

PROCEEDINGS OF THE
68th ANNUAL SCIENTIFIC MEETING
SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

YOU are the
Captain
Now



The Breakers - Palm Beach, Florida | June 15-19, 2025

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WEEK AT A GLANCE

SUNDAY JUNE 15

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

SUNDAY SOCIAL EVENTS

5:30 pm	Welcome Reception
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MONDAY JUNE 16

SCIENTIFIC SESSION

6:30 am	Residency Roadmap Brett T. Phillips, MD
7:30 am	Presidential Welcome
7:45 am	Face Renaissance Panel
9:45 am	Member/General Papers
11:00 am	Keynote Presentation - Captain Richard Phillips
12:30 pm	Mini-Craniaofacial Symposium

MONDAY SOCIAL EVENTS

1:00 pm	Tennis Tournament
5:00 pm	Resident Trivia Competition
6:30 pm	College Tailgate Theme Dinner (Badges Required)

TUESDAY, JUNE 17

SCIENTIFIC SESSION

7:30 am	Round 1 Resident Glancy Competition
8:20 am	Round 2 Resident Glancy Competition
11:00 am	Honorary Upchurch Lecture: David H. Song, MD
11:30 am	The Ship is Sinking - What Do You Do Now?

TUESDAY SOCIAL EVENTS

12:30 pm	Toast to Trudie Luncheon
1:00 pm	Golf Tournament
5:00 pm	Early Career Social

WEDNESDAY, JUNE 18

SCIENTIFIC SESSION

7:00 am	Just the Facts Panel
8:00 am	Charting New Seas in Hand Surgery
9:40 am	Honorary Jurkiewicz Lecture: Linda G. Phillips
10:30 am	Breast Mastery Panel
11:45 pm	Business Meeting (<i>Lunch to be served</i>)

WEDNESDAY SOCIAL EVENTS

6:30 am	Fun Run
6:30 pm	Black Tie Gala (<i>RSVP Required</i>)

THURSDAY, JUNE 19

SCIENTIFIC SESSION

7:45 am	Society Updates
9:00 am	Power Panel - Ultrasound Course
12:00 pm	Closing Remarks: Galen Perdakis, MD

PRESIDENTIAL WELCOME



Dear Colleagues, Friends, and Guests,

Welcome to the 68th Annual Meeting of the Southeastern Society of Plastic and Reconstructive Surgeons!

It is a privilege to gather once again at The Breakers with our remarkable community of surgeons, educators, researchers, and trainees in a setting that fosters both professional growth and personal connection. This year's meeting reflects the dedication and vision of our Program Chair, Dr. Holly Wall, and the outstanding Program Committee. They have crafted a truly exceptional experience filled with education, innovation, and inspiration.

We are excited to present a robust scientific program, including Quick Shot Research Presentations, member presentations, and the esteemed Glancy Competition showcasing the incredible work of our resident researchers. Engaging panels will cover critical topics in our field—from facial rejuvenation and breast reconstruction to challenging cases and breast surgery mastery. We're also proud to offer a new hands-on ultrasound course on our final day, ensuring we continue to expand our practical skillsets.

We are honored to host two spectacular guest lecturers: Dr. David Song as this year's Upchurch Lecturer and Dr. Linda Phillips as the Jurkiewicz Lecturer. Both will speak to the evolving role of plastic surgeons as leaders—a topic as timely as it is essential. We're also thrilled to welcome Captain Richard Phillips as our keynote speaker, sharing his extraordinary story and insights on "Strength and Adaptability."

This year's meeting also includes perennial favorites like "Just the Facts," which will dive into today's hot-button issues in plastic surgery, as well as our annual afternoon mini-symposium—this time focusing on craniofacial surgery.

Beyond the scientific sessions, the Southeastern meeting is known for its camaraderie, collegiality and sense of community. Our meeting would not be the same without time to spend with our friends, colleagues and family. Be sure to join us for the Opening Reception, the always-enjoyable golf and tennis tournaments, or simply unwind by the beach or pool. And don't miss our theme dinner—this year is a spirited college tailgate! We encourage everyone to show off their team colors and school pride. All of this will be capped off with the annual Black-Tie Gala, filled with awards, transitions, music and dancing.

Thank you for being part of this vibrant society and for joining us at what promises to be an outstanding meeting. I look forward to connecting with each of you throughout the week.

Warm Regards,

Bruce A. Mast, MD, FACS

President 2024-2025



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**"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

See the Registration Desk for details related to any events.

SUNDAY, JUNE 15

3:00–5:00 pm	Early Registration	<i>Ponce de Leon Ballroom Foyer</i>
4:00–5:30 pm	Resident Quick Shots Session	<i>Ponce de Leon Ballroom</i>
5:30–7:00 pm	Welcome Reception	<i>Ponce de Leon Ballroom Foyer & Patio</i>
7:00 pm	Past Presidents and Program Chair Dinners <i>By Invitation Only. See Registration Desk for details.</i>	

Dinner on your own. Reservations highly recommended.

MONDAY, JUNE 16

6:30–7:30 am	Residency Roadmap: Planning for the Future Brett T. Phillips, MD, MBA	<i>Ponce de Leon Ballroom</i>
8:00–10:00 am	Spouse/Guest Breakfast Registered Spouse/family/guests only. <i>Name badge required</i>	<i>Ponce de Leon Ballroom</i>
1:00 pm	Annual Tennis Tournament <i>Registration is required.</i> Registered participants are responsible to make their way to the tennis facility by 1:00 pm - <i>Additional fees apply.</i>	<i>The Breakers Tennis Facility</i>
5:00–6:00 pm	Resident Trivia Competition <i>This promises to blend academic excellence with unfiltered fun!</i>	<i>Ponce de Leon Ballroom</i>
6:30–8:30 pm	Theme Dinner - College Tailgate Open to all paid registrants. Dress in your favorite team colors and be ready for games, libations, and tailgate food. <i>Name badge required</i>	<i>The Ocean Lawn</i>

TUESDAY, JUNE 17

8:00–10:00 am	Spouse/Guest Breakfast Registered Spouse/Family/Guests only <i>Name Badge Required</i>	<i>Ponce de Leon Ballroom</i>
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SOCIAL/RECREATIONAL/SPOUSE EVENTS

12:30 pm	Toast to Trudie Luncheon <i>RSVP Preferred</i>	<i>Gulfstream</i>
1:00 pm	Annual Golf Tournament <i>Registration is Required.</i> <i>Registered participants are responsible to make their way to the golf facility by 12:30 pm. Additional fees apply.</i>	<i>Ocean Course</i>
5:00 pm	Early Career Social and Job Fair	<i>Gold Room</i>
Dinner on your own. Reservations highly recommended.		

WEDNESDAY, JUNE 18

6:30 am	Annual Fun Run <i>Registration preferred but not required. Participants should meet in the lobby of the Breakers by 6:15 am. No Fee</i>	<i>Meet in Hotel Lobby</i>
8:00–10:00 am	Spouse/Guest Breakfast <i>Registered Spouse/Family/Guests only</i> <i>Name Badge Required</i>	<i>Ponce de Leon Ballroom</i>
6:30–10:00 pm	Black Tie Dinner <i>Open to paid registrants 16 and older.</i> Assigned Seating – See the registration desk for details. Registrants MUST RSVP in advance of the meeting. Residents of the Glancy Competition (and spouses) are complimentary, but MUST confirm prior to meeting. All other residents and spouses, a separate registration is required.	<i>Venetian Ballroom</i>

THURSDAY, JUNE 19

7:30–9:30 am	Spouse/Guest Breakfast <i>Registered Spouse/Family/Guests only</i> <i>Name Badge Required</i>	<i>Ponce de Leon Ballroom</i>
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2025 SPECIAL GUEST LECTURERS


**Scott P. Bartlett, MD - Mini-Craniofacial Symposium
Keynote Lecturer**

Scott P. Bartlett, M.D., is well known for his work in facial plastic surgery in children and adults, treating them for both reconstructive and cosmetic concerns. In his reconstructive work, Dr. Bartlett treats patients with facial trauma, facial palsy, congenital abnormalities and defects of the face following skin cancer surgery. In the area of cosmetic surgery, he has special interests in the face and neck, concentrating on nasal, eyelid and facial rejuvenation procedures. In addition to surgical treatments, Dr. Bartlett uses injectables and fillers, laser resurfacing, and state-of-the art implant materials. By combining his expertise in infant and adult reconstruction with aesthetic procedures, he is able to marry form and function in restoration.

Dr. Bartlett is a member of the Edwin and Fannie Gray Hall Center for Human Appearance, a team of specialists dedicated to improving ways of treating appearance related problems. He is also the holder of the Peter Randall Endowed Chair in Pediatric Plastic Surgery and of the Friends of Brian Endowed Chair in Pediatric & Reconstructive Surgery at the Children's Hospital of Philadelphia. His research is directed to learning the effects of aging on the structure of the face and refining methods of facial reconstruction. His other research interests include growth and development of the face and implant materials. He is widely published in specialty journals and books.

Dr. Bartlett lectures worldwide and is a member of prestigious plastic surgery societies such as the American Association of Plastic Surgeons, the American Society of Plastic Surgeons and the International Society of Craniomaxillofacial Surgery, of which he is a former President. He is a fellow of the American College of Surgeons and the American Academy of Pediatrics. He is the Section Editor in Pediatric / Craniofacial for Plastic and Reconstructive Surgery, the most widely read journal in the specialty. Each year he travels to Poland in a volunteer capacity where he performs surgery and trains Polish physicians in methods of facial reconstruction for children and adults.

Dr. Bartlett is Chief of Plastic Surgery of Children's Hospital of Philadelphia and is a Professor of Plastic Surgery at the University of Pennsylvania Medical Center. He completed his pre-medical studies at Weber State College in Utah and his medical studies at Washington University School of Medicine in St. Louis, Missouri. He interned and did his surgical and plastic surgery residencies at Massachusetts General Hospital in Boston. At Harvard University, he was a research fellow in surgical immunology and later a craniomaxillofacial and pediatric fellow at the University of Pennsylvania Medical Center and Children's Hospital of Philadelphia. He is board certified in Plastic Surgery.

We are honored to have Dr. Bartlett provide the Keynote lecture for the Mini-Craniofacial Symposium and to take part on the Southeastern program.

2025 SPECIAL GUEST LECTURERS



Dino Elyassnia, MD - The Aesthetic Society Traveling Professor

Dr. Elyassnia comes from a family of surgeons and knew at an early age that this would be his calling. He completed his undergraduate training at the University of California, San Diego where he graduated Summa Cum Laude and received the Biology Outstanding Achievement Award given to the top student in the entire department. Dr. Elyassnia went on to obtain his medical degree at the USC School of Medicine. He graduated in the top 1% of his class and scored in the top 1% nationally on the medical licensing exam. While in medical school his interest in plastic surgery blossomed. His achievements at USC allowed him to obtain an appointment to the combined general surgery and plastic surgery training program at the University of California San Francisco, one of the most sought-after positions in the country. At UCSF, Dr. Elyassnia received a broad education in plastic and reconstructive surgery and learned directly from many leaders in the field. To further develop his interest in cosmetic surgery, he pursued subspecialty training with the best plastic surgeons in Manhattan. There he completed an Aesthetic Fellowship at the New York Eye and Ear Infirmary, home to arguably the busiest fellowship clinic in the country. This is one of only a handful of highly competitive cosmetic surgery fellowships in the United States. Few plastic surgeons complete additional training, such as this, dedicated to aesthetic surgery.

Today Dr. Elyassnia practices a broad spectrum of plastic surgery in San Francisco while maintaining a focus on cosmetic surgery of the face, breast, and body. Dr. Elyassnia is a caring individual who is in constant pursuit of perfection and takes great pride in his work. His talents earned him the opportunity to join The Marten Clinic of Plastic Surgery in San Francisco headed by Dr. Timothy J. Marten, a world-renowned plastic surgeon. The Marten Clinic has been recognized as one of the world's best addresses for plastic surgery (W Magazine, August 2001). He is currently sought after as a lecturer at national and international plastic surgery meetings on facial rejuvenation and fat grafting and has published extensively on these topics.

We are honored to have Dr. Elyassnia as The Aesthetic Society Traveling Professor.

2025 SPECIAL GUEST LECTURERS



Captain Richard Phillips - Special Keynote Lecturer

For five days in April 2009, the world was glued to their TV screens as Captain Richard Phillips became the center of an extraordinary international drama when he was captured by Somali pirates who hijacked his ship, the first hijacking of a U.S. ship in more than 200 years.

The hostage drama began on Wednesday, April 8th when a small band of pirates swung grappling hooks and climbed ropes from their skiff onto the Maersk Alabama, a container ship ferrying food aid to East Africa. Firing into the air as they leapt aboard the ship, many of the crew members scrambled into a designated safe room aboard the vessel.

On the bridge, the pirates held four sailors at gunpoint, but the crew of 20 outnumbered the four attackers. They managed to wound the apparent leader of the pirates in the hand with an ice pick and regain control. The crew demanded the other pirates leave the ship, but the pirates had scuttled their own small boat. They demanded an escape boat, fuel and food.

To protect his crew, Captain Phillips made a conscious decision to put himself directly in harm's way, knowing full well that he might pay the ultimate price for his decision. Amid the standoff, he offered himself as a hostage.

Once the pirates settled into one of the ship's covered lifeboats, the crew attempted to trade the pirate they had captured for Captain Phillips. After they released their captive, the pirates refused to honor the agreement and fled with nine days of food rations and Captain Phillips. Held hostage as a human shield in a small lifeboat with three pirates, he had little to hope for or cling to — except the knowledge that he had done absolutely everything he could to save the lives of the 20 sailors aboard his ship.

The U.S. Navy responded to the scene, and negotiations were ongoing between the pirates and the captain of the USS Bainbridge. On Friday April 10th, Captain Phillips jumped out of the lifeboat and managed to swim a few yards toward the nearby destroyer, but the pirates went in after him and managed to haul him back in. The standoff dragged on until April 12th, when Navy SEAL snipers saw one of the pirates aim his AK-47 machine gun at Capt. Richard Phillips's back and concluded he was in "imminent danger."

President Barack Obama, who spoke with Captain Phillips by phone after he was freed, said, "I share the country's admiration for the bravery of Captain Phillips and his selfless concern for his crew. His courage is a model for all Americans."

Captain Richard Phillips is the author of *A Captain's Duty: Somali Pirates, Navy SEALs, and Dangerous Days at Sea*, about his experience and his remarkable rescue. This dramatic story was also transformed into an Academy-Award and Golden-Globe nominated film, *Captain Phillips*, which hit the big screens in fall of 2013.

2025 SPECIAL GUEST LECTURERS

Captain Phillips is a graduate of the Massachusetts Maritime Academy, a member of the International Organization of Masters, Mates & Pilots Union, and a licensed American merchant mariner. He became Captain of the MV Maersk Alabama in 2009. Captain Phillips married Andrea Coggio in 1987. They have two children, Mariah and Danny and reside in Underhill, Vermont.

We are honored to have Captain Richard Phillips as our Keynote Speaker at the 2025 annual Southeastern meeting.



Photo: Petty Officer 2nd Class Jon Rasmussen, U.S. Navy

2025 SPECIAL GUEST LECTURERS

**Linda G. Phillips, MD- Honorary Jurkiewicz Lecturer**

Dr. Linda G. Phillips is a nationally and internationally recognized leader in the field of plastic surgery. As Chief of the Division of Plastic Surgery at the University of Texas Medical Branch (UTMB) in Galveston, Dr. Phillips combines her clinical expertise with a strong commitment to teaching and research. In her leadership role, she also plays an active part in UTMB's administrative efforts, contributing to committees focused on faculty development and advancing women in the medical profession.

An esteemed member of 26 prestigious professional organizations, Dr. Phillips is affiliated with the American Surgical Association, the Plastic Surgery Research Council, the American Society of Plastic & Reconstructive Surgeons, and the Society of University Surgeons, among others. She is a fellow of both the American Association of Plastic Surgeons and the American College of Surgeons. Throughout her career, Dr. Phillips has held significant leadership positions, including serving as President or Chair of several key organizations, such as the Association of Women Surgeons, the Plastic Surgery Research Council, the Residency Review Committee for Plastic Surgery, the American Board of Plastic Surgery, the Plastic Surgery Foundation, and the Texas Society of Plastic Surgeons. She has recently completed a term as President of the American Association of Plastic Surgeons and Vice Chair of the Board of Regents for the American College of Surgeons.

Dr. Phillips' clinical expertise covers a range of complex procedures, particularly in breast and body contouring surgery, including post-massive weight loss procedures, as well as aesthetic surgeries such as breast augmentation, lifts, abdominoplasties, facelifts, neck lifts, and eyelid surgeries. Her research focuses on the biochemical aspects of wound healing and its direct implications for improving clinical outcomes.

Over the years, Dr. Phillips has been recognized with numerous honors and accolades. She has been featured in the Best Doctors in America database, named in the Guide to America's Top Surgeons, and included in Texas Monthly's list of Texas "Top Docs" and Texas Super Doctors. Additionally, she has received prestigious awards, including the "Young at Heart" Award from the American Society of Plastic Surgeons, the Outstanding Mentor Award from The Aesthetics Society, and the Distinguished Service Award from the Plastic Surgery Foundation.

We are honored to have Dr. Phillips provide the honorary Jurkiewicz Lecture.

