442$). TWR was a significant predictor of major complications after adjusting for BMI, N2N, and IMF ($p=0.049$). This relationship strengthened when TWR was taken as a ratio with BMI after adjusting for IMF and N2N ($p=0.009$).

CONCLUSION: After adjusting for other patient characteristics, BMI is not a significant predictor of the development of complications. Conversely, TWR is a significant predictor of the development of complications. Thus, TWR is more critical than BMI for determining the safety of BBR.



POSTERS FOR PRESENTATION

POSTERS FOR PRESENTATION

Poster viewing is located in the Amelia Foyer of the convention center. The numbered poster titles below correspond to the location in the poster hall.

- #1** “No Touch Technique for Tissue Expander and Acellular Dermis Breast Reconstruction”
Henry Wilson, MD

- #2** “In A Little While: Anticipating Changes In Bundled Payments For The Treatment Of Patients With Acute, Life-threatening Dermatologic Emergencies, Through Prevention Of Healthcare Associated Infections”
Paul Diegidio, MD; Shiara Ortiz-Pujols, MD; Lauren M. Dibiase, MS; David J. Weber MD, MPH; David van Duin MD, PhD; Samuel W. Jones, MD, FACS; Bruce A. Cairns, MD, FACS; C. Scott Hultman, MD, MBA, FACS

- #3** “Mitigation Of Hypertrophic Scar Contraction And Stiffening Via An Elastomeric Biodegradable Scaffold”
Mohamed M. Ibrahim, MD, Elizabeth R. Lorden, BS, Kyle J. Miller, BA, Latif Bashirov, MD, Ellen Hammett, BS, Manuel Medina, MD, Youngmee Jung, BS, Ali Rastegarpou, MD, Angelica M. Selim, MD, Kam W. Leong, PhD, Howard Levinson, MD.

- #4** “Myofibroblasts Contribute to but are not Necessary for Wound Contraction”
Mohamed M. Ibrahim, MD, Lei Chen, MD, Jennifer E. Bond, PhD, Manuel A. Medina, MD, Licheng Ren, MD, George Kokosis, MD, Angelica M. Selim, MD, Howard Levinson, MD

- #5** “Patient Satisfaction Following Amputation or Reduction in Macrodystrophia Lipomatosa”
Ovunc Akdemir, M.D.*; Hilmi Karadeniz, M.D.; Ouat Uzumcigil, M.D., Ahmet Dogan, M.D.; William Lineaweaver, M.D., F.A.C.S.**

- #6** “Burn care in Mississippi: A 5 year profile of a single state wide burn center”
William Lineaweaver M.D., F.A.C.S.; Tanya Oswald, M.D.; Craig Adams, M.D.; Fred Mullins, M.D.

POSTERS FOR PRESENTATION

- #7** “Twenty-Year Review of a Single Surgeon’s Experience with Lambdoidal Synostosis: Surgical Technique with Clinical Review”
J Roberto Ramirez MD; Charles Rodriguez-Feo BS; Julian Winocour MD; Marcia Spear DNP; Kevin Kelly MD, DDS
- #8** “Feasibility and Safety of Adipose-derived Wound Paste in a Murine Model of Full Thickness Wounding”
Akane Yu, Ning Yang, Hulan Shang, Adam J. Katz
- #9** “A Randomized, Blinded Phase I/II Dose Escalation Clinical Trial Evaluating Autologous Fat Transfer (AFT) for Scar Prevention and Remodeling: Study Design and Preliminary Results”
Justine Pierson, Hulan Shang, Ning Yang, David Drake, Catherine Ratliff, Rodney Chan, Gale Mankoff, Adam J. Katz
- #10** “Microsurgery Competency During Plastic Surgery Residency: An Objective Skills Assessment Evaluation of an Integrated Residency Training Program”
Erin L. Doren, Rakan A. Alkahtani, Matthew Applebaum, Ali M. Ghanem, Simon R. Myers, Michael Harrington, David J. Smith, Jr.
- #11** “The Use of Resorbable Mesh in Craniosynostosis”
Charles Pierce, DO, MPH; Petros Konofaos, MD, PhD; Robert Wallace, MD
- #12** “Autologous Breast Reconstruction Implant Augmentation (A.B.R.I.A.): Indications and Outcomes ”
Clayton Crantford MD, Ryan Rebowe MD, Austin Bond BS, James Thompson MD, & Ivo Pestana MD
- #13** “Cost Analysis of Simultaneous Versus Staged Bilateral Carpal Tunnel Release”
Paul Phillips, MD; Tara Lee MPH; James W. Kennedy, MD
- #14** “The Timing and Significance of Microvascular Events in Head & Neck Reconstruction”
Saif Al-Bustani, MD, DMD; Grace Kim Austin, MD; Emily Cohn Ambrose, MD; Justin Miller, MD; Trevor G. Hackman, MD; Eric G. Halvorson, MD

POSTERS FOR PRESENTATION

- #15** “Integrative Medicine and Plastic Surgery”
Nirav Patel, BS; Justine Pierson, MS; Tim Lee, BS; Bruce Mast, MD, Bernard Lee, MD, MBA; Irene Estores, MD; Dhruv Singhal MD
- #16** “Digital Photo Security: What Plastic Surgeons Need to Know”
Virginia A. Thomas, Patricia B. Rugeley, BSN, MHA, CHC, and Frank H. Lau, MD
- #17** “Safety in High-volume Hyaluronic Acid Dermal Filler Injection with Perlane for Facial Rejuvenation”
Zuriarrain A, Newman M, Kusuma S
- #18** “Outcomes of Free Flap Breast Reconstructions at a Tertiary Care Facility versus a Specialty Surgical Hospital”
Rahul Vemula, MD ; Matthew Freeman; Cameron Callaghan; David A. Jansen MD FACS; Abigail Chaffin MD FACS ; John T Lindsey MD FACS
- #19** “The Impact of Mesh Reinforcement with Components Separation for Abdominal I Reconstruction”
Seyed Amirhossein Razavi, MD; Karen A. Desai, MD; Peter W. Thompson, MD; Alexandra M. Hart, MD, Albert Losken, MD
- #20** “The Value Added From Plastic and Reconstructive Surgery Care at Major Medical Centers”
Kate J Buretta, MD; Danielle L Sobol, BS; Eugenia H Cho, BS; Scott T. Hollenbeck, MD
- #21** “Biofabrication of a Three-dimensional, In Vitro Model of Implant Capsule Formation.”
Harmon Katrina A, Lane Brooks A, Goodwin Richard L, Eberth John F, Friedman Harold I
- #22** “An Evaluation into the Impact of Methicillin-Resistant Staphylococcus Aureus (MRSA) in Breast Reconstruction Patients.”
Alexandra Hart, M.D., Karan Desai, M.D., Jason Yoo, M.D., Albert Losken, M.D.

POSTERS FOR PRESENTATION

- #23** “Long-term Changes in Lifestyle and BMI Following Reduction Mammaplasty”
Kirsten Baecher, MD; Alexandra Hart MD; Albert Losken MD
- #24** “Pedicled Anterolateral Thigh Flap for Complex Genital, Lower Abdomen and Perineal Wounds”
Nora E. Burkart, MD, Mabel Gamboa, MD, FACS
- #25** “Obstructive Sleep Apnea in Children with Cleft Lip and/or Palate: Results of a Cross-Sectional Population-Based Study”
Anna R. Carlson, MD; Danielle L. Sobol, BS; Irene J. Pien, BS; Alexander C. Allori, MD, MPH; Jeffrey R. Marcus, MD; Stephanie Watkins, PhD, MSPH; Arthur S. Aylsworth, MD; Robert Meyer, PhD, MPH; Luiz Pimenta, DDS, PhD; Ronald Strauss, DMD, PhD; Barry Ramsey, BS; Eileen Raynor, MD
- #26** “Age at Referral Limits Treatment Options in Craniosynostosis”
Brad M Gandolfi, Danielle Sobol, Alexander C Allori, Herbert E Fuchs, Jeffrey R Marcus
- #27** “The Impact of Collegiate Football on the Volume of Facial Fracture Consultations”
Brad Nesmith, MD; Courtney Wold, MD DMD; Ariel Anderson, BS, Joseph Diaz, BS; Gileno Fonseca Filho, BS; Raja Sawhney, MD; Ben Schlott, MD DMD; Dhruv Singhal, MD
- #28** “Nipple Malposition after Nipple Sparing Mastectomy”
Carrie K. Chu, Albert Losken, Grant Carlson
- #29** “Effect of Advanced Age on Flap-Related Outcomes in DIEP Breast Reconstruction”
Radbeh Torabi MD, Mark W. Stalder MD, Matthew Bartow BS, Charles Dupin MD, M. Whitten Wise MD, Hugo St. Hilaire DDS MD

POSTERS FOR PRESENTATION

- #30** “Incidence Of Flap-Related Complications In Obese Patients Undergoing DIEP Breast Reconstruction: An Analysis Of 306 Flaps In 219 Patients”
Mark W. Stalder MD, Radbeh Torabi MD, Andrew Freel MD, Matthew Bartow BS, M. Whitten Wise, MD, Charles Dupin MD, Hugo St. Hilaire DDS MD
- #31** “Outcomes of Virtual Surgical Planning for Free Fibula Flap Reconstruction in Patients with Advanced Osteoradionecrosis of the Mandible”
Mark W. Stalder MD, Matthew Bartow BS, Allyson J. Darga BS, Rizwan Aslam DO, Hugo St. Hilaire DDS MD
- #32** “Keloids and Their Treatment”
Amanda Daggett MS3; Somjade J. Songcharoen MD; Ricky P. Clay MD
- #33** “Impact of Bilateral Autologous Breast Reconstruction with DIEP Flap on Back Pain and Symmetry in Patients with Scoliosis”
Amanda Zimmerman, MD; Ashely Ali, MD; Deniz Dayicioglu, MD
- #34** “The Role of Tissue Expanders in Staged Abdominal Wall Reconstruction”
Yan T. Ortiz-Pomales, MD ; Emma Celano; Albert Losken, MD
- #35** “Fetal Bovine Acellular Dermal Matrix Use in Revisionary Aesthetic Breast Surgery”
Carmen Kavali, MD
- #36** “Safety of Pre-op Chemoprophylaxis in Plastic Surgery Patients”
W. Joseph Campbell, Rachael Cohen-Shohet, Justine Pierson, Bruce Mast
- #37** “Botulinum Toxin Type A as an Alternative to Surgery for the Treatment of Persistent Congenital Muscular Torticollis”
Brian Boland, MD, Nathan Eberle, Eric Stelnicki, MD

POSTERS FOR PRESENTATION

- #38** “Nipple Reconstruction: A Retrospective Review of 641 Procedures and Risk Factors Associated with Poor Outcomes”
Michael Reynolds, MD, Ellen Satteson, MD, Austin Bond, BA, Ivo Pestana, MD, James Thompson, MD
- #39** “Tongue-Lip Adhesion as Primary Treatment of Airway Obstruction in Pierre Robin Sequence”
Sarah Fernandez, MD, Ashley Lentz, MD
- #40** “Surgery Complication Rates Following Surgeon Sleep Deprivation: A Review of Published Studies”
Scott Corlew, MD, William Lineawaver, MD, Feng Zhang, MD, Ph.D

NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



PAST PRESIDENTS & LECTURERS

PAST PRESIDENTS

1958	Founding	1986	John R. Reynolds
1959	Neal Owens*	1987	John R. Royer
1960	Greer Ricketson*	1988	James H. Carraway
1961	Robert F. Hagerty*	1989	John H. Hartley, Jr.
1962	Lorenzo H. Adams*	1990	W. Michael Bryant
1963	Clifford C. Snyder*	1991	Allen H. Hughes
1964	Samuel E. Upchurch*	1992	Norman M. Cole
1965	McCarthy DeMere*	1993	Edward A. Luce
1966	Charles Horton*	1994	Benjamin H. Wofford
1967	Francis Marzoni*	1995	William F. Mullis
1968	Andrew M. Moore*	1996	Thomas W. Orcutt
1969	Carter P. Maguire*	1997	J. Barry Bishop
1970	James H. Hendrix*	1998	Kenna S. Given
1971	John R. Lewis*	1999	W. Howard Kisner
1972	James G. Stuckey*	2000	R. Cole Goodman
1973	James B. Cox	2001	L. Franklyn Elliott
1974	William M. Berkeley*	2002	Andrew M. Moore, II
1975	Henry T. Brobst*	2003	Ronald J. Johnson
1976	John M. Hamilton	2004	William H. Wallace
1977	Jerome E. Adamson	2005	Michael E. Beasley
1978	Byron Green	2006	Anthony J. Pizzo
1979	George W. Hoffman*	2007	R. Bruce Shack
1980	William E. Huger*	2008	Suman K. Das
1981	Eugene F. Worthen	2009	James W. Wade
1982	Joel W.L. Mattison*	2010	James Moore
1983	James H. Fleming*	2011	James C. Grotting
1984	Robert C. Reeder*	2012	W. Byron Barber
1985	Andrew W. Walker*	2013	Ann Ford Reilley
		2014	Harold I. Friedman

*deceased

PAST UPCHURCH LECTURERS

Samuel Upchurch (1909–1968) was born in Clanton, Alabama on April 13, 1909. He died in 1968 at the age of 59 at University Hospital in Birmingham, Alabama. He started his undergraduate education at the Citadel in Charleston, SC in 1925 and later finished his A.B. degree at Vanderbilt University in 1929. He stayed at Vanderbilt to complete his M.D. degree in 1933 and then began his surgical training at Duke University. He became Chief Resident in Surgery and stayed on the Duke faculty as Instructor in Surgery. He then trained in plastic surgery in St. Louis under Drs. Barrett Brown, Frank McDowell, and Louis Byars.

During World War II, he was ordered to active duty and installed as a Major in the Surgical Division of the 65th General Hospital, which was sent to England for the duration of the war. He ultimately became Regional Consultant in Plastic Surgery for the Eighth Air Force. After the war, he returned to St. Louis for an additional year of training with the plastic surgical group, and in 1947 he moved to Birmingham, Alabama and became the pioneer plastic surgeon in Alabama. He was soon made Chief of the Division of Plastic Surgery. He published numerous scientific articles and was an investigator in the use of silicones as a soft tissue substitute. He was President of the Southeastern Society of Plastic and Reconstructive Surgeons in 1964. Upon his death, his wife, Ann (Samford) Upchurch, bequeathed to the Society the funds for the establishment of the Upchurch Educational Fund and the annual Upchurch Lectureship.

