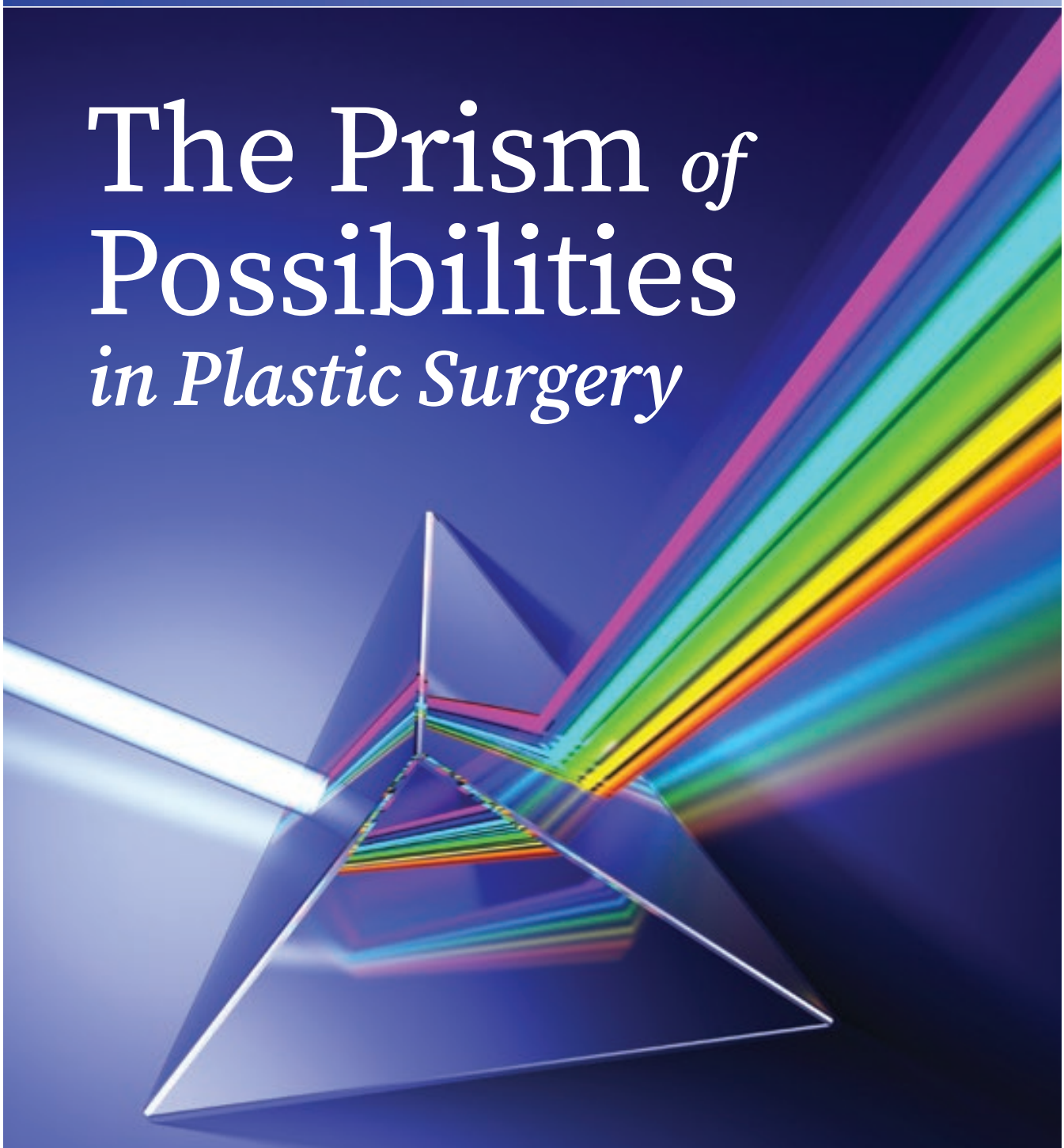
PROCEEDINGS OF THE

62ND ANNUAL SCIENTIFIC MEETING

SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

The Prism *of* Possibilities *in Plastic Surgery*



JUNE 8-12, 2019

THE RITZ-CARLTON, NAPLES, FLORIDA

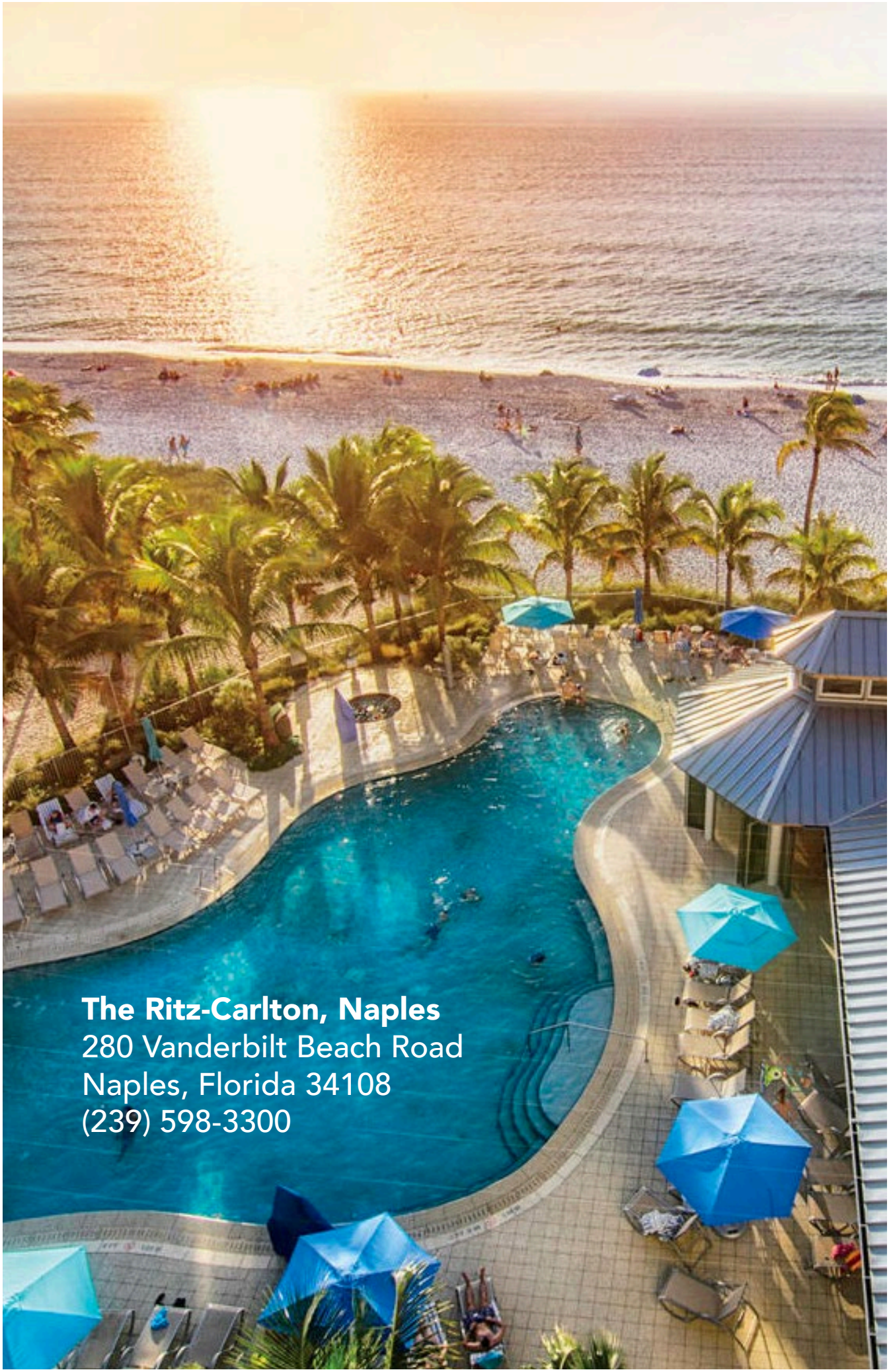

The Ritz-Carlton, Naples
280 Vanderbilt Beach Road
Naples, Florida 34108
(239) 598-3300

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SATURDAY, JUNE 8

8:00 am	Board Meeting
4:00 pm	Early Registration

SOCIAL EVENTS	
6:00 pm	Welcome Reception
7:30 pm	Past Presidents Reception & Dinner

SUNDAY, JUNE 9

SCIENTIFIC SESSION	
7:00 am	Registration Open–Continental Breakfast Visit Exhibits and Poster Viewing
8:00 am	Presidential Welcome Remarks
8:10 am	Resident Competition Papers
9:15 am	Challenging Cases & Complications: Reconstruction
10:15 am	Break–Visit Exhibits and Poster Judging
10:45 am	Member Papers
11:45pm	Keynote Presentation
12:45pm	Resident Jeopardy Bowl

SOCIAL EVENTS	
8:00 am	Spouse/Guest Hospitality Suite
1:00 pm	Toast to Trudie Luncheon
1:00 pm	Past Presidents Luncheon
1:30 pm	Tennis Tournament
7:00 10:00 pm	Theme Dinner - Lilly Palooza

MONDAY, JUNE 10

SCIENTIFIC SESSION	
6:30 am	Registration Open–Continental Breakfast Visit Exhibits & Poster Viewing
7:00 am	MOH's Facial Defect Reconstruction
8:00 am	Resident Competition Papers
9:15 am	Evidence-based Approach to Common Hand Surgery Problems
10:15 am	Break–Visit Exhibits & Poster Judging
10:45 am	Member Papers
11:30 am	Upchurch Lecture
12:30 pm	Medical Student Poster Awards
12:45 pm	Special Resident Session

SOCIAL EVENTS	
8:00 am	Spouse/Guest Hospitality Suite
1:30 pm	Golf Tournament



TUESDAY, JUNE 11

6:30 am	Registration Open–Continental Breakfast Visit Exhibits & Poster Viewing
7:00 am	Just The Facts Panel
8:00 am	Gender Reaffirmation: Current Status
9:15 am	Rhinoplasty
10:15 am	Special Achievement Award
10:45 am	Break–Visit Exhibits
11:15 am	Member Papers
11:45 am	Jurkeiwicz Lecture
12:45 pm	SESPRS Annual Business Meeting
12:45 pm	Resident Luncheon

SOCIAL EVENTS

6:00 am	Fun Run
8:00 am	Spouse/Guest Hospitality Suite
7:00 pm	Black Tie Reception & Dinner

WEDNESDAY, JUNE 12

7:00 am	Registration Open - Continental Breakfast
8:15 am	Research Grant Reports
9:00 am	Safety Panel: Strategies & Controversies
10:15 am	Physican Burnout & Wellness: Taking Care of Ourselves
11:30 am	Closing Remarks: Mark A. Codner, MD Meeting adjourns

The SESPRS 62nd Annual Scientific Meeting

Endorsed by

The American Society of Plastic Surgeons (ASPS)

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS, INC.

PRESIDENTIAL WELCOME



Welcome everyone to the 62nd Annual Meeting of the Southeastern Society of Plastic and Reconstructive Surgeons. The beautiful Ritz-Carlton here in Naples, Florida, will serve as a lovely venue for our Scientific Meeting for 2019.

I am excited to hear the great Scientific Program that Dr. David B. Drake has put together with his committee this year. Highlights in the academic program include the Upchurch Lecture this year where our own Southeastern member, Dr. Robert J. Allen, will speak. My teacher, mentor and good friend, P.G. Arnold, will be giving the Jurkiewicz Lecture this year, which is sure to be outstanding. The panels, hot topics, presentations and "JUST THE FACTS" panel will both entertain and enrich us all.

We have not only the resident competition this year for the Glancy Award for best paper, but we have added this year a medical student poster competition. As medical students now are more commonly heading into a direct track into plastic surgery, much of their research interest is started as medical students. We as a Society want to encourage and benefit from these medical student's research. These posters will be a new event this year.

When we survey our membership each year, overwhelmingly the best part of the meeting overall is the collegiality and simply the ability to interface with other members. The Ritz-Carlton provides us a spectacular backdrop for such interaction.

The weekend starts with a welcome reception in the Center Court of the Ritz. Our theme dinner will be around the pool, weather permitting, which is themed Lilly Palooza. It will be a palooza featuring Lilly Pulitzer colors. This is designed to be entertainment for the entire family. The black-tie dinner on Tuesday night will be in the formal ballroom. We have the same excellent band that played at last year's black tie, so we are sure to be entertained.

Finally, in closing I would like to tell you that being the President of the Southeastern Society has been both an honor and a thrill. I have enjoyed every minute of it and have really looked forward to this meeting. My wife and I have put a lot of planning into the social events and we certainly hope that you all enjoy the 62nd Annual Scientific Meeting of the Southeastern Society of Plastic and Reconstructive Surgeons.

Sincerely,

Stephan J. Finical, MD

President 2018-2019

PRESIDENT
Stephan J. Finical, MD
Charlotte, NC

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Atlanta, Georgia

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Lynn A. Damitz, MD
Chapel Hill, North Carolina

Carmen Kavali, MD
Atlanta, Georgia

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

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

SOCIAL, RECREATIONAL & SPOUSE EVENTS

SOCIAL / RECREATIONAL / SPOUSE EVENTS

All registered members and guests may attend the events below. Many events require additional registration fees. The Black Tie event is restricted to guests 16 years or older. See the SESPRS Registration Desk for details related to any events.

SATURDAY, JUNE 8

4:00–5:00 pm	**Early Registration**	Vanderbilt Ballroom
6:00–8:00 pm	**Welcome Reception**	Center Court
7:30–10:00 pm	**Past Presidents Reception and Dinner** *By Invitation Only. See Registration Desk for details.*	

Dinner on your own. Reservations highly recommended.

SUNDAY, JUNE 9

7:00–8:00 am	**Registered Attendee Breakfast** Registered Spouse/family/guests welcome. Name badges required.	Vanderbilt Ballroom
8:00–10:00 am	**Spouse/Guest Breakfast** Registered Spouse/family/guests only	Artisans
12:45–1:30 pm	**Resident Jeopardy Bowl** Please register.	Vanderbilt Ballroom
1:00 –2:30 pm	**Toast to Trudie** Special Luncheon for Women in plastic surgery ***Registration preferred:*** Hosted by Holly Wall, MD, Lynn Damitz, MD & Carmen Kavali, MD ***Support provided by Allergan***	Finical's Suite
1:00 pm	**Past Presidents Luncheon**	The Grill
1:30 pm	**Annual Tennis Tournament** *Registration is required.* Short walk to The Ritz-Carlton tennis courts. Registered participants are responsible to make their way to the tennis facility by 12:45 pm *Additional fees apply.*	The Ritz-Carlton Tennis Courts
7:00–10:00 pm	**Theme Dinner** Open to all paid registrants. Children of all ages welcome! It is a "Lilly Palooza" themed event, dress bright, cool and comfortable. *See the Registration Desk for Details.* ***Portion of event support provided by Galatea***	Pool Deck

MONDAY, JUNE 10

6:30–7:30 am	**Registered Attendee Breakfast** Registered Spouse/family/guests welcome. Name badges required.	Vanderbilt Ballroom
8:00–10:00 am	**Spouse/Guest Breakfast** Registered Spouse/family/guests only	Artisans
12:30 –1:30 pm	**Special Resident Session** "Written and Oral Board Preparation" Michael Harrington, MD	Vanderbilt Ballroom
1:30 pm	**Annual Golf Tournament** *Registration is Required.* Lunch provided. Transportation to and from the Golf Course will be provided. Registered golfers are responsible to make their way to the transportation area at the front of the main building by 12:45 pm. *Additional fees apply.*	Tiburon Golf Course

Dinner on your own. Reservations highly recommended.

TUESDAY, JUNE 11

6:00 am	**Annual Fun Run** Registration preferred but not required. No Charge. Participants should meet in the lobby of the main building at 5:45 am.	Main Building Lobby
6:30–7:30 am	**Registered Attendee Breakfast** Registered Spouse/family/guests welcome. Name badges required.	Vanderbilt Ballroom
8:00–10:00 am	**Spouse /Guest Breakfast** *Registered Spouse/family/guests only.*	Artisans
12:30 pm	**Resident Luncheon** *Registration required.* Guest Lecturer: William Kuzon, MD.	Artisans
7:00–11:00 pm	**Black Tie Reception and Dinner** ***Open to paid registrants 16 and older.*** Registrants **MUST RSVP** in advance of the meeting. Resident's of the Glancy Award Competition (and spouses) are complimentary, but MUST confirm prior to meeting. All other residents and spouses, a separate registration is required. ***Reception Support provided by Allergan***	Ritz-Carlton Ballroom

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



Robert J. Allen, MD

2019 Honorary Upchurch Lecturer received his medical degree from the Medical University of South Carolina and his residency at Louisiana State University in general and plastic surgery. After completion of his training in Louisiana he moved to New York City for a one-year fellowship in microsurgery at New York University Medical Center. He is Clinical Professor of Plastic Surgery at NYU Medical Center, the Medical University of South Carolina, and LSU Health Sciences Center.

Our Upchurch Lecturers are a very special part of our annual meeting and we are honored to have Dr. Allen, a long time SESPRS member, present his lecture titled "The Theory of Everything".



Phillip G. Arnold, MD

2019 Honorary Jurkiewicz Lecturer born in North Carolina on September 24, 1941, PG grew up in the mountain town of Spruce Pine. He attended Georgia Military Academy in Atlanta, Georgia and graduated in 1958. He entered Davidson College in the fall of that year and graduated with a BS degree in 1962. He received his MD degree at the University of North Carolina in Chapel Hill in 1967 and began his General Surgery training that same year at UNC which was eventually completed in 1974. He has been honored by both Davidson College and UNC School of Medicine as a Distinguished Graduate.

His formal General Surgery training was paused for two years when he volunteered for the Army in 1969. He was a surgeon at The 45th Surgical Hospital, M.U.S.T. (MASH), as well as Brigade Surgeon for The First Air Calvary. He was awarded 3 Bronze Stars, 2 Air Medals, the Combat Medics Badge and the Vietnamese Service Cross. He was honorably discharged with the rank of Major in 1971. He returned to UNC and completed his General Surgery residency in 1974. His plastic surgery residency was at Emory University from 1974-1976 with Dr. M.J. Jurkiewicz.

He became a consultant on staff at Mayo Clinic in Rochester, MN in 1976 and rose to the rank of Professor of Surgery in 1987. He was Chair of Plastic Surgery at Mayo Clinic from 1989 until 2002. He retired from active surgical practice at Mayo Clinic Rochester in 2007. He is co-author of 4 textbooks on Reconstructive Surgery, 19 book chapters,

78 peer-reviewed articles, 26 instructional videotapes and 2 films. He was a contributing member in over 22 national and international surgical organizations. He is an honorary member of the British Association of Plastic and Reconstructive and Aesthetic Surgery, as well as a Fellow (ad hominem) of The Royal College of Surgeons, Edinburgh. Dr. Arnold's interests in Plastic Surgery involved reconstructive surgery of the trunk and extremities as well as aesthetic surgery.



Geoffrey R. Keyes, MD

Dr. Keyes is the current visiting professor for The Rhinoplasty Society. In addition to being a past president of The Rhinoplasty Society, he has served as president of the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), chairman of the board of trustees of AAAASF, president of the Aesthetic Society Education and Research Foundation (ASERF), the California Society of Plastic Surgeons (CSPS) and the Los Angeles Society of Plastic Surgeons (LASPS). He is currently an associate professor of plastic surgery at the University of Southern California – Keck School of Medicine and operates a private practice in Los Angeles, California.

He has had an interest in data collection, designing and creating the first Internet based quality assurance and peer review program in 1999 that currently has over 16,000,000 procedures and outcomes collected from surgeons operating in AAAASF accredited outpatient facilities.

Dr. Keyes will lecture on all aspects of Rhinoplasty and play an important role in our Safety panel.



William M. Kuzon, Jr., MD, PhD

Dr. William M. Kuzon, Jr. is the Reed O. Dingman Collegiate Professor of Surgery in the Section of Plastic Surgery at the University of Michigan. He is certified in Plastic Surgery by the American Board of Plastic Surgery and by the Royal College of Physicians and Surgeons of Canada. He served as the Section Head for Plastic Surgery at The University of Michigan from 2001 to 2012 and directed the Integrated Plastic Surgery Residency Program at Michigan from 2001-2010. He is currently Chief of Surgery at the VA Ann Arbor Healthcare System.

Dr. Kuzon received his M.D. from the University of Rochester School of Medicine and Dentistry and his Ph.D. in Community Health from the University of Toronto. He completed his plastic surgery residency at the University of Toronto in 1991 and received additional training in hand surgery and in microvascular reconstruction in Toronto and at the University of Pittsburgh before joining the faculty of the University of Michigan Section of Plastic Surgery in 1992. Dr. Kuzon has an active research program related to skeletal muscle and peripheral nerve physiology as it relates to reconstructive surgery. His current focus of interest is the biomechanical pathophysiology of ventral hernias. He has published over 100 peer-reviewed papers in scientific journals on a wide spectrum of plastic surgery topics and has given keynote lectures at many universities and scientific meetings. He has received numerous awards for his research including The Distinguished Service Award from the Plastic Surgery Foundation (2017), the AAPS Academic Scholar Award (1992-95),

AAPS Research Achievement Award, Basic Science (2018), and the AAPS Distinguished Fellow Award (2018). He currently is also engaged in gender reaffirmation surgery and will present a lecture entitled "Gender Reaffirmation: Current Status"



Victor Strecher, PhD, MPH

2019 Honorary Keynote presentation "Life On Purpose: How Living for What Matters Most Changes Everything" by Dr. Strecher. Socrates said that an unexamined life isn't worth living. Aristotle went further to say that a purposeless life isn't even worth examining. Victor Strecher reconsiders directions taken in health and wellness and discusses new strategies for improving health, well-being, and resilience. This presentation examines ancient philosophy along with the latest scientific knowledge for living a more fully engaged life.



Neal R. Reisman, MD, JD

Special Guest Lecturer Neal Reisman, MD, JD is past Chief of Plastic Surgery at Baylor-St. Luke's Medical Center, Clinical Professor of Plastic Surgery at the Baylor College of Medicine Division of Plastic Surgery, and past President – The Aesthetic Surgery Education and Research Foundation.

Dr. Reisman completed his general surgery and plastic surgery residencies at Temple University and the Eastern Virginia Graduate School of Medicine in Virginia, with fellowships in Plastic Surgery at Canniesburn in Great Britain and Hand and Microsurgery in Baltimore, Maryland. He received his law degree from the South Texas College of Law and is admitted to the State Bar of Texas.