2025 SPECIAL GUEST LECTURERS



David H. Song, MD, MBA - Honorary Upchurch Lecturer

Dr. Song serves as the Chief Medical Officer and Vice President of Medical Affairs for MedStar Georgetown University Hospital where he has the primary responsibility for establishing and leading the entirety of medical affairs of the hospital to assure the provision of high quality, efficient, safe, and equitable care. In this role, he also performs responsible administrative and professional work in planning, budgeting, organizing and supervising activities of the hospital. Dr. Song also serves a dual role as the enterprise physician executive director for MedStar Health's Perioperative Service Line. In this role, he has primary oversight and responsibility for operational excellence in all 9 acute care operating rooms and adjacencies.

Prior to serving in his current roles, Dr. Song served as MedStar Health's Physician Executive Director for MedStar Plastic & Reconstructive Surgery, MedStar Integrated Surgical Services and Academic Chair for the Department of Plastic Surgery and Surgery (Interim) at Georgetown University Medical Center. As such, he directed the full range of surgical services for the enterprise directly responsible for the \$85M+ P&L annual budget with the oversight of over 120 providers, including 80+ full-time employed surgeons.

An internationally celebrated expert in plastic surgery, Dr. Song is known for his pioneering work in chest wall reconstruction techniques, particularly DIEP flap procedures breast reconstruction, and oncoplastic surgery. He is also a specialist in performing lymphovenous bypass and lymph node transplant using microsurgical and super-microsurgical techniques to reduce the severity of lymphedema and established the first and largest Lymphatic Surgery Center in the Mid-Atlantic region.

A widely published and prolific researcher, Dr. Song has served as an associate editor for plastic surgery's leading professional journals, a reviewer for many other medical publications, and an author or co-author of over 200 peer reviewed articles, chapters, and textbooks. He is a frequent invited guest lecturer at major medical schools and hospitals and appears regularly as a speaker at national and international conferences. He is an elected member of the American Surgical Association, and American Association of Plastic Surgeons as well as honorary member of both the British Association of Plastic and Reconstructive Surgeons and the Korean Society of Plastic and Reconstructive Surgeons.

Before joining MedStar, Dr. Song served as Associate Dean of the Pritzker School of Medicine, Vice-Chair of Surgery, and Section Chief of Plastic and Reconstructive Surgery at The University of Chicago Medicine. He is a past president of the American Society of Plastic Surgeons and past Chair for the American Board of Plastic Surgery, and currently serves as the Chair for the ACGME Plastic Surgery Residency Review Committee. Dr. Song received his medical degree with thesis from the University of California School of Medicine, Los Angeles. He then fulfilled his internship at the University of Chicago Hospitals, where he subsequently completed the rest of his training: a combined residency in general surgery and plastic surgery, followed by a fellowship in reconstructive microsurgery. Dr. Song also holds an MBA from the University of Chicago Booth School of Business with a focus on strategy and marketing.

We are honored to have Dr. Song provide the honorary Upchurch Lecture.

2025 PRESENTERS

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SPECIAL GUEST LECTURERS

Scott P. Barlett, MD
 Dino Elyassnia, MD

Linda G. Phillips, MD
 Captain Richard Phillips

David H. Song, MD, MBA

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2025 PRESENTERS

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2025 PRESENTERS

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Coru Rogers	Sharon Stanley, MD	Jospeh Williams , MD
Christopher M. Runyan, MD, PhD	Peyton Stauffer, BS	Jeyhan Wood, MD, FACS
Rachel Safeek, MD, MPH	John Stranix, MD	Jun Yao, RN
Paymon Sanati-Mehrizi, MD	Lauren Doyle Strauss, DO	David Zabel, MD
Ellen Satteson, MD	Shannon Su	Eric Zeng, BS
Benjamin Savitz, BS	Holman Taylor, BA	Ting Zhang, BS
Harel Schwartzberg, MD	Wesley Thayer, MD, PhD	Logan Ziegler, MS
Ramy Sharaf	James T. Thompson, MD	
Orr Shaully, MD	Ricardo Torres-Guzman, MD	

LEARNING OBJECTIVES 68TH ANNUAL SCIENTIFIC MEETING

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

- Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,
- Identify and evaluate the latest aesthetic facial techniques and technology for invasive and non-invasive procedures,
- Discuss and evaluate courage, endurance, leadership, and heroism relating to the importance of teamwork through adversity,
- Review and discuss revolutionary techniques in comprehensive breast reconstruction to improve patient outcomes,
- Identify the challenges and changes in plastic surgery procedures to improve safe patient outcomes,
- Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery,
- Evaluate techniques and innovation in hand surgery to identify potential application to a surgeons practice,
- Identify masterful techniques in breast surgery to improve patient outcomes.

**Educational Grant Provided by:
Mentor Worldwide, LLC**

2025 EXHIBITORS



Please scan to view exhibitor descriptions

2025 ACCREDITATION & DESIGNATION



ACCREDITATION

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Society of Plastic Surgeons (ASPS) and the Southeastern Society of Plastic and Reconstructive Surgeons (SESPRS). The ASPS is accredited by the ACCME to provide continuing medical education for physicians.

DESIGNATION

The American Society of Plastic Surgeons (ASPS) designates this live activity for a maximum of **21.5 AMA PRA Category 1 Credits™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the **21.5** credits, **1.5** have been identified as applicable to patient safety.

RECOGNITION STATEMENT

The Continuing Medical Education (CME) credits offered by this activity are enhanced by ASPS Learner Credit Reporting for learners who have opted into this reporting. Successful completion of this CME activity enables active American Board of Surgery (ABS) members the opportunity to earn credit toward the CME requirement of the ABS's Continuous Certification program when claimed within 30 days of completion of the activity.

Participants in ASPS-accredited education who want their CME credits reported to certifying and state licensing boards must opt-in to reporting and add their NPI as well as state license ID and/or collaborating board ID(s) before claiming credit.

DISCLOSURE POLICY

The American Society of Plastic Surgeons (ASPS) requires all instructors, planners, reviewers, managers, and other individuals in a position to control or influence the content of an activity to disclose all relevant financial relationships or affiliations. All identified conflicts of interest must be resolved and the educational content thoroughly vetted by ASPS for fair balance, scientific objectivity, and appropriateness of patient care recommendations. ASPS also requires faculty/authors to disclose when off-label/unapproved uses of product are discussed in a CME activity or included in related materials.

Disclaimer: All relevant financial relationships for planners, faculty, and others in control of content (either individually or as a group) are reviewed by the ASPS Continuing Education Committee and have been mitigated, if applicable.

ADDITIONAL PROGRAMS

For Physician Assistants and Nurse Practitioners, these credits have been designated as AMA PRA Category 1 Credits™ by an ACCME accredited organization and are applicable to these certifications. These credits/hours may be applicable to your profession.

Check PlasticSurgery.org/CME

2025 DISCLOSURES

INVITED INSTRUCTOR/PANELIST AND PROGRAM COMMITTEE DISCLOSURE LISTING

Mayowa Abiodun, MD

AFFILIATIONS: Candidate and young member committee member, SESPRS, DEI Committee member, SESPRS, Nominating committee member, SESPRS. **OUTSIDE RELATIONSHIPS:** Allergan EEDI Advisory Committee Member, RTI Voice of the Experts Consultant. **PUBLIC FINANCIAL INTERESTS:** RTI -Consulting Fees, Allergan Consulting Fees, Bimini Consulting Fees. **PRIVATE FINANCIAL INTERESTS:** Bimini Consulting Fees.

Scott Paul Bartlett, MD

PRIVATE FINANCIAL INTERESTS: TalexMedical - Officer, No Compensation, Stock Shares (all types), RheoTek Medical Officer, No Compensation, Stock - Shares (all types).

Alicia Billington, MD, PhD

AFFILIATIONS: consultant for BD (ongoing), and also doing an FDA study with BD, and Motiva (one time event). **PUBLIC FINANCIAL INTERESTS:** BD Consulting Fees, Motiva Consulting Fees.

Jonathan Black, MD

PUBLIC FINANCIAL INTERESTS: Stryker Consulting Fees.

Timothy Booth

OUTSIDE RELATIONSHIPS: American Society of Pediatric Neuroradiology Board Member **PRIVATE FINANCIAL INTERESTS:** Bracco Diagnostics, Inc Speakers Bureau Member.

Stephanie Bray

AFFILIATIONS: ACPA - Program Committee Member, ACEPS Program Committee Member, Curriculum Committee Member. ASPS In-Service Exam Committee Member, Resident Education Committee Member, Program Committee Member.

M. Bradley Calobrace, MD

AFFILIATIONS: Aesthetic Society - Board of Directors, Aesthetic surgery Journal - Editor. **PUBLIC FINANCIAL INTERESTS:** Alastin Payment for Speaking Engagement and Advisory Committee Member, Allergan Advisory Committee Member, BD/Galatea - Speakers Bureau Member, Mentor Speakers Bureau Member, Motiva Speakers Bureau Member. **PRIVATE FINANCIAL INTERESTS:** Revelle Payment for Speaking Engagement and Advisory Committee Member, miraDry Payment for Speaking Engagement, Sientra (Tiger Aesthetics) Speakers Bureau Member.

Chris Campbell, MD, FACS

AFFILIATIONS: Past-President Virginia Society of Plastic Surgeons, Board of Trustees Southeastern Society of Plastic Surgeons, Secretary of the ASPS Assembly of State and Regional Societies. **INSTITUTIONAL GRANTS:** Abbvie, Inc - Artia Clinical Trial - Principal Investigator for UVA site. **PUBLIC FINANCIAL INTERESTS:** Mentor Johnson & Johnson Consulting Fees, Integra Life Sciences Consulting Fees, Abbvie, Inc Researcher.

Holly Casey Wall, MD, FACS

AFFILIATIONS: Southeastern Society of Plastic and Reconstructive Surgery - Vice President, The Aesthetic Society Aesthetic Cruise Co-Chair. **PUBLIC FINANCIAL INTERESTS:** Establishment Labs Stock - Shares (all types). **PRIVATE FINANCIAL INTERESTS:** Brij Medical Stock - Sares (all types), PatientFi Stock - Shares (all types).

2025 DISCLOSURES

Cristen Catignani, MD

PRIVATE FINANCIAL INTERESTS: United Aesthetics Alliance Compensation / Salary, Stock - Shares (all types), Employee / Owner.

Abigail Chaffin, MD

AFFILIATIONS: Chair, Subcouncil of State and Regional Societies ASP 2024-2025; Vice Chair, Subcouncil of State and Regional Societies ASP 2023-2024; Board of Trustees SESPRS June 2021- June 2024. Chair - Research in Education Committee of ACEPS, September 2024-present; Co-Chair - Research in Education Committee of ACEPS, 2021-2024.

PUBLIC FINANCIAL INTERESTS: Aroa Biosurgery Consulting Fees, Travel Expenses. PRIVATE FINANCIAL INTERESTS: Urgo Medical North America Consulting Fees, Travel Expenses.

Harvey Chim, MD

AFFILIATIONS: Board of directors, AAHS, ASPN, SESPRS, Associate editor: JHS (Am), HAND, JHS AP volume

Committee member; ASPS, AAHS, ASPN, ASSH, PSRC. INSTITUTIONAL GRANTS: Research funding to institution: Neuraptive, Integra. PUBLIC FINANCIAL INTERESTS: Alafair biosciences Consulting Fees. PRIVATE FINANCIAL INTERESTS: Newclip Technic Consulting Fees.

Lynn Damitz, MD

AFFILIATIONS: I began my term as ASPS Board Vice President of Health Policy and Advocacy in October 2021 to present which oversees the ASPS Legislative Advocacy Committee, Health Care Delivery Committee, Patient Safety Committee, Coding and Payment Policy Committee as well the PlastyPAC Board of Governors. I was an ASPS representative to the ACS National Accreditation Program for Breast Centers Board until October 2023. I currently serve as the Secretary (June 2024) and was Parliamentarian (June 2023-June 2024) as well as the Chair of the Finance Committee (2021-2024), and am a member of the ACCME and Ad Hoc Medical Student Competition Committees of the Southeastern Society of Plastic Surgeons and am a member of the SESPRS ACCME and Medical Student Committees. I am a Past President of the North Carolina Society of Plastic Surgeons Executive Board serving Nov 2021, completing my term October 2022. As of August 2022, I am a member of the Scientific Program Committee for the American Association of Plastic Surgeons. I am a member of the The Annals of Plastic Surgery and the American College of Surgeons Case Reviews in Surgery Editorial Board, as well as a Reviewer for The Aesthetic Surgery Journal, Ophthalmic Plastic and Reconstructive Surgery Journal, FACE: Journal of the American Society of Maxillofacial Surgeons and the International Journal of Gynecological Cancer. I am an American Board of Plastic Surgery Advisory Council member (comprehensive) 5/2021-5/2024, renewed 5/2024-5/2027. I am a member of the American Society of Plastic Surgeons, The Aesthetic Society, the American Association of Plastic Surgeons, the American Council of Educators in Plastic Surgery and the American College of Surgeons. PUBLIC FINANCIAL INTERESTS: Allergan Inc Food & Beverage, AbbVie Inc Food & Beverage, Mentor Worldwide Food & Beverage, Pfizer Stock - Shares (all types).

Lisa David, MD

AFFILIATIONS: President elect of ASCFS, Member Plastic Surgery RRC, Oral board examiner plastic surgery, PRS section reviewer, ACEPS VP of education.

Deniz Dayicioglu, MD

AFFILIATIONS: ASPS, ASRM, WSRM, ASMS, SESPRS, SESPRS committee member, EBOPRAS.

Jorge De La Torre, MD, MSHQS, FACS

AFFILIATIONS: Committee Member, SESPRS.

2025 DISCLOSURES

Onelio Garcia, MD

AFFILIATIONS: President, The Aesthetic Foundation (ASERF), Consultant, Gluteal Fat Grafting Task Force. **PUBLIC FINANCIAL INTERESTS:** Solta Consulting Fees, Payment for Speaking Engagement, Bard BD Consulting Fees, Mentor Payment for Speaking Engagement, Consulting Fees, Springer Publishers Royalty Arrangement. **PRIVATE FINANCIAL INTERESTS:** MTF Consulting Fees.

Michael Golinko, MD, MA

PRIVATE FINANCIAL INTERESTS: ImageAssist, INC Director Stock - Options (all types).

Kevin Hao

PRIVATE FINANCIAL INTERESTS: LinkBio Corp Consulting Fees.

Daniel Haynes, MD

PUBLIC FINANCIAL INTERESTS: 3M Company, Stock Owner, Abbott Laboratories Stock Owner, AbbVie Inc. Stock Owner, Adolor Corporation Stock Owner, Advanced Med Optics, Stock Owner, AmerisourceBergen Co. Stock Owner, Ariad Pharmaceuticals Stock Owner, Bausch Health Cos Stock Owner, Baxter International Stock Owner, Beckman Coulter Stock Owner, Biogen Idec Stock Owner, Boston Scientific Stock Owner, Bristol-Myers Squibb Stock Owner, Celgene Corp Stock Owner, Covidien Ltd Stock Owner, CVS Health Stock Owner, Dentsply Sirona Stock Owner, Elevance Health Stock Owner, Encompass Health Stock Owner, GE Healthcare Stock Owner, Genentech Stock Owner, Genzyme General Corp Stock Owner, GlaxoSmithKline Stock Owner, Health Management Associates Inc Stock Owner, Incyte Genomics Stock Owner, Mallinckrodt Stock Owner, McKesson Corp. Stock Owner, Medical Action Industries Stock Owner, Medical Properties Trust Inc Stock Owner, Medtronic Stock Owner Merck Stock Owner, Mylan Laboratories Stock Owner, Myriad Genetics Stock Owner, Nektar Therapeutics Stock Owner, Novartis Stock Owner, Onyx Pharmaceuticals Stock Owner, Opko Health, Stock Owner, Perrigo Stock Owner, Pfizer Incorporated Stock Owner, Regeneron Pharmaceuticals Stock Owner, Sanofi Aventis ADR Stock Owner, Sirna Therapeutics Stock Owner, Steris PLC Stock Owner, Stryker Stock Owner, Teva Pharmaceuticals Stock Owner, Thermo Fisher Scientific Stock Owner, Universal Health Services Stock Owner, Valeant Pharmaceuticals Stock Owner, Vertex Pharmaceuticals Stock Owner, Viasys Healthcare Stock Owner, Viatrix Stock Owner, Walgreen Company Stock Owner, Zimmer Biomet Stock Owner.

Kent Higdon, MD

AFFILIATIONS: Member at Large and Communications Commissioner for The Aesthetic Society, Finance Committee Member TAS, Product Development Cmte Member TAS, ACCME Chair and Board Member for the Southeastern Society of Plastic and Reconstructive Surgeons, Member of the Editorial board for the Aesthetic Surgery Journal and ASJ open forum. **INSTITUTIONAL GRANTS:** Axogen gave a grant to my department to fund research around breast reconstruction when I was faculty there and within the last 24 months. **PUBLIC FINANCIAL INTERESTS:** Baxter Royalty Arrangement, Aziyo Consulting Fees, Allergan Consulting Fees.

Scott Hollenbeck, MD, FACS

AFFILIATIONS: Southeastern Society of Plastic and Reconstructive Surgeons (SESPRS) - Board Member; Assistant Secretary. **PRIVATE FINANCIAL INTERESTS:** Founder and Equity holder - InSoma Bio; preclinical biotech company.

Ian Hoppe, MD

AFFILIATIONS: President, MS chapter ACS.

Charles Hultman, MD, MBA, FACS

PUBLIC FINANCIAL INTERESTS: Avita Medical - Consulting Fees, Payment for Speaking Engagement.