PAST UPCHURCH LECTURERS

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

PAST JURKIEWICZ LECTURERS

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

FUTURE SESPRS MEETINGS

FUTURE ANNUAL SCIENTIFIC MEETINGS

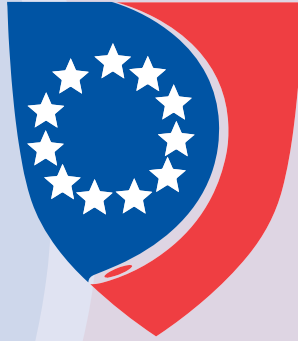
June 11-15, 2016	Disney's Grand Floridian Resort, Orlando, FL
June 10-14, 2017	The Cloister, Seal Island, GA
June 16-20, 2018	The Breakers, Palm Beach, FL

FUTURE OCULOPLASTIC SYMPOSIUM

January 21, 2016	Intercontinental Hotel, Atlanta, GA
January 19, 2017	Intercontinental Hotel, Atlanta, GA
January 18, 2018	Intercontinental Hotel, Atlanta, GA

FUTURE ATLANTA BREAST SURGERY SYMPOSIUM

January 22-24, 2016	Intercontinental Hotel, Atlanta, GA
January 20-22, 2017	Intercontinental Hotel, Atlanta, GA
January 19-21, 2018	Intercontinental Hotel, Atlanta, GA



AWARD WINNERS

AWARD WINNERS

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
Andrew Moore II	2010

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

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

AWARD WINNERS

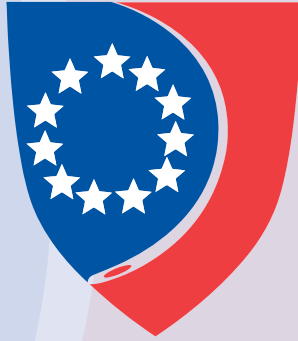
GLANCY AWARD

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, Gen 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 as a child of pneumonia. 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 1977 Emory University	Leonard Miller 1984 Emory University
H. Louis Hill 1978 Emory University	Richard Sadove 1985 Eastern Virginia Medical School
E.D . Newton 1979 University of Tennessee	Mason Williams 1986 Eastern Virginia Medical School
Dan H. Shell 1981 University of Tennessee	David Hurley 1987 University of Virginia
Donato Viggiano 1982 University of Tennessee	J.D. Stuart 1988 University of Virginia
Larry Nichter 1983 University of Virginia	James H. Schmidt 1989 University of Florida

AWARD WINNERS

Paul A. Watterson 1990 Emory University	M.I. Okwueze 2004 Vanderbilt University
Michael G. Kanosky 1991 University of Mississippi	Robert EH Ferguson 2005 Kentucky Clinic
Joseph M. Woods, IV 1992 Vanderbilt University	Dean DeRoberts 2006 Wake Forest
David Brothers 1993 University of N.C. at Chapel Hill	Howard Levinson 2007 Duke University
Scott N. Oishi 1994 University of Kentucky	S. S. Tholpady 2008 University of Virginia
Gregory Mackay 1995 Emory University	Scott Hollenbeck 2009 Duke University
R.C. High 1996 Bowman Gray School of Medicine	Yvonne Pierpont 2010 University of South Florida
Henry F. Garazo 1997 Medical College of Georgia	Anthony Capito 2011 University of Virginia
Kim Edward Koger 1998 Duke University	Matthew Blanton 2012 Duke University
J. Timothy Katzen 1999 Vanderbilt University	Michael Lynch 2013 University of Kentucky
Richard Rosenblum 2000 Vanderbilt University	Brent R. DeGeorge 2014 University of Virginia
Colin Riordan 2001 Vanderbilt University	
Julia MacRae 2002 University of Virginia	



2015 MEMBER ROSTER

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Nour Abboushi *Active*
Panacea Plastic Surgery
1368 Wellbrook Circle, Suite B
Conyers, GA 30012
(770) 929-0634
nourabboushi@yahoo.com



Peter A. Aldea *Active*
Cosmetic Surgery Specialists of Memphis
6401 Poplar Ave., Suite 360
Memphis, TN 38119
(901) 752-1412
lookgreatsurgery@yahoo.com
Patricia Eby, MD



Robert J. Allen *Active*
The Center for Microsurgical Breast
Reconstruction
New York, NY and Metairie, LA
(888) 890-3437
boballen@diepflap.com
Linda



Michael F. Angel *Active*
Samaritan Medical Center
826 Washington St.
Watertown, NY 13601
(601) 984-5180
mangel@me.com



Ralph Leo Aquadro, III *Active*
East Alabama Plastic Surgery
778 N. Dean Rd., Suite 400
Auburn, AL 36830
(334) 321-4989
trey.aquadro@gmail.com
Amy Aquadro



Peter B. Arnold *Active*
University of Mississippi Medical Center
2500 North State St.
Jackson, MS 39216
(601) 984-5180
parnold@umc.edu



Adam C. Augenstein *Active*
Hunstad Kortess Center
11208 Statesville Rd., Suite 300
Huntersville, NC 28078
(704) 497-1931
dr.a@hkcenters.com



Leonik Ahumada *Active*
Ocala Plastic Surgery
3320 SW 34th Circle
Ocala, FL 34474
(352) 629-8154
clrobinson@ocalaplasticsurgery.com
Salesia



Amy Kathleen Alderman *Active*
The Swan Center for Plastic Surgery
4165 Old Milton Pkwy., Suite 200E
Alpharetta, GA 30005
amyaldermanmd@yahoo.com
Michael Steiger



Erica D. Anderson *Active*
Emory University
3200 Downwood Circle NW
Suite 640
Atlanta, GA 30327
(404) 778-6880
ericadanderson@aol.com



David J. Applebaum *Active*
David J. Applebaum MD FACS
1599 NW 9th Ave.
Boca Raton, FL 33486
(561) 347-7777
drabaum4@aol.com
Joanne



Louis C. Argenta *Life*
Wake Forest University
Medical Center Blvd.
Winston Salem, NC 27157
(336) 716-4416
rshelton@wfubmc.edu
Mary Jo



H. Daniel Atwood *Active*
H. Daniel Atwood MD
1794 Joyce St., Suite 1
Fayetteville, AR 72703
(501) 443-7771
hdatwood@gmail.com
Miriam



William Troy Austin *Active*
Southeastern Aesthetic Surgery
447 N. Belair Rd., Suite 105
Evans, GA 30809
(706) 854-2080
taustinmd@seaplasticsurgery.com

2015 MEMBER ROSTER



L. Dwight Baker *Active*
Dothan Plastic Surgery
105 Professional Ln.
Dothan, AL 36303
(334) 793-3113
baker.dwight@gmail.com



Joseph C. Banis, Jr. *Active*
Joseph C. Banis, Jr. MP PSC
901 Dupont Rd.
Suite 202
Louisville, KY 40207
(502) 589-8000



Yoav Barnavon *Active*
Yoav Barnavon, MD PA
1150 North 35 Ave., Suite 550
Hollywood, FL 33021
(954) 987-8100
barnavony@yahoo.com



Kenneth R. Barraza *Active*
Plastic & Hand Surgery Associates
2550 Flowood Dr., Suite 200
Flowood, MS 39232
(601) 939-9999
krbarraza@comcast.net
Jana



Patrick Louis Basile *Active*
Fort Belvoir Community Hospital
3237 Fiddlers Hammock Ln.
Ponte Vedra Beach, FL 32082
patrickbasile@yahoo.com
Shannon M. Basile



Michael E. Beasley *Active*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
(704) 372-6846
mbeasley@charlotteplasticsurgery.com
Denise



James S. Beckman, Jr. *Life*
2081 Dime Dr.
Springdale, AR 72764
(479) 751-7345
jbeckman@therapon.com
Charley Kay



Thomas J. Baker *Life*
9155 S. Dadeland Blvd.
Suite 1708
Miami, FL 33156
(305) 670-9995



William Byron Barber *Active*
Barber Center for Plastic Surgery
1591 Yanceyville St., Suite 100
Greensboro, NC 27405
(336) 275-3430
drbarber@barberplasticsurgery.com
Henrietta



Fredric M. Barr *Active*
Palm Beach Plastic & Cosmetic Surgery
1411 N. Flagler, Suite 5800
West Palm Beach, FL 33401
(407) 833-4122
fmbarrmd@aol.com
Elizabeth



Freddie T. Barron *Life*
1504 Kensington Dr.
Knoxville, TN 37922
(865) 769-3962
marjibarron@aol.com



Joseph G. Bauer *Active*
The Swan Center for Plastic Surgery
4165 Old Milton Pkwy., Suite 200
Alpharetta, GA 30005
(770) 667-0904
jbbauer@swancenteratlanta.com
Tracy



Michael Beckenstein *Active*
Michael S. Beckenstein Plastic Surgery
800 St. Vincent's Dr., Suite 610
Birmingham, AL 35205
(205) 933-9308
drbenckenstein@msbmd.com



Phillip H. Beegle, Jr. *Active*
Atlanta Plastic Surgery
975 Johnson Ferry Rd. NE, Suite 100
Atlanta, GA 30342
(404) 256-1311
phbeegle@atlplastic.com
Ann

2015 MEMBER ROSTER



Michael P. Bentley *Active*
Plastic Surgery Associates of Montgomery
6727 Taylor Ct.
Montgomery, AL 36117
(334) 284-2800
janet@psaom.com
Rhonda



Gaurav Bharti *Active*
East Tennessee State University
1110 Southwest Ave.
Johnson City, TN 37604
(404) 255-2975
bharti@mail.etsu.edu



J. Barry Bishop *Life*
Plastic Surgery Associates
24 Memorial Medical Dr.
Greenville, SC 29605
(864) 295-4160
barrbishop@aol.com



Elizabeth R. Blakemore *Active*
Upstate Plastic Surgery
301 The Pkwy
Greer, SC 29650
(864) 968-0168
earoth00@yahoo.com



Kristin A. Boehm *Active*
Buckhead Facial Plastic Surgery
1218 West Paces Ferry Rd.
Suite 108
Atlanta, GA 30327
(404) 233-3937
kboehm@hotmail.com



Diane G. Bowen *Active*
Golden Isle Center for Plastic Surgery
1015 Arthur J. Moore Dr.
St. Simons Island, GA 31522
drdiane@drdianebowen.com



Stephane Alain Braun *Active*
Vanderbilt Medical Center
D-4207 MCN
Nashville, TN 37232
stephane.braun@vanderbilt.edu
Kelly Bennett



A. Griswold Bevin, Jr. *Life*
1207 Dairyland Rd.
Chapel Hill, NC 27516
biff@nc.rr.com
Pricilla



Hal Bingham *Life*
5000 SW 125th Blvd.
Suite 2104
Gainesville, FL 32608
(351) 548-1024

Paul W. Black *Life*
439 By Way
Highlands, NC 28741
(828) 526-9681
blackpw@aol.com
Rebecca J. Schilling



Phillip K. Blevins *Life*
University of Mississippi Medical Center
5316 Kaywood Dr.
Jackson, MS 39211
(601) 918-7667
phillip.blevins@va.gov



Richard T. Bosshardt *Active*
Bosshardt & Marzek Plastic Surgery
Associates
1879 Nightingale Ln., Suite A2
Tavares, FL 32778
(352) 742-0079
rtbosshardt@aol.com



Shelby Brantley *Active*
Plastic & Hand Surgery Associates
2550 Flowood Dr., Suite 200
Flowood, MS 39232
(601) 939-9999
sbrantley@phsa-ms.com
Elizabeth



Earl Edward Breazeale, Jr. *Active*
The Breazeale Clinic
2068 Lakeside Centre Way
Knoxville, TN 37922
(865) 342-0300
ebreazeale14@gmail.com

2015 MEMBER ROSTER



Roger T. Brill *Active*
Roger T. Brill MD FACS PA
6520 NW 9th Blvd.
Gainesville, FL 32605
(352) 331-7987
jingram6520@bellsouth.net
Claudia

Robert G. Brown *Life*
302 Third Ave.
Opelika, AL 36801
(334) 745-6271



W. Michael Bryant *Life*
1991 Hyde Park St., Suite 2
Sarasota, FL 34231
(941) 951-0388
srqmike38@verizon.net
Millie



Jennifer B. Buck *Active*
Palm Harbor Plastic Surgery Centre
35080 US Highway 19 North
Palm Harbor, FL 34684
(727) 789-5711
jbuckmd@tampabay.rr.com



Patrick J. Budny *Active*
Plastic Surgery Associates of Montgomery
6727 Taylor Ct.
Montgomery, AL 36117
(334) 284-2800
janet@psaom.com
Pat



Robert W. Burk, III *Active*
Ponte Vedra Plastic Surgery
209 Ponte Vedra Park Dr.
Ponte Vedra Beach, FL 32082
(904) 273-6200
rb@pvps.com
Nancy



Peter N. Butler *Active*
Gulf Coast Plastic Surgery
543-A Fontaine St.
Pensacola, FL 32503
(850) 476-3223
pnbutlermd@yahoo.com



Christopher J. Brooks *Active*
Brooks Plastic Surgery
1150 North 35th Ave.
Suite 670
Hollywood, FL 33021
jessica@brookspasticsurgery.com



John S. Bruno *Life*
Ft. Myers Plastic Surgery Center
15971 Glen Isle
Fort Myers, FL 33912
(239) 936-2522
jsbruno@embargo.com
Ernestine



Mark A. Brzezienski *Active*
The Plastic Surgery Group
979 E. Third St., Suite C-920
Chattanooga, TN 37403
(423) 756-7134
Brzezienskim@thepsg.org



Glenn S. Buckspan *Life*
Aesthetic Surgery and Laser Center
2204 Crestmoor Rd.
Nashville, TN 37215
(615) 385-3309
gsb42@aol.com
Suzanne



Reuben A. Bueno *Life*
4120 Ridgefield Dr.
Apt. 201
Nashville, TN 37205
(301) 310-2024
rbueno1938@hotmail.com
Ofelia



Janis Burns-Tutor *Life*
300 Lochinvar Loop
Pontotoc, MS 38863
office@drburnstutor.com
Forrest Tutor