Throughout his career, Dr. Reisman has written and delivered more than 450 major medical meeting presentations and articles on cosmetic surgery, aesthetic breast surgery, ethics, patient safety, medico-legal and business issues, and the current practice and future organization of cosmetic and plastic surgery.

Dr. Reisman will be on one of our panel members during the Strategies and Controversies Safety Panel lecturing on Lowering Liability Related to Safety Issues. He will also join Dr. Victor Strecher to discuss Physician Burnout and Wellness: Taking Care of Ourselves.

SPECIAL GUEST LECTURERS FOR 2019

PROGRAM CHAIRMAN
David B. Drake, MD

SPECIAL GUEST LECTURERS
Robert J. Allen, MD
Phillip G. Arnold, MD
Geoffrey R. Keyes, MD
William M. Kuzon, Jr., MD, PhD
Victor Strecher, PhD, MPH
Neal R. Reisman, MD, JD

SESPRS MEMBER PRESENTERS
Robert J. Allen, MD
Gaurav Bharti, MD
Christopher Campbell, MD
Harvey Chim, MD
Alvin Cohn, MD
Brent R. DeGeorge, Jr., MD
Stephan J. Finical, MD
Michael A. Harrington, MD
Daniel F. Haynes, MD
Scott T. Hollenbeck, MD
C. Scott Hultman, MD
John T. Lindsey, MD
Albert Losken, MD
Bruce A. Mast, MD
Benjamin C. McIntyre, MD
Wyndell Merritt, MD
Gabriele Miotto, MD, MEd
Pat Pazmino, MD
Brian D. Rinker, MD
Henry C. Vasconez, MD
S. Anthony Wolfe, MD
Lesley Wong, MD
Thomas Zaydon, Jr., MD

GLANCY COMPETITION PRESENTERS
Jack C. Burns, MD
Rachel Cohen-Shohet, MD
Mathew T. Epps, MS, MD
Thomas Gallagher, MD
Shepard P. Johnson, MBBS
Pallavi Archana Kumbla, MD
David C. Lobb, MD
Lily Mundy, MD
Christopher Schneider, MD
David M. Straughan, MD
Nicholas J. Walker, MD
Brielle Weinstein, MD

RESIDENT, NON-MEMBER & STUDENT PRESENTERS
Robert J. Allen, Jr., MD
Ryan C. DeCoster, MD
Alan Matarasso, MD
Alexander F. Mericli, MD
Rene Myers, MD
Jeremie D. Oliver, BS, BA
Kristen Rezak, MD
Christine Schaeffer, MD

SESSION MODERATORS & SECRETARIES
Peter Arnold, MD
Mark Craig, MD
Lynn Damitz, MD
Brent R. DeGeorge, Jr., MD
Kent Higdon, MD
Scott T. Hollenbeck, MD
Carmen Kavali, MD
John T. Lindsey, MD
Albert Losken, MD
Bruce A. Mast, MD
Benjamin C. McIntyre, MD
Brian D. Rinker, MD
John G. Sparrow, MD
Henry C. Vasconez, MD
Timothy S. Wilson, MD
Thomas J. Zaydon, Jr., MD

PROGRAM OBJECTIVES

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

- Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practices,
- Identify challenges that lead to complications in reconstructive surgeries,
- Discuss new strategies for improving health, well-being, and resilience,
- Discuss pertinent anatomy when thinking about head and neck reconstruction. Analyze MOHs defects and reconstructive options of the head and neck,
- Review the current evidence for the management of common hand and upper extremity conditions, including thumb basal joint arthritis, nerve injuries in the hand, cubital tunnel syndrome, and swan neck deformity and discuss current evidence-based practices to provide improved patient outcomes,
- Review the evolution of microsurgical breast reconstruction,
- Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery,
- Review current perspectives in transgender surgery,
- Discuss established aesthetic and functional concepts related to rhinoplasty surgery,
- Review life lessons from surgical training and the potential application to plastic surgery,
- Identify new strategies and controversies as it relates to patient safety,
- Identify symptoms of burnout, discuss and implement mental and physical wellness strategies throughout a career in plastic surgery, and mitigate burnout when symptoms arise.

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 may have been received from more than one company. Commercial supporters 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 supporters 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.

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 *17 AMA PRA Category 1 Credit(s)™* . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the 17 credits, 2.75 have been identified as applicable to patient safety.

This symbol throughout the program identifies a safety credit. 

COMMERCIAL SUPPORT RECEIVED FROM

MENTOR

Planner/Reviewer*	
Robert J. Allen, MD	Nothing to disclose
Robert J. Allen, Jr. MD	Nothing to disclose
Peter Arnold, MD	Consultant with Integra LifeSciences – receives consulting fees
Phillip G. Arnold, MD	Nothing to disclose
Gaurav Bharti, MD	Speaker with Allergan and Inmode – receives consulting fees; Trainer with Biomup and Inmode - receives honorarium
Jack C. Burns, MD	Nothing to disclose
Christopher Campbell, MD	Researcher with Allergan - grant recipient
Harvey Chim, MD	Nothing to disclose
Rachel Cohen-Shohet, MD	Nothing to disclose
Alvin Cohn, MD	Speaker panel with Allergan and Sientra - receives nothing
Mark Craig, MD*	Speaker and Trainer with Inmode - receives consulting fees
Lynn Damitz, MD*	Nothing to disclose
Ryan C. DeCoster, MD	Nothing to disclose
Brent R. DeGeorge, Jr., MD	Nothing to disclose
David B. Drake, MD*	Nothing to disclose
Mathew T. Epps Sr., MS, MD	Nothing to disclose
Stephan J. Finical, MD*	Consultant with Allergan
Thomas M. Gallagher, MD	Nothing to disclose
Michael A. Harrington, MD*	Speaker with Integra - receives speaking fees
Daniel F. Haynes, MD*	Nothing to disclose
Kent Higdon, MD*	Nothing to disclose
Scott T. Hollenbeck, MD*	Nothing to disclose
C. Scott Hultman, MD	Nothing to disclose
Shepard P. Johnson, MBBS	Nothing to disclose
Carmen Kavali, MD*	Speaker and trainer with Allergan – receives honorarium
Geoffrey R. Keyes, MD	Nothing to disclose
Pallavi Archana Kumbla, MD	Nothing to disclose
William M. Kuzon, Jr., MD, PhD	Nothing to disclose
Frank Lau, MD*	Nothing to disclose
Mark Leyngold, MD*	Nothing to disclose
John T. Lindsey, MD	Nothing to disclose
David C. Lobb, MD	Nothing to disclose

2019 ANNUAL MEETING DISCLOSURES

Albert Losken, MD	Speaker with RTI Surgical - receives speaker fees
Bruce A. Mast, MD*	Stockholder with Axogen; Author with Thieme - receives royalties
Thomas McFadden, MD*	Nothing to disclose
Benjamin C. McIntyre, MD*	Nothing to disclose
Alexander F. Mericli, MD	Nothing to disclose
Wyndell Merritt, MD	Nothing to disclose
Gabriele Miotto, MD, Med	Nothing to disclose
Lily Mundy, MD	Product developer with Arthrex, receives consulting fees
Rene Myers, MD	Resident Educator with KLS Martin - receives educational grants
Jeremie D. Oliver, BS, BA	Nothing to disclose
Pat Pazmino, MD	Nothing to disclose
Galen Perdikis, MD*	Nothing to disclose
David Plank, MD*	Nothing to disclose
Neal R. Reisman, MD, JD	Nothing to disclose
Kristen Rezak, MD	Nothing to disclose
Brian D. Rinker, MD*	Nothing to disclose
Christopher Runyan, MD*	Nothing to disclose
Susan Russell*	Nothing to disclose
Christine Schaeffer, MD	Nothing to disclose
Christopher Schneider, MD	Nothing to disclose
Erin Schwarz*	Nothing to disclose
John G. Sparrow, MD	Nothing to disclose
David M. Straughan, MD	Nothing to disclose
Victor Strecher, PhD, MPH	Founder Kumanu, Inc - stockholder
Henry C. Vasconez, MD	Nothing to disclose
Nicholas J. Walker, MD	Nothing to disclose
Brielle Weinstein, MD	Nothing to disclose
Timothy S. Wilson, MD*	Nothing to disclose
S. Anthony Wolfe, MD	Nothing to disclose
Lesley Wong, MD	Nothing to disclose
Cindy Wu, MD*	Nothing to disclose
Thomas Zaydon, Jr., MD*	Nothing to disclose



SCIENTIFIC PROGRAM

SATURDAY, JUNE 8

All general sessions located in Vanderbilt Ballroom.
Exhibits and poster facilities located in the Vanderbilt Ballroom

4:00–5:00 pm	**Early Registration**	Vanderbilt Ballroom

SUNDAY, JUNE 9

7:00 am	**Registration Open**	Vanderbilt Ballroom
7:00–8:00 am	**Continental Breakfast** Visit Exhibits and Poster Viewing	Vanderbilt Ballroom
8:00–8:10 am	**Welcoming Remarks:** Stephan J. Finical, MD	Vanderbilt Ballroom
8:10–9:00 am	**Resident Competition Papers** (7 minutes each) Moderator: Lynn Damitz, MD Secretary: Kent Higdon, MD	Vanderbilt Ballroom

#1 "Soft Tissue Regeneration for Critical Extremity Wounds: A Prospective, Randomized Controlled Trial of a Tissue Engineering-based Technique" (page 31)
Christopher Schneider, MD – Louisiana State University

#2 Reducing Opioid Prescribing after Ambulatory Plastic Surgery: A Prospective Cohort Study" (page 34)
Shepard P. Johnson, MBBS – Vanderbilt University

#3 "Single-Stage Adipofascial Turnover (AFT) Flap as an Alternative Option For Large Nasal Defects Usually Requiring Two-Stage Forehead Flap" (page 36)
Thomas Gallagher, MD – Virginia Tech Carillion Plastic and Reconstructive Surgery

#4 "MinION: Rapid Culture-independent Metagenomic Bacterial Pathogen Identification During Breast-implant Salvage Procedures" (page 37)
Mathew T. Epps, MS, MD – University of Tennessee College of Medicine, Chattanooga

#5 "Preoperative Evaluation of the Superficial Fascial System Can Predict Wound Complications in Body Contouring Surgery" (page 43)
David M. Straughan, MD – Tulane University

#6 "Pre-pectoral vs Sub-pectoral Breast Reconstruction in High Body Mass Index Patients" (page 45)
Nicholas Walker, MD – Wake Forest Baptist Health

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

9:00–9:15 am	**Discussion**	
9:15–10:15 am	**Challenging Cases and Complications: Reconstruction** Moderator: Benjamin McIntyre, MD	Vanderbilt Ballroom
	Oncologic Chest Wall Defects Scott T. Hollenbeck, MD	
	Surgical Management of Chronic Neuropathic Pain After Burn Injury C. Scott Hultman, MD	
	You Can Do It! : Lower Extremity Reconstruction with Perforator and Propeller Flaps Benjamin McIntyre, MD	
	Abdominal Wall Reconstruction Following Oncologic Resection Alexander F. Mericli, MD	
	Objective: Identify challenges that lead to complications in reconstructive surgeries.	
10:15–10:45 am	**Break** – Visit Exhibits & Poster Judging	Vanderbilt Ballroom

10:45–11:30 am	**Member Papers (7 Minutes each)** Moderator: Mark Craig, MD Secretary: John G. Sparrow, MD **#1 Avulsion Fat Grafting Gluteoplasty (page 46)** Gaurav Bharti, MD **#2 ULTRABBL: Ultrasound Guided BBL: Safe Gluteal Fat Grafting Under Real Time Intra-operative Ultrasound Guidance (page 48)** Pat Pazmino, MD **#3 Rhinoplasty for Beginners: An Algorithm for Decision Making (page 49)** Gabriele Miotto, MD, MEd **#4 The Nose in Orbital Hypertelorism: Review of a 44-Year Experience by a Single Surgeon (page 51)** S. Anthony Wolfe, MD **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practices.	Vanderbilt Ballroom
11:30–11:45 am	**Discussion**	
11:45–12:45 pm	**Keynote Presentation :** **"Life On Purpose: How Living for What Matters Most Changes Everything"** Victor Strecher, PhD, MPH **Objective:** Discuss new strategies for improving health, well-being, and resilience.	Vanderbilt Ballroom
12:45–1:30 pm	**Resident Jeopardy Bowl** Moderator: Kent Higdon, MD and Albert Losken, MD	Vanderbilt Ballroom

MONDAY, JUNE 10

6:30 am	**Registration Open**	
6:30–7:30 am	**Continental Breakfast** Visit Exhibits and Poster Viewing	Vanderbilt Ballroom
7:00–8:00 am	**MOH's Facial Defect Reconstruction** Michael A. Harrington, MD **Objective:** Discuss pertinent anatomy when thinking about head and neck reconstruction. Analyze MOHs defects and reconstructive options of the head and neck.	Vanderbilt Ballroom
8:00–9:00 am	**Resident Paper Competition** (7 minutes each) Moderator: Bruce A. Mast, MD Secretary: Timothy S. Wilson, MD	Vanderbilt Ballroom

#7 "Oncologic Safety of Autologous Fat Grafting to the Reconstructed Breast" (page 52)
Jack C. Burns, MD – University of Kentucky

#8 "Early Breast Cancer Related Lymphedema Mitigation with Immediate Lymphovenous Anastomosis" (page 54)
Brielle Weinstein, MD – University of South Florida

#9 "Identifying Factors Most Important to Lower Extremity Trauma Patients: Key Concepts from the Development of a Patient-Reported Outcome Instrument for Lower Extremity Trauma, The LIMB-Q" (page 55)
Lily Mundy, MD – Duke University

#10 "The Use of Ultrasound Guidance for the Treatment of Raynaud's Disease with Botulinum Toxin" (page 57)
David C. Lobb, MD – University of Virginia

#11 "The Feasibility of a Sensate Profunda Artery Perforator Flap in Autologous Breast Reconstruction: An Anatomic Study for Clinical Application" (page 60)
Pallavi Archana Kumbla, MD – University of Alabama

#12 "Mastopexy: What are We Doing? How are We Teaching It?" (page 61)
Rachel Cohen-Shohet, MD – University of Florida

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

9:00–9:15 am	**Discussion**	
9:15–10:15 am	**Evidence-based Approach to Common Hand Surgery Problems** Moderator: Brent R. DeGeorge, Jr., MD	Vanderbilt Ballroom

Evidence-based Approach to Nerve Gap in the Hand or Upper Extremity
Brian D. Rinker, MD

Evidence-based Approach to Thumb Basilar Joint Arthritis
Harvey Chim, MD

Evidence-based Approach to Dupuytren's Contracture
Brent R. DeGeorge, Jr., MD

Evidence-based Approach to Extensor Tendon Injury and Rehabilitation
Wyndell Merritt, MD

Objective: Review the current evidence for the management of common hand and upper extremity conditions, including thumb basal joint arthritis, nerve injuries in the hand, cubital tunnel syndrome, and swan neck deformity and discuss current evidence-based practices to provide improved patient outcomes.

10:15–10:45 am	**Break** – Visit Exhibits & Poster Judging	Vanderbilt Ballroom
10:45–11:20 am	**Member Papers** (7 minutes each) Moderator: Scott T. Hollenbeck, MD Secretary: Carmen Kavali, MD	Vanderbilt Ballroom

#5 Microsurgical Breast Reconstruction in the Obese Patient Using Abdominal Flaps: Complication Profile and Patient-Reported Outcomes (page 63)
Brian D. Rinker, MD

#6 Laterality and Patient-reported Satisfaction Following Autologous Breast Reconstruction with Abdominal Tissue: An 8-year Examination of BREAST-Q Data (page 65)
Robert J. Allen, Jr., MD

#7 The Impact Oncoplastic Reduction has on Long-Term Recurrence in Breast Conservation Therapy (page 67)
Albert Losken, MD

#8 Immediate Latissimus Dorsi Prosthetic Reconstruction in the Setting of Postmastectomy Radiation: Analysis of 376 Breast Reconstructions (page 68)
Alvin Cohn, MD

#9 Is Thoracodorsal Nerve Transection Needed in Latissimus Dorsi Breast Reconstruction? (page 70)
Bruce A. Mast, MD

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

11:20–11:30 am	**Discussion**	
11:30–12:30 pm	**Upchurch Lecturer "A Theory of Everything"** Robert J. Allen, MD **Objective:** Review the evolution of microsurgical breast reconstruction.	Vanderbilt Ballroom
12:30–12:45 pm	**Medical Student Poster Award Presentations**	Vanderbilt Ballroom
12:45–1:30 pm	**Special Resident Session** **"Written and Oral Board Preparation"** Michael A. Harrington, MD	Vanderbilt Ballroom

TUESDAY, JUNE 11

6:30 am	**Registration Open**	Vanderbilt Ballroom
6:30–7:30 am	**Continental Breakfast** Visit Exhibits	Vanderbilt Ballroom
7:00–8:00 am	**Just the Facts Panel** Moderator: Bruce A. Mast, MD **Panel Members:** **Free Flap Hourly Monitoring is a Must for 5 Days** Rene Myers, MD – University of Alabama **Combining Aesthetic Procedures in Distinct Anatomic Regions Should be Avoided Due to Risk Elevation** Daniel F. Haynes, MD – East Tennessee University **Pre-pectoral Device Breast Reconstruction is a Fad, Driven by Marketing and MD Consultants** Lesley Wong, MD – University of Kentucky **Textured Implants: Should They be Removed and Never Used?** Kristen Rezak, MD – Duke University **Objective:** Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery.	Vanderbilt Ballroom
8:00–9:00 am	**Gender Reaffirmation: Current Status** William M. Kuzon, Jr., MD **Objective:** Review current perspectives in transgender surgery.	Vanderbilt Ballroom
9:00–9:15 am	**Discussion**	
9:15–10:00 am	**Rhinoplasty** Geoffrey R. Keyes, MD **Objective:** Discuss established aesthetic and functional concepts related to rhinoplasty surgery.	Vanderbilt Ballroom
10:00–10:15 am	**Discussion**	

10:15–10:45 am	**Special Achievement Award: Leonard Furlow, MD** Moderator: Henry C. Vasconez, MD	Vanderbilt Ballroom
10:45–11:15 am	**Break** – Visit Exhibits	Vanderbilt Ballroom
11:15–11:45 am	**Member Papers (7 Minutes Each)** Moderator: John T. Lindsey, MD Secretary: Peter Arnold, MD **#10 Portable Color-Flow Ultrasound (PCFU) Facilitates Precision Flap Planning and Perforator Selection in Reconstructive Plastic Surgery (page 71)** John T. Lindsey, MD **#11 Post-Mastectomy Radiation Therapy (PMRT) Before and After Immediate-Based Breast Reconstruction: A Systematic Review Analyzing the Effect of Radiation Timing on Infection Rate and Need for Explanation (page 73)** Jeremie D. Oliver BS, BA **#12 Biointegration of a New Porcine Acellular Dermal Matrix with Increased Elasticity in an in Vivo Model of Two-stage Breast Reconstruction with Radiation (page 76)** Christopher Campbell, MD **#13 The Role of Oncogenic JAK/STAT3 Pathway Mutations in the Pathogenesis of Breast Implant-Associated Anaplastic Large Cell Lymphoma (Page 78)** Ryan C. DeCoster, MD **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practices.	Vanderbilt Ballroom
11:45–12:45 pm	**Jurkeiwicz Lecturer - P.G. Arnold, MD** **War Surgery a Compelling Teacher** **Objective:** Review life lessons from surgical training and the potential application to plastic surgery.	Vanderbilt Ballroom
12:45 pm	**SESPRS Annual Business Meeting** Please register–lunch will be served	Vanderbilt Ballroom
12:45–3:00 pm	**Resident Luncheon** *(Residents & Fellows Only)* William M. Kuzon, Jr., MD "**Everything is Awesome"**	Artisans

TUESDAY

WEDNESDAY, JUNE 12

7:30–8:30 am	**Continental Breakfast**	Vanderbilt Ballroom
8:15–9:00 am	**Research Grant Reports** Moderator: Brian D. Rinker, MD **Microporous Annealed Particle Scaffold for Articular Cartilage Regeneration** Christine Schaeffer, MD **Transcriptome-Wide Microarray Analysis to Determine Molecular Mechanisms in Breast Implant-Associated Anaplastic Large Cell Lymphoma: A Pilot Case-Control Study** Henry C. Vasconez, MD **Objective:** Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practices.	Vanderbilt Ballroom
9:00–10:00 am	**Safety Panel: Strategies and Controversies** Moderator: Thomas Zaydon, Jr., MD **Caprini and Abdominoplasty** Geoffrey R. Keyes, MD **Lowering Liability Related to Safety Issues** Neal R. Reisman, MD **"Serotonin Syndrome " Prevention, Recognition and Treatment** Thomas Zaydon, Jr., MD **Teams, Systems and Protocols** Galen Perdikis, MD **Objective:** Identify new strategies and controversies as it relates to patient safety.	Vanderbilt Ballroom
10:00–10:15 am	**Discussion**	

10:15–11:15 am	**Physician Burnout and Wellness: Taking Care of Ourselves** Neal R. Reisman, MD , Victor Strecher, PhD, MPH **Objective:** Identify symptoms of burnout, discuss and implement mental and physical wellness strategies throughout a career in plastic surgery, and mitigate burnout when symptoms arise.	Vanderbilt Ballroom
11:15–11:30 am	**Discussion**	
11:30 am	**Closing Remarks** Mark A. Codner, MD	



ABSTRACTS

RESIDENT GLANCY COMPETITION ..... 8:10–9:00 am

#1 Soft Tissue Regeneration for Critical Extremity Wounds: A Prospective, Randomized Controlled Trial of a Tissue Engineering-based Technique

Christopher Schneider, MD[1], Angela Chiu, PhD[2], Hui-Yi Lin, PhD[2], Hugo St. Hilaire, MD, DDS[1], Frank Lau, MD[1]

[1] Department of Plastic Surgery, Vanderbilt University, Nashville, TN, USA
[2] Department of Plastic Surgery, University of Michigan Health System, Ann Arbor, MI, USA

Background: Critical extremity wounds with exposed bone/tendon require soft tissue reconstruction for limb salvage (LS). Flap-based limb salvage (fLS) has drawbacks including high failure rates, amputation rates, and costs. We developed a novel tissue engineering-based limb salvage (teLS) technique. In teLS, dehydrated human amnion-chorion membrane (dHACM) is applied to exposed bone/tendon. Definitive closure is achieved with skin grafts. To evaluate teLS vs. fLS, we performed a prospective, multicentered, randomized clinical trial (RCT) with crossover for treatment failure.