2025 DISCLOSURES

Sonu Jain, MD

AFFILIATIONS: Board of Directors Member AAHS 2022-2024. INSTITUTIONAL GRANTS: Research Funding to Institution from Axogen for RANGER Study. PUBLIC FINANCIAL INTERESTS: Integra LifeSciences Consulting Fees, MicroAire Consulting Fees. PRIVATE FINANCIAL INTERESTS: Checkpoint Surgical, Inc Consulting Fees.

James Johnson

INSTITUTIONAL GRANTS: US DoD (United States Department of Defense) ARMY MEDICAL RESESEARCH AND MATERIAL COMMAND (AMRMC) MTEC (Medical Technology Enterprise Consortium) Award # W81XWH2290018. Burn for Providers Program BP2 (A Research Program investigating the validity of Simulation Training and Assessment Mobile Virtual Reality Software to Improve Burn Care Practitioner Cognitive Behaviors augmented with Hands-On Biomimetic Simulation Procedure Tasks Trainers to Improve Burn Care Practitioner Psychomotor Behaviors within Both Military and Civilian Burn Care Practice). PI: Jeff Carter, MD, Co-I: James Johnson, Total Funding Period: 09/22/2022 – 09/21/2028, Total Costs: \$9,489,404, Co-I Effort: 50%.

Adam Katz, MD

PRIVATE FINANCIAL INTERESTS: GID Bio Compensation / Salary, Stock - Shares (all types), KMD Surgical Solutions Stock - Shares (all types), Employee / Owner.

Carmen Kavali, MD

AFFILIATIONS: Southeastern Society of Plastic and Reconstructive Surgeons (prior Board Member, current committee member--all unpaid), Georgia Society of Plastic Surgeons (past President, unpaid), Physicians for Patient Protection (President, unpaid), Georgia Alliance for Patient Protection (President, unpaid), The Aesthetic Society (member, unpaid), American Society of Plastic Surgeons (member, unpaid). PUBLIC FINANCIAL INTERESTS: Allergan - Consulting Fees, Payment for Speaking Engagement. PRIVATE FINANCIAL INTERESTS: Brijit Medical Stock - Shares (all types).

Ashley Lentz, MD

AFFILIATIONS: Florida Society of Plastic Surgeon, Board of Directors, Southeastern Society of Plastic Surgeons, Board of Directors.

John Lindsey, MD

AFFILIATIONS: Southeastern Society of Plastic and Reconstructive Surgeons, President 2023-2024. Immediate Past President 2024-2025, Chairman, Board of Directors, Houma Outpatient Surgery Center.

Richard Lipton

AFFILIATIONS: American Headache Society – Board Member, American Migraine Foundation – Board Member. INSTITUTIONAL GRANTS: NNIH, NIA, SOL (NIA), NINDS, Alzheimer's Association - Paid to my institution. OTHER: Royalties: Wolffs Headache 7th and 8th Eds, Oxford Press University, Wiley, Informa. PUBLIC FINANCIAL INTERESTS: Abbvie (Allergan) - Advisory board, consulting fees, Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events, Axsome Therapeutics - Advisory board, consulting fees, Biohaven Holdings - Advisory board, stock options, Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events, Eli Lilly - Advisory board, consulting fees, Grifols - consulting fees, Karuna Therapeutics - Advisory board, consulting fees, Lundbeck - Advisory board, consulting fees, Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events, Pfizer - Advisory board, consulting fees, Payment or honoraria for lectures, presentations, speakers bureaus, manuscript writing or educational events, Satsuma - consulting fees, Scilex - consulting fees, Teva Pharmaceutical Industries - consulting fees, Tonix Pharmaceuticals - consulting fees. PRIVATE FINANCIAL INTERESTS: Axon Medical Technologies Advisory board, consulting fees, stock

2025 DISCLOSURES

options, Clexio consulting fees, Cooltech Medical Technologies stock options, Manistee Advisory board, stock options, Shiratronics -Advisory board, consulting fees, Wizemed stock options.

Albert Losken, MD

PUBLIC FINANCIAL INTERESTS: SIA Stock - Options (all types). PRIVATE FINANCIAL INTERESTS: Bimini Health Consulting Fees, Novus Consulting Fees.

Kazlin Mason

AFFILIATIONS: Faculty, University of Virginia, Member, American Cleft Palate/Craniofacial Association (ACPA). Co-Chair, ACPA Membership Committee, Member, American Speech-Language Hearing Association (ASHA). Editor, Perspectives of the ASHA Special Interest Groups, Science Writer, The Informed SLP. INSTITUTIONAL GRANTS: NIDCD R21DC021023, NIDCR R21DE033155.

Bruce Mast, MD

AFFILIATIONS: President-elect, Board Member: Southeastern Society of Plastic and Reconstructive Surgeons, Advisory Council American Board of Plastic Surgery, Advisory Council American College of Surgeons, Editorial board, Aesthetic Surgery Journal. PUBLIC FINANCIAL INTERESTS: Axogen, Inc -Stock - Options (all types), Thieme Medical Publishing Royalty Arrangement.

David Mathes, MD

PUBLIC FINANCIAL INTERESTS: Novo Nordisc Consulting Fees. PRIVATE FINANCIAL INTERESTS: MTF Consulting Fees.

Suhail Mithani, MD

AFFILIATIONS: ASSH, AAHS. INSTITUTIONAL GRANTS: Integra: Ended, KCI: Ended. PUBLIC FINANCIAL INTERESTS: Integra - Payment for Speaking Engagement. PRIVATE FINANCIAL INTERESTS: Restor3D Stock - Options (all types), Tissium Consulting Fees, Safeview Surgical Consulting Fees, Tulavi Consulting Fees.

Kurtis Moyer, MD

AFFILIATIONS: SESPRS Trustee, VASPS Board Member until 2023.

Rene Myers, MD

PUBLIC FINANCIAL INTERESTS: Smith and Nephew - Food & Beverage.

Galen Perdikis, MD

AFFILIATIONS: ABPS Director, SESPRS Board, Vice President. PRIVATE FINANCIAL INTERESTS: BRIJ Medical Stock - Options (all types), Advisory Committee Member, Learner Centric Applications - Officer ; LCA: 13% Equity Position.

Linda Phillips, MD

AFFILIATIONS: Board of Regents, ACS.

Brett Phillips, MD, MBA

INSTITUTIONAL GRANTS: Stryker Research Grant. OTHER: compensated for RTI Focus Group at ASPS 2024.

Stephenie Poris, MD

PRIVATE FINANCIAL INTERESTS: Sciton - Payment for Speaking Engagement.

2025 DISCLOSURES

Kristen Rezak, MD, FACS

AFFILIATIONS: President NCSPS, Women in Academic Surgery Committee ACEPS, DEI Committee ACEPS, DEI Committee SESPRS.

Corianne Rogers, MD

PUBLIC FINANCIAL INTERESTS: Avita Speakers Bureau Member, Kerecis (acquired by Coloplast) Speakers Bureau Member.

Christopher Runyan, MD, PhD

PRIVATE FINANCIAL INTERESTS: KLS Martin Consulting Fees.

Orr Shaul, MD

INSTITUTIONAL GRANTS: Georgia Research Alliance. Menely, LLC Officer, Mercuri Gaming, LLC Officer, Athena, LLC Officer.

David Song, MD, MBA, FACS

AFFILIATIONS: Chair, ACGME RC Plastic Surgery. PRIVATE FINANCIAL INTERESTS: Elsevier Royalty Arrangement.

Lauren Strauss

AFFILIATIONS: Member of American Headache Society and Southern Headache Society. OUTSIDE RELATIONSHIPS: Board of Southern Headache Society - Officer.

Marc Walker, MD, MBA, FACS

AFFILIATIONS: Officer, Hand Help Inc. PUBLIC FINANCIAL INTERESTS: Endo - Payment for Speaking Engagement. PRIVATE FINANCIAL INTERESTS: Tulavi Therapeutics Consulting Fees, Sonex Health Payment for Speaking Engagement, Somavac Consulting Fees.

Simeon Wall, Jr., MD, FACS

PUBLIC FINANCIAL INTERESTS: Establishment Labs Stock - Shares (all types). PRIVATE FINANCIAL INTERESTS: PatientFi Stock - Shares (all types), Brij Medical Stock - Shares (all types).

Rebecca Wells

OTHER: I have NIH funding that goes to my institution. I am a Board member (unpaid, voluntary roles) of Southern Headache Society and American Headache Society. In 2023, I have received an honorarium to speak from Southern Headache Society, CME event, faculty speaker and University of Buffalo, Grand Rounds speaker. In 2024, I received an honorarium to speak at the Southern Headache Society, CME event, faculty speaker.

Joseph Williams, MD

AFFILIATIONS: Section Editor - Journal FACE. Treasurer - American Society of Craniofacial Surgeons.

David Zabel, MD

PUBLIC FINANCIAL INTERESTS: Smith and Nephew Consulting Fees.

2025 DISCLOSURES

The following planners/faculty members/reviewers have no relevant financial relationships or affiliations to disclose:

Jasmina Abdalla	Denise Danos	Emily Hecox, MD
Amulya Addepalli	John Dean, MD	Jadyn Heffern
Aditya Agarwal	Riley Dean, MD	John Hill, MD
Syeda Hoorulain Ahmed, MD	Brent DeGeorge, Jr., MD, PhD	Anthony Hoang
William Anderson, MD	Mihir Desai, MD	Martin Hoard
Rohan Arora	Robert DeVito, MD	John Holtrop, MD
Madeline Bald	Katherine Dillon	Amanda Hua Fang
Kelsey Baran, DO	David Drake, MD	Laura Humphries, MD
Adam Beck	Brian Drolet, MD	Stefanie Hush
Joshua Bell, MD	Dev Dwivedi	Allyson Huttinger, MD
Panambur Bhandari	Adekunle Elegbede, MD	Alejandro Isoula
Jessica Biagiotti, MD	Shady Elmaraghi, MD	Vishnu Iyer
Michael Boyajian, MD	Ashlie Elver, MD	Yash Jani
Carter Boyd, MD	Ashlie Elver, MD	Leanne Jeong
Anna Boydston	Dino Elyassnia, MD	Raeesa Kabir
Colin Brady, MD	Mark Feldmann, Jr., MD	Christopher Kalmar, MD
Morgan Brgoch	Adam Fleming	Alex Kane, MD
Hilliard Brydges, MD	Cameron Fontenot	Christina Kapsalis, MD
Ashrita Budharaju	Jenny Foster	Huseyin Karagoz, MD, PhD,
Kristina Buller, DO	Gabriela Garcia Nores, MD	Bo Hyun (Allen) Kong
Bennett Calder, MD	Paul Ghareeb, MD	Emma Kostoff
Anthony Capito, MD	Mary Gingrass, MD	Meredith Kugar, MD
Jennifer Carr, MD	Gabriella Glassman, MD	Sandhya Kumar
Elliott Chen, MD	Barite Gutama, MD	Keerthi Kurian
Katherine Chiasson, MD	H. Harvak Hajebian, MD	Lauren Kuykendall, MD
Jesse Chou, MD	Jennifer Hall, MD	Elizabeth Laikhter, MD
Beth Collins, MD	Rami Hallac, PhD	Madeleine Landau
Tracey Cook, MD	Pranav Haravu, MD	Nicole Le, MD, MPH
Lauren Cook	Michael Harrington, MD, MP	Garrison Leach, MD
Ronald Cornely	Alexandra Hart, MD	Michael Lebhar, MD
Lauren Curwick, MD	Joseph Hartman	Daniel Lee
Daniel Cuzzone, MD	Dominick Haynes	Jamie Levine, MD

2025 DISCLOSURES

Austin Lignieres, MD	Todd Nichols	James Sikes
Steele Liles	Adeyemi Ogunleye	Amanda Silva, MD
William Lineaweaver	Anjali Om, MD	Matthew Sink
Rebecca Lipscomb	Susan Orra, MD	Liza Smirnoff
Yusha (Katie) Liu, MD, PhD	Anamaria Parus, MD	Magdalena Soldanska, MD
Grace Anne Longfellow	Ishan Patel	Gabriella Squeo, MD
Evan Lynch, MD	Jessica Pawly, MD	Sharon Stanley, MD
Sahith Mandala, MD	Nancy Perry	Peyton Stauffer
Alan Matarasso, MD, FACS	Ivo Pestana	Jenna Stoehr, MD
Ron McCall	Kendall Pitre	John Stranix, MD
Jack McCarthy, MD	Kristyn Pocock	Shannon Su
Elizabeth McCauley	Nikitha Potturi, MD	John Sullivan, MD
Carrie McGroarty	William Powers, III	Holman Taylor
Benjamin McIntyre, MD	Alexandria Pumilia, MD	Wesley Thayer, MD
Ryan McKee, MD	Imad Radi	James Thompson, MD
Devin Melancon	Elizabeth Recktenwald, MD	Ricardo Torres-Guzman, MD
Daniel Alejandro Mendoza	Christopher Reid, MD	Robert Travis, MD
Genevieve Messa	Michael Reynolds, MD	Jared Troy, MD
Rahul Mhaskar	Leely Rezvani	Alexander Velazquez
Sarah Miller	Joseph Rigdon	Dhruv Viswanathan
Kelly Modi	Brian Rinker, MD	Eric Waetjen
John Moody	Kyle Robinson, MD	Hibo Wehelie
Meredith Moore, MD	Susan Russell	Douglas Welkert, MD
Samantha Morin	Rachel Safeek	Eileen Wen
Lindsey Morrow	Paymon Sanati-Mehrizi, MD	John West
Tatjana Mortell	Eileen Satteson	Timothy Wilson, MD
Mohammed Mumtaz	Benjamin Savitz	Jeyhan Wood, MD
Laiba Murad	Harel Schwartzberg, MD	Julia (Jun) Yao
Adeem Nachabe, MD	Ramy Sharaf	Eric Zeng
Idorenyin Ndem, MD	Riley Shegos	Ting Zhang
Timothy Nehila	Ramin Shekouhi	Logan Ziegler
Sriya Nemani	Pragna Shetty, MD	
Joseph Nguyen	Amogh Shetty	



SCIENTIFIC PROGRAM

SCIENTIFIC PROGRAM

SUNDAY JUNE 15

7:30–12:00 pm	SESPRS Board Meeting	<i>Gulfstream</i>
4:00–5:30 pm	Quick Shot Presentations Moderators: Blair Wormer, MD and Jared M. Davis, MD	<i>Ponce de Leon</i>
4:00–4:03	1. Is One Technique Superior? A Comparison of the Short Scar Facelift and the Conventional Facelift (p. 40) Kelsey Baran, DO – University of Florida	
4:04–4:07	2. The Effect of Neoadjuvant Chemotherapy on Implant Loss in Immediate Tissue Expander Based Breast Reconstruction (p. 42) Robert G. DeVito, MD – University of Virginia	
4:08–4:11	3. Open versus Laparoscopic Omental Harvest for Sternal Wound Reconstruction (p. 44) Amanda Fang, MD – University of Alabama	
4:12–4:15	4. The Effect of the Extended SMAS on Submandibular Gland Ptosis (p. 45) John Holtrop, MD – Tulane University	
4:16–4:19	5. Trends in Plastic Surgery Applicant Publications (p. 47) Anjali Om, MD – Emory University	
4:20–4:30	Discussion	
4:31–4:34	6. Change of Plane in Implant Based Breast Reconstruction and Patient Reported Outcomes (p. 49) Anamaria Parus, MD – University of South Florida	
4:35–4:38	7. Impact of Scarring Disorders and Surgical Techniques on Development of Capsular Contracture in Breast Augmentation (p. 51) Nikitha Potturi, MD – Virginia Tech	
4:39–4:42	8. Rewiring Relief: The Role of Nerve Pedicle Transfer in the Reduction of Pain Medication Usage (p. 53) Elizabeth Recktenwald, MD – University of Kentucky, MD	
4:43–4:46	9. Outcomes and Complications Associated with Operative Fixation of Perilunate Dislocations: A Systematic Review (p. 55) Rachel Safeek, MD, MPH – University of Florida	
4:47–4:50	10. Patient Reported Outcomes and the Use of Bone Grafting in Distal Radius Osteotomy for Malunion Correction: A Systematic Review (p. 56) Orr Shaully, MD – Emory University	
4:51–5:00	Discussion	
5:01–5:04	11. Implant Augmentation after Autologous Reconstruction: A 14-Year Review of Hybrid Breast Reconstruction Outcomes (p. 57) Jenna R. Stoehr, MD – University of South Florida	

SCIENTIFIC PROGRAM

5:05–5:08	12. Digital Nerve Coaptation vs. Standard of Care for Partial and Ray Digital Amputations (<i>p. 58</i>) John M. Sullivan III, MD - University of Mississippi
5:09–5:12	13. Synovial Flap for Recurrent Carpal Tunnel Syndrome Long-Term Follow Up (<i>p. 59</i>) Robert Travis MD – Virginia Tech
5:13–5:16	14. Assessing Financial Disclosure in Non-Invasive Fat Reduction Research: Do Corporate Payments Impact Study Outcomes? (<i>p. 60</i>) Jasmina Abdalla, BS – University of Virginia
5:17–5:20	15. Aesthetic Flat Closure: Assessing the Financial and Clinical Viability of an Emerging Post-Mastectomy Option (<i>p. 61</i>) Hibo M. Wehelie, BS – University of Virginia
5:21–5:30	Discussion
	Objective: Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,