M. Bradley Calobrace *Active*
Calobrace Plastic Surgery
2341 Lime Kiln Ln.
Louisville, KY 40222
drbrad@calobrace.com

2015 MEMBER ROSTER



Christopher Alan Campbell *Active*
University of Virginia
PO Box 800376
Charlottesville, VA 22908
(434) 924-8116
cac5rb@hscmail.mcc.virginia.edu



C. Brett Carlin *Active*
Carlin Plastic Surgery
3634 Sunset Blvd.
W. Columbia, SC 29169
(803) 926-0969
bcarlin@carlinplasticsurgery.com
Liz



Martin J. Carney *Active*
Carney Center for Cosmetic & Plastic
Surgery, 1868 Wildwood Dr.
Virginia Beach, VA 23454
(757) 481-4455
drcarney@carneycenter.com
Nadia



Michael P. Cash *Active*
Nashville Plastic Surgery
2201 Murphy Ave., Suite 301
Nashville, TN 37203
michael@nashvilleplasticsurgery.com



Robert Chandler *Active*
Plastic Surgery Group of Memphis
80 Humphreys, Suite 100
Memphis, TN 38120
(901) 761-9030
rchandler@memphisplasticsurgery.com
Deborah



Angela Cheng *Active*
Emory University
1365C Clifton Rd. NE
Atlanta, GA 30322
angelacheng@emory.edu



J. Allen Clark, III *Active*
Plastic Surgery Associates of Montgomery
6727 Taylor Ct.
Montgomery, AL 36117
(334) 284-2800
janet@psaom.com



D. J. Campbell *Active*
Northeast Georgia Plastic Surgery
Associates
1296 Sims St., Suite B
Gainesville, GA 30501
djcampbell@negpsa.com
Jennifer



Grant W. Carlson *Active*
Emory Health Care
1365 C Clifton Rd.
Atlanta, GA 30322
(404) 778-5233
grant_carlson@emory.org
Karen



James H. Carraway *Life*
Plastic & Cosmetic Surgery Center of
EVMS, 5589 Greenwich Rd., Suite 100
Virginia Beach, VA 23462
(757) 557-0300
jcplassurg@aol.com
Judy



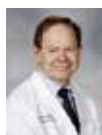
Abigail Elizabeth Chaffin *Active*
Tulane University, Plastic and
Reconstructive Surgery
1430 Tulane Ave., SL-22
New Orleans, LA 70112
achaffin@tulane.edu
Andrew Galloway



Elliott Chen *Active*
University of South Carolina
2 Medical Park
Suite 302
Columbia, SC 29201
elliottchen@hotmail.com



Orlando Joseph Cicilioni, Jr. *Active*
Orlando Cosmetic Surgery
2501 N Orange Ave., Ste #209
Orlando, FL 32804
(407) 681-3223
Ocicilioni@aol.com



Ricky P. Clay *Active*
University Mississippi Medical Center
2500 North State St.
Jackson, MS 39216
(601) 984-5180
rclay@umc.edu
Emily

2015 MEMBER ROSTER



Michael S. Clinton *Active*
Clinton Plastic Surgery Center
7191 Cahaba Valley Rd., Suite 200
Birmingham, AL 35242
(205) 408-9787
drc@clintonps.com
Betsy



Mark A. Codner *Active*
Mark Codner MD Plastic Surgery
1800 Howell Mill Rd., Suite 140
Atlanta, GA 30318
(404) 351-4151
macodner@gmail.com
Jane



Norman M. Cole *Life*
2208 Lake Ridge Drive
Belmont, NC 28012
(704) 266-4167
n_cole@bellsouth.net



Sherry S. Collawn *Active*
UAB Division of Plastic Surgery
3757 Kinross Dr.
Birmingham, AL 35242
(205) 871-4440
scollawn@uabmc.edu
James



Gustavo Colon *Life*
4224 Houma Boulevard
Suite #120
Metairie, LA
gacolon@bellsouth.net



John P. Connors, III *Active*
Plastic Surgery Group of Atlanta
755 Mount Vernon Highway, Suite 250
Atlanta, GA 30328
(404) 348-4456
drconnors@drjohnconnors.com



Daniel Scott Corlew *Active*
St. Thomas Rutherford Hospital
2111 Riverview Dr.
Murfreesboro, TN 37129
(615) 849-9025
dscorlew@gmail.com



Brian Coan *Active*
6216 Fayetteville Rd., Suite. 103
Durham, NC 27713
(919) 484-4884
drcoan@careplasticsurgery.com



Alvin B. Cohn *Active*
Grotting & Cohn Plastic Surgery
PO Box 43192
Birmingham, AL 35243
(205) 930-1600
albcohnmd@gmail.com



Robert A. Colgrove, Jr. *Active*
Robert A. Colgrove, Jr., MD
4355 Cobb Pkwy., PMB 216, Suite J
Atlanta, GA 30339
(770) 955-9000
atlplastic@hotmail.com
Claudia



Roger Stewart Collins *Active*
Collins Plastic Surgery, 8300 Health Park
Suite 205
Raleigh, NC 27615
(919) 462-8385
stewartcollins@gmail.com
Leslie Collins



Ralph W. Colpitts *Active*
The Plastic Surgery Center of SWLA
2000 Southwood Dr., Suite B
Lake Charles, LA 70605
(337) 497-1958
rwcopitts@hotmail.com
Kathy



Lee E. Corbett *Active*
Corbett Cosmetic Aesthetic Surgery and
MediSpa
13125 Eastpoint Park Blvd.
Louisville, KY 40223
(502) 721-0330
drlecorbett@msn.com



Mark H. Craig *Active*
Accent Plastic & Reconstructive Surgery
2147 Southridge Dr.
Tupelo, MS 38801
(662) 377-6290
markcraigmd@me.com
Dianne

2015 MEMBER ROSTER



James E. Craigie *Active*
Center for Natural Breast Reconstruction
1300 Hospital Dr., Suite 120
Mt. Pleasant, SC 29464
(843) 849-8418
drccraigie@ecplasticsurgery.com
Diane



Gary R. Culbertson *Active*
IRIS Surgery Center
18 Miller Rd.
Sumter, SC 29150
(803) 773-6361
gcul2047@FTC-I.net



Suman K. Das *Active*
Suman Das MD
1320 Fontaine Dr.
Jackson, MS 39211
(601) 362-0611
sushrata@aol.com



Glenn M. Davis *Active*
Davis Plastic Surgery
2304 Wesvill Ct., Suite 360
Raleigh, NC 27607
(919) 785-1220
drgmDavis@aol.com
Maryann



James Wilson Davis *Active*
Aesthetic Surgery Associates
Bldg II, #850
1100 Johnson Ferry Rd.
Atlanta, GA 30342
(404) 252-0301
jwdjr52@gmail.com



Jorge I. De La Torre *Active*
University of Alabama at Birmingham
510-20th Street South, FOT-1101
Birmingham, AL 35294
(205) 934-2307
jdltd@uab.edu



Joseph Cart deBrux, Jr. *Active*
GHS Plastic Surgery & Aesthetics
200 Patewood Dr., Suite B480
Greenville, SC 29615
cdebrux@ghs.org
Kirsten



Carl Wayne Cruse *Active*
University of South Florida
2 Tampa General Cir.
PO Box 1289
Tampa, FL 33601
(813) 844-8546
wcruse@health.usf.edu



Lynn Ann Damitz *Active*
University of North Carolina Chapel Hill
7034 Burnett, Womack Bldg., CB 7195
Chapel Hill, NC 27599
lynn_damitz@med.unc.edu
James Curtis



Lisa R. David *Active*
Wake Forest University
Medical Center Blvd.
Winston-Salem, NC 27157
(336) 716-4559
ldavid@wfubmc.edu
Patrick Mattingly



Jefferson U. Davis *Active*
Houston Health Care
1601 Watson Blvd.
Warner Robins, GA 31093
(478) 322-4950
judavis@hhc.org
Suzanne



Howard G. Dawkins *Life*
Aesthetic Plastic Surgery
2577 Stantonsburg Rd.
Greenville, NC 27834
(252) 752-1406
hdawkins@lookasbeautiful.com
Annette



John A. Dean *Active*
Associates in Plastic Surgery
8425 Cumberland Pl.
Baton Rouge, LA 70806
(205) 924-7514
dean@plasticsurgerybr.com



Anthony J. Defranzo *Active*
Wake Forest University
Medical Center Blvd.
Winston Salem, NC
(336) 716-415027157

2015 MEMBER ROSTER



Stephen J. Delatte *Active*
Stephen J. Delatte MD
917 Coolidge Blvd.
Lafayette, LA 70503
(337) 269-4949
Stephen@stephendelatte.com
Gwen



John W. Derr, Jr. *Active*
Plastic and Aesthetic Surgery Specialists
4001 Kresge Way, Suite 320
Louisville, KY 40207
(502) 895-5850
jderr@aesthetics.org



Thomas M. DeWire, Sr. *Active*
Advanced Arts of Cosmetic Surgery
3974 Springfield Rd.
Glen Allen, VA 23060
(804) 290-0200
DrDeWire@comcast.net
Sandra



Jimmy L. Dixon *Life*
101 Virginia St.
St. Simons Island, GA 31522
(912) 258-1724
drjdixon@comcast.net



David B. Drake *Active*
UVA Health Systmes
Box 800376
Charlottesville, VA 22908
(434) 924-2123
DBD9U@virginia.edu



Charles Dupin *Active*
Westbank Plastic Surgery
1111 Medical Center Blvd. South 640
Marrero, LA 70072
(504) 349-6460
cldupinmd@gmail.com



Charles L. Dyas, Jr. *Active*
Charles L. Dyas, Jr. MD
2860 A. Dauphin St.
Mobile, AL 36606
(251) 471-3211
bayareaplasticsu@bellsouth.net
Joyce



Joseph B. Delozier, III *Active*
Delozier Cosmetic Surgery Center
209-23rd Ave. North
Nashville, TN 37203
(615) 565-9000
Jan
carlla@drdelozier.com



Ankit R. Desai *Active*
Florida Plastic Surgery Group
14540 Old St. Augustine Rd., Suite 2391
Jacksonville, FL 32258
(904) 262-3372
ardesaimd@gmail.com



Luis Miguel Diaz *Active*
Michael Diaz MD
970 Tommy Murro Dr., Suite B
Biloxi, MS 39532
(228) 396-2663
lmikediaz@hotmail.com



William L. Dowden *Active*
Dowden Plastic Surgery
715 Shaker Dr., Suite 100
Lexington, KY 40504
(859) 277-9435
WLD@DowdenPlasticSurgery.com
Linda



Deason C. Dunagan *Active*
Dunagan, Yates & Allison Plastic Surgery
Center
303 Williams Ave., Suite 1421
Huntsville, AL 35801
(256) 536-4448
dunagan@dyaplasticsurgery.com



Alan J. Durkin *Active*
Ocean Drive Plastic Surgery
5070 N. Hwy A1A, Suite A
Vero Beach, FL 32963
(772) 234-3700
drdurkin@facebreastandbody.com
Roxanne Engel, PhD



Nathan Bradley Easterlin *Active*
Renew Plastic Surgery
2500 Starling St., Suite 603
Brunswick, GA 31520
easterlin_nb@yahoo.com
Marie

2015 MEMBER ROSTER



Felmont F. Eaves, III *Active*
Emory University
3200 Downwood Circle
Suite 640
Atlanta, GA 30327
(404) 778-6880
feaves@emory.edu



Harry V. Eisenberg *Life*
1506 The Oaks Dr.
Maitland, FL 32751
(407) 539-2223
heisenberg@cfl.rr.com



L. Franklyn Elliott *Active*
Atlanta Plastic Surgery
975 Johnson Ferry Rd. NE, Suite 100
Atlanta, GA 30342
(404) 256-1311
felliott@atplastic.com



O'Neil J. Engeron *Life*
615 Dunn St.
Houma, LA 70360
(985) 868-2320
drengeron@bellsouth.net
Gloria



Walter L. Erhardt, Jr. *Active*
Walter Erhardt MD
Cosmetic, Plastic & Reconstructive
Surgery, 506 4th St.
Albany, GA 31701
(229) 432-9325
erhardtmd@mindspring.com

Heber C. Ethridge *Life*
142 Sundown Rd.
Mason, MS 39110
(601) 856-4525
mbethridge@bellsouth.net
Miriam



James E. Eyssen *Active*
Associates in Plastic & Reconstructive
Surgery, 3404 Navajo Dr.
Chattanooga, TN 37411
(423) 624-0021
belva@aprs.md
Bebbee



Patricia L. Eby *Active*
Cosmetic Surgery Specialists of Memphis
6401 Poplar Ave., Suite 360
Memphis, TN 38119
(901) 752-1412
pleby@earthlink.net



Jay D. Ellenby *Life*
2954-B Aventura Blvd.
Aventura, FL 33180
(305) 933-6033
drellenby@aol.com



Scott J. Engel *Active*
Sarasota Plastic Surgery Center
2255 S. Tamiami Trail
Sarasota, FL 34239
(941) 366-8897
sengelm@yahoo.com



Detlev Erdmann *Active*
Duke University Medical Center
Box 3181
Durham, NC 27710
(919) 684-3320
detlev.erdmann@duke.edu



Benjamin D. Eskra *Active*
Eskra Plastic Surgery
2400 Wayne Memorial Dr., Suite B
Goldsboro, NC 27534
(919) 587-4400
benjamin.eskra@waynehealth.org
Tracy



Christopher Ewart *Active*
Augusta Plastic Surgery Associates
1348 Walton Way, Suite 6300
Augusta, GA 30901
(706) 724-5611
ewart@augplastic.com
Angela



Robert K. Fabric *Life*
3000 Island Blvd., S-323
Aventura, FL 33160
(305) 792-4747
DocFab2000@aol.com

2015 MEMBER ROSTER



Michael A. Fallucco *Active*
Florida Plastic Surgery Group
14540 Old St. Augustine Rd.
Suite 2391
Jacksonville, FL 32258
(904) 262-3372
mfallucco@gmail.com



Mark E. Feldmann, Jr. *Active*
Carilion Clinic and Reconstructive Surgery
3 Riverside Circle
Roanoke, VA 24016
mefeldmann@carilionclinic.org
Kathryn Feldmann