Methods: Consecutive LS patients at three institutions were randomized to teLS or fLS. The primary endpoint was persistent exposed critical structures and osteomyelitis. For cost analysis, all charges were collected and normalized using Medicare Cost-to-Charge ratios. Statistical analysis was performed by a biostatistician.
Results: Between August 2016 and October 2018, 53 patients were enrolled in the trial. No significant demographic or wound quality differences existed between treatment groups (Table 1). The primary LS success rate was 80.8% for teLS vs. 75% for fLS ($p=0.71$, Fig. 1).

Mean total charges was $79,385 teLS vs. $442,195 fLS (82.1% cost reduction, $p<0.0001$). Significant cost savings were observed in four cost categories (Fig. 2).

Conclusions: These data suggest that teLS is clinically more efficacious than fLS. Furthermore, teLS offers several advantages: 1) fLS remains a "surgical lifeboat"; 2) dHACM treatments can be performed in clinic; 3) teLS can be performed without microsurgical expertise thus improving patient access to LS. teLS is exceptionally cost effective and should be evaluated as a first-line treatment option in healthcare systems.

Table 1. Overview of reconstructive outcomes.

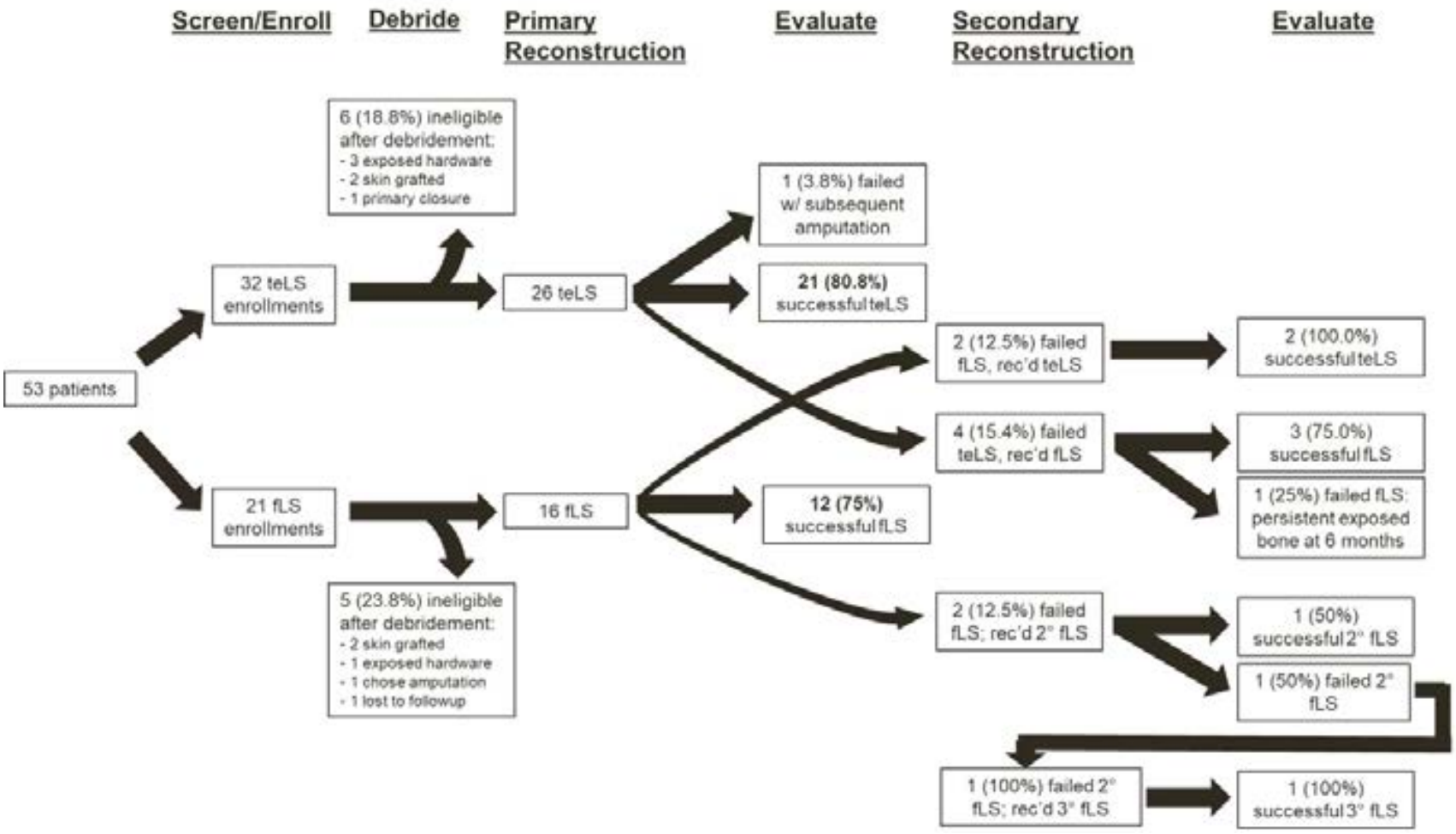
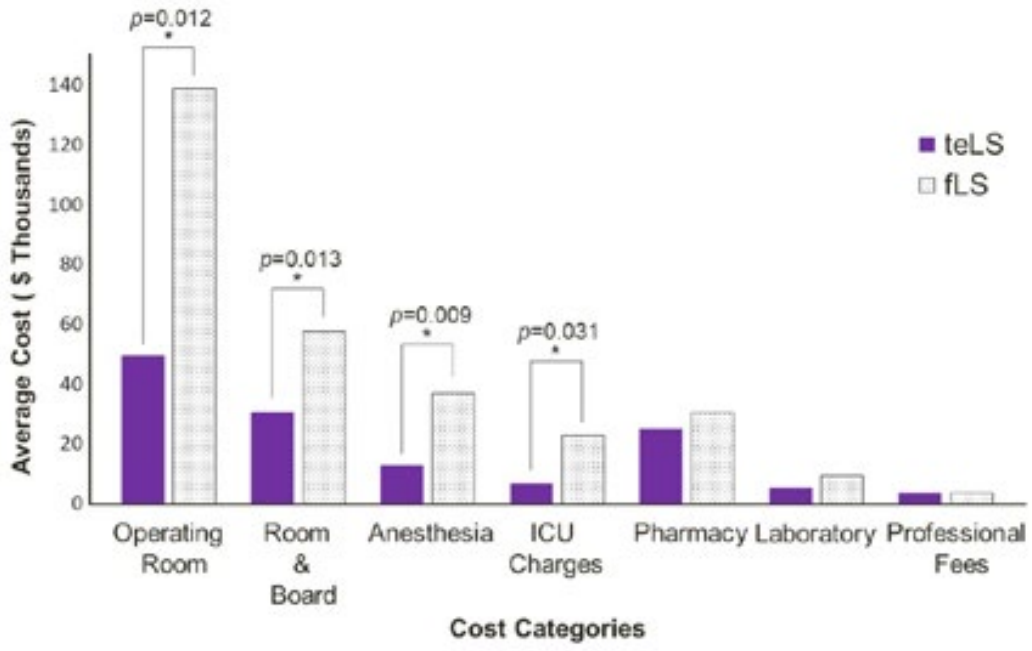


Table 2. Demographics & Wound Characteristics.

	teLS (n=26)	fLS (n=16)	p-value
Average Size	43.4 ± 50.4 cm^2	93.9 ± 107.1 cm^2	0.13
Left Limb Right Limb	15 (57.7%) 11 (42.3%)	8 (50%) 8 (50%)	0.75
Bone Tendon Bone + Tendon Nerve	11 (42.3%) 11 (42.3%) 3 (11.5%) 1 (3.8%)	9 (56.3%) 4 (25.0%) 3 (18.8%) 0	0.46
Gustilo 3B Gustilo 3C	14 (100%) 0	10 (83.3%) 2 (16.7%)	0.20

	teLS (n=26)	fLS (n=16)	p-value
Age	48.7 ± 19.8	43.6 ± 11.6	0.33
Male Female	19 (73.1%) 7 (26.9%)	12 (75.0%) 4 (25.0%)	1.00
Black White Other	11 (42.3%) 15 (57.7%) 0	5 (31.3%) 9 (56.3%) 2 (12.5%)	0.75
BMI	27.9 ± 7.0	28.0 ± 8.2	0.49
Non-Smoker Smoker	18 (69.2%) 8 (30.8%)	7 (43.8%) 9 (56.2%)	0.12

Figure 2. teLS Yields Significant Cost Savings



RESIDENT GLANCY COMPETITION ..... 8:10–9:00 am

#2 Reducing Opioid Prescribing after Ambulatory Plastic Surgery: A Prospective Cohort Study

Shepard P. Johnson MBBS[1], Blair A. Wormer MD[1], Galen Perdikis MD[2], Brian Drolet MD[3]

[1] Fellow, Plastic and Reconstructive Surgery, Vanderbilt University Medical Center, Nashville, TN
[2]. Chair, Department of Plastic Surgery, Vanderbilt University Medical Center, Nashville, TN
[3]. Associate Residency Program Director and Assistant Professor, Department of Plastic Surgery, Department of Biomedical Informatics and the Center for Biomedical Ethics and Society, Vanderbilt University Medical Center, Nashville, TN

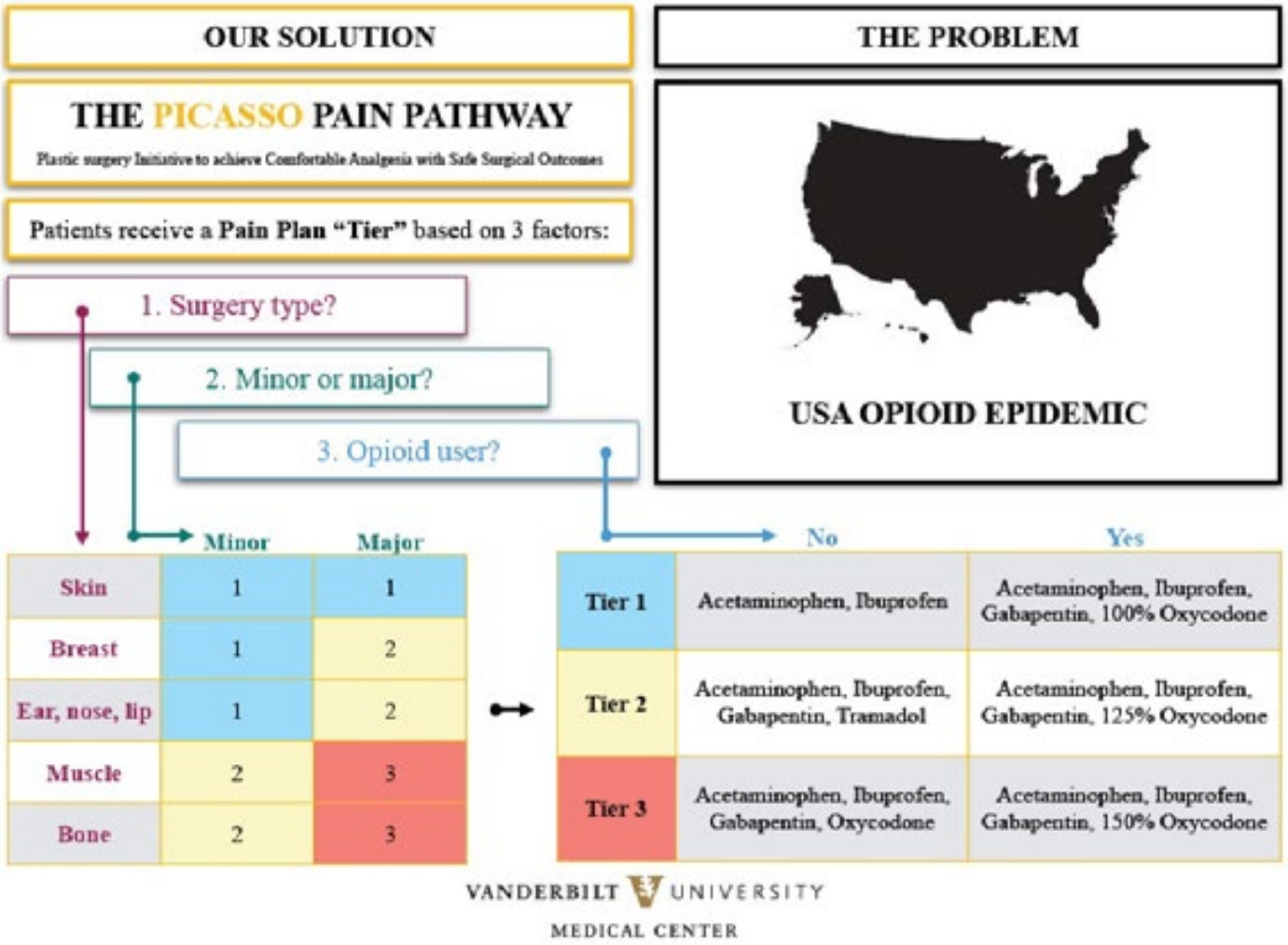
Purpose: To evaluate opioid prescribing after implementation of a department-wide pain protocol for standardization of analgesia after ambulatory plastic surgery.

Methods: In this prospective cohort study, we compared prescribing patterns after implementation of a multimodal pain protocol, PICASSO, to historical controls in our academic plastic surgery practice. The protocol was initiated on July 1st, 2018 and applied to adult patients undergoing outpatient surgery. PICASSO provides an algorithm for analgesic prescribing based on type of surgery and patient factors (Figure 1). A hospital-based pharmaceutical database was used to identify opioid and non-opioid prescriptions filled, and univariate analyses were performed to compare cohorts.

Results: The pre-protocol and post-protocol cohorts consisted of 539 and 632 patients, respectively. There was no difference in age (48.2 vs 48.3) or gender (27.8% vs 32.4% male). The proportion of patients filling opioid prescriptions went down from 95% to 76% after PICASSO. The oral morphine equivalent (OME) per day (38.7 vs 27.6) and total OME per opioid prescription (217.5 vs 87.2) were significantly less in the PICASSO cohort. Additionally, the proportion of patients filling non-opioid prescriptions was significantly greater in the PICASSO cohort, including acetaminophen (60.7% vs 86.9%), ibuprofen (8.7% vs 74.2%), and gabapentin (23.6% vs 57.9%).

Conclusions: The PICASSO pain protocol resulted in a 20% decline in opioid prescriptions and a 2.5-fold decrease in the OME per prescription, equivalent to eighteen oxycodone (5mg) pills. This algorithmic protocol can improve the analgesic prescribing culture in a plastic surgical department, thereby minimizing excess opioids available for misuse or abuse.

Figure 1. PICASSO Pain Protocol Poster



#3 Single-Stage Adipofascial Turnover (AFT) Flap As An Alternative Option For Large Nasal Defects Usually Requiring Two-Stage Forehead Flap

Gallagher, Thomas, M.D.; Truong, Albert, M.S.; Capito, Anthony, M.D., FACS

Virginia-Tech Carilion Plastic and Reconstructive Surgery

Background: Large nasal defects involving the tip, ala, and/or columella with denuded cartilage have traditionally required a two-stage forehead flap. As many Mohs patients are presenting older with increased medical co-morbidities, a single-stage adipofascial turnover (AFT) flap with a full-thickness skin graft was developed by the senior author as an alternative method. The authors hypothesize that the AFT flap would have similar success rates and less expense than the forehead flap.

Methods: A retrospective review of all patients in the senior author's practice who underwent either a forehead flap or AFT flap between January 2016 and February 2019 was conducted. The two groups were compared regarding success, complications, and cost.

Results: There were 7 forehead flap patients and 11 patients with AFT flaps. Complications were: forehead group 43% (3/7) and AFT group 18% (2/11). There was one mortality, one revision for asymmetry, and one with airflow obstruction in the forehead group. The AFT group had one partial skin graft loss and one incisional dehiscence. Both patients healed with local wound care only. There were no flap failures, and the costs averaged over $25,000 less in the AFT group.

Conclusion: This review demonstrates that the single-stage adipofascial turnover flap with FTSG is a safe, reliable, and less expensive alternative to the forehead flap. The forehead flap will remain a workhorse in nasal reconstruction, but multiple surgeries increase cost and could contribute to higher complication rates. The AFT flap appears to be an efficacious and reasonable option compared to the forehead flap.

RESIDENT GLANCY COMPETITION ..... 8:10–9:00 am

#4 MinION: Rapid culture-independent metagenomic bacterial pathogen identification during breast-implant salvage procedures

Mathew T. Epps[1], MS, MD, Taylor K. Pels[1], BA, Jason P. Rehm[1], MD, J. W. Kennedy[1], MD FACS, Mark A. Brzezienski[1], MS, MD FACS

[1]University of Tennessee College of Medicine Chattanooga, Department of Plastic Surgery

Goals/Purpose: Implant-associated infections continue to complicate reconstructive breast surgery. Traditional culture-based studies, requiring multiple days for completion, delay targeted anti-microbial treatment. Next-generation Sequencing (NGS) allows for rapid non-discretionary whole-genome DNA sequencing through nanopore technology. The MinION™ is a USB-powered palm-sized NGS nanopore device. Though NGS nanopore sample preparation protocols are in their infancy, this device has promise in bacterial species and antimicrobial-resistance identification. In this study, the MinION™ is utilized to rapidly identify infectious pathogens during implant-based breast reconstruction (IBR) salvage techniques.

Methods/Technique: Peri-prosthetic fluid collections were aspirated prior to implant-salvage procedures. Study aspirates (n=3) underwent both traditional bacterial culture and metagenomic analysis. Bacterial DNA (16S) was purified and amplified from a 1cc specimen aliquot, then sequenced using the MinION™ (10-30min sequencing). A standard E. coli lambda-virus was the control. Real-time analysis was performed using ONT's Epi2ME software (CARD database) and compared to culture findings.

Results: Sequence data from the study set (n=3) accurately matched culture results and identified bacterial species with gene allele alignment to antibiotic-resistance genes included in the CARD-database across multiple taxons. Additionally, NGS sequencing revealed polyclonal infections not identified during routine culture.

Conclusion: This study demonstrates the potential to identify infectious pathogens during IBR salvage procedures in near real-time using the MinION™, in comparison to protracted traditional culture techniques, though refinements in specimen preparation protocols are essential. NGS technologies may revolutionize the speed and accuracy of pathogen diagnosis, improve antimicrobial stewardship, and additionally may perhaps be a tool for the surveillance of a BIA-ALCL genetic footprint.

Table1. Patient Demographics. TE = Tissue expander; ADM = Acellular Dermal Matrix.

Sample	Age	Dx	WBC	CRP	Che-mo-Tx/ Rad-Tx	Procedure(s) Prior to Sample Collection	Sample Collection Date	Sample Collection Procedure
PT1	37yo	Breast cancer	9.5	-	Y	Pre-pectoral bilateral TE/ADM reconstruction	POD #26	I&D right breast, sub-sequent TE removal (failed salvage)
PT2	38yo	Breast cancer	15.0	2.65	Y	Pre-pectoral bilateral TE/ADM reconstruction	POD #22	Left breast seroma aspiration (successful salvage)
PT3	35yo	Breast cancer	19.5	-	Y	Pre-pectoral bilateral TE/ADM reconstruction	POD #21	I&D left breast, sub-sequent TE removal (failed salvage)

Table 2. MinION™ sequencing and microbial culture results. WIMP = What's in My POT bacterial genotype identification software; ARMA (CARD) = The Comprehensive Antibiotic Resistance Database.

Sample	Culture Results	MinION™ Sequencing Results	CARD Resistant Genes	CARD Align-ments	Average % Alignment
PT1	MRSA; resistant to penicillin	MRSA; resistant to penicil-lin, daptomycin, fluoro-quinolones, rifampicin	MRSA 252	7 alignments to 5 genes	91%
			MRSA USA300	7 alignments to 1 gene	90%
			S. aureus	3 alignments to 2 genes	95%
			Pasteurella multocida resis-tant to spectinomycin	14 alignments to 1 gene	75%
PT2	Enterobacter cloacae complex	S. aureus Enterobacter cloacae complex			
			E. coli K-12 resistant to streptomycin	2 alignments to 2 genes	87%
PT3	**MRSA; resistant to erythromycin**	**MRSA; resistant to penicillin, methicillin, floroquinolones, daptomycin, rifapicin erythromycin**	**MRSA 252**	**9 alignments to 5 genes**	**93%**
			MRSA USA300_	**9 alignments to 1 gene**	**89%**
			Streptoccocus oralis		
			Staphyloccucus equorum		
		E. coli			

Figure 1. Chest CT showing a suspected implant-associated infection. Percutaneous aspirate (Sample PT3) was obtained for microbial culture studies and Next-generation Sequencing (NGS) from the left breast pocket in the preoperative area prior to reconstruction-salvage procedure.



Figure 2. Abscess aspiration. Sterile field pre-operative percutaneous abscess aspiration for both traditional laboratory microbial culture analysis and Next-generation Sequencing (NGS) Analysis.



Figure 3. MinION™ Device. MinION™ USB-powered NGS Device with the nanopore flow cell.



Figure 4. Nanopore technology. As a single DNA strand is pulled through a charged lipid membrane within the MinION™ flow cell, each DNA base-pair has a characteristic charge signature that is detected by a proprietary cellular array as the base passes through the embedded pore. The MinION™ flow cell contains ~1100 to 1500 pores that sequence simultaneously.

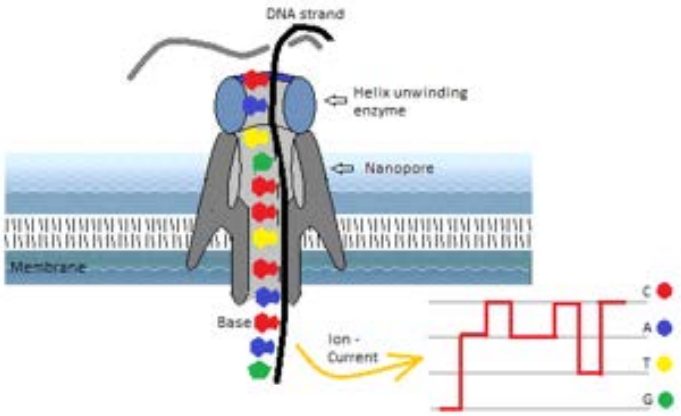


Figure 5. Nanopore Sample Preparation to NGS Workflow. PCR = Polymerase Chain Reaction; WIMP = What's in my POT software; ARMA(CARD) = The Comprehensive Antibiotic Resistance Database.