MONDAY JUNE 16

6:30 am	Rise and Shine Coffee Bar	<i>Ponce de Leon</i>
6:30–7:30 am	Residency Roadmap: Planning for the Future Brett T. Phillips, MD, MBA	<i>Ponce de Leon</i>
7:30 am	Presidential Welcome Bruce A. Mast, MD	<i>Ponce de Leon</i>
7:45–9:15 am	Face Renaissance: Advanced Techniques in Lifting and Rejuvenation Moderator: Galen Perdikis, MD and Ashley Lentz, MD	
	Preservation Rhinoplasty Dino Elyassnia, MD	
	40 Year Experience with Forehead Flaps Scott P. Bartlett, MD	
	Facial Rejuvenation from Baby Boomer to the Millennial Generation: A Young Practice Perspective Stephenie Poris, MD	
	My Evolution in Facelift: Where I Came From and Where I Am Going Beth Collins, MD	
9:00 - 9:15	Discussion	
	Objective: Identify and evaluate the latest aesthetic facial techniques and technology for invasive and non-invasive procedures	

SCIENTIFIC PROGRAM

9:15–9:45 am	Breakfast and Visit Exhibits	<i>Ponce de Leon</i>
9:45–11:00 am	Member/General Papers Moderators: David B. Drake, MD and Brett T. Phillips, MD	<i>Ponce de Leon</i>
9:45–9:50	1. Evaluation of Absorbable Vancomycin Beads in Groin Reconstruction Following Vascular Bypass Graft Procedure (p. 63) Leanne D. Jeong, BS and Jorge de la Torre, MD	
9:51–9:56	2. Polyethylene Glycol-mediated Axonal Fusion Promotes Early Postoperative Recovery of Median and Ulnar Nerves Following Sunderland V Traumatic Injuries of the Distal Forearm: A Double Blind Randomized Clinical Trial (p. 64) ▲ Barite Gutama, MD and Wesley Thayer, MD	
9:57–10:02	3. An Evaluation of Flap Dimensions and Complications in Immediate Breast Reconstruction (p. 65) Daniel F. Haynes, MD	
10:03–10:08	4. Introduction and Utilization of “Spray-On Skin” at an Urban, Level-1 Trauma Center: Learning Curve Analysis of 125 Consecutive Patients with Full-Thickness Wounds and Defects, Treated with Autologous Skin Cell Suspension (p. 66) ▲ C. Scott Hultman, MD, MBA	
10:09–10:14	5. Solving the Endoscopic Forehead Conundrum: Go Deep to the Deep Temporal Fascia (p. 67) John T. Lindsey, MD	
10:14–10:24	Discussion	
10:24–10:29	6. Evaluating the Performance of Different Pedicles in Reduction Mammoplasty: A Comparative Analysis (p. 69) Christopher A. Campbell, MD	
10:30–10:35	7. Timing of the Dangle Protocol After Lower Extremity Free Flap Reconstruction: A Retrospective Chart Review (p. 70) Adeem Nachabe, MD	
10:36–10:41	8. Five Year Experience with the ‘Big Easy’ Breast Reduction: A Safe and Reproducible Approach to Gigantomastia (p. 73) ▲ John A. Dean, MD	
10:42–10:47	9. Open Abdominal Wall Reconstruction Comparing a Vertical Laparotomy Incision To a Mid-transverse Incision and Wound Sequelae (p. 74) Imad Radi, MD	
10:48–10:53	10. The Impact of Intraoperative Parameters on Pediatric Craniosynostosis Surgical Outcomes (p. 75) Idorenyin Ndem, MD	
10:53–11:00	Discussion	

SCIENTIFIC PROGRAM

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

11:00–12:30 pm

Keynote Speaker - Strength and Adaptability
Captain Richard Phillips

Ponce de Leon

Objective: Discuss and evaluate courage, endurance, leadership, and heroism relating to the importance of teamwork through adversity,

12:30–5:00 pm

SESPRS Mini-Craniofacial Symposium
Moderator: Michael S. Golinko, MD

Ponce de Leon

12:45–1:40 pm

Keynote Lecture: Lessons Learned in the Surgical Management of Hemifacial Microsomia ▲
Scott P. Bartlett, MD

1:40–2:40 pm

Toughest/Most Interesting/Humbling/Engaging Cases
Moderators: Colin M. Brady, MD, and Scott P. Bartlett, MD
Case Presenters: Colin M. Brady, MD, Michael S. Golinko, MD, Laura Humphries, MD, Alexis S. Tashima, MD

2:40–2:50 pm

Coffee Break

2:50–3:30

S. Anthony Wolfe Resident Abstract Competition
Moderator: Michael S. Golinko, MD and Ian C. Hoppe, MD

2:50–2:54 **1. Alar Suspension in Primary Cleft Rhinoplasty (p. 76)**
William M. Anderson, MD – Virginia Tech

2:54–2:58 **2. Recombinant Human Bone Morphogenetic Protein-2 (rhBMP-2) as an Alternative to Autologous Bone Graft in Pediatric Craniofacial Reconstruction: A Systematic Review (p. 77)**
Jesse Chou, MD – University of Virginia

2:58–3:02 **3. The Impact of Medicaid Expansion on State-Level Medicaid Reimbursement for Orthodontic Care: A Cost Analysis (p. 78)**
Ashlie A. Elver, MD – University of Mississippi

3:02–3:06 **4. Differing Levator Veli Palatini Reposition Techniques in Primary Palatoplasty and the Impact on Incidence of Velopharyngeal Insufficiency Revisional Surgeries (p. 79)**
Gabriella E. Glassman, MD – Emory University

3:06–3:10 **5. Variability in Delivery of Orthodontic Care Across ACPA-Approved Teams in the United States (p. 80)**
Emily E. Hecox MD – University of Mississippi

3:10–3:14 **6. Frontal Sinus Volume in Normocephalic Nonsyndromic Sagittal Craniosynostosis: A Multi-Institutional Comparative Study (p. 82)**
Michael Lebhar, MD – University of Mississippi

3:14-3:18	7. A Single Institution's Experience with Posterior Vault Distraction Osteogenesis in a Low Resource Environment (p. 83) Austin A. Lignieres, MD – University of Mississippi
3:18-3:22	8. Longitudinal Observation of a Novel Technique for Excision and Reconstruction of a Nasal Mass in Pai Syndrome (p. 84) Jack T. McCarthy MD – University of South Carolina
3:22-3:30	Discussion
	Objective: Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice
3:30-4:30 pm	Facial Gender-Affirming Panel: A CMF Perspective Moderators: Jonathan S. Black, MD, Christopher M. Runyan, MD
3:30-3:50	Midfacial Considerations in Gender-Affirming Surgery Michael Alperovich, MD, MSc
3:50-4:10	Establishing a Facial Gender-Affirming Clinic in the Southeast Johnathan S. Black, MD
4:10-4:30	Facial Gender-Affirming Surgery: The UCLA Experience Justine C. Lee, MD, PhD
4:30-5:00 pm	Special Topics Panel: State of CMF Surgery and Fellowships = CMF Joseph K. Williams, MD

TUESDAY JUNE 17

7:00-8:00 am	Rise and Shine Coffee Bar	<i>Ponce de Leon</i>
7:30-8:20 am	Glancy Resident Competition - Session 1 Moderators: Brian D. Rinker, MD and Gabriele Garcia-Nores, MD	<i>Ponce de Leon</i>
7:30-7:37	1. Patient Reported Outcomes After Surgical Treatment for Neurogenic Thoracic Outlet Syndrome with at Least 1 Year Follow Up (p. 86) Joshua Bell, MD – University of Florida	
7:38-7:45	2. A Novel 3D Printed Simulator to Teach Metacarpal Fixation with Kirschner Wires (p. 91) Michael K. Boyajian, MD – Wake Forest University	
7:46-7:53	3. Sarcopenia in Autologous Breast Reconstruction with DIEP Flaps: A Propensity Score Matched Analysis (p. 92) Jesse Chou, MD – University of Virginia	
7:54-8:01	4. The Impact of S-Code versus CPT Code Utilization for DIEP Flaps: A Reimbursement Analysis in an Underserved State (p. 93) Ashlie A. Elver, MD – University of Mississippi	

8:02-8:09	5. Keep Your Friends Close and Your Teammates Closer: The Impact of Consistent Team Staffing in Microsurgical Breast Reconstruction (p. 94) Pranav N. Haravu, MD – Duke University	
8:10 –8:20	Discussion	
8:20-9:10 am	Glancy Resident Competition - Session 2 Moderators: Paul Ghareeb, MD and Mayowa Abiodun, MD	<i>Ponce de Leon</i>
8:20 –8:27	6. Understanding Macromastia-Associated Headache and the Impact of Reduction Mammoplasty: A Pilot Prospective Cohort Study (p. 96) Elizabeth Laikhter, MD – Wake Forest University	
8:28-8:35	7. Exploring Indications for Nerve Pedicle Transfer in the Distal Hand: The Impact of Injury Mechanism and the Timing of Surgery on Long-Term Pain and Functional Hand Outcomes (p. 97) ▲ Evan B. Lynch, MD, PhD – University of Kentucky	
8:36-8:43	8. Use of Topical Arista™ and Intravenous Tranexamic Acid in Breast Reduction Patients Reduces Hematoma Rates (p. 99) ▲ Anjali Om, MD – Emory University	
8:44-8:51	9. Reconstruction of Massive Ventral Hernias with Free Latissimus Dorsi Flap: Mid-Term Patient Reported Outcomes Analysis (p. 101) Rachel Safeek, MD, MPH – University of Florida	
8:52-8:59	10. The Paraspinous Muscle Deep Release Technique for Posterior Trunk Reconstruction: A Institutional Experience (p. 102) Jenna R. Stoehr, MD – University of South Florida	
9:00 –9:10	Discussion	
	Objective: Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,	
9:10-9:45 am	Breakfast and Visit Exhibits	<i>Ponce de Leon</i>
9:45-10:45 am	Breast Reconstruction Revolution Moderators: Kent K. Higdon, MD and Katherine F. Chiasson, MD	<i>Ponce de Leon</i>
9:45 –10:00	Navigating the DIEP SIEA and How to Make Decisions David H. Song, MD, MBA	
10:00 –10:10	Autologous Breast Reconstruction in the Massive Weight Loss Patient Kristin M. Rezak, MD	
10:15 –10:30	Navigating Complexity in Breast Reconstruction ▲ David Mathes, MD	
10:30 –10:45	Discussion	
	Objective: Review and discuss revolutionary techniques in comprehensive breast reconstruction to improve patient outcomes	

11:00–11:30 am	Upchurch Lecture - Plastic Surgery Leadership in Healthcare Systems and Hospitals David H. Song, MD, MBA	
11:30–12:45 pm	The Ship is Sinking – What Do You Do Now? Moderator: Harvey W. M. Chim, MD	<i>Ponce de Leon</i>
11:30–11:40	Hand Disaster Case Harvey W. M. Chim, MD	
11:40–11:50	Facial Disaster Case Carmen Kavali, MD	
11:50–12:00	Micro Disaster Case Benjamin C. McIntyre, MD	
12:00–12:10	Craniofacial Disaster Case Christopher M. Runyan, MD	
12:10–12:20	Breast Disaster Case Galen Perdikis, MD	
12:20–12:30	Body Disaster Case Holly C. Wall, MD	
12:30–12:45	Discussion	
	Objective: Identify the challenges and changes in plastic surgery procedures to improve safe patient outcomes	

WEDNESDAY JUNE 18

6:30–7:30 am	Rise and Shine Coffee Bar	<i>Ponce de Leon</i>
7:00–8:00 am	Just the Facts Moderator: Brian D. Rinker, MD	<i>Ponce de Leon</i>
7:00 –7:12	Are Fasciocutaneous or Muscle Flaps Better for Lower Extremity Osteomyelitis? Jared Troy, MD – University of South Florida	
7:12 –7:24	Do We Operate on Too Many Orbital Floor Fractures? Daniel A. Cuzzzone, MD – Emory University	
7:24 –7:36	Should We be Performing Prophylactic Lymphatic Surgery at the Time of all Axillary Node Dissections? Kunle Elegbede, MD, PhD – Mayo Clinic Florida	
7:36–7:48	Does Routine Use of TXA Prevent Hematomas? Susan Orra, MD – Vanderbilt University	
7:48–8:00	Discussion	

	Objective: Identify and describe best evidence (the “facts”) regarding various pertinent problems in plastic surgery,	
8:00–9:15 am	Charting New Seas in Hand Surgery Moderators: Harvey W. M. Chim, MD and Marc E. Walker, MD	<i>Ponce de Leon</i>
8:00–8:10	Nerve Stimulation and New Nerve Conduits Brent R. DeGeorge, Jr., MD, PhD	
8:10–8:20	Fat Grafting in Hand Surgery Marc E. Walker, MD	
8:20–8:30	New Thin Flap Options Harvey W. M. Chim, MD	
8:30–8:40	MFC/MFT Flaps Suhail Mithani, MD	
8:40–8:50	Small Joint Denervation in Hand Surgery John B. Hill, MD	
8:50–9:00	Innovation in Hand Surgery Education Sonu A. Jain, MD	
9:00–9:15	Discussion	
	Objective: Evaluate techniques and innovation in hand surgery to identify potential application to a surgeons practice,	
9:15–9:45 am	Breakfast and Visit Exhibits	
9:40–10:30 am	Jurkiewicz Lecture - Taking Your Seat at the Plastic Surgery Leadership Table Linda G. Phillips, MD	<i>Ponce de Leon</i>
10:30–11:15 am	Breast Mastery Moderators: Simeon Wall, Jr., MD and Alexandra Hart, MD	<i>Ponce de Leon</i>
10:30–10:40	“I Want a Divorce!” Navigating Breast Implant Removal and Revision Mary Gingrass, MD	
10:40–10:50	Demystifying the Subfascial Plane M. Bradley Calobrace, MD	
10:50–11:00	Breast Asymmetries Cristen M. Catignani, MD	
11:00–11:15	Discussion	
	Objective: Identify masterful techniques in breast surgery to improve patient outcomes	
11:15–11:45 am	Research Grant & Mark A. Codner Fellowship Grant Reports Moderator: Brent R. DeGeorge, Jr., MD, PhD	<i>Ponce de Leon</i>

	2024-2025 Research Grant Report: The Role of Common Lymphatic Endothelial and Vascular Endothelial Reception-1 9CLEVER-1) in Lymphedema Huseyin Karagoz, MD	
	2024-2025 Mark A. Codner Aesthetic and Breast Fellowship Report The CaloAesthetics Fellowship - Supporting More than Breasts Tracey N. Cook, MD	
11:45 am	2025-2026 Research Grant Awards	
	Objective: Discuss presenter's research projects, the results, and the potential application to plastic surgeons' practice,	
11:45–12:15 pm	SESPRS Annual Member Business Meeting	<i>Ponce de Leon</i>

THURSDAY JUNE 19

7:30–8:30 am	Breakfast and Visit Exhibits	
7:45–9:00 am	Society Updates Moderator: Lynn A. Damitz, MD ASPS – Alan Matarasso, MD The Aesthetic Society – Kent K. Higdon, MD ASPS Advocacy Update – Abigail E. Chaffin, MD	<i>Ponce de Leon</i>
9:00–12:00 pm	Power Panel – Ultrasound Course Moderators: Brent DeGeorge, MD and Marc E. Walker, MD Ultrasound Instructors: Christopher A. Campbell, MD, Brent R. DeGeorge, Jr, MD, PhD, Onelio Garcia, Jr, MD, John T. Lindsey, MD, Kristen M. Rezak, MD, Holly C. Wall, MD, Simeon Wall, Jr, MD	<i>Ponce de Leon</i>
9:00–9:10	Introduction and Overview Speaker: Brent R. DeGeorge Jr, MD, PhD Objective: course flow, and relevance of ultrasound in modern plastic surgery.	
9:10–10:10	1. Ultrasound Basic for the Plastic Surgeon Brent R. DeGeorge Jr, MD, PhD - Review principles of ultrasound and image acquisition and optimization. - Techniques for needle localization and ultrasound guided procedures. 2. Breast: Revolutionizing Implant and Soft Tissue Management Christopher A. Campbell, MD - Scanning protocols for implant characterization and rupture diagnosis. - Ultrasound-guided seroma aspiration and preoperative pectoralis nerve blocks.	

	3. Trunk: Practical Applications in Reconstructive Surgery John T. Lindsey, MD - Ultrasound-guided nerve blocks (PECS, TAP, SAP). - Perforator mapping for flaps: DIEP, ALT, TDAP, and MSAP. 4. Buttock: Ensuring Safety in Fat Grafting Procedure Onelio Garcia, Jr., MD - Using ultrasound to visualize fascial layers. - Cannula guidance for fat injection between the deep gluteal fascia and superficial fascia. 5. Extremity: Musculoskeletal Imaging and Intervention Marc E. Walker, MD - Sonoanatomy of the hand, wrist, and peripheral nerves. - Image optimization for dynamic diagnostics and ultrasound-guided procedures.
10:10–10:20	Introduction to Hands-On Workshop Speaker: Holly C. Wall, MD Objective: Overview of hands-on stations and procedural applications for each anatomical area.
10:20–11:45	Hands-On Workshop: Rotating Skill Stations Participants can visit stations focusing on region-specific techniques with expert faculty and live models or phantom simulators Hands-On Workshop Clinical Skills Station 1: Breast - Implant scanning, rupture diagnosis, and seroma aspiration. Station 2: Trunk - Perforator identification for flap planning. - Nerve block guidance. Station 3: Buttock - Safe fat grafting with ultrasound visualization. - Identifying fascial planes. Station 4: Extremity Systematic scanning protocols for the wrist, hand, and peripheral nerve. - Guided injections and diagnostic imaging.
12:00 pm	Closing Remarks Galen Perdakis, MD



ABSTRACTS

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

1 Is One Technique Superior? A Comparison of the Short Scar Facelift and the Conventional Facelift

Kelsey Baran, DO¹, Ryan M. McKee, MD¹, Ramy Sharaf², Rohan Arora², Lindsey Morrow², Joseph Hartman², Bruce A. Mast, MD, FACS¹

¹ Division of Plastic and Reconstructive Surgery, Department of Surgery, University of Florida, Gainesville, FL,

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Background: Surgical techniques to address facial aging can be broadly thought of as conventional facelift or short scar lift^{1,2,3}. The senior author has used the minimal access cranial suspension (MACS) lift for patients with lesser degrees of aging, while the conventional lift has addressed more advanced aging⁴. However, MACS lift has been criticized as providing inadequate rejuvenation^{4,5}. The aim of this study is to assess the efficacy of the MACS lift, by comparison to the conventional lift in a single practice.