Stephan J. Finical *Active*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
(704) 372-6846
sfinical@charlotteplasticsurgery.com
Maryallys



R. Jobe Fix *Active*
University of Alabama at Birmingham
510 South 20 Street, FOT 1102
Birmingham, AL 35294
(205) 934-3358
jfix@uabmc.edu
Kathleen



Andrew Charles Freel *Active*
Associates in Plastic Surgery
13725 Clarendon Dr.
Baton Rouge, LA 70810
(225) 924-7514
freel@plasticsurgerybr.com



James H. French *Active*
James H. French MD
3299 Woodburn Rd., Suite 490
Annandale, VA 22003
(703) 560-2850
JHF@cpsdocs.com
Kathy



David W. Friedman *Active*
Cleveland Clinic FL
2950 Cleveland Clinic Blvd.
Weston, FL 33331
friedmd@ccf.org
Sherry Friedman



Timothy E. Fee *Active*
Coastal Cosmetic Center
4147 Southpoint Dr. E
Jacksonville, FL 32216
(904) 332-6774
tfee@coastalcosmetic.com



E. Ronald Finger *Life*
Finger & Associates
410 Mall Blvd., Suite E
Savannah, GA 31406
(912) 354-4411
erf110@aol.com
Cheryl



Jack Fisher *Active*
Dr. Jack Fisher
310-23rd Avenue North, Suite 101
Nashville, TN 37203
(615) 329-4227
jfisher@drjackfisher.com
Clare



James L. Fowler *Active*
UMG Plastic Surgery + Aesthetics
200 Patewood Dr., Suite B-480
Greenville, SC 29615
(864) 454-4570
jlfowler@ghs.org



Ronald A. Freeman *Active*
Plastic Surgery Associates of Macon
440 Charter Blvd., Suite 2202
Macon, GA 31210
(478) 474-5700
delores@plastic-surgery-assoc.com
Mary



Harold I. Friedman *Active*
University of South Carolina
2 Medical Park Rd., Suite 302
Columbia, SC 29203
(803) 545-5800
HFriedmanDr@sc.rr.com
Clarke



John C. Frist *Life*
146 Ensworth Ave.
Nashville, TN 37205
(615) 385-0177
jfrist@comcast.net
Jennifer

2015 MEMBER ROSTER



Leonard T. Furlow, Jr. *Life*
3001 NW 28th Terrace
Gainesville, FL 32605
lfurlow@cox.net
Libby



Tom T. Gallaher *Active*
Gallaher Plastic & Reconstructive Surgery
PO Box 51866
Knoxville, TN 37950
(865) 671-3888
tgall82797@aol.com



Thomas J. Gampfer *Active*
University of Virginia Health Systems
Box 800376
Charlottesville, VA 22908
(434) 924-5068
tjg6f@virginia.edu
Cynthia



Robert Garza *Active*
Garza Plastic & Reconstructive Surgery
4322 Harding Rd.
Suite 326
Nashville, TN 37205
(615) 620-7800
rgarza@garzasurgery.com



Stanley B. Getz, Jr. *Active*
CMC Cosmetic & Plastic Surgery
1025 Morehead Medical Dr., Suite 300
Charlotte, NC 28204
(704) 446-6810
stanley.getz@carolinashealthcare.org
Claudette Talior



Kenna S. Given *Active*
Kenna S. Given, MD PC
748 Tripps Ct.
Augusta, GA 30909
(706) 721-2198
cgiven@comcast.net



Neumon T. Goshorn *Active*
Goshorn Aesthetic Clinic
1044 Brookfield Rd., Suite 102
Suite 102
Memphis, TN 38119
(901) 682 4456
neumon6@gmail.com



Gregory C. Gaines *Active*
Gaines Plastic Surgery
108 NW 76th Dr., Suite A
Gainesville, FL 32607
(352) 333-9600
gcegaines@hotmail.com



G. Mabel Gamboa *Active*
Georgia Regents University
Section of Plastic Surgery
1467 Harper St HB-5040
Augusta, GA 30912
(706) 721-6863
mgamboa@gru.edu



Onelio Garcia, Jr. *Active*
Aesthetic Plastic Surgery Miami
3850 Bird Rd., Suite 102
Miami, FL 33146
(305) 448-8900
ogarciamd@aol.com
Susan



Timothy J. Germain *Active*
Germain Plastic Surgery
1355 Beverly Rd., Suite 200
McLean, VA 22101
(703) 442-8040
GermainPlasticSurgery@gmail.com
Jennifer McQuade, MD



Bahair H. Ghazi *Active*
Atlanta Plastic & Reconstructive
Specialists
5673 Peachtree Dunwoody Rd., Suite 870
Atlanta, GA 30342
(404) 255-2975
bahair@gmail.com



R. Cole Goodman *Life*
Mercy Clinic of Fort Smith
7409 Rivercrest Cir.
Fort Smith, AR 72903
(479) 314-4713
coleg1@sbcglobal.net



Sutton L. Graham, II *Active*
Aesthetic Center for Breast & Cosmetic
Surgery
615 Halton Rd.
Greenville, SC 29607
(864) 676-1707
aesthctr@earthlink.net

2015 MEMBER ROSTER



Braun H. Graham *Active*
Sarasota Plastic Surgery
2255 South Tamiami Trail
Sarasota, FL 34239
(941) 366-8897
bgraham1550@gmail.com
Jeanne



John M. Griffin *Active*
Center for Plastic Surgery
365 East Paces Ferry Rd.
Atlanta, GA 30305
(404) 814-1000
jmg367@comcast.net



James C. Grotting *Active*
Grotting & Cohn Plastic Surgery
One Inverness Center Pkwy., Suite 100
Birmingham, AL 35242
(205) 930-1600
jcgrotting@gmail.com
Ann



Cesar A. Gumucio *Active*
Cesar A. Gumucio MD PC
489 N Milledge Ave.
Athens, GA 30601
(706) 613-6650
cesgumucio@aol.com



Josef Hadeed *Active*
Josef Hadeed MD
Center for Plastic and Reconstructive
Surgery
8929 Wilshire Blvd., Suite 425
Beverly Hills, CA 90211
hadeedmd@gmail.com



Kevin F. Hagan *Active*
Vanderbilt University Medical Center
1161-21st Ave. South, D-4207 MCN
Nashville, TN 37232
(615) 936-0160
kevin.hagan@vanderbilt.edu
Janie



Peter C. Haines *Active*
Center for Plastic Surgery
7033 St. Andrews Rd., Suite 204
Columbia, SC 29212
(803) 732-5788
pchaines@gmail.com
Marguerite



Byron E. Green *Life*
4 Rose Ave.
Mobile, AL 36608
(251) 980-1317
begscg@gulfnet.com
Sally



Lawrence R. Gross *Active*
Southern Crescent Plastic Surgery
919 Eagles Landing Pkwy.
Stockbridge, GA 30281
(770) 389-0446
scps919@aol.com
Alice



Charles Gruenwald, Jr. *Life*
Charles Gruenwald MD
4309 Bluebonnet Blvd.
Baton Rouge, LA 70809
(225) 925-3140
cgmd@drgruenwald.com
Stacy



Roxanne J. Guy *Active*
Brevard Plastic Surgery & Skin Treatment
Center, 111 East Hibiscus Blvd.
Melbourne, FL 32901
(321) 727-1600
rguy@cfl.rr.com
Curt

George J. Haedicke *Life*
4600 N. Habana, Suite 22
Tampa, FL 33614
(813) 874-7529
George.Haedicke@va.gov



Richard C. Hagerty *Active*
Charleston Plastic Surgery
261 Calhoun St., Suite 200
Charleston, SC 29401
(843) 722-1985
cpspa@bellsouth.net
Barbara



John M. Hamilton *Life*
300 Beach Dr. NE
Unit 2302
St. Petersburg, FL 33701
(727) 822-1887

2015 MEMBER ROSTER



Michael Stephen Hanemann, Jr. *Active*
Hanemann Plastic Surgery
5233 Dijon Dr.
Baton Rouge, LA 70808
(225) 766-2166
mshanemann@yahoo.com



Michael Andrew Harrington *Active*
University of South Florida
2 Tampa General Circle
Suite G215
Tampa, FL 33606
michaelharringtonmd@gmail.com
Christi

John H. Hartley *Life*
1184 E. Rochester Dr.
Cashiers, NC 28717
(828) 743-7223
mtmnnanc@hotmail.com
Kathy



Kent Victor Hasen *Active*
Aesthetic Plastic Surgery of Naples
4081 Tamiami Trail N., C203
Naples, FL 34103
(239) 262-5662
drhasen@drhasen.com
Dellene Marie Hasen



Daniel F. Haynes *Active*
East Tennessee State University
PO Box 70575
Johnson City, TN 37614
(423) 439-6771
haynesd@etsu.edu
Mimi



Darrell L. Henderson *Active*
Plastic Surgery Associates
1101 S College Rd., Suite 400
Lafayette, LA 70503
plasticsx@aol.com



Rhett C. High *Active*
Raleigh Plastic Surgery Center
1112 Dresser Ct.
Raleigh, NC 27609
(919) 872-2616



Larry Harper *Active*
Tallahassee Plastic Surgery Clinic
2452 Mahan Dr., Suite 101
Tallahassee, FL 32308
(850) 877-2126



John B. Harris *Active*
John B. Harris MD
1030 North A1A
Ponte Vedra Beach, FL 32082
(904) 285-7202
info@johnbharrismd.com



Tracy Harvey *Active*
Charleston Plastic Surgery
261 Calhoun Street
Suite 200
Charleston, SC 29401
(843) 722-1985
t_harvey1@yahoo.com



Cauley W. Hayes *Life*
Hayes Hand Center
979 E. Third St., Suite 900
Chattanooga, TN 37403
(423) 265-7414
papadocx@gmail.com



William J. Hedden *Active*
Hedden Plastic Surgery
140 Village St., Suite 100
Birmingham, AL 35242
(205) 980-1744
bill@heddenmd.com
Patricia Shea



Kent Higdon *Active*
Vanderbilt Medical Center
1161-21st Avenue South D-4207
Nashville, TN 37232
(615) 936-3364
kent.higdon@vanderbilt.edu
Elizabeth



Charles H. Hill *Life*
1332 S. Lake Shore Dr.
Sarasota, FL 34231
(941) 924-3180
chill01@verizon.net

2015 MEMBER ROSTER



Stanley M. Hirschberg *Life*
Winchester Plastic Surgery Specialists
3034 Valley Ave., Suite 100
Winchester, VA 22601
(540) 465-5005
smh@shentel.net



Roy Hobbs *Active*
Precision Plastic Surgery
2995 Reidville Rd., Suite 150
Spartanburg, SC 29301
(864) 641-1491
drhobbs@gmail.com
Esther Hobbs



Howard Holderness, Jr. *Life*
North Carolina Plastic Surgery Center
1126 N. Church St., Suite 101
Greensboro, NC 27415
(336) 275-0919
angie@ncplasticcenter.net
Mary Dare



Arden L. Hothem *Life*
999 East Lake Dr.
Gainesville, GA 30506
(770) 536-5354
ahothem@charter.net



George Eli Howell, II *Active*
Mississippi Premier Plastic Surgery
971 Lakeland Dr., Suite 315
Jackson, MS 39216
(601) 981-2525
gehowell2@msn.com



David H. Humphreys *Active*
Plastic Surgery Center
5 Livingston St.
Asheville, NC 28801
(828) 253-3866
drhumphreys@thepsc.org



Michael E. Jabaley *Life*
Plastic & Hand Surgery Associates
2550 Flowood Dr., Suite 200
Madison, MS 39110
(601) 939-9999
mjabaley@phsa-ms.com
Mary



Joseph J. Hirschfeld *Active*
Bay Area Cosmetic Surgical Center
3000 E Fletcher Ave., Suite 260
Tampa, FL 33613
(813) 972-2299
hirschfeldmd@aol.com



William F. Hogan *Life*
3542 Par Ln.
Titusville, FL 32780
(321) 264-8645
billhoganmd@gmail.com



Scott T. Hollenbeck *Active*
Duke University Medical Center
DUMC 3945
Durham, NC 27710
(919) 681-5079
scott.hollenbeck@duke.edu



Paul S. Howard *Active*
Dr. Paul S. Howard Plastic Surgeon
PO Box 660180
Birmingham, AL 35266
(205) 871-3361
drfacelift@aol.com



Charles Scott Hultman *Active*
University of North Carolina Chapel Hill
7038 Burnett-Womack Bldg, CB#7195
Chapel Hill, NC 27599
(919) 966-2300
cshult@med.unc.edu
Suzanne



J. Robert Israel *Life*
65 Spring Hollow Ln.
Fairview, NC 28730
jrobertisrael@aol.com
Chris



A. Dean Jabs *Active*
Cosmetic Surgery Associates
1515 Chain Bridge Rd.
McLeran, VA 22101
(703) 506-0683
jabs@cosmeticplastics.com

2015 MEMBER ROSTER



Ashish K. Jain *Active*
Jain Plastic Surgery
2522 Warm Springs Rd.
Columbus, GA 31904
(706) 322-9313
ajjain98@hotmail.com



George Russell Jennings *Active*
Shoals Plastic Surgery
203 West Avalon Ave.
Suite 300
Muscle Shoals, AL 35661
russj73@yahoo.com
Brandy



Roxanne Johnson-Giebink *Active*
Brevard Plastic Surgery & Skin Treatment
Center
1033 S Florida Ave.
Rockledge, FL 32955
(321) 632-0416
James

Young S. Kang *Life*
1515 Deyerle Rd. SW
Roanoke, VA 24018
yskang@cox.net
Betty



Fred B. Kaserman *Life*
3860 Lakeland Dr.
Lenoir City, TN 37772
(865) 694-9886
fredkaserman@gmail.com
Dickie



Carmen Kavali *Active*
Kavali Plastic Surgery
6045 Barfield Rd., Suite 100
Atlanta, GA 30328
(404) 250-3333
erik@drkavali.com



James E. Kelly, III *Active*
Western Arkansas Plastic, Hand and
Reconstructive Surgery Center
PO Box 10810
Fort Smith, AR 72917
(479) 709-8300
jpkelly3@aol.com



Sonu A. Jain *Active*
Ohio State University
915 Olentangy River Rd., Suite 3200
Columbus, OH 43212
(614) 366-0119
sonu.jain@osumc.edu