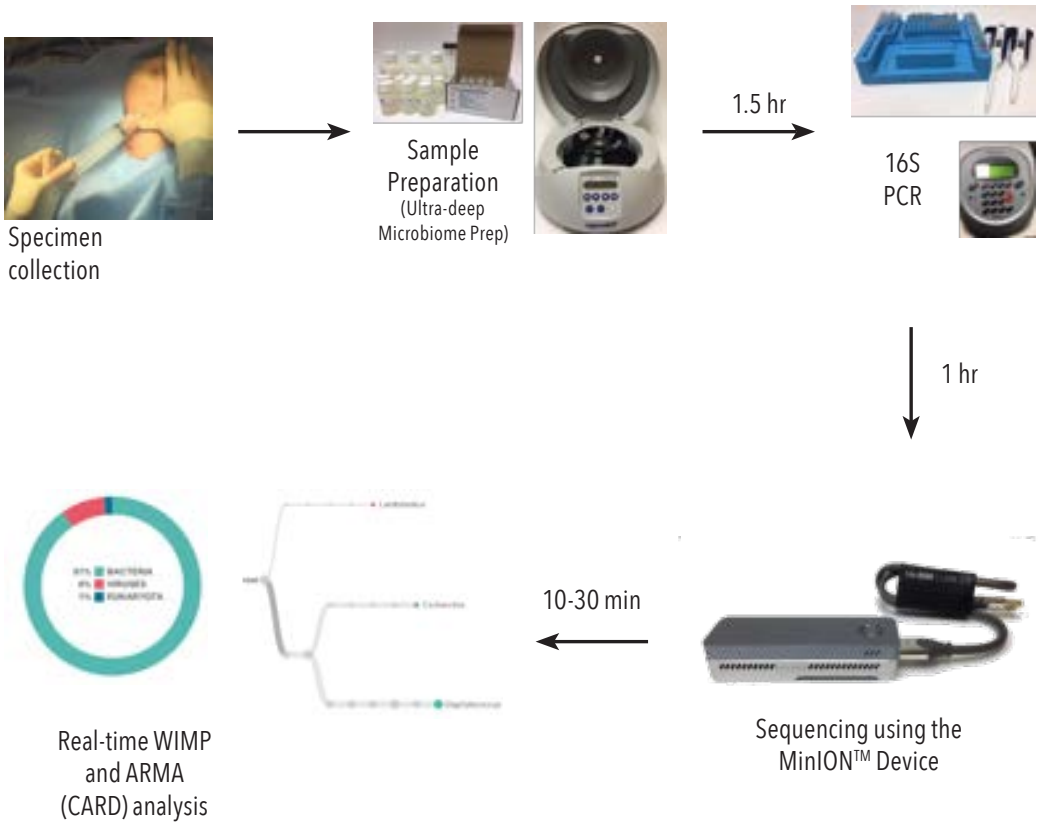
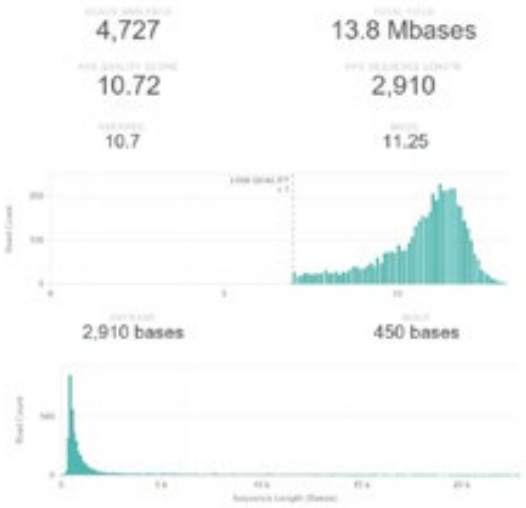
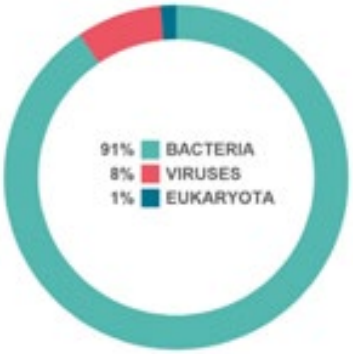


Figure 6. Epi2ME WIMP (What's in My Pot) analysis of Sample PT3. (A) Sequencing data (30min) including number of sequenced reads, number of bases, read quality, and read length. (B) Distribution of reads according to domain. (C) Reads classified according to bacterial species. (D) Alignment to antibiotic resistant gene taxons.

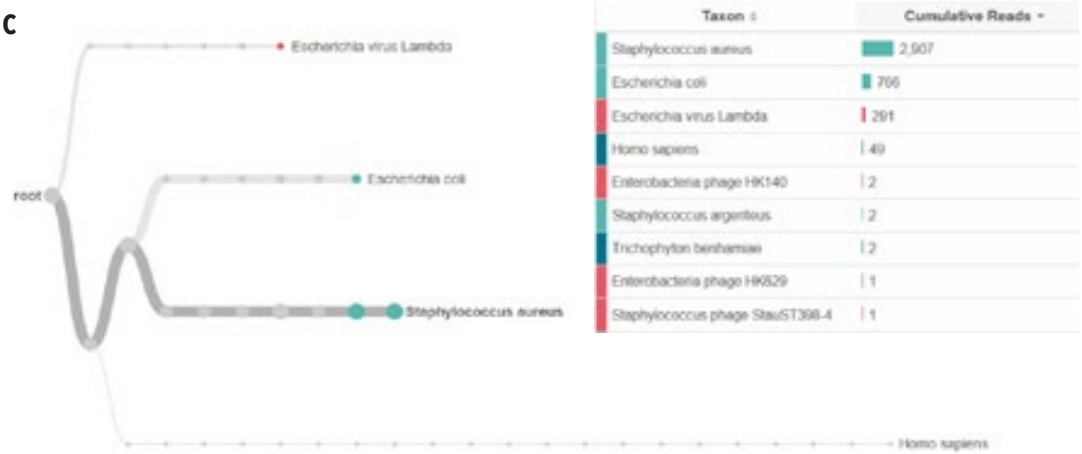
A



B



C



C

Gene	▼ Alignments	Average Accuracy	Taxon
mphC	9	86.7%	Staphylococcus equorum
PC1 beta-lactamase (blaZ)	9	89.1%	Staphylococcus aureus subsp. aureus USA300_TCH959
mecA	6	92.5%	Staphylococcus aureus
aad(6)	4	94.0%	Streptococcus oralis
Staphylococcus aureus rpoB mutants conferring resistance to rifampicin	3	93.0%	Staphylococcus aureus subsp. aureus MRSA252

RESIDENT GLANCY COMPETITION ..... 8:10–9:00 am

#5 Preoperative Evaluation of the Superficial Fascial System Can Predict Wound Complications in Body Contouring Surgery

David M. Straughan, MD[1]; Michelle E. McCarthy, MS[1]; Richard Guidry, BS[2]; Christopher Homsy, MD[1]; Shimul Patel, MD, FACS[1]; Abigail E. Chaffin, MD, FACS[1], Hugo St. Hilaire, MD[2]; Michael Dancisak, PhD[3]; John T. Lindsey, MD, FACS

[1]Department of Plastic and Reconstructive Surgery, Tulane University, New Orleans, Louisiana
[2]Department of Plastic and Reconstructive Surgery, Louisiana State University, New Orleans, Louisiana
[3]Department of Biomedical Engineering, Tulane University, New Orleans, Louisiana

Background: Lockwood established the importance of the Superficial Fascial System (SFS) in patients undergoing body contouring surgery. Recent anatomical studies have demonstrated a wide variability of the SFS. The authors aim to assess if the preoperative evaluation of the SFS using ultrasound can predict wound complications in these patients.

Methods: A retrospective study of patients undergoing body contouring surgery was performed. Preoperatively, ultrasound images were obtained of the SFS. Using Cellprofiler, Mean Gray Values (MGV) were calculated to quantify this structure (Figure 1). Chart review was performed to identify post-operative wound complications.

Results: Thirty-six patients were included: 30 abdominoplasties, 3 bilateral medial thigh lifts, and 3 bilateral brachioplasties. The overall wound complication rate was 25%. There were no significant differences in body mass index, smoking status, weight of resected specimen, or diabetes when comparing the complication and non-complication groups. However, the MGV was significantly greater in the non-complication group compared to the complication group (0.135 +/- 0.008 vs. 0.099 +/- 0.005, respectively; $p = 0.03$). The average MGV for the entire cohort was 0.127. Patients with MGV greater than 0.127 had a wound complication rate of 0% compared to that of 39% for patients with an MGV less than 0.127 ($p=0.005$) (Figure 2).

Conclusions: We have shown that the preoperative evaluation of the SFS with ultrasound can predict postoperative wound complications in patients undergoing body contouring surgery.

Figures 1A and 1B:

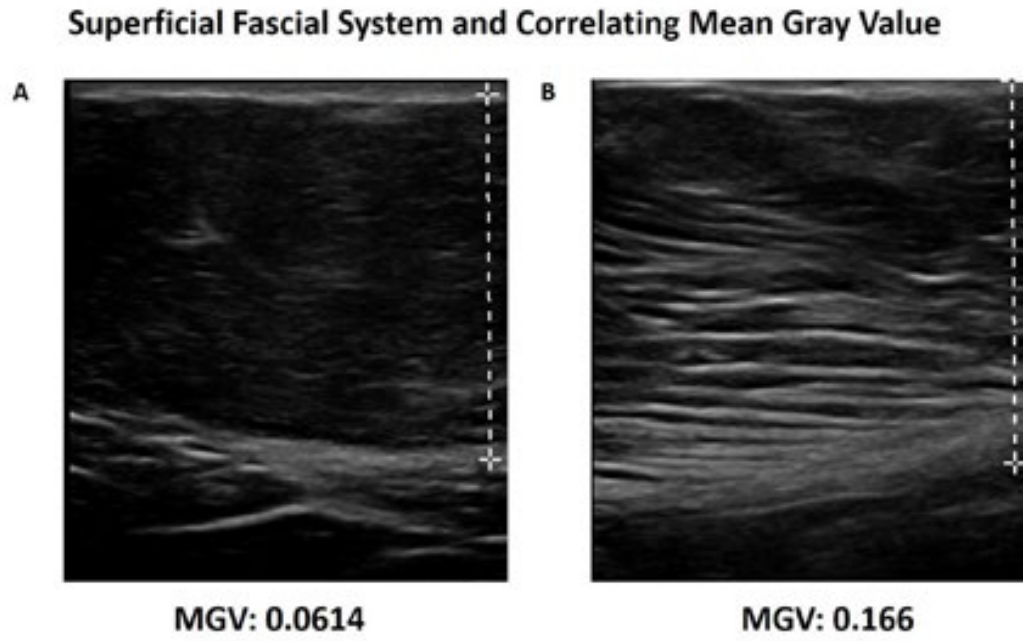


Figure 1: Ultrasound imaging of subcutaneous tissues shows variability of the Superficial Fascial System (SFS). Figure 1A demonstrates a sparse amount of SFS (Mean Gray Value 0.0614) while Figure 1B demonstrates a robust amount of SFS (Mean Gray Value 0.166). The vertical white dashed lines correspond to subcutaneous tissue with muscle below.

Figure 2:

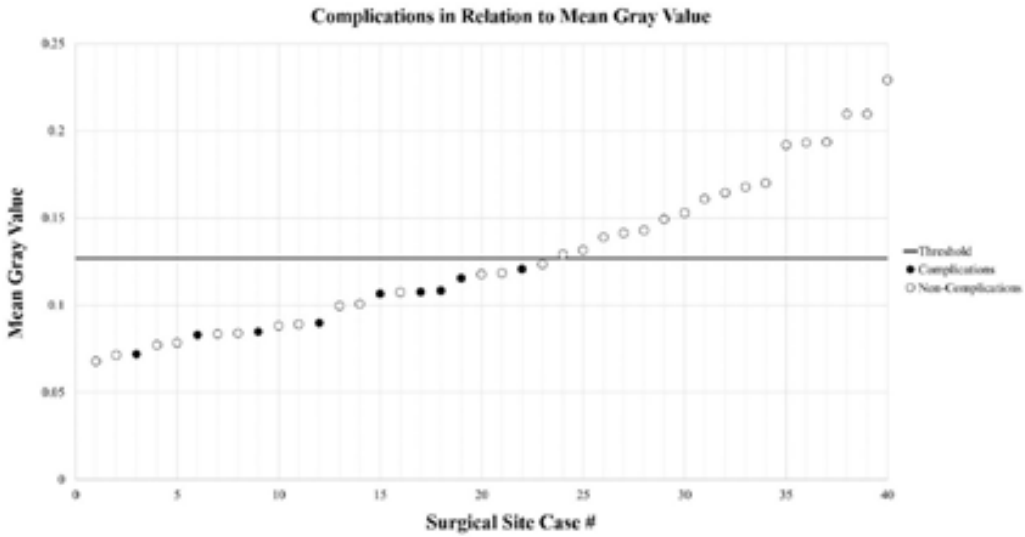


Figure 2: When using the average mean gray value (MGV) of 0.127 as a threshold, the wound complication rate was significantly higher for patients below this threshold compared to those above ($p = 0.005$).

RESIDENT GLANCY COMPETITION ..... 8:10–9:00 am

#6 Pre-pectoral vs Sub-pectoral Breast Reconstruction in High Body Mass Index Patients.

Walker, Nicholas J.[1], Park, Jungwon G. [1], Rebowe, Ryan E. [1], Marks, Malcolm W. [1], Runyan, Christopher M. [1], Tucker, Scott L.[2]

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Introduction: The effect of increased Body Mass Index (BMI, kg/m2) on complication rates in pre-pectoral breast reconstruction is not well established. The purpose of this study is to compare complication rates between different BMI groups in sub-pectoral and pre-pectoral reconstruction. A secondary aim is to present our experience in transitioning from sub-pectoral to pre-pectoral techniques.

Methods: A single surgeon, retrospective review of prosthetic breast reconstructions over four years was completed. During this period, reconstructions transitioned from sub-pectoral to pre-pectoral technique. Patients were stratified into different BMI groups (<25, 25-35, and >35) and complication rates noted.

Results: 195 prosthetic breast reconstructions (sub-pectoral n=103, pre-pectoral n=92) were performed. There was no increase in reoperations/major complications associated with transition from the sub-pectoral to pre-pectoral technique (p=0.18, sub-pectoral n=5/103, 5%, pre-pectoral n=10/92, 11%). When examining patients by BMI and reconstruction technique, there was a higher incidence of implant exposure in pre-pectoral group BMI >35 (p=0.04, n=2/19, 11%) compared to sub-pectoral BMI >35 (n=0/9) and more minor asymmetries in pre-pectoral BMI ≥25 (p=0.02, n=9/73, 12.3%) compared to sub-pectoral BMI ≥25 (n=0/69). When examining BMI as a continuous measure, the odds of reoperation increased 7% per 1 unit increase regardless of reconstruction technique. This trended toward but did not reach statistical significance (p=0.076, OR 1.07, 95% CI 0.99-1.15).

Conclusions: Overall, transition from sub-pectoral to pre-pectoral reconstruction showed no statistical difference in outcomes. With increasing BMI, there is a trend towards higher major and minor complication rates in pre-pectoral breast reconstruction compared to sub-pectoral breast reconstruction.

MEMBER PAPERS ..... 10:45–11:30 am

#1 Avulsion Fat Grafting Gluteoplasty

Gaurav Bharti, MD

Introduction: There continues to be a steadily increasing demand for buttocks contouring procedures. Patients presenting with buttock deflation and ptosis require not only volume replenishment but also an excisional procedure to achieve the desired result. Systematic reviews comparing gluteal augmentation techniques show the lowest rate of complications with fat grafting as compared to autologous flap or implant augmentation[1–3]. Although fat embolism is a dreaded risk, subcutaneous placement of fat has been shown to be safe and effective[4,5]. Drawing inspiration from avulsion brachioplasty and avulsion thighplasty[6,7], we have developed a technique called avulsion fat grafting gluteoplasty which combines liposuction, skin removal, and gluteal fat grafting. This technique preserves vasculature and lymphatics. As seroma is the most common complication after buttocks lift[8,9], the avulsion technique may mitigate this risk and as well as the risk of hematoma. Lipobody lifting has been previously described and has been shown to have a decreased rate of seroma and hematoma.[10,11] With our combination technique, we seek to improve buttocks aesthetics by incorporating fat grafting for volume correction and minimize complications by utilizing the skin avulsion technique.

Methods: Every patient who underwent avulsion gluteoplasty by a single surgeon was reviewed and included in the study. Seven patients were included with an average age of 48 (range 34-62) and average BMI was 24.7 (range 20-31). Six patients were Caucasian and 1 was black.

Technique: Markings are performed by bimanual palpation to gather excess tissue with the final incision line centered low so that it is hidden beneath undergarments. The operation is performed prone under general anesthesia. Power-assisted liposuction of the resection pattern, and possibly other marked areas, is performed and fat is harvested for transfer. In the area of the resection pattern, thorough liposuction of the superficial layer is performed with a basket tip cannula to separate the skin from the underlying tissues. After verifying the markings, skin incisions are made through the dermis and tissue is avulsed from medial to lateral on both sides. Deep closure of the SFS and dermis is performed followed by fat grafting into the subcutaneous plane in the buttocks. After completion of fat grafting final skin closure is performed.

Results: All patients were satisfied with their result. One patient, who underwent gluteal implant removal developed bilateral gluteal seromas in the old implant pockets treated with serial aspiration. There were no other complications.

Conclusions: Avulsion gluteoplasty is safe and effective with a low complication rate. This technique is ideally suited to patients with buttock deflation and ptosis who need combined skin reduction and volume augmentation.

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MEMBER PAPERS ..... 10:45–11:30 am

#2 ULTRABBL: Ultrasound Guided BBL: Safe Gluteal Fat Grafting Under Real Time Intra-Operative Ultrasound Guidance

Pat Pazmino, MD

Goals/Purpose:
The Brazilian butt lift (BBL) has the highest growth rate of any aesthetic procedure in the America. However, its mortality rate is the highest of any aesthetic procedure: estimated to be as high as 1:3000 by a recent ASAPS study. Although a consensus to stay superficial- above the deep gluteal fascia has been reached, there is currently no way to determine the true position of the cannula tip before fat graft injection. Real time continuous ultrasound can allow for precise and safe fat graft placement as well as prevent the inadvertent position of the cannula tip below the deep gluteal fascia.

Methods:
Power assisted liposuction was used for fat harvesting on 123 patients. Fat graft placement in two separate subcutaneous compartments was performed under real time ultrasound visualization.

Results:
123 consecutive cases of Ultrasound Guided Brazilian Butt Lifts (UltraBBL) will be reviewed. Ages ranged from 19 to 58, 113 women, 10 men, BMI 23 to 33; with fat graft volumes from 200 cc to 1300 cc per side. There were no instances of infections, fat pulmonary embolisms, DVTs, or fat necrosis. 5 patients received a staged secondary procedure. 121 of 123 patients were extremely satisfied with their results at 6 months.

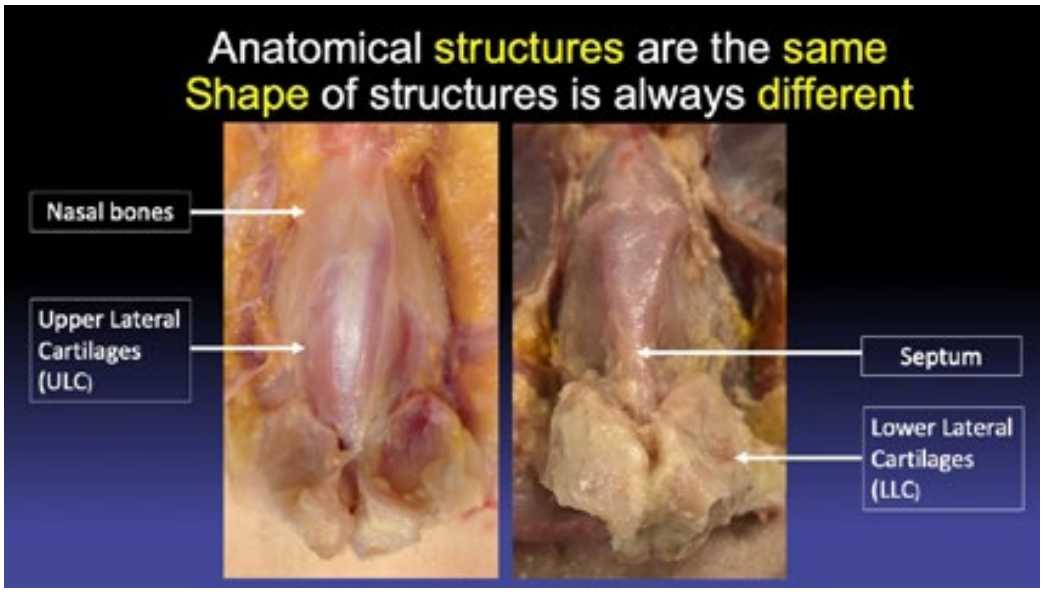
Conclusion:
Real time intra-operative ultrasound allows for reproducible fat grafting in specific subcutaneous gluteal compartments. This is not possible without ultrasound visualization. Grafting can be performed to create specific aesthetic effects. Ultrasound video can also document that the cannula never went below the deep gluteal fascia.