Methods: A retrospective review was performed to identify all patients who underwent facial rejuvenation surgery by the senior author between January 2011 to June 2024. Demographic data, type of procedure, and patient-reported satisfaction were recorded. Clinical photographs were evaluated using the Global Aesthetic Improvement Scale (GAIS, Figure 1) by four independent graders without a background in Plastic Surgery.

Results: 157 patients underwent 160 facial rejuvenation procedures: 93 (58%) MACS lifts and 67 (42%) conventional. Demographic data was recorded (Table 1). The mean follow up was 4 months and post-operative patient satisfaction was 87%. Forty patients were randomly selected for photo analysis, n=20 for both MACS and conventional lift. The overall GAIS score was 4.12. The GAIS score for conventional lifts was 4.11 compared to 4.13 for MACS lifts.

Conclusion: The short scar lift and conventional lift each offer unique advantages with equivalent outcomes and success in properly selected patients. Both procedures should be in a surgeon's armamentarium to provide an individualized approach to facial aging.

Global Aesthetic Improvement Scale (GAIS)	
Score	Description
1 (worse)	Appearance worse than the original condition.
2 (no change)	Appearance is essentially the same as the original condition.
3 (improved)	Obvious improvement in appearance from the initial condition, but a touch-up or retreatment is indicated.
4 (much improved)	Marked improvement in appearance from the initial condition, but not completely optimal for this patient.
5 (very much improved)	A touch-up would slightly improve the result.
	Optimal result for this patient.

Figure 1. Global Aesthetic Improvement Scale (GAIS) used for photo analysis.

Patients Factors	Value
Male	n = 6 (3%)
Female	n = 151 (97%)
Age (mean)	n = 62 years
BMI (mean)	n = 24
Follow Up (mean)	4 months (range 1-14 months)
Type of Procedure	
MACS Lift	n = 93 (58%)
Conventional Lift	n = 67 (42%)
Complications	
Hematoma	n = 4 (2.5%)
Skin Necrosis	n = 1 (0.6%)

Table 1. Demographic data of patients undergoing Facial Rejuvenation



Figure 2. Conventional (above) versus MACS (below) lift side-by-side comparison. Both patients had a GAIS score of 4.5.

References

- 1 Ivy, Edward J. M.D.; Lorenc, Paul Z. M.D.; Aston, Sherrell J. M.D.. Is There a Difference? A Prospective Study Comparing Lateral and Standard SMAS Face Lifts with Extended SMAS and Composite Rhytidectomies. *Plastic and Reconstructive Surgery* 98(7):p 1135-1143, December 1996.
- 2 Avashia, Yash J. MD1; Stuzin, James M. MD2; Cason, Roger W. MD3; Savetsky, Ira L. MD1; Rohrich, Rod J. MD1. An Evidence-Based and Case-Based Comparison of Modern Face Lift Techniques. *Plastic and Reconstructive Surgery* 152(1):p 51e-65e, July 2023.
- 3 Tonnard, Patrick M.D.; Verpaele, Alexis M.D.; Monstrey, Stan M.D., Ph.D.; Van Landuyt, Koen M.D.; Blondeel, Philippe M.D., Ph.D.; Hamdi, Moustapha M.D.; Matton, Guido M.D.; Tonnard, Patrick L. M.D.. Minimal Access Cranial Suspension Lift: A Modified S-Lift. *Plastic and Reconstructive Surgery* 109(6):p 2074-2086, May 2002.
- 4 Mast, Bruce A. MD. Advantages and Limitations of the MACS Lift for Facial Rejuvenation. *Annals of Plastic Surgery* 72(6):p S139-S143, June 2014.
- 5 Lotte F. Hijkoop, Hieronymus P.J.D. Stevens, Berend van der Lei. The minimal access cranial suspension (MACS) lift: A systematic review of literature 18 years after its introduction. *Journal of Plastic, Reconstructive & Aesthetic Surgery* 75(3):p 1187-1196, March 2022.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

2 The Effect of Neoadjuvant Chemotherapy on Implant Loss in Immediate Tissue Expander Based Breast Reconstruction

Robert G. DeVito MD¹, Hibo M. Wehelie BS¹, Eileen Wen BS², Alejandro Mendoza Isoula BS², Scott T. Hollenbeck MD¹, John T. Stranix MD¹, Chris A. Campbell MD¹

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Background: Implant-based reconstruction represents the most common method of breast reconstruction today. Many surgeons approach implant-based breast reconstruction in two stages, the first stage being placement of a tissue expander at the time of mastectomy. Neoadjuvant chemotherapy, which has become commonplace, can have systemic effects that potentially place patients at risk for implant loss, infection, wound, and other complications.

Methods: We performed a retrospective review of all cases of implant-based breast reconstruction at a single institution between 2017 and 2024. A total of 210 patients met inclusion criteria of immediate tissue expander placement. 51% of cases were bilateral and 319 total breasts were reconstructed. 71 patients underwent neoadjuvant chemotherapy and 139 did not. Using regression analysis patients were matched for laterality, age, BMI, and ASA status. Patients were separated into neoadjuvant chemotherapy and non-neoadjuvant chemotherapy cohorts. Primary outcomes were all-cause implant loss, wound, infection, and seroma.

Results: The rate of tissue expander loss in patients who underwent neoadjuvant chemotherapy was 19% (20/105 breasts), and the rate of implant loss in patients who did not undergo neoadjuvant chemotherapy was 10% (22/214 breasts). On chi-square analysis and Fisher exact tests this difference was statistically significant ($p=0.007$). On regression analysis neoadjuvant chemotherapy increased risk of implant loss by 15% ($p=0.039$). There were no statistically significant differences in wound, seroma, and infection.

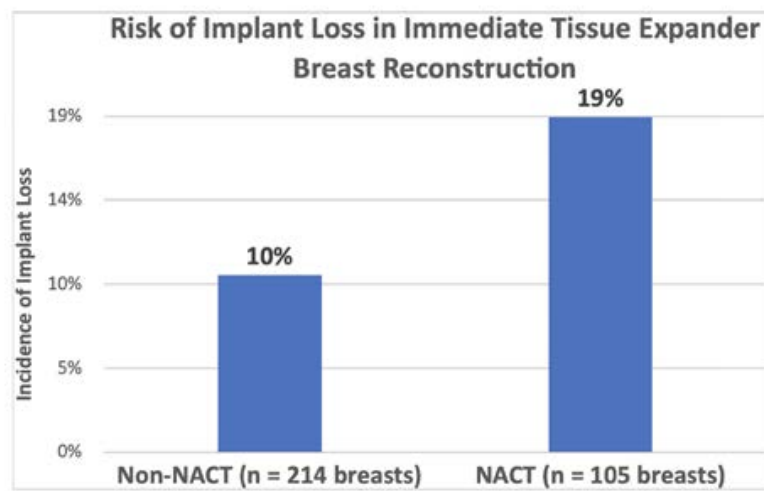
Conclusion: In this study neoadjuvant chemotherapy is an independent risk factor for implant loss after immediate tissue expander-based breast reconstruction. Further analysis of technique, implant factors, and specific chemotherapeutic agents are warranted.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

Table 1:

Cohort	Implant Loss	Wound	Seroma	Infection
Non-NACT (n = 214)	10%	24%	39%	12%
NACT (n = 105 breasts)	19%	21%	40%	11%
P-Value	p = 0.007	p = 0.13	p = 0.95	p = 0.68

Figure 1:



SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

3 Open versus Laparoscopic Omental Harvest for Sternal Wound Reconstruction

Amanda Fang MD, Jorge de la Torre MD, MSHA

University of Alabama at Birmingham, Division of Plastic Surgery

Introduction: The omental flap is highly vascularized reliable flap for sternal reconstruction. It can be harvested laparoscopically with the assistance of general surgery or harvested openly through the midline abdominal incision. Our goal is to evaluate the differences in outcomes between the two approaches.

Methods: Patient with sternal wounds who underwent omental flap reconstruction were reviewed from 2015-2024 at our institution. Demographics, preoperative, intraoperative, and postoperative factors were obtained.

Results: A total of 37 patients were included in the study with 44% female and 56% male. Twenty-one(56%) of the omental harvest were obtained laparoscopically by general surgery while 44% were obtained by the primary plastic surgeon through the open approach. There was no statistical significance in average time for open harvest-based reconstruction versus laparoscopic based(3.2 hours vs. 2.8 hours, $p=.49$). The overall complication rate was 29% with no statistical difference between the two groups(33% vs 29%, $p=0.7$). No differences were seen in the average length of stay, one vs two pedicle(s) reliance, or the level of coronary artery disease prior to reconstruction. Complications were seen more when the omental flap was used as the primary reconstruction option than as secondary option after other failed reconstruction attempts(41.7% vs 7.7%, $p<0.05$). Complications were seen less when the plastic surgeon also performed sternal debridement during the reconstruction(42.9% vs 12.5%, $p<0.05$).

Conclusion: No major differences in complications were seen in laparoscopic versus open omental flap harvest. It is notable that additional sternal debridement overall decreased complications rates. Both omental harvest approaches can be performed based on surgeon preferences and available hospital resources.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM**4 The Effect of the Extended SMAS on Submandibular Gland Ptosis**

John Holtrop MD; Jadyne Heffern MS4; H. Harvak Hajebian MD; Tatjana Mortell MS4; John Lindsey MD

Tulane University School of Medicine

Background: Conventional facelift surgery may fail to adequately address submandibular gland ptosis (SMGP), prompting recommendations for partial gland resection. Alternatively, the extended SMAS technique involves a more extensive SMAS-platysma dissection, providing lower facial and neck rejuvenation while preserving the submandibular glands. This study aims to quantify the effect of the extended SMAS technique on SMGP.

Methods: This retrospective cohort study analyzed 53 patients who underwent extended SMAS facelift surgery over a ten-year period in the senior author's practice (Table 1). Photographic analysis was used to quantify SMGP correction and cervicomental angle (CMA) improvement.

Results: All patients were available at a mean follow-up of 8.4 months (range: 1–34 months). Mean SMGP decreased from 8.9 mm preoperatively (range: 0–23 mm) to 0.1 mm postoperatively (range: 0–3.9 mm), with an average improvement of 8.01 mm ($P < 0.001$). Mean CMA improved from 152° (range: 100–180°) to 121° (range: 92–156°), with a mean change of 30.8° ($P < 0.001$), Table 2. Two patients (3.8%) were dissatisfied, and three (5.7%) required office revisions.

Conclusion: The extended SMAS facelift technique effectively controls SMGP, nearly eliminating submandibular gland visibility on postoperative photographic analysis while enhancing neck angularity. This improvement may result from the thorough release of the cervical and parotid retaining ligaments, as well as the platysma-auricular ligament. This level of SMAS-platysma flap mobilization may create a more effective sling-like effect on the contents of the digastric triangle, potentially obviating the need for submandibular gland resection.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

Table 1. Patient demographic and perioperative characteristics	
No. patients	53
	Mean (range)
Age at surgery (years)	62.4 (43 – 74)
	Value (%)
Male	5 (9.4)
Female	48 (90.6)
History of prior facial surgery	10 (18.9)
Former smoker	23 (43.4)
History of hypertension	12 (22.6)
History of diabetes	2 (3.8)
	Mean (range)
Length of follow-up (months)	8.4 (1 – 32)
Patient dissatisfaction, <i>n</i> , (%)	2 (3.8)
Office revisions, <i>n</i> , (%)	3 (5.7)

Table 2. Post-operative changes to SMGP and CMA after Extended SMAS				
	Pre-op	Post-op	Change	<i>P</i> value
	Mean (range)			
SMGP (mm)	8.9 (0 – 23.3)	0.09 (0 – 3.8)	8.01 (0 – 23.3)	<0.001*
CMA (degrees)	152 (100 – 180)	121 (92 – 156)	30.8 (0 – 60)	<0.001*
Abbreviations: SMGP, Submandibular gland ptosis; CMA, Cervicomental angle P-value calculated using paired two-tailed t-tests assuming equal variances *Level of significance < 0.05 is considered statistically significant				

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM**5 Trends in Plastic Surgery Applicant Publications**

Anjali Om¹, Ishan Patel², Dev Dwivedi², Amogh Shetty², Amulya Addepalli³, Kelly Modi², Aditya Agarwal³, Vishnu Iyer², Dhruv Viswanathan³, Stephanie M.C. Bray⁴

1. Division of Plastic Surgery, Emory University, Atlanta, Georgia, United States

2. Albany Medical College

3. Rensselaer Polytechnic Institute

4. Division of Plastic Surgery, Albany Med Health System

Background: Publications are a key element of a successful plastic surgery residency application. Trends in the number of publications across years and the subspecialties within plastic surgery that successful applicants publish in is not well studied.

Methods: A list of all integrated plastic surgery programs was obtained from the American Society of Plastic Surgery website and current residents were identified using corresponding residency program webpages. Manuscripts published prior to residency were queried using PubMed and ResearchGate and filtered into the following categories: craniofacial, aesthetic, breast, gender affirming, microsurgery, hand, basic science, non-plastic surgery, and nonsurgical. The number of first author publications was noted.

Results: A total of 914 residents from 87 programs were included. From 2019 to 2024, the overall number of publications (12.4 vs. 7.00, $p<0.001$) and first author papers (3.80 vs 1.89, $p=0.001$) significantly increased (Figure 1). On average, applicants had the most non-plastic surgery (2.30), nonsurgical (1.73), and craniofacial (1.49) papers published and had the least microsurgery (0.509), hand (0.324), and gender affirming (0.348) papers ($p<0.05$). From 2019 to 2024, the number of aesthetic (1.16 vs 0.272, $p<0.0001$), breast (1.42 vs. 0.628, $p=0.001$), hand (0.824 vs. 0.193, $p=0.0003$), microsurgery (0.824 vs 0.235, $p=0.001$), gender affirming (0.503 vs 0.125, $p=0.007$), and non-plastic surgery (2.77 vs. 1.22, $p=0.005$) papers significantly increased (Figure 2).

Conclusion: The number of total and first author publications from successful plastic surgery applicants have significantly increased over the past six years, with applicants increasingly publishing aesthetic, breast, hand, microsurgery, gender affirming, and non-plastic surgery publications.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

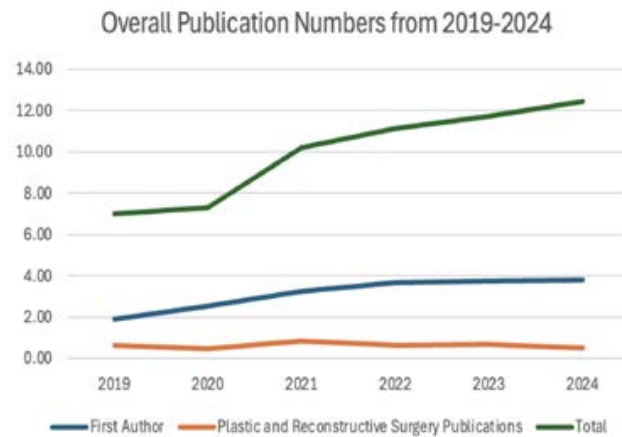


FIGURE 1. Overall Trends in Publication Numbers from Plastic Surgery Applicants from 2019 to 2024.

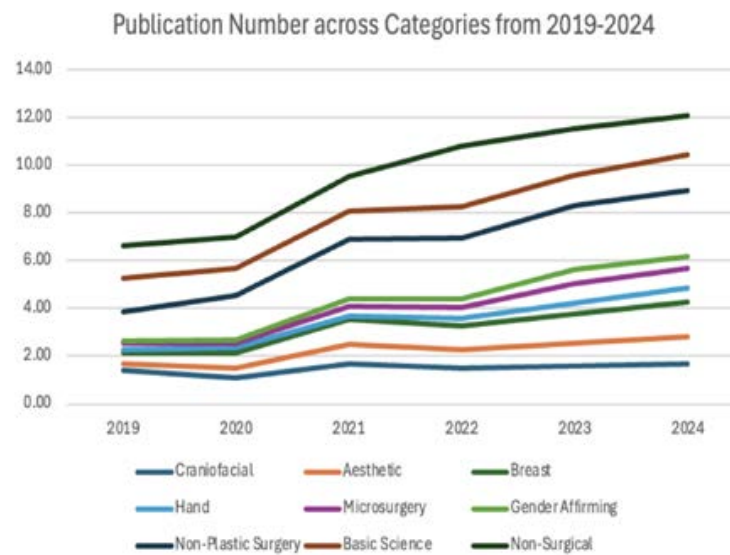


FIGURE 2. Publication Numbers across Sub-Specialty Categories from Plastic Surgery Applicants from 2019 to 2024.