Ronald J. Johnson *Active*
Wolf River Plastic Surgery
7910 Wolf River Blvd.
Germantown, TN 38138
(901) 737-1050
drjohnson@cosmedex.com



Ram Kalus *Active*
Plastic Surgery of the Carolinas
578 Lone Tree Dr., Suite 102
Mount Pleasant, SC 29464
(843) 881-3881
rkalus1@mac.com



Raymond S. Kaplan *Life*
18 Rutledge Ave.
Charleston, SC 29401
(843) 958-8877
ray.kaplan@yahoo.com
Lynn Bowley



Adam J. Katz *Active*
University of Florida
PO Box 100138
Gainesville, FL 32610
(352) 273-8670
adam.katz@surgery.ufl.edu



Kevin M. Keller *Active*
Upstate Plastic Surgery
301 The Parkway
Greenville, SC 29650
(864) 968-0168
jroberts@upstateplasticsurgery.com
Tamela



Kevin J. Kelly *Active*
Vanderbilt University Medical Center
D-4207 Medical Center North
Nashville, TN 37232
(615) 936-0160
kevin.kelly@vanderbilt.edu
Jana

2015 MEMBER ROSTER



J. Woodfin Kennedy *Active*
The Plastic Surgery Group
979 E. 3rd St., C #920
Chattanooga, TN 37403
davisj@thepsg.org
Carrie Kennedy



Gilson J. Kingman *Active*
Forsyth Plastic Surgery
2901 Maplewood Ave.
Winston-Salem, NC 27103
(336) 765-8620
drkingman@forsythplasticsurgery.com



David S. Kirn *Active*
David S. Kirn MD
2376 Alexandria Dr.
Lexington, KY 40504
(859) 296-3195
kirn@kirnplasticsurgery.com



Robert J. Knowling *Active*
The Cosmetic Sugery Center of Huntsville
4011 Balmoral Dr. SW
Huntsville, AL 35801
(256) 881-4212
robertknowling@comcast.net



Phillip Limbaugh Lackey *Active*
Bellefonte Cosmetic & Reconstructive
Surgery
1000 Ashland Dr., Suite 303
Ashland, KY 41101
pllackey@gmail.com



F. True Lansden *Active*
Coastal Islands Cosmetic and
Reconstructive Surgery, 537 NW Lake
Whitney Pl., Suite 101
Port St. Lucie, FL 34986, (772) 204-8870
flansden@comcast.net
Lisa



Stephen M. Lazarus *Active*
Aesthetic Plastic Surgery Associates
801 Weisgarber Rd., NW, Suite 500
Knoxville, TN 37909
(865) 588-1662
lazdoc@comcast.net
Holy



Mary Kim *Active*
LSU Health Sciences Center
1501 Kings Hwy.
PO Box 33932
Shreveport, LA 71130
(318) 675-6154
mkim@lsuhsc.edu



Elizabeth A. Kinsley *Active*
Elizabeth A. Kinsley MD
1441 Ochsner Blvd.
Covington, LA 70433
(985) 893-3737
info@doctorkinsley.com
Roger Vitter, DMD



Wendell H. Kisner *Life*
16025 Highland Bluff Ct.
Baton Rouge, LA 70810
kisner@cox.net
Jane



Robert E. Knowling *Life*
12231 South Fox Den Dr.
Knoxville, TN 37934
ejknowling@charter.net
Jamie



William A. Lambeth, III *Life*
Lambeth Plastic Surgery and Aesthetics
4201 Lake Boone Tr., Suite 103
Raleigh, NC 27607
(919) 782-1818
wlambeth@nc.rr.com
Diane



Robert A. Laughlin *Life*
Hilton Head Island Plastic Surgery
Island Medical Plaza
35 Bill Fries Dr., Bldg. E
Hilton Head, SC 29926
(843) 681-4088, boblaugh@aol.com
Linda



Mark H. Leech *Active*
Chattanooga Plastic Surgery
1616 Gunbarrel Rd., Suite 103
Chattanooga, TN 37421
(423) 826-8200
mhltn@aol.com
Linda

2015 MEMBER ROSTER



Todd S. Lefkowitz *Active*
Lexington Plastic Surgery
2728 Sunset Blvd., Suite 105
West Columbia, SC 29169
(803) 730-8178
tslefkowitz@lexhealth.org



Ashley K. Lentz *Active*
University of Florida
PO Box 100138
1600 SW Archer Rd.
Gainesville, FL 32610
(352) 256-4208
lentz@surgery.ufl.edu



John T. Lettieri *Active*
Carolina Plastic Surgery
100 E Wood St., Suite 100
Spartanburg, SC 29306
(864) 583-1222
jtl2@bellsouth.net
Evelyn



George A. Levine *Life*
8700 N. Kendall Drive, Suite 102
Miami, FL 33176
(305) 279-1532
georgealevine@aol.com
Jean



Kant Lin *Active*
University of Virginia
1105 Hilltop Rd.
Charlottesville, VA 22903
(434) 960-6650
kyl5s@virginia.edu



William C. Lineaweaver *Active*
Joseph M Still Burn and Reconstructive Ctr
Suite 1427 North Tower, 4 West, 1850
Chadwick Dr., Jackson, MS 39204
(601) 824-3977
william.lineaweaver@jmsburncenters.com



Albert Losken *Active*
Emory Healthcare
550 Peachtree St., Suite 9000
Atlanta, GA 30308
(404) 686-8143
alosken@emory.edu



Carl W. Lentz, III *Active*
Lentz Plastic Surgery
1040 W. International Speedway Blvd.
Daytona Beach, FL 32114
(386) 252-8051
cwleintz@mac.com



E. Dwayne Lett *Active*
The Lett Center
660 S. Mount Juliet Rd., Suite 210
Mount Juliet, TN 37122
(615) 443-0901
lett6@hotmail.com
Donna



Jocelyn Leveque *Active*
Jocelyn E. Leveque MD PA
543-A Fontaine St.
Pensacola, FL 32503
(850) 476-3223
leveque1@gcps.gccoxmail.com
Brett Sullivan



Howard Levinson *Active*
Private Diagnostic Clinic
Duke University
BOX 3181
Durham, NC 27710
howard.levinson@duke.edu



John T. Lindsey *Active*
East Jefferson General Hospital
4228 Houma Blvd., Suite 500
Metairie, LA 70006
(504) 885-4508
jlindseyplassurg@aol.com
Jeannine



James N. Long *Active*
University of Alabama at Birmingham
Faculty Office Tower, Suite 1160
510 20th Street South
Birmingham, AL 35294
(205) 934-3312
jnlong@uabmc.edu



Maria LoTempio *Active*
LoTempio Plastic Surgery for Women
630 Third Ave., Suite 601
New York, NY 10017
(212) 427-2020
mmlotempio@gmail.com

2015 MEMBER ROSTER



Edward J. Love *Active*
The Plastic Surgery Institute
One Lile Ct., Suite 100
Little Rock, AR 72205
(501) 224-1859
cami@edwardjlovemd.com
Cami



Edward A. Luce *Active*
University of Tennessee Health Science
Center
Memphis, TN
(901) 761-9030
edluce@yahoo.com
Karen Quigley M.D.



W. Glenn Lyle *Active*
Raleigh Plastic Surgery Center
1112 Dresser Ct.
Raleigh, NC 27609
(919) 872-2616
drwglyle@aol.com
Elizabeth



James J. Madden, Jr. *Active*
Vanderbilt University Medical Center
1161-21st Ave., D-4207 MCN
Nashville, TN 37232
(615) 936-0160
angelene.timbs@vanderbilt.edu



Dev A. Manisundaram *Active*
Plastic & Hand Surgery Associates
2550 Flowood Dr., Suite 200
Flowood, MS 39232
(601) 939-9999
bjones@phsa-ms.com
Brinda



Malcolm W. Marks *Active*
Wake Forest University
Medical Center Blvd.
Winston Salem, NC 27157
(336) 748-4172
mmarks@wfubmc.edu
Sharon



Bruce A. Mast *Active*
University of Florida Plastic Surgery
PO Box 100138, 1600 SW Archer Rd.
Gainesville, FL 32610
(352) 273-8670
bruce.mast@surgery.ufl.edu
Lynn Findley



James E. Lovett, III *Active*
Upstate Plastic Surgery
301 The Parkway
Greer, SC 29650
(864) 968-0168
jelovett@upstateplasticsurgery.com
Jill



Martin J. Luftman *Life*
Plastic Surgery Associates, Martin J.
Luftman MD
1401 Harrodsburg Rd., Suite B-360
Lexington, KY 40504
(859) 278-8504
mluftman@gmail.com



Billy P. Lynn *Active*
Augusta Plastic Surgery Associates
4350 Towns Centre Dr., Suite 1400
Evans, GA 30809
(706) 651-8400
cindy.wolfe@srplasticsurgery.net
Sandra



R. Kevin Majzoub *Active*
Louisville Plastic Surgery Consultants
6440 Dutchman's Pkwy., Suite 210
Louisville, KY 40205
(502) 899-9996
rkmajzoub@louisvillePSC.com



Jeffrey R. Marcus *Active*
Duke University Medical Center
200 Trent Dr., Box 3974
Durham, NC 27710
(919) 668-3110
jeffrey.marcus@duke.edu



Hamid Massiha *Life*
Massiha Plastic Surgery Center
One Park Island Dr.
New Orleans, LA 70122
(504) 282-4949
massihamd@aol.com



Carlos Mata *Active*
Carlos Mata MD
2310 West Ray Rd.
Chandler, AZ 85224
(480) 686-8121
camata22@gmail.com

2015 MEMBER ROSTER



David C. Matthews *Active*
David Matthews MD PA
1719 South Blvd., Suite B
Charlotte, NC 28203
(704) 375-2955
cathyearp@davidmatthewsmd.com
Susan



Nathan Mayl *Life*
Suria Plastic Surgery
411 N. New River Dr. East, Unit 3301
Ft. Lauderdale, FL 33301
(954) 491-6191
nathanmayl@hotmail.com
Eileen



James M. McDonough *Active*
Asheville Plastic Surgery
5 Livingston at Victoria
Asheville, NC 28801
(828) 254-1234
jmcndonough@avplasticsurgery.com
Judy



Benjamin Clayton McIntyre *Active*
Plastic Surgery Consultants
1220 Blanding St.
Columbia, SC 29201
(803) 779-1200
benmcintyre@gmail.com



Charles A. McLaughlin, Jr. *Active*
Charles A. McLaughlin MD PA
Plastic & Reconstructive Surgery
2727 W. MLK Blvd., Suite 510
Tampa, FL 33607
(813) 879-8358
drmcLaughlin@tampabay.rr.com

John W. Menard *Active*
Menard Plastic Surgery
401 Town Center Blvd., Suite B
Tuscaloosa, AL 35406
(205) 391-9038
johnmenard@gmail.com
Debbie



Schuyler Metlis *Active*
Hannibal Regional Medical Group
6500 Hospital Dr.
Hannibal, MO 63401
(573) 629-3500
scm49@aol.com
Laurie



G. Patrick Maxwell *Active*
Maxwell Aesthetics Plastic and
Reconstructive Surgery, 2020 Twenty First
Ave. South, Nashville, TN 37212
(615) 932-7700
gpm@maxwellaesthetics.com
Stephanie



John B. McCraw *Life*
University of Mississippi Medical Center
2500 North State St.
Jackson, MS 39216
(601) 815-1313
johnmccraw@yahoo.com
Cynthia



Thomas C. McFadden, Jr. *Active*
Advanced Cosmetic Surgery
29 Rocky Slope Rd.
Greenville, SC 29607
(864) 242-3223
myplasticsurgeon@yahoo.com
Catherine



David McKee *Active*
David E. McKee MD
3443 Dickerson Pike, Suite 740
Nashville, TN 37207
(615) 868-4091
demckee@comcast.net



Christopher L. McLendon *Active*
Renaissance Plastic Surgery
200 Westpark Dr., Suite 200
Peachtree City, GA 30269
(770) 450-1245
cmclendon@rpsmd.com
Melinda



Wyndell H. Merritt *Life*
Wyndell H. Merritt MD FACS
7660 E Parham Rd., Suite 200
Henrico, VA 23294
(804) 282-2112
wyndell@hotmail.com



Stephen E. Metzinger *Active*
Aesthetic Surgical Associates
3223 Eighth St., Suite 200
Metairie, LA
(504) 309-7061
metzingermd@cox.net

2015 MEMBER ROSTER



Timothy J. Mickel *Active*
Mickel Plastic Surgery
903 North Second St.
Monroe, LA 71201
(318) 388-2050
tmickel@gmail.com
Stephanie



Cynthia L. Mizgala *Active*
A Woman Plastic Surgeon
4720 South I-10 Service Rd. West
Suite 105
Metairie, LA 70001
(504) 885-4515
redspa504@gmail.com



Christian Mogelvang *Life*
Naples Plastic Surgery
PO Box 3316
Naples, FL 34106
(239) 643-0566
cmogelvang@earthlink.net
Sandy



J. Michael Moore *Active*
Plastic Surgeons of Lexington
1401 Harrodsburg Rd., Suite B488
Lexington, KY 40504
(859) 276-3883
mmoree@plasticsoflex.com
Diana



James L. Moore *Life*
Athens Regional Medical Center
1199 Prince Ave.
Athens, GA 30606
(706) 475-2299
jlmoore@armc.org



Gerard C. Mosiello *Active*
Tampa Palms Plastic Surgery
15243 Amberly Dr.
Tampa, FL 33647
(813) 631-1500
jerry@tampapalmsplasticsurgery.com



Mirsad Mujadzic *Active*
Georgia Regents University
1467 Harper St., Bldg HB-5040
Augusta, GA 30912
mmujadzic@gru.edu
Erimina



Robert Alan Miller *Active*
Aesthetic & Reconstructive Surgery
105 Collier Rd., Suite 3010
Atlanta, GA 30309
rmillerram@aol.com
Dana Snyder Miller



David L. Mobley *Active*
Sarasota Plastic Surgery
2255 S. Tamiami Trail
Sarasota, FL 34239
(941) 366-8897
dmobley@sarasotaplasticsurgery.com
Margaret



Andrew M. Moore, II *Active*
Plastic Surgeons of Lexington
1401 Harrodsburg Rd., Suite B488
Lexington, KY 40504
(859) 276-3883
kfarrer@plasticsoflex.com