#3 Rhinoplasty for Beginners: An Algorithm for Decision Making

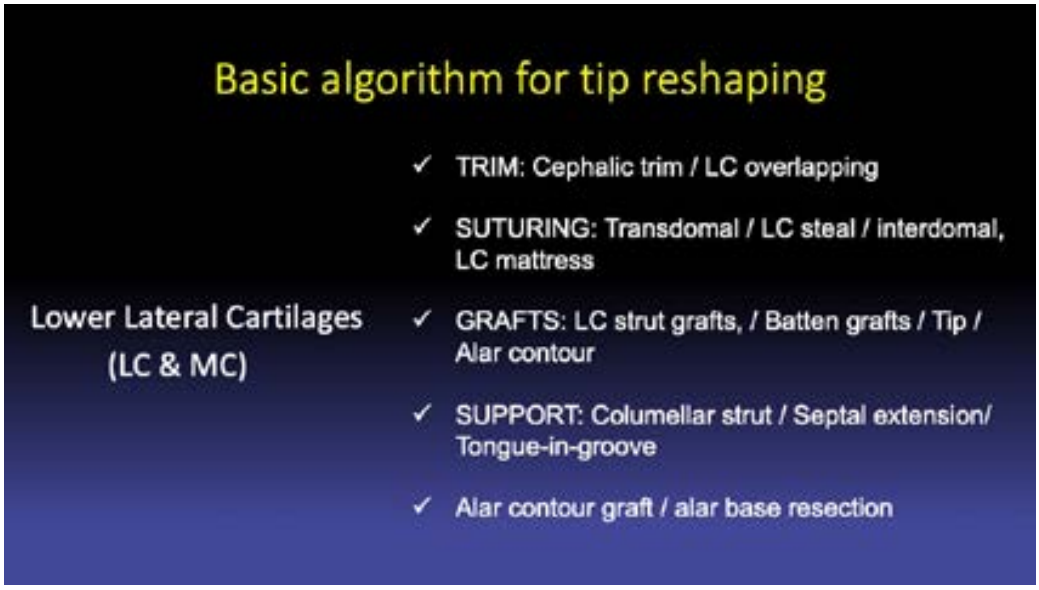
Gabriele Miotto MD, MEd

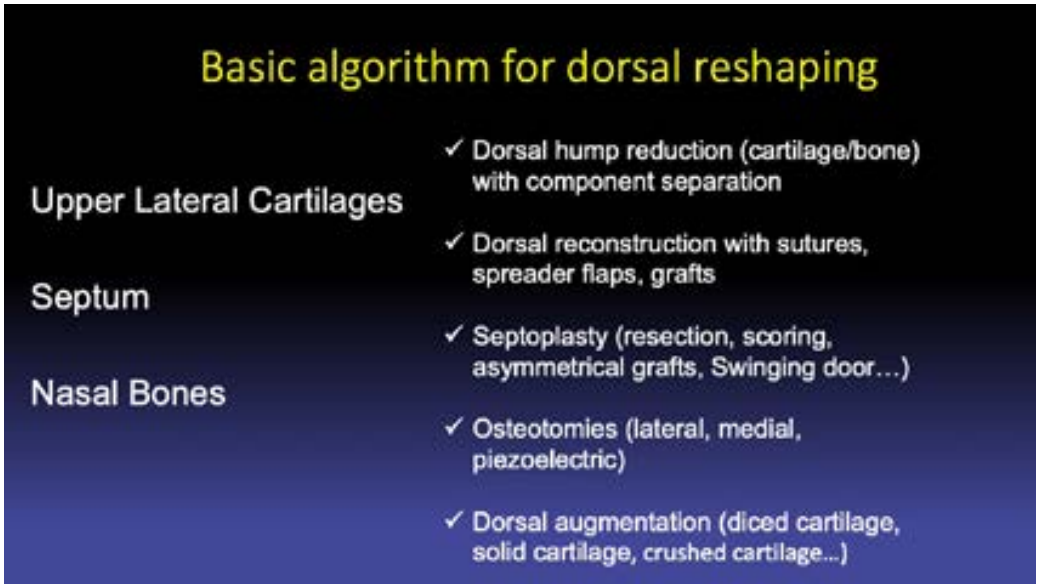
Background: Patients looking for a rhinoplasty have different deformities causing poor nasal shape. Common deformities of the tip cartilage are the bulbous or round tip, boxy or square tip, associated or not with alar base excess and notching. Other deformities include tip under-projection, over-projection, dorsal hump and septal deviation. Surface and light reflection analysis can be effective guides in the decision-making process of what to do in rhinoplasty for beginner rhinoplasty surgeons and for residents and fellows learning rhinoplasty.

Methods: Over the last five years the concepts of anatomy dissection, surface analysis and light reflection analysis have been used as a foundation for teaching our annual rhinoplasty course using fresh cadavers. The emphasis on the subtleties of the nasal anatomy and anatomy shape shows that the nasal structures are the same, but their shape is always different and needs to be modified accordingly for optimal results.



Results: Sixteen graduating chief residents and fellows at the Division of Plastic and Reconstructive Surgery at Emory University have learned the basic rhinoplasty algorithm and increased rhinoplasty understanding and confidence to perform the procedure. These concepts have also been used by the author in planning and performing rhinoplasties over the last 10 years.





Conclusion: Understanding that ideal anatomy shape will create an ideal light reflection of the different nasal aesthetic units can simplify surgical planning and decision making. Beginning with the ideal end shape in mind can help us create a more objective idea of what needs to be modified in a rhinoplasty and use selected techniques individually for tip and dorsal work.

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#4 The Nose in Orbital Hypertelorism: Review of a 44-Year experience by a Single Surgeon

S. Anthony Wolfe, MD, Erin Wolfe, BS, Sydney Mathis,
Jonatan Hernandez Rosa, MD, Sana Bhatti, MD

Introduction: Paul Tessier once famously quipped that orbital hypertelorism correction was no more than an extended rhinoplasty, i.e., a normal nose could not be obtained unless the orbital cavities were in normal position. Orbital hypertelorism can be corrected with box osteotomy and facial bipartition. Correction of resultant nasal deformities must be undertaken at the original operation or at a subsequent procedure in order to create an acceptable aesthetic result.

Methods: All patients who underwent surgical correction of orbital hypertelorism between January 1975 to March 2019 were identified following retrospective chart review. Data collected included age, gender, procedure, postoperative complications and follow-up operations.

Results: 83 patients who underwent surgical correction of orbital hypertelorism were identified. Examination of outcomes showed that in cases where nasal reconstruction is done concomitantly with hypertelorism correction, a Gillies/ Converse type scalping flap was required.

Conclusions: On the basis of a 44-year experience with orbital hypertelorism, the following conclusions can be drawn:

1. Do not operate on patients younger than 6.

2. Expect repeat operations on the nose.

3. The paramedian forehead flap can be used for secondary rhinopoeses but should not be used if there is a fresh craniotomy beneath.

4. If a coronal incision must be made by neurosurgeons, the plastic surgeon should be present to ensure that the incision will not burn the bridges for subsequent nasal reconstruction.

5. Moving the orbits is not difficult; getting a normal nose is.

6. One common characteristic seen with hypertelorism is a short nose which must be lengthened.

#7 Oncologic Safety of Autologous Fat Grafting to the Reconstructed Breast

Jack C. Burns, MD[1]; Ryan C. DeCoster, MD[1,2]; Krishna S. Vyas, MD, PhD, MHS[3]; James P. Mercer, BS[4]; Henry C. Vasconez, MD[1]

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Background: Autologous fat grafting (AFG) is used to augment breast reconstruction following mastectomies; however, the oncological safety of AFG has been questioned. The purpose of this study is to compare the locoregional recurrence (LRR) in breast reconstruction patients that received AFG to those that did not.

Methods: A retrospective, matched case-control study was conducted from January 2000 – August 2017 at the authors' institution. Inclusion was limited to female patients ages 18 – 75 years who underwent mastectomy and breast reconstruction with or without AFG. Cases (AFG) and controls (non-AFG) were matched in a 1:3 ratio. Data were stratified by AFG status and/or mastectomy status (therapeutic or prophylactic). Odds of LRR are reported in odds ratios (OR) with 95% confidence intervals (CI).

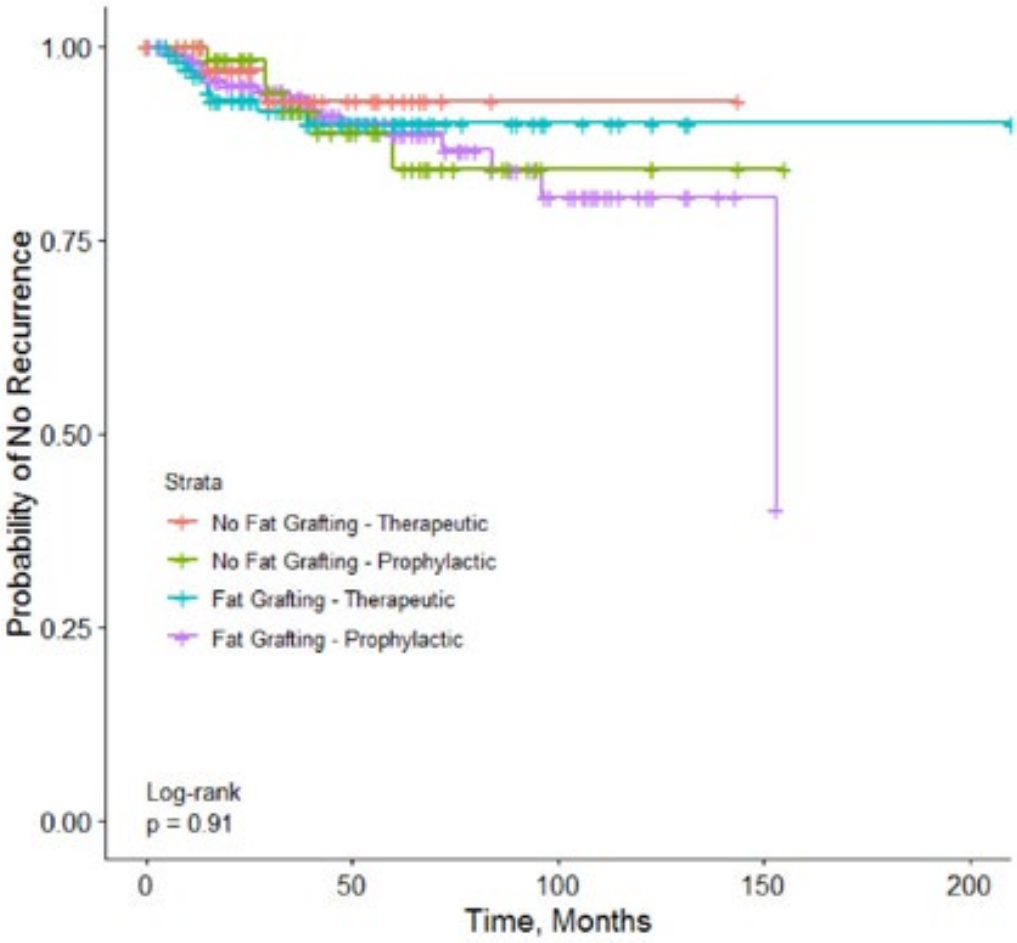
Results: Overall, 256 patients met study criteria. Of those patients, 72 (28.1%) received AFG while 184 (71.9%) did not. No statistically significant increase in odds was noted in LRR for patients undergoing therapeutic mastectomies (OR 0.87, CI 0.31 – 2.60; $p < 0.78$) or prophylactic mastectomies (OR 0.57, CI 0.09 – 2.35; $p < 0.49$) when comparing those receiving AFG to those that did not. A Kaplan-Meier curve showing the time to LRR is shown in Figure 1. No statistical differences in disease-free survival were found between groups ($p = 0.91$ by log rank test).

Conclusion: AFG is an oncologically safe method for use in breast reconstruction that does not increase the likelihood of LRR. Larger studies with longer follow-up are needed to elucidate the long-term safety of this procedure.

Funding Sources: RCD is supported by an NIH/NCI training grant (T32CA160003). This research was partially supported by the William S. Farish Endowed Chair in Plastic Surgery.

Disclosures: The authors have no associations or financial disclosures to report that create a conflict of interest with the information presented in this article.

Figure 1: Kaplan-Meier curve for time to LRR stratified by fat grafting status and therapeutic/prophylactic status (n = 256 patients).



#8 Early Breast Cancer Related Lymphedema Mitigation with Immediate Lymphovenous Anastomosis

Brielle Weinstein MD,[1] Amanda Zimmerman, MPH, MD[1], Ellen Robertson, MD[1], Tina Tavares, RN[2], Thanh Tran, MPH[1], Rachel Karlnoski, PhD[1], Nicholas J Panetta, MD, FACS[1]

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[3] Division of Plastic Surgery, Mayo Clinic, Rochester, MN
[4] College of Medicine, University of Kentucky, Lexington, KY

Introduction: Breast cancer related lymphedema (BRCL) is a progressive disease that poses tremendous physical, psychosocial and financial burden on patients. Immediate lymphovenous anastomosis at the time of axillary lymph node dissection (ALND) is emerging as a potential therapeutic paradigm to decrease the incidence of BRCL in high-risk patients who historically have a 20-40% risk of early onset lymphedema.

Methods: 41 consecutive patients underwent reverse lymphatic mapping and immediate supermicrosurgical LVA at time of ALND at a tertiary care cancer center. Patients were followed prospectively in a multidisciplinary lymphedema clinic including plastic surgery, physical therapy, dietary and case management at three month intervals with clinical exam, limb girth and L-Dex bio impedance. Statistics analyzed with Fischer exact test.

Results: 39 patients met inclusion. The mean post-operative L-dex was 2.3 (normal range -10 to 10). Mean follow up was 173 days. Two (4.8%) developed clinical evidence of lymphedema with abnormal L-dex, suffering onset at 5 months during adjuvant treatment. Patients with 6 month follow up treated with adjuvant radiation and adjuvant chemotherapy had a statistical difference (p=0.05) compared to those without combined adjuvant therapy. An average of 2.5 /- 1.58 anastomoses were performed per patient (range 1-6). There was no statistical difference (p=0.2258) between single and multi-lymphatic style.

Conclusion: This series of consecutive patients demonstrate a 4.8% incidence of early onset BCRL with iLVA and an increased risk in those undergoing combined adjuvant treatment. This early data represents an encouraging and substantial decrease in high-risk patients.

#9 Identifying Factors Most Important to Lower Extremity Trauma Patients: Key Concepts from the Development of a Patient-Reported Outcome Instrument for Lower Extremity Trauma, The LIMB-Q

Lily Mundy[1], Jordan Grier[2], Andrea Pusic[3], Mark Gage[2], Scott Hollenbeck[1]

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[2]Division of Orthopaedic Trauma, Department of Orthopaedic Surgery, Duke University
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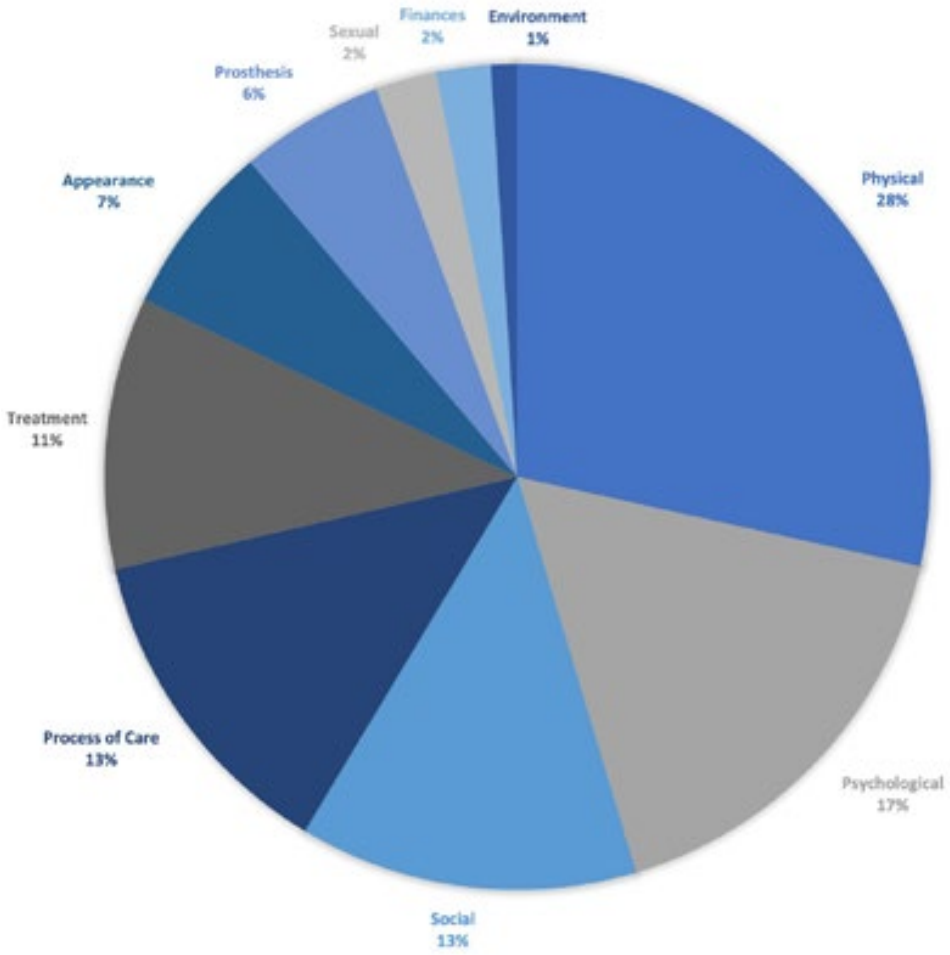
Purpose: Severe lower extremity injuries are challenging to treat. The aspects of limb salvage and amputation most important to patients are not well-defined. Our aim is to develop a conceptual framework for a patient-reported outcome (PRO) instrument for lower extremity trauma patients, by defining issues and concepts most important to this patient population.

Methods: We used an interpretative description qualitative approach. Limb-threatening lower extremity trauma patients requiring soft tissue reconstruction or amputation were recruited at a single-institution via purposeful sampling to maximize variability. Thirty-three participant interviews were needed to reach content saturation. These participants were aged 19-79 years, 63.6% male (n=21), after reconstruction (n= 15, 45.5%), amputation (n=11, 33.3%), or amputation after failed reconstruction (n=7, 21.2%). Semi-structured qualitative interviews were recorded, transcribed and coded line-by-line. Concepts were labeled with major and minor themes and refined through a process of constant comparison. Analysis led to the development of a conceptual framework and item pool to inform the development of a patient-reported outcome measure.

Results: In total, 2,430 unique codes were identified and used to generate the conceptual framework covering 10 major themes (Figure 1).

Conclusion: This study is the first to establish a comprehensive set of concepts, identifying what is most important to severe lower extremity trauma patients. These findings can be used to inform and focus research and clinical care, and provides the framework to develop a lower extremity trauma-specific PRO instrument: the LIMB-Q.

Figure 1. Distribution of patient codes within conceptual framework



#10 The Use of Ultrasound Guidance for the Treatment of Raynaud's Disease with Botulinum Toxin

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Purpose: Botulinum Toxin (Botox) for the treatment of episodic vasospasm of the hand is well established. We examined the anatomic feasibility and clinical effectiveness of ultrasound as an adjunct for the delivery of Botox to the hand to reduce the risk of intrinsic muscle weakness associated with using a traditional landmark-based surface anatomy approach.

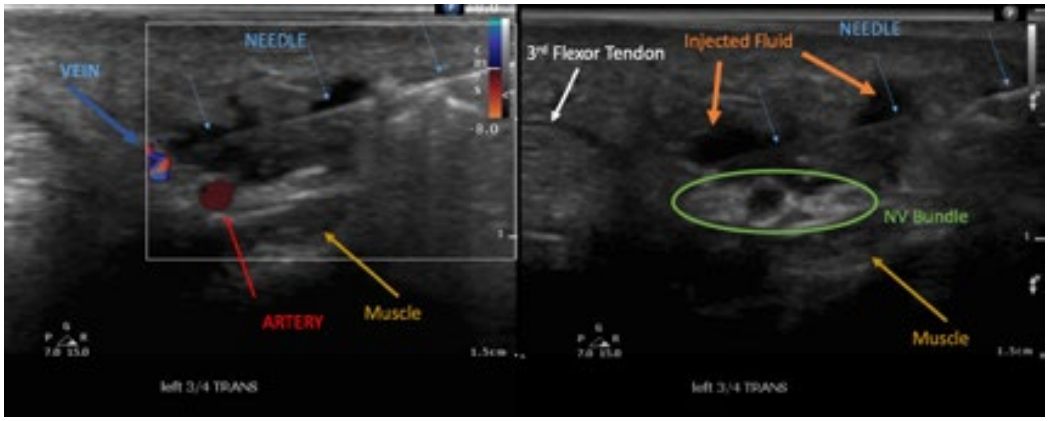
Methods: Cadaveric hand specimens were injected with dye using either a landmark-based surface anatomy approach or ultrasound guidance targeting the common digital arteries. After dissection, areas of distribution of the dye at the levels of the neurovascular bundles and intrinsic muscles were objectively analyzed using Image J.

Five patients diagnosed with Raynaud's Disease of the hand who had failed other non-operative interventions were treated with Botox using ultrasound guidance (PICTURE 1). Demographic data, co-morbidities, and Patient-Reported Outcomes Measurement Information System (PROMIS) Upper Extremity were collected (TABLE 1).

Results: The cadaver hand injected with dye using the traditional landmark-based approach demonstrated significantly increased infiltration of the intrinsic muscles compared to the hand injected using ultrasound guidance (GRAPH 1). The area of vasculature infiltrated by dye was not statistically different between the two techniques (PICTURE 2).

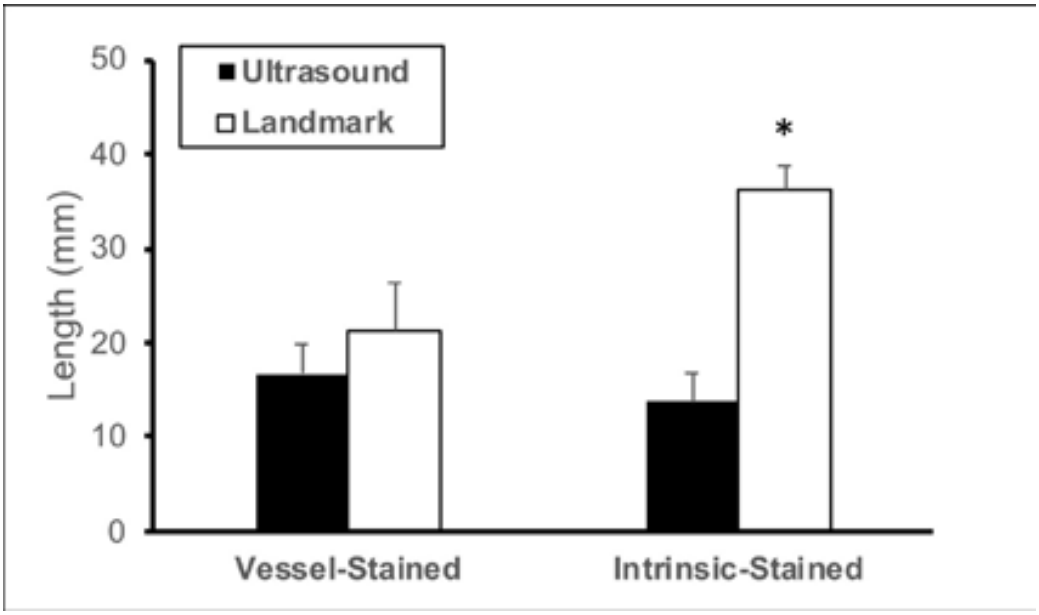
All patients treated with Botox using ultrasound guidance reported improvement in symptom intensity and frequency and in function while zero patients reported intrinsic hand weakness (TABLE 2).