SUNDAY - QUICK SHOT PRESENTATIONS..... 4:00 – 5:30 PM**6 Change of Plane in Implant Based Breast Reconstruction and Patient Reported Outcomes**

Anamaria Parus MD, Meredith Moore MD, Rahul Mhaskar PhD, Logan Zeigler MS, Lauren Kuykendall MD

Plastic Surgery Department, University of South Florida

Objective: Few studies discuss a change of implant plane for breast reconstruction from sub-pectoral to pre-pectoral and the impact of this revision operation on patient reported outcomes. Our dataset reveals patient evaluation of the aesthetic and physical impact of switching implant position.

Methods: A retrospective review was performed on patients undergoing change of implant plane from sub-pectoral to pre-pectoral from 2020 to 2024. A total of 30 patients were assessed, for a total of 57 breasts. Clinical follow up ranged from 6 months to 48 months. Patient interviews regarding pre- and post-operative pain and satisfaction with reconstruction were performed.

Results: During the pre-operative visit, 24/30 (80%) patients reported chronic breast pain following subpectoral implant placement. 21/30 (70%) patients complained about the resulting animation deformity.

Regarding the interview part of our study, 23/30 patients participated, with a response rate of 77%. On a scale of 0-10 indicating the level of pain severity, the median pain level was reported 6 prior to change of plane. Median post-operative pain following change of plane to pre-pectoral was 0. On a Likert scale from 1-5, prior to change of plane, the patient satisfaction was 1.75. After the change of plane, this increased to 4.54. The complication rate was comparable with other implant-based reconstruction literature.

Conclusion: This study demonstrates the positive impact a change of plane operation may have on the physical and emotional wellbeing of breast reconstruction patients. Future considerations include a more comprehensive patient database and before and after Breast Q surveys.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

Table 1. Demographics and Clinical Characteristics

Characteristic	Total (%)
Number of patients	30
Mean time between initial reconstruction and change of plane (years)	8
History of radiation therapy	2 (6.7)
Mean age at time of change of plane (years)	55.2
Laterality	
Unilateral	3 (10)
Bilateral	27 (90)
Range of follow up time (months)	6-48
Complications requiring OR	
Impending implant exposure	2 (6.7)
Infection	2 (6.7)

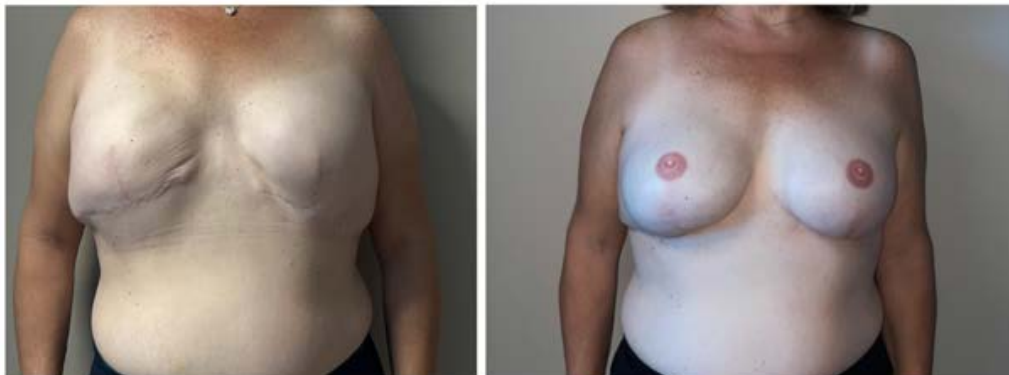


Figure 1. This is a 48-year-old female who previously had 800 cc silicone implants in the sub-pectoral plane. She was bothered by the animation deformity, the associated pain and she was overall dissatisfied with her result. She underwent change of implant plane to pre-pectoral, with exchange of implants to 790 cc, reconstruction of the bilateral inframammary folds, lateral capsulorrhaphy and lateral chest wall liposuction in a single stage operation. She underwent nipple areola tattooing and is now satisfied with her aesthetic result and reports being pain free.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM**7 Impact of Scarring Disorders and Surgical Techniques on Development of Capsular Contracture in Breast Augmentation**

Nikitha Potturi, MD; Jennifer Hall, MD; Allyson Huttinger, MD; Anthony Capito, MD, FACS

Virginia Tech Carilion Clinic, Roanoke, VA

Background: Capsular contracture (CC) is a common complication following breast augmentation and a major indication for re-operation. While pocket contamination and aberrant inflammatory processes are suspected causes, a definitive etiology has not been identified. This study investigates if disorders of aberrant scarring such as Dupuytren’s disease, hypertrophic scars, and keloids are clinically correlated to developing CC, as well as use of certain surgical techniques.

Methods: A retrospective chart review of patients undergoing breast augmentation at a single institution was conducted. Data were collected on history of aberrant scarring and use of specific surgical techniques (e.g. sizers, Keller Funnel®, antibiotic irrigation). Fisher’s exact test was used to assess statistical significance.

Results: 270 patients were identified with 29 patients (10.7%) developing CC within 6 years of surgery. No significant differences were found between the groups regarding the history of Dupuytren’s disease, hypertrophic scars, or keloids. However, the use of the Keller Funnel was significantly more common in the group without CC ($p = <0.001$). The use of sizers or type of antibiotic irrigation showed no significant impact on incidence of CC (Table 1).

Conclusion: The use of the Keller Funnel® was significantly associated with a lower incidence of capsular contracture, suggesting its benefit in breast augmentation cases. Other factors, such as history of scarring conditions or the use of different types of irrigation, did not show a significant relationship with the development of CC. These findings emphasize the importance of the “no touch” surgical technique in reducing risk of capsular contracture.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

Table 1: Factors affecting Capsular Contracture (CC)

	Total	No CC	Yes CC	p-value
	270	241 (89%)	29 (11%)	
Scarring disorders (Dupuytren's, Hypertrophic Scars, Keloids)	23	20	2	0.72
Use of Sizers	244	217	27	1.0
Use of Keller Funnel	102	99	3	0.001
Antibiotic Irrigation	253	224	29	0.23
Bacitracin	150	130	20	0.16
Betadine Irrigation	222	196	26	0.44
Irrisept Irrigation	17	16	1	1.0

SUNDAY - QUICK SHOT PRESENTATIONS..... 4:00 – 5:30 PM**8 Rewiring Relief: The Role of Nerve Pedicle Transfer in the Reduction of Pain Medication Usage**

Abi Recktenwald MD, Evan Lynch MD PhD, Morgan S Brgoch MD

University of Kentucky, Department of Surgery, Division of Hand Surgery

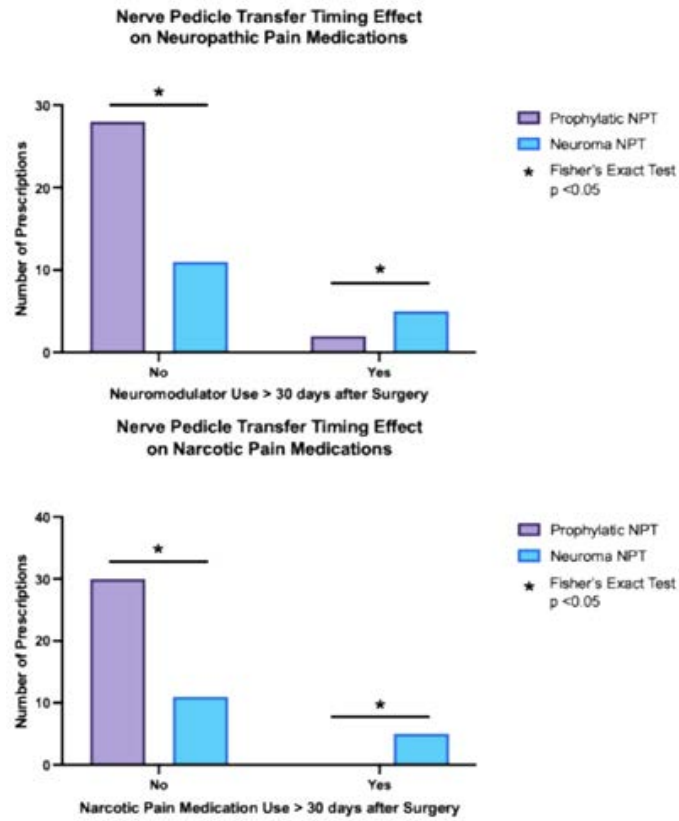
Introduction: In the USA, there are an estimated 45,000 hand and finger amputations annually. Up to 20% will develop symptomatic neuromas that result in significant disability and diminished quality of life. Nerve pedicle transfers, including regenerative peripheral nerve interface (RPNI) and targeted muscle reinnervation (TMR), have been shown to reduce the risk of opioid use disorder (OUD) in amputees, but the role in hand amputations is less clear. We investigated the effects of NPT in phalangeal and ray amputations on the use of pain medication, neuroma formation and development of chronic pain.

Methods: We performed a retrospective chart review on phalangeal and ray amputations that underwent NPT from 2020 to 2023 at our tertiary medical center. Patients were stratified by prophylactic NPT and NPT for symptomatic neuroma. Data collected included demographic information, operative technique, mechanism, residual limb pain (RLP), phantom limb pain (PLP), and usage of pain medication beyond 30 days.

Results: 16 NPTs were performed for symptomatic neuromas and 30 prophylactic NPTs were performed. 2/30 patients undergoing prophylactic NPTs required neuropathic pain medication compared to 5/16 symptomatic neuroma patients ($P = 0.0402$). 0/30 patients undergoing prophylactic NPTs required opioid pain medication compared to 5/16 symptomatic neuroma patients ($P = 0.0032$).

Conclusions: Our data demonstrates a statistically significant reduction in controlled substance prescriptions in the prophylactic NPT group compared to the symptomatic neuroma group.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 - 5:30 PM



SUNDAY - QUICK SHOT PRESENTATIONS..... 4:00 – 5:30 PM**9 Outcomes and Complications Associated with Operative Fixation of Perilunate Dislocations: A Systematic Review**

Rachel H. Safeek, MD, MPH¹, Ashrita Budharaju, BS², William K. Powers³, MD, Kevin A. Hao, MD⁴, Joshua Bell, MD¹, Harvey Chim, MD¹, Ellen Satteson, MD¹

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Introduction: Perilunate dislocations are rare, yet serious, high-energy injuries with many limiting functional sequelae, including residual pain, stiffness, and arthritis of the wrist. In this study, we review clinical outcomes and their tools for measurement following operative fixation of perilunate fracture and dislocation.

Methods: A systematic review of studies pertaining to clinical outcomes following operative management of perilunate dislocations was conducted by querying Web of Science, PubMed/MEDLINE, Cochrane, and Embase databases. PRSIMA guidelines were followed. After removal of duplicates, 246 articles were screened by two independent reviewers.

Results: Forty-four studies met inclusion criteria for the study. Most were retrospective, single center studies, encompassing 885 patients (896 wrists). Most (99.4%) were male, with a mean age of 32.3. Mean follow-up was 50.3 months (minimum average 22.4 months), with 93.3% of wrists having undergone open reduction and internal fixation (ORIF). Most (86.3%) studies reported grip strength (mean: 36.0 kg; 76.4% of contralateral side). The most used clinical scoring assessment was the Mayo Wrist Score (MWS) (N=24 studies; mean: 75.6), followed by the Disabilities of Arm, Shoulder, and Hand (DASH) score (N=15 studies; mean= 21.51) and Patient-Related Wrist Evaluation (PRWE) score (N= 12 studies; mean= 26.7). The most reported complications postoperatively were posttraumatic arthritis and residual wrist pain. Nonunion rate did not differ significantly across surgical technique (dorsal vs. volar vs. combined vs. arthroscopic).

Conclusion: Our systematic review suggests that measurement of clinical outcomes following surgical intervention for perilunate dislocations is not standardized, with a range of clinical scoring assessments being used. Furthermore, even with operative fixation, clinical outcomes for patients with perilunate dislocation remain overall varied, with some patients reporting residual pain and chronic osteoarthritis.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

10 Patient Reported Outcomes and the Use of Bone Grafting in Distal Radius Osteotomy for Malunion Correction: A Systematic Review

Orr Shauly, MD¹, Shannon Su, BS², Paul Ghareeb, MD¹

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2. Emory University School of Medicine, Department of Medicine, Atlanta, GA

Introduction: Distal radius fractures (DRF) account for up to 18% of adult fractures, with malunion occurring in up to 25% of conservatively managed cases and 10% of surgically managed cases. Symptomatic malunion can lead to significant morbidity, including loss of forearm rotation, adaptive carpal instability, and arthritis. Corrective osteotomy is a key surgical intervention, yet there is no consensus on the optimal surgical approach, fixation technique, or necessity of bone grafting. The purpose of this review is to evaluate surgical outcomes of distal radius osteotomy for malunion, compare approaches, and assess the need for bone grafting.

Methods: A search of PubMed (2000–2023) was conducted with seventeen studies meeting inclusion criteria, which required primary data on DRF malunion correction, comparative analyses of volar versus dorsal approach, bone graft necessity, and patient-reported outcomes. Data on complication rates, patient satisfaction, and clinical questionnaire scores were analyzed.

Results: Ten studies assessed volar plate fixation outcomes, with five using bone grafting and five without. Both groups demonstrated significant improvement in PROMs, radiographic measures, and grip strength. Two studies directly compared volar and dorsal approaches. Both approaches demonstrated significant improvements in range of motion and patient-reported outcomes. However, the volar approach resulted in significantly greater wrist flexion ($p=0.012$) and fewer hardware-related complications compared to dorsal plating. Three studies assessed the necessity of bone grafts and showed mixed results. While some demonstrated successful outcomes without grafting, others reported improved union rates with cancellous grafts. One study found no difference between autologous and synthetic grafts.

Conclusion: Corrective osteotomy for DRF malunion significantly improves patient outcomes, with volar plate fixation trending towards better outcomes over dorsal plating. Bone grafting may not be essential for all cases, particularly when stable fixation is achieved with cortical bony contact. Further high-quality comparative studies are needed to refine surgical decision-making.

SUNDAY - QUICK SHOT PRESENTATIONS..... 4:00 – 5:30 PM**11 Implant Augmentation after Autologous Reconstruction: A 14-Year Review of Hybrid Breast Reconstruction Outcomes**

Jenna Stoehr, MD; Peyton Stauffer, BS; Logan Ziegler, MS; Timothy Nehila, BA, Kristina Buller, DO; Rebecca Lipscomb, MPH; Rahul Mhaskar, MPH, PhD; Deniz Dayicioglu, MD

University of South Florida, Tampa, Florida

Background: Implant placement after autologous breast reconstruction can provide excellent aesthetic outcomes for patients who desire larger breasts. The aim of this study was to review outcomes of patients who underwent breast implant placement after DIEP reconstruction and compare them to patients who did not undergo hybrid reconstruction.

Materials and Methods: A retrospective cohort study was performed comparing patients who underwent hybrid breast reconstruction (implant placement after DIEP) to DIEP patients alone. The two groups were compared using Mann-Whitney U test for continuous variables and Pearson Chi-Square test for categorical variables.

Results: A total of 481 DIEP flaps performed by a single surgeon were included in the analysis, of which 20 flaps (13 patients) underwent hybrid reconstruction. Patients who underwent hybrid reconstruction were more likely to be younger (47 years old vs. non-hybrid, 52 years old, $p < 0.001$) and have a lower BMI (29, vs. non-hybrid, BMI 32, $p = 0.037$). The timing of reconstruction, laterality, smoking status, or history of massive weight loss or radiation were not significantly associated with hybrid reconstruction. The mean implant size was 256 cc (min: 150 cc, max: 340 cc). There were no significant complications after implant placement. Five out of 13 patients (38%) later underwent implant exchange.

Conclusions: Hybrid breast reconstruction with breast implant placement is a safe and efficacious adjunct procedure after autologous reconstruction. Patients undergoing hybrid reconstruction tended to have lower BMI and desired larger breasts, which may imply that their original results were limited by their donor tissue available.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

12 Digital Nerve Coaptation vs. Standard of Care for Partial and Ray Digital Amputations

John M. Sullivan III, MD; Steele I. Liles, MD; James H. Sikes, BS; John D. West, BS; Ronald R. McCall, BS;
Eric M. Waetjen, MD; Marc E. Walker, MD, MBA

University of Mississippi

Hypothesis: The current standard of care for digit amputation is nerve transection and allowed retraction which often results in neuroma formation and pain requiring additional surgery. In this report, we hypothesize that patients undergoing partial or ray amputations with digital nerve coaptation will experience a lower rate of neuroma formation, lower rate of post-operative complications, and decreased pain scores (neuropathic pain scale rating and numerical pain rating) compared to neurectomy alone.

Methods: Thirty-four retrospective patients who underwent a partial or ray amputation with digital nerve coaptation or traction neurectomy were assessed for neuroma formation, post-operative complications (infection, persistent pain, functional stiffness, wound dehiscence), and post-operative pain ratings. The pain scales that were assessed included the neuropathic pain scale (NPS) ranging from 0-100 and a numerical hand pain rating (current, best, and worst rating) ranging from 0-10. A two-tailed independent t-test and a chi-square test of independence were used to compare post-operative pain metrics.