Charles E. Moore *Life*
Charles E. Moore MD
1210 Miccosukee Rd.
Tallahassee, FL 32308
(850) 878-5184
cmoore5186@aol.com
Lynn



Martin A. Morse *Active*
Morse Hand and Plastic Surgery
10132 Colvin Run Rd., Suite F
Great Falls, VA 22066
(703) 757-6190
mamorsemd@gmail.com



Kurtis Eugene Moyer *Active*
Carillon Clinic
Riverside 3, Suite 400
Roanoke, VA 24016
kurtismoyer@yahoo.com



William F. Mullis *Life*
William F. Mullis MD
2410 Roswell Ave., Suite 301
Charlotte, NC 28209
(704) 343-2006
billmullis@me.com
Linde

2015 MEMBER ROSTER



J. Garnett Murphy *Life*
Defy Gravity
1000 Brookfield, Suite 100
Memphis, TN 38119
(901) 765-4700
Leslie



Foad Nahai *Life*
Emory Aesthetic Center
3200 Downwood Circle, Suite 640
Atlanta, GA 30327
(404) 351-0051
nahaimd@aol.com



Vincent Naman *Active*
Chattahoochee Plastic Surgery
2430 Brookstone Centre Pkwy.
Columbus, GA 31904
dian@chatplasticsurgery.com
Dian Naman



Gregory Christopher Neil *Active*
Atlantic Surgical Associates
500 S. Andrews Ave., Suite 2266
Pompano Beach, FL 33069
gcneil@yahoo.com
Carolyn Neil



Martin I. Newman *Active*
Cleveland Clinic FL
2950 Cleveland Clinic Blvd.
Weston, FL 33331
(954) 659-5212
newmanm@ccf.org



Phillip H. Nunnery *Active*
Phillip H. Nunnery MD
1936 Jenks Ave
Panama City, FL 32405
(850) 763-5959
phillipnunnery@gmail.com



John J. Obi *Life*
Jacksonville Plastic Surgery
3599 University Blvd. South, Suite 1600
Jacksonville, FL 32216
(904) 346-0060
drjjobi@aol.com



Farzad R. Nahai *Active*
Dr. Farzad R. Nahai Plastic Surgery
875 Johnson Ferry Rd. NE, Suite 300
Atlanta, GA 30342
(404) 257-9933
drnahai@gmail.com
Dana



Raja Nalluri *Active*
Nalluri Plastic Surgery
6118 S Tamiami Trail
Sarasota, FL 34231
(941) 752-7842
raja@nalluri.com



James D. Namnoum *Active*
Atlanta Plastic Surgery
975 Johnson Ferry Rd. NE, Suite 100
Atlanta, GA 30342
(404) 256-1311
jdnamnoum@atlplastic.com
Anne



Richard L. Nesmith *Active*
Gainesville Florida Plastic Surgery
6801 NW 9th Blvd., Suite 2
Gainesville, FL 32605
(352) 331-3401
connie@drnesmith.cfcoxmail.com



R. Thomas Noel *Active*
Associates in Plastic Surgery
4001 Kresge Way, Suite 220
Louisville, KY 40207
(502) 895-5466
tritomride@aol.com



Seung-Jun O *Active*
Dr. Seung-Jun O MD FACS
966 Houston Northcutt Blvd.
Suite H
Mount Pleasant, SC 29464
(843) 856-1766
doctoro@droplasticsurgery.com



Stanley A. Okoro *Active*
Georgia Plastic & Reconstructive Surgery
P O Box 388
Smyrna, GA 30081
drokoro@georgiaplastic.com
Aggie Okoro

2015 MEMBER ROSTER



Patrick J. O'Neill *Active*
O'Neill Plastic Surgery
245 Seven Farms Dr., Suite 210
Daniel Island, SC 29492
(843) 792-5346
oneillpj@oneillplasticsurgery.com



Hermann K. Orlet *Life*
JMS Burn Centers
3510 Turnberry Ln.
Martinez, GA 30907
(706) 863-9595
orlet15@comcast.net
Marianne



Richard F. Ott *Life*
Richard Ott Plastic Surgery
3536 N. Federal Hwy., Suite 100
Ft. Lauderdale, FL 33308
(954) 564-2800
rfomd@aol.com
Wanda



William Leonard Overstreet, III *Active*
Blue Ridge Plastic Surgery
420 Fifth Ave. West
Suite 300
Hendersonville, NC 28739
(828) 697-3553
wloiii63@aol.com



Ann K. Passmore *Active*
Cooper Clinic
3017 South 70th St., Suite G
Fort Smith, AR 72903
(479) 484-4750
apassmore@cooperclinic.com
Powell



Warren R. Patterson *Life*
309 Windemere Woods Dr.
Nashville, TN 37215
(615) 415-3514
wpmd01@gmail.com



Galen Perdakis *Active*
Mayo Clinic
4500 San Pablo Rd.
Jacksonville, FL 32224
(904) 953-2073
perdikis.galen@mayo.edu



Thomas W. Orcutt *Life*
PO Box 425
494 Rendezvous Rd.
Winthrop, WA 98862
(509) 996-4415
barona36@yahoo.com



Michael James Orseck *Active*
Michael J. Orseck MD
391 Serpentine Dr., Suite 250
Spartanburg, SC 29303
morseck@srhs.com
Jennifer



Kitti K. Outlaw *Active*
Outlaw Plastic Surgery
3290 Dauphin St., Suite 204
Mobile, AL 36606
(251) 471-3671
kkoutlaw@hotmail.com
Laurie



Alfredo Paredes *Active*
Tallahassee Plastic Surgery Clinic
2452 Mahan Dr., Suite 101
Tallahassee, FL 32308
(850) 877-2126
paredesmd@earthlink.net



Nathan W. Patterson *Active*
Patterson Plastic Surgery
1040 Gulf Breeze Pkwy., Suite 207
Gulf Breeze, FL 32561
(850) 934-3756
drp@pattersonplastics.com



Richard A. Pecunia *Active*
Hattiesburg Clinic Plastic Surgery
421 South 28th Ave., Suite 110
Hattiesburg, MS 39401
(601) 261-3690
rapmd@comcast.net



Jaime Perez *Active*
Plastic Surgery Center of Tampa
307 S Macdill Ave.
Tampa, FL 33609
(813) 877-3739
jperezmdpa@aol.com

2015 MEMBER ROSTER



Myron M. Persoff *Life*
Myron M. Persoff MD
3659 S. Miami Ave., Suite 4006
Miami, FL 33133
(305) 858-5255
drpersoff@drpersoff.com



Kendall K. Peters *Active*
Center for Plastic & Reconstructive
Surgery
801 N. Orange Ave., Suite 815
Orlando, FL 32801
(407) 898-1436
kendallpeters@yahoo.com



F. Leigh Phillips, III *Active*
Dr. F. Leigh Phillips, III
Cosmetic Surgery and Spa
2855 University Dr., Suite 400
Coral Springs, FL 33065
(954) 344-4344
flpmd@bellsouth.net



Richard A. Pollock *Active*
Dr. Richard Pollock MD
P.O. Box 20404
Saint Simons Island, GA 31522
(859) 494-9811
dpollock@mcpollock.com
Janice



John S. Poser *Active*
John S. Poser MD PA
12921 SW First Rd., Suite 219
Tioga, FL 32669
(352) 372-3672
info@posermc.com
Janice



Roy Powell, Jr. *Active*
Renaissance Plastic Surgery
4030 Riverside Park Blvd.
Macon, GA 31210
(478) 474-2200
rpowell@rpsmd.com



Jason N. Pozner *Active*
Sanctuary Plastic Surgery
4800 North Federal Hwy., Suite C-101
Boca Raton, FL 33431
jpoznermd@gmail.com
Larissa



Calvin R. Peters *Active*
Center for Plastic & Reconstructive
Surgery
801 N. Orange Ave., Suite 815
Orlando, FL 32801
(407) 898-1436
calpetersmd@bellsouth.net



Mark H. Peters *Active*
Dr. Mark H. Peters
181 Corporate Dr.
Houma, LA 70360
(985) 223-2602
lacosmeticdoc@comcast.net
Michelle



Anthony J. Pizzo *Life*
Skin Savvy Rx
455 Marmora Ave.
Tampa, FL 33606
(813) 870-9000
ajpizzomd@gmail.com



Norton A. Pope *Life*
76 Robinwood Dr.
Little Rock, AR 72227
(501) 225-9238
Jerry



Edwin C. Pound, III *Active*
Edwin C. Pound, III MD PC
993-C Johnson Ferry Rd., Site 210
Atlanta, GA 30342
(404) 256-1400
wpound@aol.com



Andrea L. Pozez *Active*
VCU Division of Plastic Surgery
1200 East Broad St.
Box 980154
Richmond, VA 23298
apozez@vcu.edu



Jeremy W. Pyle *Active*
Davis & Pyle Plastic Surgery
1112 Dresser Ct.
Raleigh, NC 27609
(919) 872-2616
jwpyle@gmail.com
Meghan

2015 MEMBER ROSTER



Karen K. Quigley *Active*
The Plastic Surgery Group of Memphis
80 Humphreys Center Dr., Suite 100
Memphis, TN 38120
(901) 761-9030
kquigley@memphisplasticsurgery.com
Ed Luce, M.D.



David B. Reath *Active*
David B. Reath MD
109 Northshore Dr., Suite 101
Knoxville, TN 37919
(865) 450-9253
drreath@dbreath.com
Lisa



Ann Ford Reilley *Life*
Associates in Plastic Surgery
18425 S. Mission Hills Ave.
Baton Rouge, LA 70810
(225) 924-7514
reilley@plasticsurgerybr.com
Brody Saxon



William L. Reno, III *Active*
Plastic Surgery Center of Hattiesburg
40 Franklin Rd.
Hattiesburg, MS 39402
(601) 296-3405
brenomd@hotmail.com



Sam W. Richwine, Jr. *Life*
Northeast Georgia Plastic Surgery
Associates
1296 Sims St., Suite B
Gainesville, GA 30501
(770) 534-1856
srichwinejr@charter.net



Francis 'Frank' W. Rieger *Active*
Hyde Park Cosmetic Surgery Center
607 South Magnolia Ave.
Tampa, FL 33606
(813) 254-7600
friegermd@gmail.com
Carla



Chadwell M. Robbins *Active*
Robbins Plastic Surgery
2201 Murphy Ave., Suite 307
Nashville, TN 37203
(615) 401-9454
chad.robbins@robbinsplasticsurgery.com
Elizabeth



Richard F. Radocha *Active*
Gessler Clinic
635 First St. North
Winter Haven, FL 33881
(863) 298-3275
drbbr1@aol.com



David S. Reid, IV *Active*
Hilton Head Island Plastic Surgery
35 Bill Fries Dr., Bldg E
Hilton Head, SC 62269
(843) 681-4088
rejuvin8r@aol.com



Andre J. Renard *Life*
Parkway Plastic Surgeons
2401 University Pkwy., #204
Sarasota, FL 34243
(941) 351-6131
renarddd@aol.com
Carol



Daniel Q. Richardson *Active*
Gulf Coast Plastic Surgery
390 Courthouse Rd.
Gulfport, MS 39507
(228) 897-1400
danielrichardson@bellsouth.net
Courtney



Ronald Riefkohl *Active*
Duke Regional Hospital
110 E. Carver St.
Durham, NC 27704
(919) 471-1880
rriefkohl@hotmail.com
Nancy



Brian D. Rinker *Active*
University of Kentucky
740 S. Limestone Kentucky Clinic, K454
Lexington, KY 40536
(859) 323-5887
brink2@email.uky.edu
Carmina



Lawrence B. Robbins *Life*
2600 Island Blvd.
Suite 1704
Aventura, FL 33160
lbrobbinsmd@aol.com
Marjorie

2015 MEMBER ROSTER



J. Douglas Robertson *Active*
Plastic Surgery Associates of Montgomery
6727 Taylor Ct.
Montgomery, AL 36117
(334) 284-2800
janet@psaom.com
Catherine



W. Bryan Rogers, III *Active*
King's Plastic Surgery
613 Twenty Third St., Suite 420
Ashland, KY 41101
(606) 324-2600
Denise



Gary J. Rosenberg *Life*
9899 Savona Winds Dr.
Delray Beach, FL 33446
garyrosemd@aol.com
Jennifer



Robert E. Rothfield *Active*
Western Plastic Surgery
2300 N. Commerce Pkwy., Suite 202
Weston, FL 33326
(954) 389-7999
rermmdpa@msn.com
Randi



John R. Royer *Life*
703 S. Shady Glade
Payson, AZ 85541
(928) 468-8777
jjroyer@jjroyer.com



James B. Russell *Active*
James B. Russell MD
11 Winona Dr.
Maumelle, AR 72113
(501) 256-3732
JBRussellMD@hotmail.com



Michel C. Samson *Active*
Michel C. Samson MD
3635 S. Clyde Morris Blvd., Suite. 400
Port Orange, FL 32129
(386) 756-9400
samson@samsonmd.com
Rachel



O. Gordon Robinson, Jr. *Life*
O. Gordon Robinson MD
59 Alison Dr., Suite 8
Alexander City, AL 35010
(205) 222-1608
ogrobinsonmd@yahoo.com
Kitty



Laurence Z. Rosenberg *Active*
Southeastern Plastic Surgery
2030 Fleischmann Rd.
Tallahassee, FL 32308
(850) 219-2000
uslzz@aol.com

Robert F. Roth *Life*
100 November Ln.
Wirtz, VA 24184
(540) 721-6200
bobdotroth@aol.com
Dorothy 'Dot'



Douglas S. Rowe *Life*
Plastic Surgery MCV/VCUHS
7301 Forest Ave., Suite 100
Richmond, Virginia 23226
(804) 288-5222
dsrowemd@comcast.net



C. Cayce Rumsey, III *Active*
Ponte Vedra Plastic Surgery
209 Ponte Vedra Park Dr.
Ponte Vedra Beach, FL 32082
(904) 273-6200
crumsey@aol.com
Erika



Roger B. Russell *Active*
Specialists in Plastic Surgery
3633 Harden Rd., Suite 200
Raleigh, NC 27607
(919) 785-0505
RBRussellMD@aol.com