Conclusion: Use of ultrasound for injection of a simulation material dye was significantly more accurate in this anatomical study and significantly improved patient symptoms with no hand weakness reported.

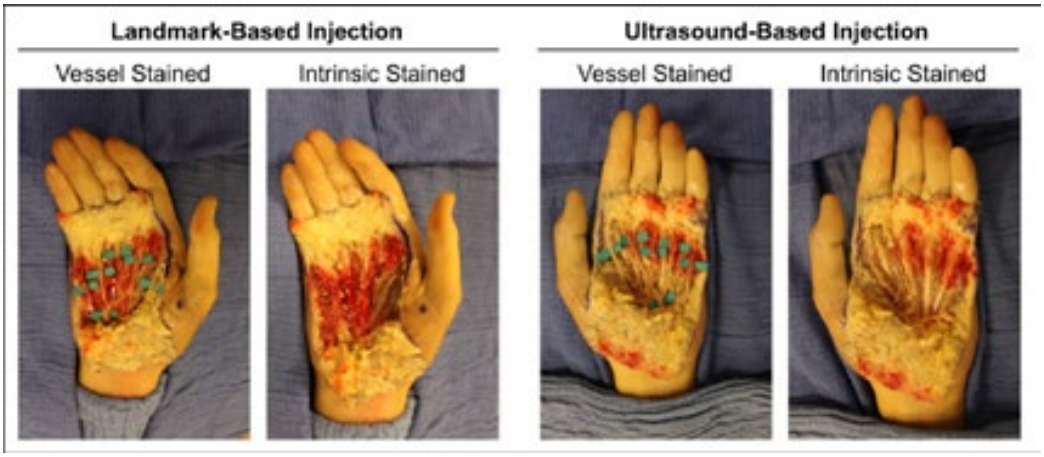


PICTURE 1 Ultrasound images of Botulinum Toxin injection in patients diagnosed with episodic vasospasm of the hand demonstrating the relevant anatomy and fluid distribution.

Table 1: Patient Demographics, Comorbidities, and Characteristics	
Demographics	
Number of Patients	5
Age (years)	57.2 ± 2.3
Male (%)	60.0%
Caucasian (%)	100.0%
BMI	25.7 ± 6.6
Right Hand Dominance	100.0%
Employed	4 (80.0%)
Comorbidities	
Raynaud's Phenomenon	5 (100.0%)
Connective Tissue Disease	2 (40.0%)
Coronary Artery Disease	0 (0.0%)
Diabetes	1 (20.0%)
Active Smoking	1 (20.0%)
Biometric Characteristics	
Charlson Comorbidity Index	4.2 ± 1.9
Brief Resilience Score	3.0 ± 0.5
Continuous variables shown as mean ± standard deviation.	
Categorical variables shown as count and percentage.	



GRAPH 1 The use of Ultrasound significantly increased the accuracy of placement of the simulation dye material when analyzed objectively using Image J.



PICTURE 2 Dissected hand specimens demonstrating the differential distribution of the simulation dye material using the examined techniques. .

Table 2: Pre and Post Treatment Patient Reported Outcome Measures

	Pre-	Post-
Wound Healing		
Fingertip Ulceration	2 (40.0%)	0 (0.0%)
Global Functioning		
PROMIS-29	34.5 ± 7.1	42.1 ± 7.6*
Pain		
Visual Analog Pain Score	7.6 ± 1.5	2.2 ± 1.1*
Sleep Quality		
PROMIS-29 Sleep Likert Scale	1.0 ± 1.0	2.8 ± 0.4*
Upper Extremity Function		
PROMIS Upper Extremity Score	44.6 ± 8.7	47.3 ± 6.2

Continuous variables shown as mean ± standard deviation.
Categorical variables shown as count and percentage.
** = significant difference between pre- and post- intervention ($p < 0.05$).*

#11 The Feasibility of a Sensate Profunda Artery Perforator Flap in Autologous Breast Reconstruction: An Anatomic Study for Clinical Application

Pallavi Archana Kumbla, MD; Bin Song, MD; Jorge I. de la Torre MD, MSHA, FACS; R. Jobe Fix, MD, FACS

University of Alabama at Birmingham, Division of Plastic Surgery

Background: The profunda artery perforator (PAP) flap has been demonstrated to be an effective method of autologous breast reconstruction, particularly when the abdominal donor site is contraindicated. However, there are no current reports regarding the use of a sensate PAP flap in this type of reconstruction. The objective of this study is to describe the feasibility and anatomic location of the sensory nerves supplying the PAP flap in relation to surface landmarks for use in autologous breast reconstruction.

Methods: In this anatomic study, ten cadaver lower limbs were microsurgically dissected. We investigated the posterior femoral cutaneous nerve (PFCN), which supplies sensation to the skin of the posterior thigh and distribution of the PAP flap. The midline of the posterior thigh and gluteal crease were used for surface landmarks. The diameter and length of the nerve branches were documented.

Results: There were between two and five PFCN branches, with an average of three branches, found within the distribution of the PAP flap. Measurements were taken from the gluteal crease and midline to the nerve branches. The average distance caudal to the gluteal crease was 2.4 cm (0 to 7 cm). The average distance medial to the midline was 4.3 cm (0.2 to 8.1 cm). The average diameter of the nerve branches was 1.8 mm (1 to 2.5 mm). The average length of nerve branches from the flap to the fascia was 2.0 cm (1.5 to 2.4 cm). The maximum length of the nerve branches from the flap to the main trunk of the PFCN was 7.8 cm when tracing the nerve branches intramuscularly.

Conclusions: The findings from this study provide an anatomic basis for the sensate PAP flap that would potentially provide an additional dimension to the use of this perforator flap in autologous breast reconstruction. These preliminary results are promising but further physiological studies are warranted to validate the use of this sensate flap.

#12 What are we doing? How are we teaching it?

Rachel Cohen-Shohet, MD, Joshua Bloom, MD, Bruce Mast, MD

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

Introduction: Training residents for cosmetic surgery is challenging. This study's goal is to identify the mastopexy spectrum, comparing private and academic practice, and determine the impact on resident training and readiness.

Methods: An IRB approved retrospective analysis of the senior author's mastopexy practice was performed: 5 years private; 5 years academics consecutively. Indications for surgery, type of surgery and complications (return to OR, hospital readmission, prosthesis loss, non-operative hematoma, seroma, wound dehiscence, infection) were recorded. Surveys (Figure 1) were sent to all graduated, board-certified plastic surgeons (all in private practice) who trained performing mastopexy with the lead surgeon in our apprenticeship model.

Results: A total of 246 mastopexies were reviewed (155 in private practice and 91 in academic setting). Fischer's exact test was performed. There was a statistically significant difference in number of cosmetic and reconstructive mastopexies ($p = 0.0001$). Table 1 shows indications for mastopexy. Table 2 shows mastopexy subtypes. Mastopexy alone and revision mastopexy/augmentation were significantly more prevalent in private practice ($p=0.0184$ and $p =0.0047$ respectively). There was no statistical difference in major or minor complications between private and academic setting (Table 3; $p =0.0604$ and $p=0.1816$ respectively). All graduated trainees reported being "comfortable" or "very comfortable" performing mastopexies.

Discussion: Pure mastopexy represents a minority of mastopexy surgery, both in private and academic practice. Mastopexy in academics is more likely in conjunction with reconstruction/balancing. Despite lesser representation of pure cosmetic mastopexy, trainees are well prepared for mastopexy. This indicates principles and techniques of aesthetic surgery are adequately taught.

Figure 1: Survey sent to graduated residents. All questions answered on a 1-5 scale, with 1 being "very uncomfortable" and 5 being "very comfortable"

1.	How comfortable did you feel performing mastopexy by the end of residency?
2.	How comfortable do you feel performing mastopexy now in practice?
3.	How many years have you practiced?
4.	On average, how many mastopexies do you perform a year?

Table 1: Indications for Mastopexy in Private Practice vs. Academic

Indications	**Private Practice**	**Academic Institution**	**Total**
Ptosis not otherwise identified	62	21	83
Postpartum Atrophy	15	19	34
Non-surgical Weight Loss	9	5	14
Surgical Weight Loss	22	9	31
Asymmetry	1	2	3
Recon/Balancing	9	22	31
Revision Previous Aug	37	13	50
Total	155	91	

Table 2: Comparison of Mastopexy Subtypes Between Private Practice and Academic Institution

Mastopexy Subtype	**Private Practice**	**Academic Institution**	***p*-value**
Mastopexy alone	63	23	0.0184
Primary Mastopexy/ Augmentation	72	40	0.791
Revision Mastopexy/ Augmentation	12	19	0.0047
Mastopexy other	8	9	0.1945

Table 3: Comparison of Major and Minor Complications between Private Practice and Academic Institution

	Private Practice (%)	**Academic Institution (%)**
Major Complications	5 (3.2%)	8 (8.7%)
Minor Complications	14 (9.6%)	8 (15.3%)

#5 Microsurgical Breast Reconstruction in the Obese Patient Using Abdominal Flaps: Complication Profile and Patient-Reported Outcomes

Brian Rinker, MD

Background: Ever greater numbers of obese patients are seeking breast reconstruction. This study is designed to assess whether our assumptions of safety are valid for the obese patient undergoing microsurgical breast reconstruction.

Methods: Records of 109 consecutive patients who underwent microsurgical breast reconstruction over 15 years were reviewed. Patients were divided into obese (BMI ≥ 30 kg/m2) (n=59) and non-obese (n=52) groups. Groups were compared for homogeneity and complication rates using Fisher's exact test. Breast-Q surveys were mailed to all patients, and satisfaction ratings were compared.

Results: Median age was 49 years. Follow-up was 6 to 112 months (median 19 months). Procedures included 107 MS2 TRAM flaps, 29 DIEP, and 13 SIEA flaps. The two groups did not differ significantly in age, follow-up, pathology type, chemotherapy or radiation, or smoking history. More patients in the obese group had diabetes ($p<0.01$). There was a higher incidence of mastectomy flap necrosis (19.3% versus 7.7%, $p<0.01$), unplanned reoperations(38.6% versus 21.1%, $p<0.01$), and hernia/bulge(10.5% versus 0%, $p=0.03$) in the obese group, but no difference was seen in microsurgical complications(7.0 % versus 3.8 %, $p=0.21$). Overall wound complications did not differ, but the obese group had more complications requiring intervention(15.8% versus 3.8%, $p<0.01$). Survey data (response 30%) showed no statistically significant difference in any Breast-Q category between the groups.

Conclusions: Obesity was associated with increased donor site complications and reoperation, however, patient satisfaction remained high. Patients should be counseled regarding risks, but high BMI should not be considered an absolute contraindication for microsurgical breast reconstruction.

	Obese (n=59)	Non-obese (n=52)	P value
Mean Age	49.6	48.9	0.65
BMI	34.6	26.4	**<0.01**
Bilateral	36 %	37 %	0.81
Chemotherapy	47 %	55 %	0.22
Radiation	12 %	17 %	0.18
Diabetes	9 %	2 %	**<0.01**
Smoking	15 %	17 %	0.45
Mastectomy flap necrosis	19.3 %	7.7 %	**<0.01**
Microsurgical complications	7.0 %	3.8 %	0.21
All wound complications	28 %	23 %	0.38
Major wound complications	15.8 %	3.8 %	**<0.01**
Hernia or bulge	10.5 %	0 %	**0.03**

#6 Laterality and Patient-reported Satisfaction Following Autologous Breast Reconstruction with Abdominal Tissue: An 8-year Examination of BREAST-Q Data.

Robert J. Allen Jr. MD, Nikhil Sobti MS, Thais Polanco MD, Meghana Shamsunder MPH, Joseph Dayan MD, Evan Matros MD, Colleen McCarthy MD, Joseph Disa MD, Peter Cordeiro MD, Babak Mehrara MD, Andrea Pusic MD, Jonas Nelson MD

Introduction: Despite the rise in rate of contralateral prophylactic mastectomy (CPM), few studies have evaluated PROs to assess satisfaction between unilateral and bilateral breast reconstruction. This study aims to investigate patient satisfaction following autologous reconstruction to determine if differences exist between unilateral and bilateral reconstructions to better guide clinical decision-making.

Methods: The current study examined prospectively collected BREAST-Q results following abdominal free flap breast reconstruction procedures performed at a tertiary academic medical center from 2009 – 2017 years. The reconstruction module of the BREAST-Q was used to assess patient satisfaction between laterality groups at the following time intervals: 1 year, 2 year, 3 years, and > 3 years.

Results: Overall, 405 patients who underwent autologous breast reconstruction completed the BREAST-Q during the interval of follow up. Cross-sectional analysis at 1 year, 2 years, and 3 years revealed similar satisfaction scores between groups, however bilateral reconstruction patients demonstrated higher satisfaction scores at >3 years ($p=0.04$). Bilateral reconstruction patients reported lower scores of abdominal well-being at 1 year, 2 years, and > 3 years ($p = 0.01$, $p = 0.03$, and $p = 0.01$ respectively).

Conclusion: These results suggest that satisfaction does not differ with the laterality of the reconstructive procedure up to three years post-operatively, but may diverge beyond three years. However, bilateral reconstruction patients have lower satisfaction with the abdominal donor site. These data can be utilized in preoperative counseling, informed consent, and expectations management in patients considering CPM and subsequent bilateral reconstruction.

Figures

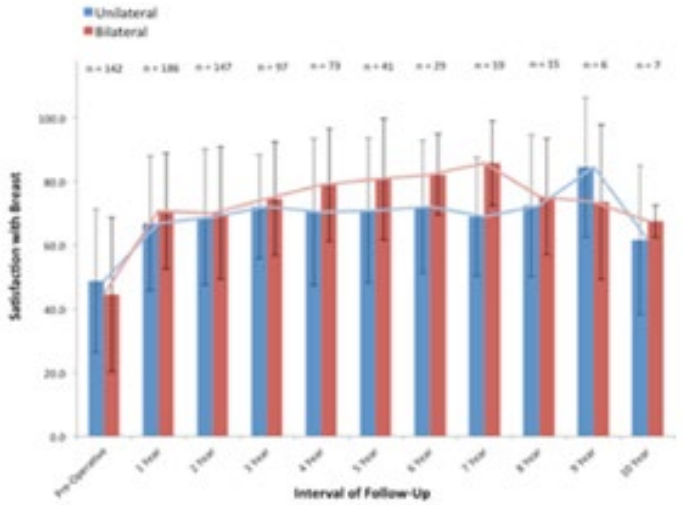


Figure 1. Cross-sectional analysis of BREAST-Q scores for satisfaction with breast between laterality groups throughout interval of observation (years 1 – 10).

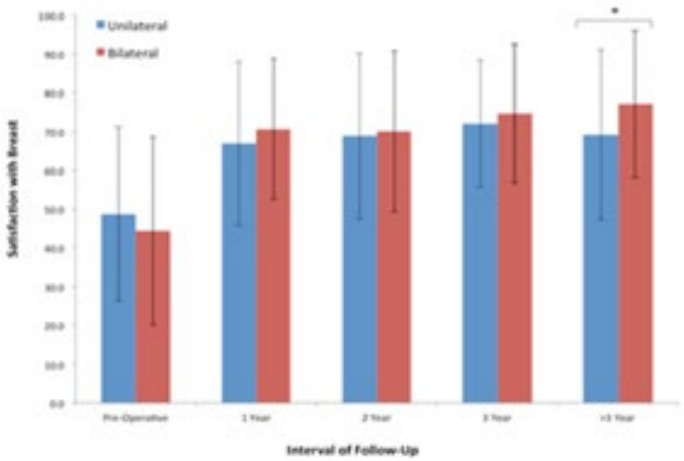


Figure 2. Cross-sectional analysis of BREAST-Q scores for satisfaction with breast between laterality groups at the following time intervals: pre-operative, 1 year, 2 years, 3 years, and > 3 years, post-operatively.

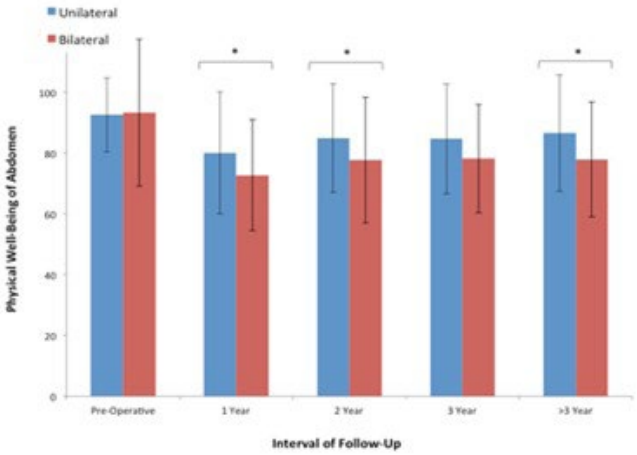


Figure 3. Cross-sectional analysis of BREAST-Q scores for physical well-being of the abdomen between laterality groups at the following time intervals: pre-operative, 1 year, 2 years, 3 years, and > 3 years, post-operatively.

#7 The Impact Oncoplastic Reduction has on Long-Term Recurrence in Breast Conservation Therapy

Losken A, Smearman E, Hart AM, Broeker JS, Styblo TM, Carlson GW

Introduction: The use of oncoplastic reduction techniques have many proven benefits over lumpectomy alone. While it often broadens the indications for breast conservation therapy and allows a more generous resection, the impact it has on tumor recurrence is unclear. The purpose of this review was to evaluate the impact it has on recurrence.

Methods: A prospectively maintained database of patients who underwent oncoplastic reduction techniques at the time of tumor resection was queried. These patients were matched with lumpectomy alone group. For inclusion in the study, patients were at least 10 years since the time of the tumor resection. The main outcome of interest was tumor recurrence.

Results: There were 95 patients in the oncoplastic group and 104 patients in the lumpectomy only group with an average follow up of 8.3 years and 7.8 years respectively. Patients in the oncoplastic group were younger (51.6 vs 61.4 years, $p<0.001$) and had larger tumors (1.6 vs 1.1 cm, $p<0.001$). Positive margin was lower in the oncoplastic group (10% vs 34%, $p=0.003$) and local recurrence was slightly lower in the oncoplastic group (6% vs 12%, $p=0.34$). Overall recurrence was similar (23% vs 15%, $p=0.13$). Only 10% of patients with recurrence had DCIS in the oncoplastic group compared to 56% in the lumpectomy group ($p=0.007$). For patients with DCIS, overall recurrence was lower in the oncoplastic group (14% vs 30%, $p=0.15$).

Conclusions: The oncoplastic reduction technique does provide better margin control which tends to reduce the incidence of local recurrence especially in patients with DCIS.

#8 Immediate Latissimus Dorsi and Prosthetic Reconstruction in the Setting of Postmastectomy Radiation: Analysis of 376 Breast Reconstructions

Katherine Chiasson M.D., Ryan Restrepo M.D., Palavi Kumbla M.D., Alvin Cohn M.D

Purpose: In immediate breast reconstruction (IBR) the plastic surgeon must strive for optimum aesthetic outcomes without knowing if postmastectomy radiation (PMRT) is necessary. Here we review immediate use of latissimus dorsi myocutaneous flaps (LD) and implants, regardless of need for adjuvant radiation, to determine the safety and efficacy of this approach.

Methods: A single surgeon practice with standardized reconstructive algorithm was reviewed: LD and tissue expander (TE) for immediate reconstruction following mastectomy; followed by exchange for implants, nipple reconstruction, and any adjunctive procedures such as autologous fat grafting. We retrospectively identified 201 patients (376 breasts) meeting inclusion criteria. Patient demographics and outcomes were compared based on radiation status. The primary outcome (reconstructive success) was defined as no need for further autologous reconstruction beyond the latissimus flap.

	LD+EI n=165	LD+EI with PMRT n=36
Age, mean (SD)	51.38 (10.80)	49.58 (10.13)
BMI, mean (SD)	30.09 (6.23)	32.71 (6.51)
Tobacco use, No. (%)	15 (9.1)	2 (5.6)
Complications, No. (%)		
Minor	35 (21.2)	8 (22.2)
Major	32 (19.4)	8 (22.2)
Procedures to reconstruction, mean (SD)	2.69 (0.91)	2.4 (0.84)
Reconstructive Success, No. (%)	159 (96.4)	30 (83.3)

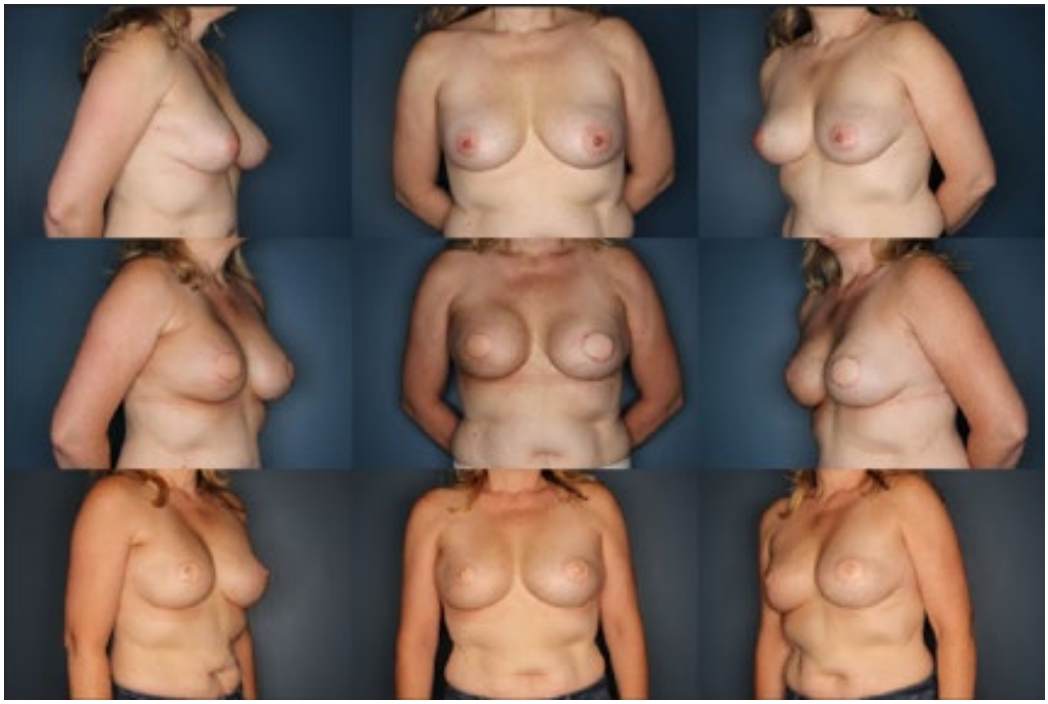


Figure 1. Preoperative, postoperative stage one, and final reconstructive results in a radiated patient.