Results: Patients who underwent digital nerve coaptation (n=7) experienced a lower average NPS rating (31.42 vs. 42.04) compared to patients who underwent the current standard of care (n=27). In addition, patients who underwent digital nerve coaptation experienced a lower average numerical pain rating (3.57 vs. 4.192). Lastly, patients who underwent digital nerve coaptation experienced a lower rate of post-operative complications (0.31 vs. 0.54).

Discussion: This pilot data indicates a positive observable outcome when comparing patients' postoperative pain for those who underwent digital nerve coaptation versus traction neurectomy. Although not sufficiently powered for statistical significance, these findings do suggest that digital nerve coaptation could be a superior method of nerve treatment in digit amputations.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

13 Synovial Flap for Recurrent Carpal Tunnel Syndrome Long-Term Follow Up

Robert Travis MD, Anthony Capito MD

Virginia Tech Carilion

Background: Recurrent carpal tunnel syndrome is a challenging surgical problem. Revision carpal tunnel release with vascularized flap coverage is indicated when scarring around the median nerve is believed to be the culprit for recurrence. Synovial flap coverage at the time of neurolysis is a described technique but long-term results have not been reported. The aims of this study were to present long-term (>1 year) patient reported survey outcomes after revision carpal tunnel release with synovial flap coverage and to identify any patient related factors associated with worse outcomes.

Methods: A retrospective review identified 28 patients who underwent revision release combined with synovial flap coverage over a 10-year time frame. Patient demographics and preoperative symptoms were collected. All patients were contacted via telephone. 21 patients completed follow-up surveys including the QuickDASH and Boston Carpal Tunnel Questionnaire (BCTQ). Data was analyzed using a Fisher's exact test with a significance set to a p value <0.05.

Results: Of the 21 survey participants, 13 had good outcomes based on a BCTQ score <2 (61.9%) and 15 had good outcomes based on a QuickDASH score ≤34 (71.4%). All patients considered the surgery successful and 18 would elect to undergo the surgery again. No patients required an additional release. No specific patient characteristics or preoperative symptoms were associated with a poor outcome. There were no major complications.

Conclusion: Revision carpal tunnel release with synovial flap coverage demonstrated good long-term patient reported outcomes. This is a reliable, effective treatment option for this challenging condition.

SUNDAY - QUICK SHOT PRESENTATIONS.....4:00 – 5:30 PM
14 Assessing Financial Disclosure in Non-Invasive Fat Reduction Research: Do Corporate Payments Impact Study Outcomes?

Jasmina Abdalla BS¹; Raeesa Kabir, BS²; Joseph Nguyen, BS¹; Keerthi Kurian, BS³; Hilliard Brydges, MD⁴; Carter J. Boyd, MD, MBA⁴; Jamie P. Levine, MD⁴

1. University of Virginia School of Medicine, Charlottesville, VA
2. University of Minnesota Medical School, Minneapolis, MN
3. California Northstate University College of Medicine, Elk Grove, CA
4. Hansjörg Wyss Department of Plastic Surgery NYU Langone Health New York, NY

Purpose: Non-invasive fat reduction techniques may offer alternatives to surgical body and facial contouring. As the biomedical industry plays a significant role in developing these techniques, it is important for physicians publishing on these treatments to disclose conflicts of interest (COI) related to industry collaborations. This study explores the relationship between COI disclosure, corporate payments, and the outcomes of non-invasive fat reduction techniques.

Methods: A systematic review using PRISMA guidelines included studies on non-invasive fat reduction published through July 2022. The Open Payments database (openpaymentsdata.cms.gov) was used to access compensation data from companies disclosed in COI statements. Study outcomes were analyzed using descriptive statistics and uni- and multi-variate analyses.

Results: Of the 86 studies, 72.1% had a COI disclosure statement. Eleven authors failed to disclose COI despite receiving compensation. Positive outcomes were more frequent in studies where the first authors disclosed COI (84.2%) versus those without (59.7%) ($p = 0.04787$). No significant differences were observed for the last authors with COI or for authors receiving compensation versus those who did not. However, the last authors who received compensation from companies manufacturing the device used in the study reported higher rates of positive outcomes (91.7%) versus those who did not (60.8%) ($p = 0.03749$). Receiver Operating Curve analysis showed a weak association between first-author compensation and study outcomes ($AUC = 0.597$).

Conclusion: This study highlights the inconsistency and incompleteness of COI reporting, as some authors failed to disclose COI in their papers despite compensation being recorded in the Open Payments database.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM**15 Aesthetic Flat Closure: Assessing the Financial and Clinical Viability of an Emerging Post-Mastectomy Option**

Hibo M. Wehelie BS, Robert G. Devito MD, Jessica Pawly MD, Chris A. Campbell MD, Scott Hollenbeck MD

University of Virginia, Department of Plastic Surgery, Maxillofacial, and Oral Health, Charlottesville, Virginia

Background: Aesthetic flat closure (AFC) is an increasingly popular alternative to breast mound reconstruction. This study evaluates its surgical outcomes and financial viability.

Methods: A retrospective review of patients who underwent mastectomy for breast cancer or elevated cancer risk (2017-2023) was done. Financial data were analyzed to compare AFC with autologous breast reconstruction (ABR) and implant-based reconstruction (IBBR). Patients who underwent delayed reconstruction were excluded. Comparisons of revision rates, follow-up visits, operative time, and postoperative outcomes between mastectomy-alone (MA) and AFC were included.

Results: Compared to ABR which has a reimbursement rate of approximately 99.4% and a direct margin of \$5,809 per case, and IBBR with a reimbursement rate of 99.9% and a direct margin of \$4,357 per case, AFC demonstrated a comparable reimbursement rate of 100% (n=21) with a direct margin of \$7,006 per case. The average operative time for mastectomy with AFC was 218 minutes, approximately 93 minutes longer than MA (125 minutes). AFC (n=21) and MA (n=172) averaged 3.4 and 1.5 postoperative visits within 90 days, respectively, with an average of less than one revision per patient in both groups ($p > 0.05$). There was no significant difference in rates of seroma, hematoma, or infection; however, wound complications were significantly higher in the AFC group compared to MA (19.0%, n=4 vs. 2.9%, n=5, $p < 0.001$).

Conclusion: Aesthetic flat closure shows comparable financial outcomes to traditional breast reconstruction options with a post-operative course similar to mastectomy-alone, supporting its inclusion as a standard post-mastectomy option.

SUNDAY - QUICK SHOT PRESENTATIONS 4:00 – 5:30 PM

Table 1. Financial Analysis and Operative Time by Procedure Type

	AFC	ABR	IBBR
Reimbursement Rate (%)	100	99.4	99.9
Average Direct Margin (%) ^b	7,006	5,809	4,357
Average Operative Time (min)	218	427	284
Average Time Added (min) ^c	93	302	159

AFC: Aesthetic flat closure, ABR: Autologous breast reconstruction, IBBR: Implant-based breast reconstruction.

^b Per operative case.

^c Average time added to mastectomy alone cases, which average approximately 125 minutes.



Figure 1. A. Anterior view of pre-operative markings for an aesthetic flat closure utilizing both vertical and transverse orientation incisions to allow for optimal skin reduction. B. Lateral view of pre-operative markings. C. Intra-operative picture after completion of oncologic portion of case. D. Intra-operative picture showing provisional closure of vertical component and decision is then made to de-epithelialize the inferior skin flap to allow for optimal aesthetics. E. Intra-operative picture after completion of de-epithelialization of inferior mastectomy skin flap. F. Immediate on table result after completion of aesthetic flat closure.

MONDAY - MEMBER/GENERAL PAPERS9:45 - 11:00 AM**1 Evaluation of Absorbable Vancomycin Beads in Groin Reconstruction Following Vascular Bypass Graft Procedure**

Leanne D. Jeong, B.S.¹; Ting D. Zhang, B.S.¹; Madeline P. Bald, B.S.¹; John P. Moody, Jr., B.S.¹; Lauren Curwick, M.D.²; Adam W. Beck, M.D.³; Jorge I. de la Torre, M.D., MSHA²; René P. Myers, M.D.²

1 University of Alabama at Birmingham, School of Medicine

2 University of Alabama at Birmingham, Division of Plastic Surgery

3 University of Alabama at Birmingham, Division of Vascular Surgery and Endovascular Therapy

Background: Limited literature exists on the efficacy of absorbable antibiotic bead (AAB) use at the time of groin reconstruction. This retrospective analysis aims to evaluate the outcomes of patients who received vancomycin AABs during groin reconstruction following a vascular bypass graft procedure at a large tertiary-care hospital.

Methods: A retrospective review was conducted of patients undergoing vascular bypass graft surgery followed by groin reconstruction by the Plastics and Reconstructive Surgery service from January 2018 to March 2024 at a single institution. Patients were grouped by whether vancomycin AABs were placed during the muscle flap/groin reconstruction. Variables evaluated included demographics, reoperations, readmissions, and other postoperative complications.

Results: A total of 52 patients met our inclusion criteria, of which 17 patients (32.7%) received vancomycin AABs. The vancomycin AAB cohort had lower rates of readmission (0%) than the control group (20%) as well as fewer reoperations (5.9% vs. 51.4%) ($P=0.0475$ and $P=0.0017$, respectively). No postoperative surgical site infections (SSI) occurred in the AAB cohort compared to 34.3% of the control group ($P=0.0049$). Additionally, chronic wound care was necessary for 48.6% of control group cases and unnecessary for all patients who received AABs ($P=0.0003$).

Conclusions: The use of absorbable antibiotic beads with muscle flap coverage for complex groin wounds was significantly associated with improved patient outcomes. Reduced rates of reoperations, readmissions, and SSI suggest that AABs may effectively lower postoperative complications and improve overall patient recovery in groin reconstruction procedures.

Table 1. Outcome measures, stratified by control vs. absorbable vancomycin antibiotic bead group

Outcome Measures	Control Group (n=35)	Absorbable Vancomycin Antibiotic Bead Group (n=17)	P-value
Mean Age (years)	56.2 (SD 16.73)	60.22 (SD 10.98)	0.3722
Readmission	7 (20%)	0 (0%)	0.0475
Reoperation	18 (51.4%)	1 (5.9%)	0.0017
Surgical Site Infection (SSI)	12 (34.3%)	0 (0%)	0.0049
Chronic Wound Care	17 (48.6%)	0 (0%)	0.0003

MONDAY - MEMBER/GENERAL PAPERS9:45 - 11:00 AM

2 Polyethylene Glycol-mediated Axonal Fusion Promotes Early Postoperative Recovery of Median and Ulnar Nerves Following Sunderland V Traumatic Injuries of the Distal Forearm: A Double-Blind Randomized Clinical Trial

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³ Division of Plastic Surgery, Department of Surgery, University of Washington, Seattle, WA, USA

Background: Up to 30% of peripheral nerve repairs fail. PEG prevents Wallerian degeneration by fusing the severed axolemma, leading to improved functional recovery in preclinical and clinical studies. This study presents preliminary results from the first randomized clinical trial on PEG-mediated neurorrhaphy in mixed sensory and motor nerves of the distal forearm.

Methods: Patients ages 18-75 with Sunderland V upper extremity nerve injury were randomized into PEG-mediated and standard neurorrhaphy cohorts. Michigan Hand Questionnaires (MHQ) and Medical Research Council (MRC) sensory/motor grading were conducted at 1 week, 1 month, 3 months, 6 months, and 12 months post-operation. Statistical analysis was performed using a mixed-effect linear regression model.

Results: Ten patients were analyzed: 7 PEG (9 nerves) and 3 non-PEG (4 nerves). Injured nerves were 62% ulnar, 38% median, and 0% radial. The cohorts had similar demographics. Within 3 months post-surgery, the PEG patients achieved $\geq S3/\geq M3$ recovery, while the non-PEG remained $\leq S2/M2$. PEG patients had higher estimated MRC sensory ($+1.44 \pm 0.609$, $p = 0.043$), MRC motor ($+1.18 \pm 0.481$, $p = 0.0298$), and mean MHQ ($+5.82 \pm 1.42$, $p = 0.0083$) scores compared to the non-PEG patients at each follow-up.

Conclusions: Patients with PEG-mediated neurorrhaphy experienced early functional recovery and significantly improved patient-reported function and quality of life, highlighting the potential in PEG-mediated mixed nerve repairs of distal forearm injuries.

MONDAY - MEMBER/GENERAL PAPERS9:45 - 11:00 AM

3 An Evaluation of Flap Dimensions and Complications in Immediate Breast Reconstruction

Daniel F. Haynes, MD; Dominick Haynes, BS; Alicia Billington, MD

East Tennessee State University, Division of Plastic Surgery, Johnson City, TN

Background: Tissue quality after mastectomy is highly correlated with ultimate reconstructive outcome. Indocyanine fluorescence imaging can be used to assess skin flap perfusion, however adds approximately \$650 in disposables cost per case, and is not available in all hospitals.

Methods: Prospective data was collected on 365 patients, 685 breasts, during immediate reconstruction with tissue expander or implant. Caliper measurements were taken of mastectomy flap edge thickness at three locations, central, medial, and lateral, and flap length was measured from flap edge to upper or lower extent of dissection.

Data was analyzed according to four outcomes: any wound issue (such as edge necrosis or ischemia requiring hyperbaric); wounds requiring surgical revision; infection requiring antibiotics; and expander or implant loss.

Results: Patients experiencing wound complications measured significantly thinner in average thickness across all flap edge measurements, and were significantly longer in upper and lower flap lengths (p-values < 0.0001). Development of wound issues correlated with device loss (odds ratio 2.01, p = 0.029), but not with subsequent infection (p = 0.754). Flap thickness of less than 3mm, length (cm) to thickness (mm) ratio > 4, or flap length of 13cm or greater were all associated with higher likelihood of healing problems and return to surgery.

Conclusion: In patients with flap thickness < 3mm or flap length > 13cm, consideration should be given to revising the flap to reach thicker tissue. If this is not feasible, the patient may benefit from deferring the procedure and performing delayed reconstruction.

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4 Introduction and Utilization of “Spray-On Skin” at an Urban, Level-1 Trauma Center: Learning Curve Analysis of 125 Consecutive Patients with Full-Thickness Wounds and Defects, Treated with Autologous Skin Cell Suspension

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Introduction: Autologous Skin Cell Suspension (ASCS), or “spray-on skin,” has documented efficacy in closing full-thickness wounds, but concern has been raised regarding potentially increased operative times and excess resource utilization. We studied outcomes of our first 125 patients treated with ASCS, at an urban, level-1 trauma center.

Methods: 125 consecutive patients with full-thickness wounds were treated with the bilayer technique of 3:1 widely-meshed autograft and 80:1 expanded ASCS. Single-cell suspension of keratinocytes, melanocytes, and fibroblasts underwent intra-operative, point-of-care preparation prior to aerosolization. Learning curves were assessed by the cumulative sum (CUSUM) method of operative times, with competency defined as initial peak of the curve and mastery by the final decline.

Results: Wound closure was achieved in 74%, 94%, and 97% of patients at 4, 8, and 12 weeks. Etiology included burns (34), NSTI (25), MVC (12), degloving (11), crush (9), fasciotomy (7), and other (27). Limb salvage occurred in 103/104 patients with extremity defects. Regarding operative times, competency was achieved by the 23rd case, and mastery occurred by the 66th case. Mean operative time decreased from 132 to 108 minutes from the competency to the mastery phase ($p=0.01$). Complications decreased from 30% to 24%, whereas length of stay remained the same at 3 weeks. The only predictor of prolonged operative times was increased wound size.

Conclusion: ASCS is an effective and reliable method for closure of full-thickness wounds. In terms of operative times and learning curves, competency can be achieved relatively quickly, but mastery may take longer than expected.

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5 Solving the Endoscopic Forehead Conundrum: Go Deep to the Deep Temporal Fascia

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Background: The standard approach to release of the orbital ligament via endoscopic technique is in the areolar plane between the temporoparietal fascia and the deep temporal fascia lateral to the temporal line of fusion. This plane of dissection is anatomically complex and contains the sentinel veins, branches of the frontal nerve and the inferior temporal septum, all of which obstruct access to the orbital ligament.

Methods: A retrospective review was performed of the senior author's approach to endoscopic forehead lifting. Comparisons of pre- and postoperative photographs were made at 6-8 weeks and >6 months postoperatively to quantitate the effectiveness of this alternative technique. Measurements of the brow height at five standardized points relative to the mid inter-pupillary line were taken (Figure 1). Patient demographics and outcomes were tabulated.

Results: Eighteen patients met inclusion criteria with 100% follow-up. The average age was 59 (43-70). Spacing between the eye and eyebrow demonstrated proportional expansion, with universal measurable increases at both time intervals (Table 1). There were no instances of frontal nerve weakness or hematoma. Average overall increase in brow height was 2.22 mm at 6-8 weeks postop and 2.64 mm at >6 months postop. All patients were satisfied with their result.

Conclusion: The plane deep to the deep temporal fascia is a viable alternative to the classic sub-temporoparietal fascial plane. This approach avoids critical anatomic structures, allows unfettered access to the orbital ligament, and provides satisfactory objective and subjective clinical results.