Larry Sargent *Active*
The Plastic Surgery Group
979 East Third St., Suite C-920
Chattanooga, TN 37403
(423) 756-7134
UTPlastics@thepsg.org
Brenda

2015 MEMBER ROSTER



James H. Schmidt *Life*
Sarasota Plastic Surgery Center
2255 S Tamiami Trail
Sarasota, FL 34239
(941) 366-8897
jschmidt@sarasotaplasticsurgery.com



Richard G. Schwartz *Active*
Palm Beach Plastic Surgery Center
1500 N. Dixie Hwy., Suite 304
West Palm Beach, FL 33401
(561) 833-4022
tbs001@aol.com



M. Brent Seagle *Life*
2820 NW 5th Ct.
Gainesville, FL 32607
mbseagle@gmail.com
Kathryn



R. Bruce Shack *Active*
Vanderbilt Medical Center
1161-21st Ave. South-D4207
Nashville, TN 37232
(615) 936-0169
bruce.shack@vanderbilt.edu
Wanda Kaye



Daniel Shell, IV *Active*
Shell Plastic Surgery
2716 West Oxford Loop, Suite 171
Oxford, MS 38655
(662) 236-6465
drshell@shellplasticsurgery.com



Fred H. Siegel *Active*
Fred H. Siegel MD
Plastic & Reconstructive Surgery
700 N Battlefield Blvd., #A
Chesapeake, VA 23322
(757) 547-2115
drsiegel@bodybysiegel.com



Karen Singer *Active*
Karen Singer MD PA
8686-31st St. North
Seminole, FL 33776
(727) 547-9244
ksinger886@aol.com



Petra R. Schneider-Redden *Active*
Hattiesburg Clinic
421 South 28th Ave., Suite 110
Hattiesburg, MS 39401
(601) 261-3690
prs12@aol.com
Curt Redden



Paul J. Scioscia *Active*
Ponte Vedra Plastic Surgery
209 Ponte Vedra Park Dr.
Ponte Vedra Beach, FL 32082
(904) 273-6200
ps@pvps.com



Gregory A. Sexton *Active*
Capital Plastic Surgery
1708 Laurel St.
Columbia, SC 29201
(803) 252-6222
gregsexton@aol.com



Joel L. Shanklin *Active*
Coastal Empire Plastic Surgery
900 Mohawk Rd., Suite A
Savannah, GA 31419
(912) 920-2090
drshanklin@drshanklin.com
Beth



Dan H. Shell, III *Active*
Shell Cosmetic Surgery Center
1068 Cresthaven Rd., Suite 200
Memphis, TN 38119
(901) 761-4844
tmb1949@aol.com



Nicholas E. Sieveking *Active*
Sieveking Plastic Surgery
204-23rd Ave. North
Nashville, TN 37203
(615) 321-1010
n.sieveking@gmail.com



Kimberly Singh *Active*
Panacea Plastic Surgery
1368 Wellbrook Circle
Suite B
Conyers, GA 30012
kimberlyannsingh@gmail.com

2015 MEMBER ROSTER



David J. Smith, Jr. *Active*
University of South Florida
7th Floor, 2 Tampa General Circle
Tampa, FL 33606
(813) 974-2413
dsmith3@health.usf.edu
Nancy



Steven J. Smith *Active*
Steven J. Smith MD
9239 Park West Blvd., Suite 201
Knoxville, TN 37923
(865) 246-6700
sjsmiths@aol.com
Susan



Randolph R. Smith *Life*
Augusta Plastic Surgery Associates
1348 Walton Way, Suite 6300
Augusta, GA 30901
(706) 724-5611
clemsonR550@aol.com
Becky Jo

Robert Allen Smith *Life*
The Clinic of Plastic Surgery
1421 N. State St., Suite 504
Jackson, MS 39202
(601) 624-6181
rasmith@keraplast.com
Jane



Somprasong Songcharoen *Life*
Somprasong Songcharoen MD
971 Lakeland Dr., Suite 315
Jackson, MS 39216
(601) 981-2525
ssongcharoen@gmail.com
Suthin



David Heath Stacey *Active*
Northwest Arkansas Center for Plastic Surgery
137 W. Van Asche Loop
Fayetteville, AR 72703
(479) 571-3100
dheathstacey@gmail.com



Harry D. Stambaugh *Life*
Commonwealth Farms
PO Box 7388
Louisville, KY 40257
(502) 895-5466
HBStambaugh@bellsouth.net
Bette



Kevin L. Smith *Active*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
(704) 372-6846
ksmith@charlotteplasticsurgery.com



Paul David Smith *Active*
University of South Florida
7th Floor, 2 Tampa General Circle
Tampa, FL 33606
pausmith@netzero.net
Kim

David H. Smith *Life*
300 Bull St., Suite 402
Savannah, GA 31401
helmars@mac.com
Roberta



Kevin R. Snodgrass *Active*
Dr. Kevin Snodgrass Plastic Surgery
184 Three Rivers Dr. NE
Rome, GA 30161
(706) 378-0200
ksnodgr236@aol.com
Cathy



John G. Sparrow *Active*
The Jackson Clinic
2863 Hwy 45 Bypass
Jackson, TN 38305
(731) 664-1375
sparrowjohn@me.com



William R. Staggers *Life*
Eastern Shore Plastic Surgery
P. O. Box 309
Montrose, AL 36559
(251) 591-3978
wrstaggers@gmail.com



David Steckler *Active*
The Clinic of Plastic Surgery
1421 N. State St., Suite 504
Jackson, MS 39202
dsteckler@gmail.com

2015 MEMBER ROSTER



Matthew Steele *Active*
Plastic Surgery Texas
800-12th Ave., Suite 100
Fort Worth, TX 76104
(817) 810-0770
mhsteelemd@gmail.com



James D. Stern *Active*
Physician's Institute of Cosmetic &
Reconstructive Surgery
3449 Johnson St.
Hollywood, FL 33021
(954) 964-4113
jdstern@mindspring.com



Daniel Stewart *Active*
University of Kentucky
K454 Kentucky Clinic
740 S. Limestone
Lexington, KY 40536
dstew3@uky.edu
Pamela



John L. Strausser *Active*
John L. Strausser MD
1900 S. Tamiami Trail
Sarasota, FL 34239
(941) 955-9096
info@drstrausser.com



John Symbas *Active*
Marietta Plastic Surgery
823 Campbell Hill St.
Marietta, GA 30060
(770) 425-0118
johnsymbas@gmail.com



Paul J. Talbot *Active*
Plastic Surgery Center of Hattiesburg
40 Franklin Rd.
Hattiesburg, MS 39402
(601) 296-3405
pjtalbot@hotmail.com
Julie



James W. Taylor *Life*
University of Tennessee Medical Center
1930 Alcoa Hwy., Suite A-235
Knoxville, TN 37920
(865) 305-6545
jtaylor1@uthsc.edu
Carol



J. Anthony Stephens *Active*
J. Anthony Stephens MD
Cosmetic & Reconstructive Plastic
Surgery, 5233 Dijon Dr., Baton Rouge, LA
70808, (225) 767-7575
anthony@doctorstephens.com
Karen



Joel Melford Stewart, Jr. *Active*
Advanced Aesthetics
100 Highland Park
LaGrange, GA 30240
(706) 756-3991
jmstewartjr@yahoo.com
Ashley



Brian H. Strand *Active*
Mandeville Plastic Surgery
200 Greenleaves Blvd., Suite 11
Mandeville, LA 70448
(985) 626-6277
brimderger@gmail.com



John Blair Summitt *Active*
Vanderbilt Medical Center
D-4207 Medical Center North
1161-21st Avenue South
Nashville, TN 37232
(615) 936-0198
blair.summitt@vanderbilt.edu



Gary E. Talbert *Active*
Arkansas Plastic Surgery
9500 Kanis Rd., Suite 502
Little Rock, AR 72205
(501) 219-8388
gtalbert@arkansasplasticsurgery.com
Heike



Nicholas A. Tarola *Active*
Tarola Plastic Surgery
1800 Medical Center Pkwy., Suite 420
Murfreesboro, TN 37129
(615) 624-8914
ntarola@gmail.com



Julia K. Terzis *Life*
The International Institute of
Reconstructive Microsurgery
27-28 Thomson Ave., Suite 620
Long Island City, NY 11101
(718) 361-2003
juliaterzis@gmail.com

2015 MEMBER ROSTER



Wesley Thayer *Active*
Vanderbilt University Medical Center
D-4207 MCN
1161-21st Ave. South
Nashville, TN 37232
(615) 936-3759
wesley.thayer@vanderbilt.edu



William O. B. Thompson *Active*
The Clinic of Plastic Surgery
1421 State St., Suite 504
Jackson, MS 39202
(601) 969-4050
drwobt@theclinicofms.com
Martha



Lee K. Thornton *Active*
Meridian Plastic Surgery
1200-22nd Avenue
Meridian, MS 39301
(601) 693-7742



Michael A. Tolson *Active*
Plastic Surgery Center
349 Suite A Dahlonega St.
Cumming, GA 30040
(770) 888-2999
tolsoncosmetic@yahoo.com
Lisa



Vernon P. Turner *Life*
Vernon Turner MD
2500 NE 40th St.
Fort Lauderdale, FL 33308
(954) 568-3031
vpturnerm@aol.com
Judy



C. Kendrick Urquhart *Active*
Urquhart Plastic Surgery Medi-Spa & Laser
Center
One Timothy Pass
Anniston, AL 36207
(256) 237-1625
Kenu@cableone.net



Luis O. Vasconez *Active*
University of Kentucky
510-20th St. South, Suite 1102
Birmingham, AL 40536
(205) 934-3245
lvasconez@uabmc.edu
Diane



William 'Trey' O. Thomas *Active*
Hattiesburg Clinic
28th Place, 421 South 28th Ave., Suite 100
Hattiesburg, MS 39401
(601) 261-3690
william.thomas@hattiesburgclinic.com
Catherine



James T. Thompson, II *Active*
Wake Forest University
Medical Center Blvd.
Winston Salem, NC 27157
(336) 716-2011
jimthomp@alumni.virginia.edu
Amy



Gordon R. Tobin *Active*
University of Louisville
550 South Jackson St.
Louisville, KY 40202
(502) 852-6880
gordon.tobin@louisville.edu
Elisabeth



Scott L. Tucker *Active*
Salem Plastic Surgery
1345 A Westgate Center Dr.
Winston Salem, NC 27103
(336) 768-8483
drtucker@salemplasticsurgery.com
Heather



John W. Tyrone, III *Active*
John W. Tyrone MD
108 NW 76th Dr., Suite A
Gainesville, FL 32607
(352) 332-1150
gatordoc@gmail.com



Henry C. Vasconez *Active*
University of Kentucky
Kentucky Clinic, Suite K454
740 S Limestone St
Lexington, KY 40536
(859) 323-6435
hcvasc@uky.edu



Victoria L. Vastine *Active*
Martha Jefferson Aesthetic &
Reconstructive Surgery, 600 Peter
Jefferson Pkwy., Suite 270, Charlottesville,
VA 22911, (434) 654-8920
victoria.vastine@gmail.com
Michael Folger

2015 MEMBER ROSTER



Frank X. Venzara *Active*
Brevard Surgical Center
280 N. Sykes Creek Pkwy., Suite A
Merritt Island, FL 32953
(321) 452-3882
fvenzara@gmail.com

John Robert Vincent *Life*
7398 West DeSoto Rd.
Walls, MS 38680
rvincnet@aol.com
Barbara



Arthur J. Von Werssowetz *Active*
Associates in Plastic Surgery
3404 Navajo Dr.
Chattanooga, TN 37411
(423) 624-0021
belva@aprs.md
Dena



Harlan I. Wald *Life*
Harlan I. Wald MD JD
1501 SE 10th St.
Fort Lauderdale, FL 33316
(754) 300-9253
hwaldd@hwaldd.com
Karen



Jimmy Lee Waldrop, Jr. *Active*
The Plastic Surgery Group
979 East Third St., Suite C-920
Chattanooga, TN 37403
(423) 756-7134
waldropj@thepsg.org



Holly Casey Wall *Active*
The Wall Center for Plastic Surgery
8600 Fern Ave.
Shreveport, LA 71105
(318) 795-0801
hollywall@wallcenter.com



Robert D. Wallace *Active*
University of Tennessee College of
Medicine
910 Madison Ave #315
Memphis, TN 38163
(901) 448-1350
rwallace@uthsc.edu



Jon P. Ver Halen *Active*
Baptist Cancer Center
Dept of Plastic and Reconstructive Surgery
3268 Duke Cir.
Germantown, TN 38138
(206) 963-8714
jpverhalen@gmail.com



William Joseph Vinyard *Active*
Plastic Surgery of Palm Beach
1620 South Congress Ave., Suite 100
Palm Springs, FL 33461
(561) 968-7111
dr.vinyard@yahoo.com
Gina Marie Vinyard



James W. Wade *Active*
James W. Wade MD
Plastic & Reconstructive Surgery
5233 Dijon Dr.
Baton Rouge, LA 70808
(225) 769-9966
jww2md@msn.com



Jeffery Walding *Active*
Southern Institute of Plastic Surgery
2800 Ross Clark Cir., Suite 2
Dothan, AL 36301
(334) 699-7477
walding@siplasticsurgery.com



Marcus Walkinshaw *Active*
University of Mississippi Medical Center
2500 N State St.
Jackson, MS 39216
(601) 984-5180
mdwalkinshaw@msn.com
Melissa



Simeon Wall, Jr. *Active*
The Wall Center for Plastic Surgery
8600 Fern Ave.
Shreveport, LA 71105
(318) 795-0801
swalljr@wallcenter.com



Mark D. Walsh *Active*
Emory University
550 Peachtree St., MOT 9th Floor
Atlanta, GA 30308
(404) 778-4130
mark.walsh@emory.edu

2015 MEMBER ROSTER



Peter A. Ward *Life*
Paducah Plastic Surgery
242 Berger Rd.
Paducah, KY 42003
(270) 217-0928
pward@ccol.net
Cindy



Paul A. Watterson *Active*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
(704) 372-6846
pwatterson@charlotteplasticsurgery.com
Cydne



John M. Weeter *Active*
Associates in Plastic Surgery
4705 Old Brownsboro Ct.
Louisville, KY 40207
(502) 895-5466
jmweeter@drweeter.com