Conclusions: Immediate reconstruction with LD+EI is a reliable and safe option, even in the setting of PMRT, as the autologous tissue mitigates many radiation sequelae. It provides a pleasing and durable result that is achieved in only two stages, with a favorable complication profile and success rate.

#9 Is Thoracodorsal Nerve Transection Needed in Latissimus Dorsi Breast Reconstruction?

Ravi Patel BS, Haley Oberhofer BS, Daniel O'Neill BS, Sonja Samant BS and Bruce Mast, MD

Purpose: Latissimus dorsi (LD) breast reconstruction is of proven efficacy. Advantages of thoracodorsal nerve transection are potential prevention of muscle spasticity/movement; disadvantages are possible long-term muscle atrophy and volume loss. This study's purpose is to provide data that would support or refute nerve transection.

Methods: A retrospective study of all LD breast reconstruction patients from 2011 to 2017 was done. Total number of flaps were identified, as was thoracodorsal nerve transection. Outcomes were noted for symptomatic muscle spasticity/involuntary movement, and complications inclusive of hematoma, seroma, capsular contracture.

Results: 125 patients had 170 flaps. 81 flaps had nerve transection; 89 did not. These cohorts had no differences in co-morbidities, indications of surgery (cancer vs prophylactic), irradiation, delayed/immediate reconstruction, use of expanders. Symptomatic muscle movement/spasticity was not significantly different: 3/78 (3.7%) in transection; 5/84 (5.6%), in non-transection (p=0.55, chi square). Incidence of seroma in the transection group was notably higher (18/81, 22% vs, 12%) but not statistically significant (p=0.09, chi square). No differences existed in all other outcomes.

Conclusions: Symptomatic spasticity or involuntary muscle movement occurs in small number of patients with LD breast reconstruction, and is not affected by thoracodorsal nerve transection. Movement after transection is likely due to aberrant nerve innervation and re-innervation. The absence of movement without transection is due to disruption of muscle position and origin after transfer. Seroma formation may be affected by increased axillary dissection required for nerve transection. These data do not support nerve transection and therefore it is not recommended.

#10 Portable Color-Flow Ultrasound (PCFU) Facilitates Precision Flap Planning and Perforator Selection in Reconstructivez Plastic Surgery

Christopher Homsy, MD, Michelle McCarthy, MS and John T. Lindsey, MD, FACS

Background: Precise flap planning and perforator selection are paramount to successful perforator flap surgery. PCFU is a convenient low-cost, easily-accessible imaging modality that has proven to be pivotal in the planning of perforator flaps where anatomic variability is the rule.

Methods: Perforator mapping was performed using an L12-4 linear ultrasound probe connected to an android tablet. Images were obtained with the Lumify® app (PHILIPS Ultrasound, Inc., Bothell, Wash.). Perforator characteristics were recorded (arterial diameter, emergence points from fascia, subcutaneous course, and projection onto the skin surface) using still images and real-time videos.

Results: 31 consecutive patients had 40 perforator flap reconstructions (Table 1). In the 15 flaps which had preoperative CTA imaging, the preoperative sonographic measurements correlated with CTA and intraoperative findings. PCFU allowed perforator flap design and selection based on the largest available perforator, the most appropriate flap thickness, and comparison of multiple donor sites including left versus right (Figures 1 – 3). Two DIEP patients required a takeback to the OR for debridement of non-flap devitalized tissue. The SGAP was abandoned intraoperatively due to proximal vascular anomalies. Overall flap success rate was 98%.

Conclusion: Our experience with PCFU has rapidly improved, allowing individualized flap selection and design based on each patient's unique perforator anatomy, reconstructive requirements, and donor site characteristics.

Table 1: Perforator Flaps

Flap Type	#	Complications
DIEP	29	2 debridements (non-flap tissue)
S-GAP	1	abandoned intraop
Lat arm	2	
ALT	4	
T-DAP	3	
TFL	1	
Total	**40**	**success 39/40 (98%)**

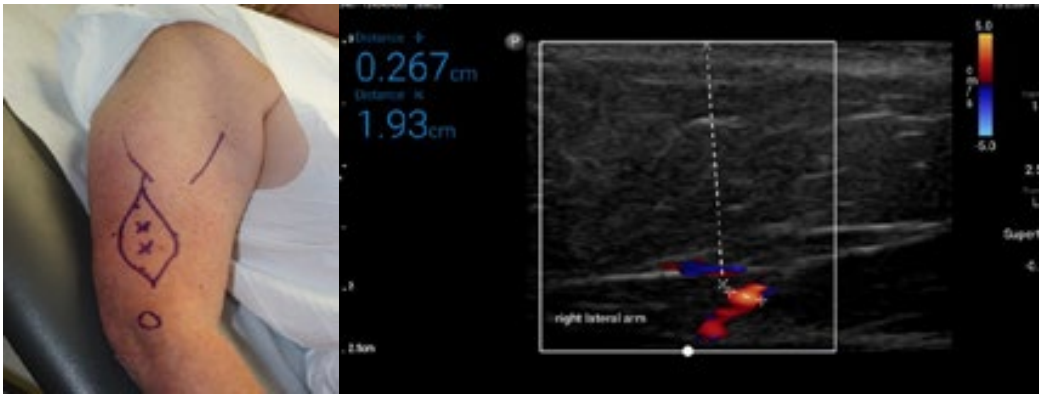


Figure 1. Design of right lateral arm flap shifted posteriorly 3 cm with respect to classic anatomical landmarks in order to capture the dominant (upper x) perforator which by ultrasound is 2.7 mm in diameter and located 1.9 cm below the skin surface at the site of fascial penetration.

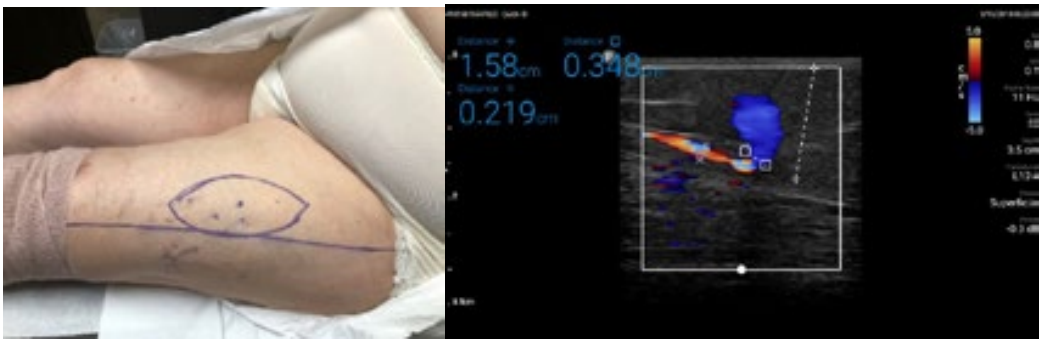


Figure 1. Design of left ALT flap shifted medially 3 cm with respect to classic anatomical landmarks in order to capture the dominant (central dot) perforator which by ultrasound is 2.2 mm in diameter and located 1.6 cm below the skin surface at the site of fascial penetration. The venacomitans is much larger than the arterial perforator and measures 3.5 mm in diameter.

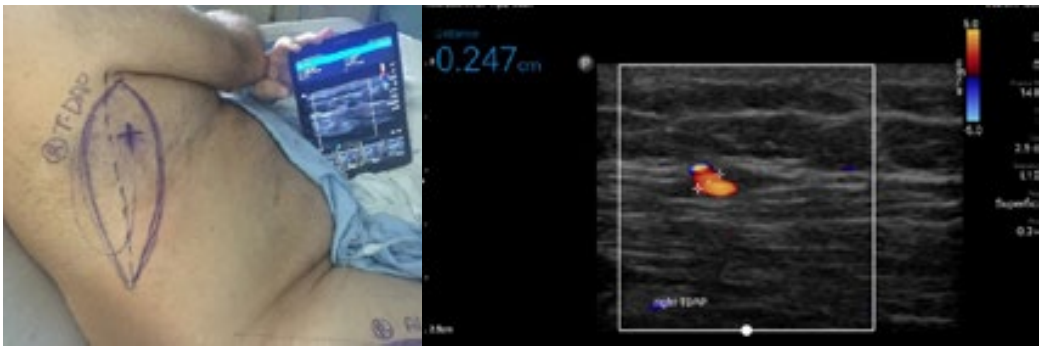


Figure 1. Design of right T-DAP flap shifted anteriorly 6 cm with respect to classic anatomical landmarks in order to capture the dominant (+ mark) perforator which by ultrasound is 2.5 mm in diameter and located 1 cm below the skin surface at the site of fascial penetration.

#11 Post-Mastectomy Radiation Therapy (PMRT) Before and After Implant-Based Breast Reconstruction: A Systematic Review Analyzing the Effect of Radiation Timing on Infection Rate and Need for Explantation

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Running Title: Systematic Review of PMRT Before and After IBR
Conflict of Interest: None
Financial Disclosure: This study was supported in part by the Mayo Clinic Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery.
Key Words: Postmastectomy radiation therapy; PMRT; implant-based reconstruction; breast implant; radiation; breast cancer; breast reconstruction; infection; explantation

ABSTRACTS TUESDAY

Abstract

Background: In those undergoing treatment for breast cancer, evidence has demonstrated significant survival improvement and a reduction in the risk of local recurrence in patients that undergo post-mastectomy radiation therapy (PMRT). There is uncertainty about the optimal timing of PMRT, before or after breast implant placement. The aim of this study was to summarize the data reported in the literature on the effect of timing of PMRT, both preceding and following implant-based breast reconstruction (IBR), and to statistically analyze the effect of timing on infection rates and need for explantation.

Methods: A comprehensive systematic review of the literature was conducted utilizing the PubMed/Medline, Ovid, and Cochrane databases without timeframe limitations. Articles included in the analysis were those reporting outcomes data of PMRT in IBR published from 2009 to 2017. Chi square statistical analysis was performed comparing infection and explantation rates between the two sub-groups at $p<0.05$.

Results: A total of 11 studies met the inclusion criteria for this study. These studies reported outcomes data for 1565 total two-stage expander-implant breast reconstruction procedures wherein PMRT was utilized (1145 prior to; 420 after implant placement). There was a statistically significant higher likelihood of infection following pre-implant placement PMRT (21.03%, p=0.000079) compared to PMRT after implant placement (9.69%). There was no difference in the rate of explantation between pre-implant placement PMRT (12.93%) and post-implant placement PMRT (11.43%).

Conclusion: This study suggests that patients receiving PMRT prior to implant placement in two-stage expander–implant reconstruction may have a higher risk of developing infection.

PMRT Before Implant Placement									
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***	***Pain***	***Wound Dehiscence***	***Infection***	***Explantation***
Nava et al	2011	50	50	49	-	-	-	10 (20%)	20 (40%)
Baschnagel et al	2012	90	90	45	24.1	1 (1.1%)	4 (4.4%)	7 (7.8%)	3 (3.3%)
Brooks et al	2012	-	97	48.5	40.8	-	8 (8.2%)	10 (10.3%)	16 (16.5%)
Sbitany et al	2014	-	113	43.9	25	-	2 (6.1%)	62 (54.9%)	20 (17.7%)
Ho et al	2014	-	113	46.1	37.3	-	4 (3.5%)	4 (3.4%)	15 (13.3%)
Hirsch et al	2014	237	240	47	33	9 (3.8%)		26 (10.8%)	33 (14%)
Fowble et al	2015	99	99	44	45	-	-	-	18 (18%)
Santosa et al	2016	104	176	47.7	16.8	-	5 (2.8%)	14 (8.0%)	3 (1.7%)
Chen et al	2016	38	38	50.3	37.8	-	5 (13.2%)	4 (10.5%)	1 (2.6%)
Wang et al	2016	-	129	47	26	-	29 (22%)	83 (64%)	19 (15%)
Pooled totals			*1145*						
PMRT After Implant Placement									
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***	***Pain***	***Wound Dehiscence***	***Infection***	***Explantation***
Anderson et al	2009	74	84	49	48	-	-	-	3 (3.6%)
Nava et al	2011	109	109	49	-	-	-	-	7 (6.4%)
Ho et al	2012	151	151	44	86	-	-	14 (9.3%)	38 (25.2%)
Santosa et al	2016	46	76	45	14.1	-	0 (0%)	8 (10.5%)	0 (0%)
Pooled totals			*420*						

Table 1. Summary of articles collected from the literature on postmastectomy radiation therapy (PMRT) prior to and following implant-based breast reconstruction (IBR); pts=patients; F/U=follow-up (months)

PMRT Before Implant Placement								
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***		***Infection***	
Nava et al	2011	50	50	49	-		10 (20%)	
Baschnagel et al	2012	90	90	45	24.1		7 (7.8%)	
Brooks et al	2012	-	97	48.5	40.8		10 (10.3%)	
Sbitany et al	2014	-	113	43.9	25		62 (54.9%)	
Ho et al	2014	-	113	46.1	37.3		4 (3.4%)	
Hirsch et al	2014	237	240	47	33		26 (10.8%)	
Santosa et al	2016	104	176	47.7	16.8	-	14 (8.0%)	
Chen et al	2016	38	38	50.3	37.8	-	4 (10.5%)	
Wang et al	2016	-	129	47	26	-	83 (64%)	
Pooled totals			*1046*				***220 (21.03%)***	***P=.000079**
								significant at P< .05
PMRT After Implant Placement								**Chi-square value=15.5813**
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***		***Infection***	
Ho et al	2012	151	151	44	86		14 (9.3%)	
Santosa et al	2016	46	76	45	14.1		8 (10.5%)	
Pooled totals			*227*				*22 (9.69%)*	

Table 2. Comparison of respective rates of infection between subgroups: 1) PMRT before vs 2) PMRT after implant placement in 2-stage expander-implant breast reconstruction; pts=patients; F/U=follow-up (months)

PMRT Before Implant Placement							
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***	***Explantation***	
Nava et al	2011	50	50	49	-	20 (40%)	
Baschnagel et al	2012	90	90	45	24.1	3 (3.3%)	
Brooks et al	2012	-	97	48.5	40.8	16 (16.5%)	
Sbitany et al	2014	-	113	43.9	25	20 (17.7%)	
Ho et al	2014	-	113	46.1	37.3	15 (13.3%)	
Hirsch et al	2014	237	240	47	33	33 (14%)	
Fowble et al	2015	99	99	44	45	18 (18%)	
Santosa et al	2016	104	176	47.7	16.8	3 (1.7%)	
Chen et al	2016	38	38	50.3	37.8	1 (2.6%)	
Wang et al	2016	-	129	47	26	19 (15%)	
Pooled totals			*1145*			***148 (12.93%)***	***P=.427821**
							Chi-square value=0.6287
PMRT After Implant Placement							
Author	***Year***	***N pts***	***N Breasts***	***Age, y (mean)***	***F/U (mo)***	***Explantation***	
Anderson et al	2009	74	84	49	48	3 (3.6%)	
Nava et al	2011	109	109	49	-	7 (6.4%)	
Ho et al	2012	151	151	44	86	38 (25.2%)	
Santosa et al	2016	46	76	45	14.1	0 (0%)	
Pooled totals			*420*			*48 (11.43%)*	

Table 3. Comparison of respective rates of explantation between sub-groups: 1) PMRT before vs 2) PMRT after implant placement in two-stage expander-implant breast reconstruction; pts=patients; F/U=follow-up (months)

#12 Biointegration of a New Porcine Acellular Dermal Matrix with Increased Elasticity in an in Vivo Model of Two-stage Breast Reconstruction with Radiation.

Patrick Cottler[1], Naidi Sun[2], Jenna Thuman[1], Kendall Bielak[1], Lisa Salopek[1], Angela Pineros-Fernandez[1], Song Hu[2], Christopher Campbell

Departments of 1Plastic Surgery and 2Biomedical Engineering, University of Virginia, Charlottesville, VA.

Background: Ideal acellular dermal matrices (ADM) for breast reconstruction exhibit porosity for rapid biointegration and high elasticity for desired clinical outcomes. In a novel in vivo model of irradiated breast reconstruction, we demonstrate excellent biointegration of Artia®, a porcine product chemically prepared to mimic the elasticity of human ADM, with the natural porosity to encourage cellular ingrowth.

Methods: Utilizing the murine dorsal skinfold model, Artia® was implanted, n=8 (35Gy radiation to the skin), and n=8 (0Gy radiation). Real-time photoacoustic microscopy (PAM) of vascular integration and oxygen saturation within the ADM were made over 14 days. At 21 days, vascular ingrowth (CD31), fibroblast scar tissue formation (smooth-muscle actin SMA, vimentin) and macrophage function (M2:M1 ratio) were evaluated.

Results: SEM demonstrates organized collagen fibrils with natural fenestrating pores to allow cellular ingrowth. Repeated PAM imaging demonstrated vascular ingrowth increasing over 14 days, with a commensurate increase in oxygen saturation within the ADM. By day 21, robust CD31 staining was seen with low SMA and vimentin fibrosis expression. M2 macrophages were over-represented consistent with a remodeling physiology.

Conclusions: Artia® demonstrates excellent incorporation, with increased oxygen saturation by 14 days, consistent with other collagen substrates. CD31 and SMA histological values demonstrate appropriately high vascularity and modest fibrosis while SEM documents the porosity ideal for biointegration. Artia® performance in this model also demonstrates consistent performance in an irradiated skin envelope. Taken together with its enhanced elasticity and handling advantages, this porcine ADM product is well poised to be clinically applicable to breast reconstruction.

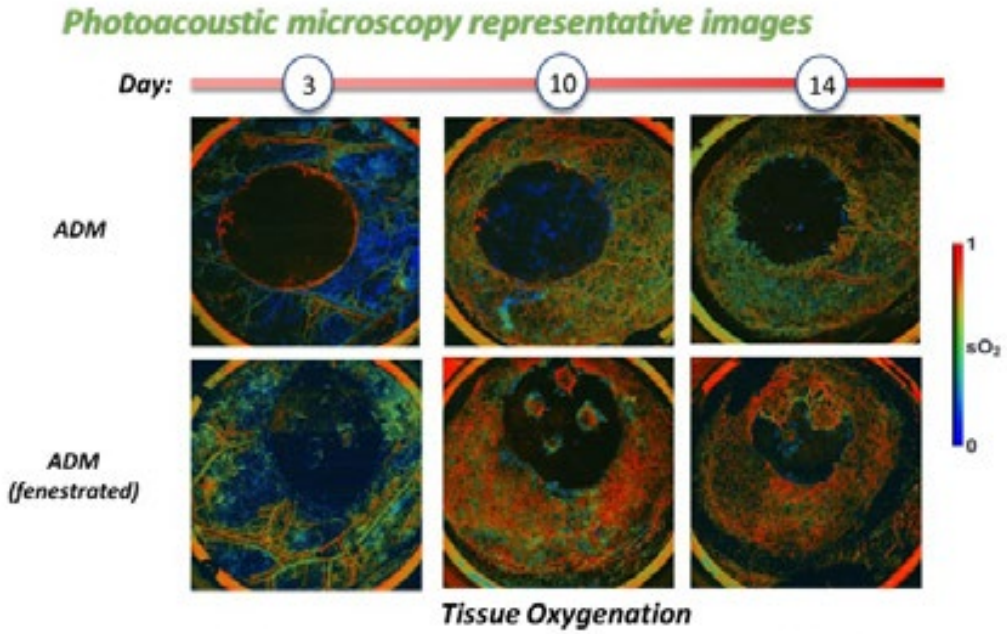


Figure 1. Repeated photoacoustic microscopy images of circular acellular dermal matrix (ADM) specimens within vascularized wound bed. Increasing oxygen saturation is demonstrated along the edges and within the ADM fenestrations over 14 days. A greater surface area of ADM has increased oxygen saturation in the presence of fenestrations

#13 The Role of Oncogenic JAK/STAT3 Pathway Mutations in the Pathogenesis of Breast Implant-Associated Anaplastic Large Cell Lymphoma

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[4] Departments of Rehabilitation Sciences and Physiology, University of Kentucky, Lexington, KY.

Background: The JAK/STAT3 pathway is a major signaling pathway that regulates a variety of intracellular processes. Mutations in the JAK/STAT3 pathway have been implicated in several malignancies including lymphomas and have recently been described in BIA-ALCL. This study aims to critically review current evidence supporting the role oncogenic JAK/STAT3 pathway mutations may play in the pathogenesis of BIA-ALCL.

Methods: A comprehensive literature search of PubMed and other scientific databases was conducted using BIA-ALCL-related search terms. Inclusion was limited to studies investigating oncogenic mutations in BIA-ALCL. All data were reported using descriptive statistics.

Results: The initial search yielded 405 articles. Titles and abstracts were reviewed for relevance and as a result, 254 articles were excluded. The remaining articles (n = 151) were reviewed in their entirety. Of those, five studies were identified that met inclusion criteria (Table 1). Collectively, oncogenic mutations in the JAK/STAT3 pathway were reported in 15/32 (46.9%) unique cases, while 12.5% (4/32) of cases harbored genetic mutations not involving the JAK/STAT3 pathway (e.g. TP 53, DNMT3A). Interestingly, 40.6% (13/32) of cases did not have an oncogenic mutation of any type.

Conclusions: Oncogenic JAK/STAT3 mutations may be central to the pathogenesis of BIA-ALCL. However, the lack of corresponding healthy controls, limited statistical power, and varying gene panels preclude interpretation and extrapolation of these data. Thus, the genetic landscape of BIA-ALCL remains undefined and the functional relevance of these genomic aberrations remains unclear. Comprehensive

genetic analyses addressing these limitations are needed to elucidate the role of JAK/STAT3 in BIA-ALCL tumorigenesis.

* HCV and TAB are co-senior authors on this study.

Funding Sources: RCD and RFB are supported by a National Institutes of Health (NIH), National Cancer Institute T32 training grant (T32CA160003). HCV, TAB, BDR, and RCD are currently co-investigators on a Southeastern Society of Plastic and Reconstructive Surgeons (SESPRS) Research Grant investigating the molecular mechanisms of BIA-ALCL. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH or SESPRS.

Table 1. Next-Generation Sequencing Data Summary of Oncogenic JAK/STAT3 Pathway Mutations in Breast Implant-Associated Anaplastic Large Cell Lymphomas

Year	Author	Article title	Article type	Sequencing type	Gene panel size	Testing of germline DNA	Utilization of corresponding healthy controls	No. of unique tumor specimens tested successfully	No. of tumor specimens harboring a JAK/STAT3 pathway mutation
2018	Blombery et al.	Frequent activating STAT3 mutations and novel recurrent genomic abnormalities detected in breast implant-associated anaplastic large cell lymphoma. *Oncotarget*, *9*(90), 36126	Original Research	Targeted-NGS	180	No*	No	9//9 (disregarding two repeat patients)	7/9 (77.8)
2018	Oishi et al.	Genetic subtyping of breast implant-associated anaplastic large cell lymphoma. *Blood*, *132*(5), 544	Letter to Editor	Targeted-NGS	5	No	No	15/15	4/15 (26.7)
2018	Letourneau et al.	Dual JAK1 and STAT3 mutations in a breast implant-associated anaplastic large cell lymphoma. *Virchows Arch*, *473*(4), 505-511	Brief Report	Targeted-NGS	26	No	No	1/1	1/1 (100)
2018	Di Napoli et al.	Targeted next generation sequencing of breast implant-associated anaplastic large cell lymphoma reveals mutations in JAK/STAT signaling pathway genes, TP53 and DNMT3A. *Br J Haematol*	Correspondence	Targeted-NGS	465	No	No	5/7	1/5 (20)
2016	Blombery et al.	Whole exome sequencing reveals activating JAK1 and STAT3 mutations in breast implant-associated anaplastic large cell lymphoma anaplastic large cell lymphoma. *Haematologica*, *101*(9), e387-e390.	Letter to Editor	WES	20,000	Yes	No	2/2	2/2 (100)

JAK/STAT3, Janus Kinase and Signal Transducer and Activator of Transcription Factor Three; NGS, Next-Generation Sequencing; WES, Whole Exome Sequencing; DNA, Deoxyribonucleic Acid; No., Number; * Germline testing performed on two patients with *TP53* mutations, but not the other cases.



POSTERS FOR PRESENTATION

MEMBER POSTERS

1. **Rhinophyma: A Tri-site Tertiary Center Review of our Experience**
   Dr. Michael D. Baratta MD, Dr. Sarvam P. TerKonda MD, Dr. Brian D. Rinker MD, Dr. Raj TerKonda MD

2. **Plastic Surgery Patient Expectations for Postoperative Opioid Prescriptions**
   Emily A. Long, BA[1], Al Valmadrid, BS[1], Blair A. Wormer, MD[2], Shepard P. Johnson, MD[2], Galen Perdikis, MD[2], Brian C. Drolet, MD[2]

3. **Changes in Lid Crease Measurements in Levator Advancement for Ptosis**
   Amena Alkeswani, Shelby Carson, Brian Westbrook, David Mateo, MD, Sherry S. Collawn, MD, PhD

4. **Delayed-Immediate" Tissue Expander Placement: Expanding the Candidacy for Pre-Pectoral Tissue Expansion in Breast Reconstruction**
   Rachel Cohen-Shohet, MD and Adam Katz, MD

5. **Dorsal Capsular Interposition Arthroplasty for Thumb Carpometacarpal Joint Osteoarthritis**
   Alfredo Lloreda, MD; Jonathan Cook, MD; Craig Forleiter, MD; Jonathan Sarik, MD; Casey Holmes, MD; Aniket Sakharpe, MD, MPH; David Friedman, MD, FACS

6. **Facial Sensory Restoration with Cadaver Nerve Grafts: A Report of Two Cases**
   Kyle Robinson, MD, Petros Konofaos, MD

7. **Multi-Centre Clinical Evaluation of a Cell Conductive Extracellular Matrix Surgical Mesh in Plastic and Reconstructive Surgery – A Case Series**
   Abigail E. Chaffin, MD, FACS, CWSP, FAPWCA; Ariel M. Abballay, MD, Gregory A. Bohn, MD; Paul M. Glat, MD; Micheal N. Desvigne, MD, FACS; Barnaby C. H. May, PhD

8. **Interfacility Transfers for Craniomaxillofacial Trauma: Streamlining Patient Care and Reducing Healthcare Cost**
   Matthew E. Pontell, MD, Juan M. Colazo, Brian C. Drolet, MD

9. **Implant Removal with Simultaneous Mastopexy and Fat Grafting Without Pre-Expansion**
   Jonathan S Lam MD, Christopher Schneider MD, Jules Walters MD, Kamran Khoobehi MD

RESIDENT POSTERS

10. The Safety of Endoscopic Carpal Tunnel Release on Poorly Controlled Diabetics

Patrick Collins, MD, Lamvy Le, MS; Chris Kalmar, MD; Albert Truong, MS; Melika Zarei, MS, Author: Anthony Capito, MD
Virginia Tech Carillion School of Medicine

11. Survey Based Assessment of Burnout Rates Among U.S. Plastic Surgery Residents in 2018

Alexandra Hart, MD., Connor Crowley, MD, Jeffery Janis, MD,
Albert Losken, MD
Emory University

12. Contemporary Analysis of Rhytidectomy Using TOPS Database with 13,346 Patients

Mustafa Chopan, MD, Sonja Samant, MS, Bruce A. Mast, MD, FACS
University of Florida

13. Do We Need Nasal Swabs? The Effects of Preoperative MRSA Colonization on Implant-Based Breast Reconstruction

Matthew A. Applebaum MD [1], Steven A. Svoboda BS [1], Christopher D. Liao BS [1], Matthew T. Joy MD [1] , Kurtis E. Moyer MD [1]
Virginia Tech Carillion School of Medicine

14. The Correlation of Fracture Patterns and Outcomes in Operative Zygomaticomaxillary Complex Fractures

Megan Rudolph, MD, Shamit Prabhu, BA, Thomas Steele, MD,
Christopher Runyan MD, PhD
Wake Forest

15. Efficacy of Pecs Blocks in Breast Reductions

Chelsea C. Wallace, MD, Brian D. Rinker, MD, Evan M. Moore, MD,
Christopher R. Howell, MD, Margaret E. Wetzel, BS, Henry C. Vasconez, MD
University of Kentucky

16. Patient Generated Data as a Novel Outcomes Instrument in Carpal Tunnel Syndrome

Heather A. McMahon, MD; John T. Heineman, MD, MPH; Brent R. DeGeorge, MD, PhD
University of Virginia

17. **Informed Patient Decision Making after Mastectomy - A Pilot Study using Patient Derived Outcomes from Self-Report and Wearable Sensors**
Heather A. McMahon, MD; Jenna M. Thuman, BA; Chris A. Campbell, MD
University of Virginia

18. **Use of Sentinel Lymph Node Incision for Second Stage Implant-Based Breast Reconstruction after Radiation**
David C Lobb, MBChB, Alexandra L Deal, MS, Christopher A Campbell, MD
University of Virginia

19. **Dorsal Decubitus Positioning for Harvesting a Vascularized Scapula Bone Graft: Characterization of Anatomical Variants and Landmarks in a Cadaveric Model**
Patrick J. Buchanan, MD, Mustafa Chopan, MD, Rachel Cohen-Shohet, MD, Trajan Cuellar, MBBS, Harvey Chim, MD
University of Florida

20. **Dehydrated Human Amniotic-Chorionic Membrane Sheets Prevent Incisional Hernia Formation: A Double-Blinded, Randomized Controlled Trial in a Validated Animal Model**
Aran Yoo MD, Celia Short MD, Mandi J. Lopez DVM, MS, PhD,
Catherine Takawira, Camille Rogers PhD, Kazi N. Islam PhD,
Patrick Greiffenstein MD, FACS, Ian Hodgdon MD FACS, Frank H Lau MD
Tulane University

21. **Pre-pectoral Breast Reconstruction with Circumferential Acellular Dermal Matrix Wrap and Double Port Expander after Nipple Sparing Mastectomy**
Makwana, SG; Cohn, AB, Mateo de Acosta, DA; Davis, CB, Gatlin, L
University of Alabama

22. **Z-plasty Transposition Flap: Expanding the Applications**
Nicholas J. Walker, MD; Thomas N. Steele, MD; Leslie B. Branch, MD;
Olivia M. Priest, MD; Lindsey W. Webb, MD; Malcolm W. Marks, MD
Wake Forest

23. **Outpatient Latissimus Dorsi Flap Breast Reconstruction: An Enhanced Recovery After Surgery (ERAS) Pathway**
Mathew T. Epps, MS, MD, Aaron J. Gilson, DO, Rob Kimmel, MD, Taylor K. Pels, BA,
Mark A. Brzezienski, MS, MD
University of Tennessee, Chattanooga

24. Effects of Oncologic Interventions and Wound Complications on the Development of Capsular Contracture in Implant-based Breast Reconstruction

Joy, Matthew T., Applebaum, Matthew A., Liao, Christopher D., Svoboda, Steven, Moyer, Kurtis E
Virginia Tech Carillion School of Medicine

25. Application of LEAN Methodology Reveals Patient Modifiable Factors to Be Prime Source of Delay in "First Start" Cases

Srikanth Kurapati MD MBA, Jorge de la Torre MD MSHA
University of Alabama

26. Correction of Cleft Earlobe Utilizing a Stair Step Repair

Carlos R. Martinez, and Elliott H. Chen
USC School of Medicine

27. Digit and Hand Replantation Analysis and Quality Improvement

Alicia Billington[1], MD, PhD; Ben Ogden[2], MD; Kathryn King[1], MD; Max Rotatori[1], MD, R, Nicole Le[2], BS, Ryan Kim[2], BS, Jason Nydick[3], DO
University of South Florida Morsani College of Medicine

28. Does Incisional Wound V.A.C. Sponge Width Affect Tension Off-loading: A Laboratory Model

Benjamin Googe, MD[1], JC Davidson, BS[2], Peter Arnold MD, PhD[1], Albelardo Medina MD[1]
University of Mississippi Medical Center

29. The Effects of Obesity on Plastic and Reconstructive Surgical Outcomes. A Nationwide Study of the NSQIP database

Daniel Crane, Elizabeth Carroll, Steven Lauzon, and Fernando Herrera
Medical College of South Carolina

30. Utilizing the Inferior Dermal Flap in Pre-Pectoral Direct-to- Implant Breast Reconstruction

Shuting Zhong, MD; Michelle C. Roughton, MD
University of North Carolina

MEDICAL STUDENT POSTERS

31. Split-Thickness Donor Site Dressings: Theory vs Practice
Kristen L. Stephens, BS, University of Mississippi Medical Center, School of Medicine
Somjade J. Songcharoen, MD, Joseph Ogrodnik, MD, Samantha R. Seals, PhD,
Peter B. Arnold, MD, PhD
University of Mississippi Medical Center

32. Optimal Placement of Transfacial Pins for External Mandibular Distraction Osteogenesis in Infants with Pierre Robin Sequence
Lyfong S. Lor, BS; Dominic Massary MD; Christopher M. Runyan, MD PhD
Wake Forest School of Medicine

33. Surgical Approaches to Mandibular Distraction Osteogenesis in Neonates with Pierre Robin Sequence
Veronica Emmerich, MS3, Lyfong Lor, MS3, Robert Siska, MD, Dominic Massary, MD,
Christopher Runyan, MD/PhD
Wake Forest School of Medicine

34. The Safety of Fat Grafting: A Retrospective Review
Carter J Boyd, R. Jobe Fix MD, Jorge I de la Torre MD, Ali Kilic MD, Rene Myers MD,
John H. Grant MD, Brad Denney MD, Andre Levesque MD, Sherry Collawn MD PhD
University of Alabama

35. Safety of Coupled Arterial Anastomosis in Autologous Breast Reconstruction
Mariel McLaughlin BS, Rachel Cohen-Shohet MD, Brooke E Porter BS,
Mark Leyngold, MD
University of Florida

36. Hand Surgery Referral Patterns Among Primary Care Physicians in the Southeastern United States
Abhishek Jain, Steve Hermiz, Fernando A. Herrera
Medical University of South Carolina

37. Comparison of Saline Expanders and Air Expanders for Breast Reconstruction
Brooke E. Porter, BS; Peter M. Vonu, BA; Bruce A. Mast, MD, FACS; Kai Yang, BS;
Peihua Qiu, PhD
University of Florida

38. Identification of Immunologic Factors Involved In Aged Mouse Response to Partial Thickness Burn Injury

Kianna R. Jackson, BS[1], Alonda C. Pollins, MLI[2], Nancy L Cardwell, BS[2], Wesley P. Thayer,MD, PhD[2,3]
Vanderbilt University

39. An Anatomical Basis for Dermoid Cysts

Erin M. Wolfe, BS, Michael Carstens, MD, Sydney Mathis, S. Anthony Wolfe, MD
University of Miami

40. The Potential for Telemedicine: A Clinical & Geographical Analysis of Burn Center Transfer Patients

Benjamin Slavin, BS[1, 2], Sami Shoucair, MD[2], Kevin Klifto, PharmD[2], Michael Grzelak, BS[2], Pragna Shetty, BS[2, 3], Vidhi Javia, BS[2], Carrie Cox, MSN, RN[2], and C. Scott Hultman, MD, MBA, FACS[2]
University of Miami

41. Demonstrating Variability of Perforator Anatomy in the Anterolateral Thigh (ALT) Flap and the Sural Artery Perforator (SAP) Flap Using Portable Color Flow Ultrasound (PCFU)

John T. Lindsey, Jr., John T. Lindsey, Sr
Louisiana State University

42. Pediatric ATV Injury and Microsurgical Reconstruction

Udayan Betarbet, BS, Angela Cheng, MD, Robert C. Fang, MD and Mark D. Walsh, MD
Emory University

43. The Biosynthetic Option as an Alternative in Complex Abdominal Wall Reconstruction

Bjorn Anderson BS, Alexandra M. Hart MD, Daniel Maxwell, DO, Albert Losken MD
Emory University

44. Inferior Pedicle Use for the Treatment of Gigantomastia

Elisa K. Atamian MS, Christopher Homsy MD, Christopher Babycos MD
Tulane University

45. Tissue Engineering Limb Salvage: A Safe and Efficacious Reconstructive Option for Pediatric Patients

Fouad Saeg BS, Elvira N. Chiccarelli MD, Hugo St. Hilaire MD DDS, Frank H. Lau MD
Tulane University

46. Tumescent-Based Radical Excision Cures Hidradenitis: A Prospective Cohort Study

Frank H. Lau, MD[1]; Haiqiao Jiao, MD[1]; Radbeh Torabi, MD[1]; Ann McKendrick, BS[1]; Amy Hui, BS[2]
Louisiana State University

47. Nontuberculosis Mycobacterial Infections: An Increasingly Recognized Infection in the Upper Extremity

Pierce Jones, BS, Jerec Ricci, MD, Lisa Steed,PhD, Milton Armstrong, MD, Fernando Herrera, MD
Medical University of South Carolina

48. Primary Repair of Upper Extremity Peripheral Nerve Injuries. An NSQIP Analysis from 2010-2016

Ryan Brennan BS, Donna Mullner MD, Fernando A. Herrera MD
Medical University of South Carolina

49. Global Volunteer Surgical Missions Among Upper Extremity Specialists in Low- and middle-Income Countries

Nicole K. Le, Neil F. Jones, and James E. Clune
University of South Florida College of Medicine

50. Stratification of Nasolabial Anatomy in Unilateral Cleft Lip patients

Jeslin Kera, Dr. Joseph Zeidan, Dr. Derek Steinbacher, and Dr. Rajendra Sawh-Martinez
University of Central Florida College of Medicine

NOTES

SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

APRIL 17, 1958



Seated (from left to right)

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

Standing (from left to right)

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



PAST PRESIDENTS, ANNUAL MEETINGS, AND SPECIAL LECTURERS

PAST PRESIDENT AND ANNUAL MEETINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RONALD J. JOHNSON
46th Annual Scientific Meeting
2003
The Breakers; Palm Beach, FL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JOHN R. ROYER
30th Annual Scientific Meeting
1987
The Grand Hotel; Point Clear, AL

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

**deceased*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

-

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

**deceased*

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

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

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

Carl R. Hartrampf 2001
Leonard T. Furlow 2003
Luis O. Vasconez 2005
T. Roderick Hester 2007
John McCraw 2009
John J. Coleman, III 2011
Jack Fisher 2013
Grant Carlson 2015
Joseph Williams, MD 2017

FUTURE ANNUAL SCIENTIFIC MEETINGS

June 7–11, 2020	The Sanctuary, Kiawah Island, SC
June 14–17, 2021	The Westin, Hilton Head, SC
June 12–15, 2022	The Four Seasons, Orlando, FL

FUTURE ATLANTA BREAST SURGERY SYMPOSIUM

January 24–26, 2020	Intercontinental Hotel, Atlanta, GA
January 22–24, 2021	Intercontinental Hotel, Atlanta, GA





AWARDS

SPECIAL ACHIEVEMENT AWARD

William J. Pitts 1977
Robert C. Reeder 1979
John R. Lewis 1981
Bernard L. Kaye 1982
Joel Mattison 1985
McCarthy DeMere 1987
Greer Ricketson 1994
Allen Hughes 1995
Richard Hagerty 1997
Erle Peacock 2001
S. Anthony Wolfe, MD 2008
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
C. Scott Hultman 2015
Galen Perdikis 2015
Brian R. Rinker, MD 2016
Bruce A. Mast, MD 2017
Joseph K. Williams, MD 2018

PICKRELL AWARD

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

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

GLANCY AWARD

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

Foad Nahai 1977
Emory University

H. Louis Hill 1978
Emory University

E.D . Newton 1979
University of Tennessee

Dan H. Shell 1981
University of Tennessee

Donato Viggiano 1982
University of Tennessee

Larry Nichter 1983
University of Virginia

Leonard Miller 1984
Emory University

Richard Sadove 1985
Eastern Virginia Medical School

Mason Williams 1986
Eastern Virginia Medical School

David Hurley 1987
University of Virginia

J.D. Stuart 1988
University of Virginia

James H. Schmidt 1989
University of Florida

Paul A. Watterson 1990
Emory University

Michael G. Kanosky 1991
University of Mississippi

Joseph M. Woods, IV 1992
Vanderbilt University

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

Scott N. Oishi 1994
University of Kentucky

Gregory Mackay 1995
Emory University

R.C. High 1996
Bowman Gray School of Medicine

Henry F. Garazo 1997
Medical College of Georgia

Kim Edward Koger 1998
Duke University

J. Timothy Katzen 1999
Vanderbilt University

Richard Rosenblum 2000
Vanderbilt University

Colin Riordan 2001
Vanderbilt University

Julia MacRae 2002
University of Virginia

M.I. Okwueze 2004
Vanderbilt University

Robert E.H. Ferguson 2005
Kentucky Clinic

Dean DeRoberts 2006
Wake Forest

Howard Levinson 2007
Duke University

S. S. Tholpady 2008
University of Virginia

Scott Hollenbeck 2009
Duke University

Yvonne Pierpont 2010
University of South Florida

Anthony Capito 2011
University of Virginia

Matthew Blanton 2012
Duke University

Michael Lynch 2013
University of Kentucky

Brent R. DeGeorge 2014
University of Virginia

Michael Lynch 2015
University of Kentucky

William D. North, MD 2016
University of Kentucky

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

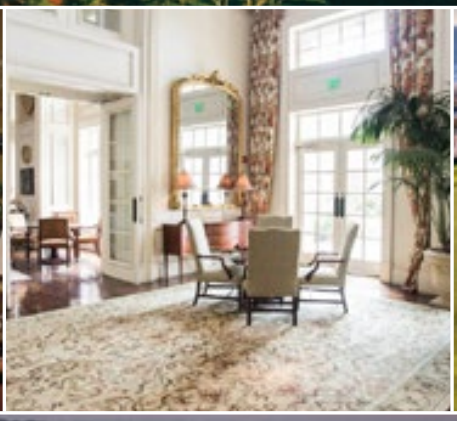
Alexandra Marie Hart, MD 2018
Emory University

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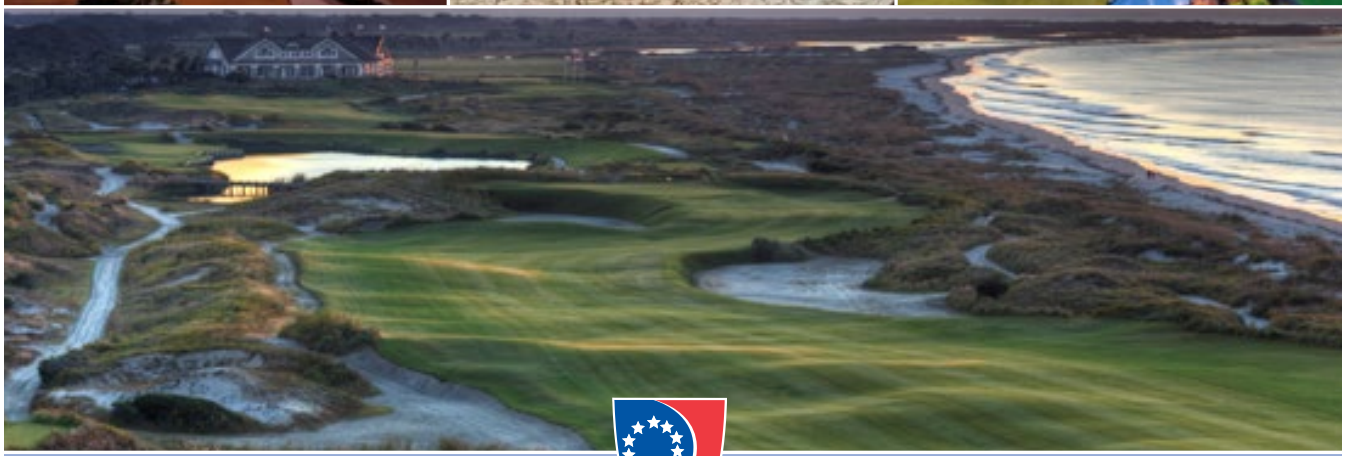
63rd ANNUAL SCIENTIFIC MEETING











JUNE 7-11, 2020

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