J. Jason Wendel *Active*
Dr. J.J. Wendel Plastic Surgery
2103 Crestmoor Rd.
Nashville, TN 37215
(615) 921-2100
jasonwendelmd@gmail.com



G. Marc Wetherington *Active*
Wetherington Plastic Surgery
406 East Second Ave.
Rome, GA 30161
(706) 235-5119
drw@wetheringtonplasticsurgery.com



Brian G. Widenhouse *Active*
Port City Plastic Surgery
2683 Lake Park Dr., Charleston, SC 29406
(843) 518-5000
drwidenhouse@portcityplasticsurgery.com
Cindy



John V. Williams *Active*
The Aesthetic Surgery Center
8777 Bluebonnet Blvd., Suite A
Baton Rouge, LA 70810. (225) 766-1899
maurapatientconsultant@brplasticsurgery.com
Mary



Richard J. Wassermann *Active*
Plastic Surgery Consultants
1220 Blanding St.
Columbia, SC 29201
(803) 779-1200
rjwpsc@bellsouth.net



Lisle Wayne, II *Life*
Evansville Plastic Surgical Associates
807 Canterbury Dr.
Evansville, IN 47715
(812) 479-7973
saw423x@aol.com
Sheila



Karen E. Wells *Active*
Karen E. Wells MD PA
508 S. Habana Ave., #180
Tampa, FL 33609
(813) 353-8809
drkewells@aol.com
Michael M. Albrink



Keith West *Active*
Marietta Plastic Surgery
823 Campbell Hill St.
Marietta, GA 30060
(770) 425-0118
drwest@mariettaplasticsurgery.com
Karen



Kenneth S. White *Active*
Wilmington Plastic Surgery
2305 Canterwood Dr.
Wilmington, NC 28401
(910) 343-0119
kswhite8910@gmail.com



Virgil V. Willard, II *Active*
Piedmont Plastic Surgery
1011 N. Lindsay St.
High Point, NC 27262
(336) 886-1667
vwillard@plasticsurgerync.com
Kay



Joseph K. Williams *Active*
Atlanta Plastic Surgery
975 Johnson Ferry Rd., Suite 100
Atlanta, GA 30342
(404) 256-1311
jwilliams@atplastic.com

2015 MEMBER ROSTER



Richard B. Williams *Active*
The Plastic Surgery Group
340 Thomas More Pkwy.
Crestview Hills, KY 41017
(513) 791-4440
swessel@tpsg.net
Sherry



Henry B. Wilson *Active*
Centra Medical Group Plastic Surgery
Center
1330 Oak Ln., Suite 100
Lynchburg, VA 24503
(434) 200-4350
hbwilson1@gmail.com



Benjamin H. Wofford *Life*
643 Longstreet Dr.
Marietta, GA 30064
Sandra



William A. Wooden *Active*
University Plastic Surgery Associates
545 Barnhill Dr., Emerson Hall 232
Indianapolis, IN 46202
(317) 274-0770
wwooden@iupui.edu
Karen



Asaf Yalif *Active*
Y Plastic and Reconstructive Surgery
145 Towne Lake Pkwy, Suite 101
Woodstock, GA 30188
(404) 822-4402
dr.yalif@gmail.com



Marshall R. Yellen *Active*
The Plastic Surgery Clinic of Jackson
10 Lynoak Cove
Jackson, TN 38305
(731) 668-2490
ymry324@aol.com

C. Gary Zahler *Life*
24 Elk Mountain Ridge
Asheville, NC 28804
(828) 236-2901
garyzahler@bhhslp.com
Deborah



Joel A. Williams, III *Active*
Williams Plastic and Reconstructive
Surgery
1506 Professional Ct.
Dalton, GA 30720
(706) 278-2700
info@joelwilliamsmd.com



Timothy S. Wilson *Active*
East Tennessee Plastic Surgery
9430 Parkwest Blvd., Suite 240
Knoxville, TN 37923
(865) 694-9886
tswmd@aol.com



S. Anthony Wolfe *Active*
S. Anthony Wolfe Aesthetic &
Reconstructive Surgery, 3100 SW 62nd
Ave., Suite 2230, Miami, FL 33155
(305) 662-4111
awolfemd@bellsouth.net
Deirdre Marshall



Eugene F. Worthen *Life*
3504 Forsythe Ave.
Monroe, LA 71201
(318) 387-5648
efworthen@comcast.net
Judy



Michael D. Yates *Active*
Michael D. Yates MD PC
303 Williams Ave. SW, Suite 1421
Huntsville, AL 35801
(256) 536-4448
noel@dyaplasticsurgery.com
Karen



Rodney B. Young, III *Active*
Palmetto Plastic Surgery
2801 Tricom St.
Charleston, SC 29406
(843) 797-5252
rod@youngheadquarters.com



Sergio M. Zamora *Active*
Serio M. Zamora MD PLC
1890 LPGA Blvd., Suite 150
Daytona Beach, FL 32117
(386) 274-5557
zamoramd@bellsouth.net

2015 MEMBER ROSTER



Harvey A. Zarem *Active*
Savannah Plastic Surgery
7208 Hodgson Memorial Dr.
Savannah, GA 31406
(912) 351-5050
hzarem@gmail.com



Michael R. Zenn *Active*
Duke University Medical Center
DUMC 3358
Durham, NC 27710
(919) 684-2666
Michael.Zenn@duke.edu
Susan



Vincent N. Zubowicz *Active*
Center for Plastic Surgery
365 East Paces Ferry Rd. NE
Atlanta, GA 30305
(404) 814-1100
zubowicz@msn.com
Christina



Thomas J. Zaydon, Jr. *Active*
Cosmetic Surgery Institute of Miami
3661 S. Miami Ave., Suite 509
Miami, FL 33133
(305) 856-0338
drzaydon@drzaydon.com
Yamila Nunez, MD



John W. Zinsser *Active*
Zinsser Plastic Surgery
1501 Maple Ave., Suite 101B, NW Bldg.
Richmond, VA 23226
(804) 474-9805
drz@zinsserplasticsurgery.com
Robin



Mark L. Zukowski *Active*
The Zukowski Center
3612 W. Lake Ave.
Wilmette, IL 60091
(847) 853-8869
facesculptor@yahoo.com
Kathy

2015 CANDIDATE MEMBERS



Jonathan Steven Black *Candidate*
University of Virginia Plastic Surgery
Box 800376
Charlottesville, VA 22908
jsb8r@virginia.edu
Katie



Trajan Alistair Cuellar *Candidate*
University of Mississippi Medical Center
2500 N. State St.
Jackson, MS 39216
tcuellar@umc.edu
Angela Cuellar



Jeffrey S. DeMercurio *Candidate*
Halifax Health
311 N Clyde Morris, Suite 500
Daytona Beach, FL 32114
(386) 238-2244
drjeffd@me.com



Michael Thomas Friel *Candidate*
University of Mississippi
2500 N. State St.
Clinical Science Bldg., L-222
Jackson, MS 39110
mfriel@umc.edu



J. Garrett Harper *Candidate*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
(704) 971-1478
gharper@charlotteplasticsurgery.com
Kristin



Joseph Lee Hill *Candidate*
Plastic Surgeons of Lexington
1401 Harrodsburg Rd., Suite B488
Lexington, KY 40504
jlhill1979@gmail.com
Cecilia



Santosh S. Kale *Candidate*
Medical College of Virginia
1200 East Broad St.
Box 980154
Richmond, VA 23298
doctorkale@gmail.com



Anthony Emil Capito *Candidate*
University Specialty Clinics
Two Medical Park Rd., Suite 302
Columbia, SC 29203
acapito15@gmail.com
Britney



Jarrod Ryan Daniel *Candidate*
Charlotte Plastic Surgery
2215 Randolph Rd.
Charlotte, NC 28207
jdaniel@charlotteplasticsurgery.com
Frederique Delphine Daniel



Brad David Denney *Candidate*
University of Alabama, FOT Suite 1102,
510-20th St.
Birmingham, AL 35245
bdenney@uabmc.edu
Ashley Dahl Denney



Joshua Groves *Candidate*
The Georgia Center for Plastic and
Reconstructive Surgery
6501 Peake Rd., Suite 1000
Macon, GA 31210
(478) 254-6608
drgroves@georgiaplasticcenter.com



Gregory D. Hicks *Candidate*
Professional Plastic Surgery Center
3801 Bee Ridge Rd., Suite #1
Sarasota, FL 34233
(941) 925-3633
ghicksmd@verizon.net



Thomas Horn *Candidate*
5361 Reynolds St.
Savannah, GA 31405
(912) 355-8000
thomashornmd@yahoo.com
Starr



Audrey Klenke *Candidate*
Pinnacle Plastic Surgery Associates
7 Mallett Way
Bluffton, SC 29910
audreyklenke@gmail.com
Trevor

2015 CANDIDATE MEMBERS



George Asbury Lawson *Candidate*
Forsyth Plastic Surgery
2901 Maplewood Ave.
Winston-Salem, NC 27103
(336) 765-8620
drlawson@forsythplasticsurgery.com



Elizabeth Marshall *Candidate*
Medical Faculty Associates
2150 Pennsylvania Ave. NW, Suite 9-400
Washington, District of Columbia 20037
(202) 741-3245
emarshall@mfa.gwu.edu



Kenneth L. Odinet *Candidate*
Kenneth Odinet, DDS MD
200 Beaulieu Dr., Bldg 6
Lafayette, LA 70508
(337) 234-8648
odinetmd@yahoo.com



Joseph William Parks *Candidate*
Florida Plastic Surgery Group
14540 Old St. Augustine Rd.
Jacksonville, FL 32258
jparksiv@gmail.com
Elizabeth



Edward J. Ricciardelli *Candidate*
Summit Plastic Surgery & Dermatology
1717 Shipyard Blvd., Suite 100
Wilmington, NC 28403
(910) 794-5355
nathan@summitcosmeticsurgery.com
Bonnie



Benjamin C. Wood *Candidate*
Wake Forest University
Medical Center Blvd.
Winston Salem, NC 27157
(336) 713-4372
wood.benjamin@gmail.com



Cindy Wu *Candidate*
University of North Carolina Chapel Hill
7040 Burnett-Womack Building, CB 7195
Chapel Hill, NC 27599
(919) 843-7732
thewugirl@yahoo.com



Andre Yuan Levesque *Candidate*
University of Alabama at Birmingham
1158 Faculty Office Tower
1720 2nd Ave. South
Birmingham, AL 35294
(205) 934-4367
andreylevesque@gmail.com



Hunter Reid Moyer *Candidate*
Atlanta Plastic Surgery
975 Johnson Ferry R., Suite 100
Atlanta, GA 30342
(404) 256-1311
hmoyer@emory.edu
Melissa



Paul Warner Papillion *Candidate*
Cool Spring Plastic Surgery
1909 Mallory Ln., Suite 104
Franklin, TN 37067
(615) 450-6988
drpapillion@gmail.com
Sarah Papillion



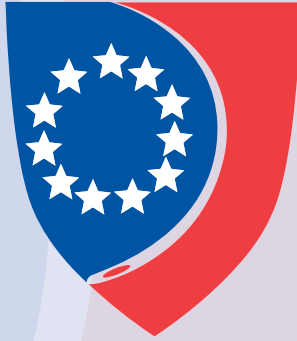
Brett Thomas Phillips *Candidate*
Duke University Medical Center
40 Duke Medical Cir.
M150, Green Zone, DMB 2824
Durham, NC 27710
brett.phillips@duke.edu
Kimberly Phillips



Mark Bernhardt Schoemann *Candidate*
Carilion Clinic Plastic Surgery
3 Riverside Cir.
Roanoke, VA 24016
markschoemann@gmail.com



Jeyhan Wood *Candidate*
University of North Carolina Chapel Hill
7033 Burnett-Womack, CB 7195
Chapel Hill, NC 27599
jeyhan_wood@med.unc.edu
Sean Wood



2015 GEOGRAPHICAL ROSTER

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ALABAMA

Alexander City

O. Gordon Robinson Jr.

Anniston

C. Kendrick Urquhart

Auburn

Ralph Leo Aquadro

Birmingham

Michael Beckenstein

Michael S. Clinton

Alvin B. Cohn

Sherry S. Collawn

Brad D. Denney

Jorge de la Torre

R. Jobe Fix

James C. Grotting

William J. Hedden

Paul Howard

Andre Yuan Levesque

James N. Long

Luis O. Vasconez

Brownsboro

Lawrence H. Bundrick Jr.

Dothan

L. Dwight Baker

Jeffery Walding

Guntersville

William Joseph Vinyard

Huntsville

Deason C. Dunagan

Robert E. Knowling

Robert J. Knowling

Michael D. Yates

Lillian

Byron E. Green

Mobile

Charles L. Dyas Jr.

Kitti K. Outlaw

Byron Green

Montgomery

Michael P. Bentley

Patrick J. Budny

J. Allen Clark III

J. Douglas Robertson

Muscle Shoals

George Russell Jennings

Opelika

Robert Brown

Tuscaloosa

John Menard

ARIZONA

Chandler

Carlos Mata

Payson

John R. Royer

ARKANSAS

Fayetteville

H. Daniel Atwood

David Heath Stacey

Fort Smith

R. Cole Goodman

James E. Kelly III

Ann K. Passmore

2015 GEOGRAPHICAL ROSTER

Little Rock

Edward J. Love
Norton Pope
Gary E. Talbert

Maumelle

James B. Russell

Springdale

James S. Beckman Jr.

CALIFORNIA

Beverly Hills

Josef Hadeed

FLORIDA

Aventura

Jay Ellenby
Robert Fabric
Lawrence B. Robbins

Boca Raton

David J. Applebaum
Jason Pozner

Coral Springs

F. Leigh Phillips III

Daytona Beach

Jeffrey S. DeMercurio
Carl W. Lentz
Sergio M. Zamora

Del Ray Beach

Gary Rosenberg

Fort Lauderdale

Nathan Mayl

Richard F. Ott

Vernon P. Turner

Harlan I. Wald

Fort Myers

John S. Bruno

Gainesville

Hal Bingham
Roger T. Brill
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Bruce A. Mast
Richard L. Nesmith
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Winter Haven

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Martinez

Hermann Orlet

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Jimmy L. Dixon
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Schuyler Metlis

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Daniel F. Haynes

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E. Dwayne Lett

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Kurtis Eugene Moyer
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Thomas W. Orcutt

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NOTES

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