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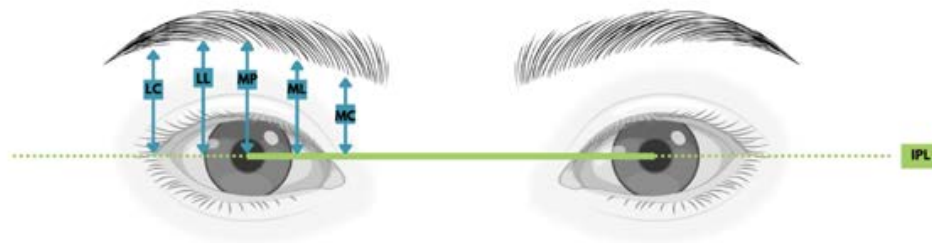


Figure 1. Anatomical landmarks used to assess brow lift relative to the mid inter-pupillary line (IPL, green dotted line): medial canthus (MC), medial limbus (ML), mid-pupil (MP), lateral limbus (LL), and lateral canthus (LC). Vertical double arrows indicate the vertically measured distances.

Table 1. Average Increase in Brow Height (mm)

IPL* to Infra-brow distance	6-8 weeks post-op		>6 months post-op	
	<i>Right</i>	<i>Left</i>	<i>Right</i>	<i>Left</i>
At medial canthus	1.9	1.8	1.9	3.0
At medial limbus	2.3	2.2	2.6	2.8
At mid-pupil	1.7	3.0	2.1	3.1
At lateral limbus	2.0	2.7	2.9	2.4
At lateral canthus	2.5	2.1	3.1	2.5

All measurement values are in units of millimeters (mm). *IPL: Mid Inter-Pupillary Line

MONDAY - MEMBER/GENERAL PAPERS9:45 - 11:00 AM**6 Evaluating the Performance of Different Pedicles in Reduction Mammoplasty: A Comparative Analysis**

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5 University of North Carolina Division of Plastic Surgery, Chapel Hill, NC.

Background: Pedicle selection for reduction mammoplasty is dictated by the interplay of surgeon experience and patient characteristics. We review clinical patient characteristics that dictate pedicle selection and review outcomes associated with the interplay between patient characteristics and technique.

Methods: A retrospective chart review of 2500 patients having undergone reduction mammoplasty at five institutions from 2010-2019 was performed to record pedicle selection, patient demographics, comorbidities, body mass index, patient measurements to determine patient selection for different pedicle techniques and clinical outcomes associated with these techniques.

Results: 1186 patients had inferior pedicle technique, 65, superior pedicle technique, 816 superomedial pedicle technique, 148 with free nipple graft and the remainder were not specified. . 6.2% of inferior and 0.5% of superomedial reductions required conversion to free nipple grafts. 1899 reduction mammoplasties were closed with wise pattern skin closure and 189 were circumvertical. Demographics were similar across groups except for higher age ($p<0.001$), BMI ($p<0.001$), and ASA score ($p<0.001$) in the free nipple graft cohort. Superomedial pedicle was used most frequently with lower sternal notch to nipple (SNN) distance while inferior pedicle was performed most frequently with higher SNN distance. Inferior pedicle was favored over other pedicle types for obesity classes I-III patients and free nipple graft was only employed for obese patients. On linear regression, superior pedicle reduction (Co-efficient = -195.2, $p=0.001$) was significantly associated with lower resection weights while free nipple grafting was associated with a higher resection weight (Co-efficient = 752.8, $p<0.001$). Inferior pedicle technique was associated with higher dehiscence, overall wound healing rates and overall complication rates than other techniques ($p<0.001$). Regression analysis demonstrated age, BMI and inferior pedicle technique as independent risk factors for overall complications and superomedial pedicle as protective against complications. BMI alone independently predicted nipple necrosis ($p=0.002$) and fat necrosis ($p<0.001$).

Conclusions: Inferior pedicle reduction remains the most popular pedicle design followed by superomedial pedicle, with wise pattern closure the most common skin closure type. SNN distance was the most impactful design metric used to choose between pedicles. Inferior pedicle and free nipple graft were used most commonly for obese patients while superior reduction was associated with lower resection weights and BMI. Inferior pedicle technique reduction mammoplasty was independently associated with increased wound healing complications. Superomedial technique performed well across different BMI classifications. As previously reported, increasing BMI and smoking had a higher complication rate.

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7 Timing of the Dangle Protocol After Lower Extremity Free Flap Reconstruction: A Retrospective Chart Review

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Introduction: The dangle protocol is a rehabilitation technique employed following free flap reconstruction of the lower extremity (LE). Evidence remains insufficient regarding the optimal postoperative day (POD) to initiate dangling. This study aims to compare the efficacy and outcomes of early versus late initiation of the dangle protocol following LE free flap reconstruction.

Methods: A retrospective chart review included all adults who underwent LE free flap reconstruction at a Level 1 Trauma Center from January 2016 to December 2022. Patients were grouped according to initiation of dangling: early (POD 4-6) and late (POD 7-8). The primary outcome was flap failure. Secondary outcomes included wound dehiscence, infection, hematoma, seroma, partial flap necrosis, pulmonary embolism, flap takeback, hospital length of stay (LOS), and intensive care unit (ICU) LOS.

Results: A total of 103 patients (mean age 43.5±14.5 years) were included: 46 in the early group and 57 in the late group. No significant difference in flap failure was observed between the groups (4.3% vs. 1.8%, p=0.585). The early group showed a significantly lower rate of wound dehiscence compared to the late group (8.7% vs. 24.6%, p=0.040). Additionally, the early group demonstrated a significant reduction in average hospital LOS (21.5 days vs. 25 days) and ICU LOS (1.5 days vs. 2 days) (p=0.010 and 0.029, respectively). Incidence of infection, hematoma, seroma, partial flap necrosis, pulmonary embolism, and flap takeback did not differ significantly between groups.

Conclusion: Early initiation of the dangle protocol may decrease hospital length of stay without adversely affecting flap outcomes.

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Table 1. Patient characteristics.

	All	Early	Late	p-value
All, n (%)	103 (100.0)	46 (100.0)	57 (100.0)	
Age, mean (std)	43.5 (14.5)	43.9 (15.0)	43.1 (14.2)	0.784
Race, n (%)				0.669
White	45 (43.7)	18 (39.1)	27 (47.4)	
Black	47 (45.6)	21 (45.7)	26 (45.6)	
Hispanic	5 (4.9)	3 (6.5)	2 (3.5)	
API	1 (1.0)	1 (2.2)		
Other	5 (4.9)	3 (6.5)	2 (3.5)	
Obesity, n (%)				0.150
No	65 (63.1)	33 (71.7)	32 (56.1)	
Yes	38 (36.9)	13 (28.3)	25 (43.9)	
Diabetes, n (%)				0.108
No	86 (83.5)	35 (76.1)	51 (89.5)	
Yes	17 (16.5)	11 (23.9)	6 (10.5)	
Hypertension, n (%)				0.548
No	60 (58.3)	25 (54.3)	35 (61.4)	
Yes	43 (41.7)	21 (45.7)	22 (38.6)	
PAD, n (%)				0.126
No	99 (96.1)	46 (100.0)	53 (93.0)	
Yes	4 (3.9)		4 (7.0)	
Smoker Current, n (%)				0.090
No	59 (57.3)	28 (60.9)	31 (54.4)	
Yes	41 (39.8)	15 (32.6)	26 (45.6)	
Unknown	3 (2.9)	3 (6.5)		
Smoker Ever, n (%)				0.831
Never	33 (32.0)	15 (32.6)	18 (31.6)	
Former	25 (24.3)	13 (28.3)	12 (21.1)	
Some Days	8 (7.8)	4 (8.7)	4 (7.0)	
Every Day	35 (34.0)	13 (28.3)	22 (38.6)	
Unknown	2 (1.9)	1 (2.2)	1 (1.8)	
Smokeless Tobacco, n (%)				0.379
Never	75 (72.8)	35 (76.1)	40 (70.2)	
Former	4 (3.9)		4 (7.0)	
Current	9 (8.7)	4 (8.7)	5 (8.8)	
Unknown	15 (14.6)	7 (15.2)	8 (14.0)	
Alcohol, n (%)				0.012
No	37 (35.9)	11 (23.9)	26 (45.6)	
Yes	44 (42.7)	20 (43.5)	24 (42.1)	
Not Currently	12 (11.7)	10 (21.7)	2 (3.5)	
Unknown	10 (9.7)	5 (10.9)	5 (8.8)	
Drug, n (%)				0.173
No	57 (55.3)	27 (58.7)	30 (52.6)	
Yes	28 (27.2)	9 (19.6)	19 (33.3)	
Not Currently	8 (7.8)	6 (13.0)	2 (3.5)	
Unknown	10 (9.7)	4 (8.7)	6 (10.5)	
IV Drug, n (%)				0.125
No	86 (83.5)	42 (91.3)	44 (77.2)	
Yes	2 (1.9)		2 (3.5)	
Unknown	15 (14.6)	4 (8.7)	11 (19.3)	

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Table 2. Outcomes

	All	Early	Late	p-value
All, n (%)	103 (100.0)	46 (100.0)	57 (100.0)	
Flap Failure, n (%)	3 (2.9)	2 (4.4)	1 (1.8)	0.585
Venous Congestion, n (%)	4 (3.9)	0 (0)	4 (7.0)	0.126
Venous Insufficiency, n (%)	1 (1.0)	1 (2.2)		0.447
Wound Dehiscence, n (%)	33 (32.0)	8 (17.4)	25 (43.9)	0.003
Complicating Infection, n (%)	28 (27.2)	12 (26.1)	16 (28.1)	0.172
Flap Hematoma, n (%)	11 (10.7)	4 (8.7)	7 (12.3)	0.216
Flap Seroma, n (%)	5 (4.9)	1 (2.2)	4 (7.0)	0.208
Partial Flap Necrosis, n (%)	22 (21.4)	5 (10.9)	17 (29.8)	0.013
Complete Flap Necrosis, n (%)	1 (1.0)	1 (2.2)		0.447
Pulmonary Embolism, n (%)	4 (3.9)	1 (2.2)	3 (5.3)	0.304
Debridement of Flap, n (%)	39 (37.9)	15 (32.6)	24 (42.1)	0.101
Flap Takeback, n (%)	41 (39.8)	14 (30.4)	27 (47.4)	0.036
Flap Takeback Reason				
Hematoma/Seroma/Infection, n (%)	18 (17.5)	6 (13.0)	12 (21.1)	0.121
Vascular compromise, n (%)	16 (15.5)	6 (13.0)	10 (17.5)	0.180
Planned debridement, n (%)	31 (30.1)	10 (21.7)	21 (36.8)	0.044
Wound dehiscence, n (%)	12 (11.7)	2 (4.3)	10 (17.5)	0.029

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8 A Five Year Experience with the 'Big Easy' Breast Reduction: A Safe and Reproducible Approach to Gigantomastia

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Background: Gigantomastia is broadly defined as macromastia requiring a surgical resection of greater than 1500 grams of breast tissue per breast. Patients presenting with gigantomastia pose significant operative challenges and are often not deemed candidates for reduction mammoplasty as a result of a less favorable risk profile. The Big Easy Breast Reduction (BEBR) is a technique proposed to improve the reliability of reconstructive success for patients with gigantomastia. This study presents a five-year, multi-surgeon experience with the technique.

Methods: 337 consecutive patients underwent reduction mammoplasty for gigantomastia from 2020-2025 by the senior author, using the BEBR technique. The technique avoids use of a vertical scar, eliminates flap undermining, and employs free nipple grafting. Two additional surgeons adopted the technique for treatment of an additional 18 patients, including three in the oncoplastic setting. Endpoints including patient demographics, operative times, and major complication rates were recorded.

Results: The median specimen weight per breast was 2055g (range 509-5532g). The average patient BMI was 40.1 (range 25.1-63.1). Median operative time, measured by total time spent by the patient in the operating room, was 1 hour, 55 minutes. No patients required return to operating room for hematoma, infection, or scar revision. There were no occurrences of partial or complete free nipple graft loss. Consistent symmetry and aesthetic outcomes were achieved.

Conclusion: The BEBR technique demonstrates a safe, efficient approach for gigantomastia management, yielding reliable aesthetic outcomes. The reported series demonstrates the ease of procedure, reproducibility across multiple institutions, and indications.

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9 Open Abdominal Wall Reconstruction Comparing a Vertical Laparotomy Incision to a Mid-transverse Incision and Wound Sequelae

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Introduction: Open abdominal wall reconstruction (AWR) for ventral hernia repair (VHR) is common, with vertical midline incisions traditionally preferred. While transverse incisions are an alternative, vertical incisions are favored over low-transverse incisions for easier transversus abdominis release (TAR) in the upper abdomen. However, a mid-transverse incision may be an alternative, especially for patients needing a concomitant panniculectomy, as it offers better upper abdominal exposure. This study compares outcomes between the mid-transverse and vertical incision techniques.

Methods: This is a retrospective analysis of a database from a single surgeon performing VHR from 2012 -2019. The groups were transverse (TI) or vertical midline (VI) incision. Demographic data and hernia characteristics were collected. Surgical outcomes were evaluated including hospital length of stay (LOS) and incidence of wound complications. Data was analyzed. Statistical significance was defined as p-value <0.05.

Results: 647 patients underwent abdominal wall reconstruction, with 126 patients in the VI group and 521 in the TI group. The two groups were similar in terms of demographic characteristics, including age, sex, BMI, and comorbidities ($p>0.05$). The mean hospital length of stay was similar $TI=8.9 \pm 7.5$ days compared to the $VI=9.9 \pm 9.8$ days, $p>0.05$. The TI group demonstrated a similar incidence of wound-related complications, including infection (15% vs. 9%, $p=0.17$), and wound breakdown (15% vs. 12%, $P=0.5$).

Conclusion: This study demonstrates that the mid-transverse incision for VHR is associated with similar incidence of wound complications, compared to vertical incision. These findings suggest that transverse incisions may offer a viable alternative to VI in patients that need skin resection secondary to excess or non-viable skin when a low transverse incision compromises exposure of the upper abdomen.

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10 The Impact of Intraoperative Parameters on Pediatric Craniosynostosis Surgical Outcomes

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Purpose: This study aims to assess the impact of intraoperative parameters on surgical outcomes in craniosynostosis surgeries.

Methods: A retrospective review from January 2018 and December 2022 analyzed intraoperative data: body temperature, mean arterial pressure (MAP), end tidal volume (VTe), and estimated blood loss (EBL). Outcomes measured included hospital stay duration, opioid usage, postoperative fever, complications, and transfusion requirements, analyzed via linear and logistic regression.

Results: Of the 97 procedures in 93 patients, 66 (67.74%) were open cranial vault reconstructions (OCVR), and 31 (32.26%) were endoscopic (ECVR). Arterial lines collected data in 95 cases. Overall, an increase in intraoperative MAP was associated with increased postoperative opioid doses (0.30, $p=0.003$), longer postoperative febrility (1.5, $p=0.03$), and higher EBL (0.11, $p=0.03$). In OCVR, MAP was significantly associated with shorter hospital stays (-0.75, $p=0.001$) and decreased odds of an intraoperative transfusion need (OR 0.86, $p=0.03$).

ECVRs displayed a positive relationship with hospital stay (1.3, $p<0.001$). A greater VTe discrepancy from the suggested 8mL/kg IBW was not significantly associated with postoperative complications (0.91, $p=0.71$) but significantly associated with fewer opioid administrations (-0.10, $p=0.01$). Declines in intraoperative temperature below 36.5°C were associated with longer hospital stays both overall (1.5, $p<0.001$) and in OCVR (2.3, $p<0.001$). Declines in temperature were not associated with longer hospital stays in ECVR (-0.22, $p=0.20$).

Conclusions: Our data suggests that both MAP and normothermia play an important role in determining immediate postsurgical outcomes. Future higher powered, prospective studies may be able to elucidate effect of intraoperative parameters on secondary outcomes or complications.

MONDAY - S. ANTHONY WOLFE RESIDENT ABSTRACT COMPETITION. 2:50 – 3:30 PM

1 Alar Suspension in Primary Cleft Rhinoplasty

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Background: The nasal deformities associated with cleft lip pose a significant challenge for the plastic surgeon. Use of alar suspension sutures is widely accepted as a powerful technique to control alar position at the time of lip repair. The goal of this study is to investigate how alar suspension techniques affect nostril symmetry as patients reach skeletal maturity, as long-term follow-up is lacking in current literature.

Methods: A retrospective review was performed of patients who underwent McComb alar suspension at the time of unilateral cleft lip repair at the authors' institution from 1998 to 2007. Standardized photographs at interval follow-ups were evaluated using photo analysis software. Nasal symmetry was quantified by measuring the difference in nostril height between the cleft and non-cleft side at each follow-up.

Results: 25 patients with adequate follow-up were included in the study. The percent difference in relative nostril height increased in 20 of 25 patients over the follow-up duration. Repeated measures ANOVA revealed a significant increase in relative nostril height from age 6 to 18 ($F(6, 144)=3.57$, $p=0.0025$).

Conclusion: The McComb alar suspension suture is an effective method of elevating the depressed cleft alar rim at the time of lip repair. Due to the progressive nostril asymmetry that can develop as patients reach adulthood, suture tensioning and degree of initial alar elevation must be done with caution.

MONDAY - S. ANTHONY WOLFE RESIDENT ABSTRACT COMPETITION. 2:50 – 3:30 PM

2 Recombinant Human Bone Morphogenetic Protein-2 (rhBMP-2) as an Alternative to Autologous Bone Graft in Pediatric Craniofacial Reconstruction: A Systematic Review

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University of Virginia

Background: Craniofacial reconstruction in pediatric patients commonly utilizes autologous bone graft, such as iliac crest bone grafts (ICBG). Recombinant human bone morphogenetic protein-2 (rhBMP-2) allografts may reduce operative time and donor-site morbidity. This review assesses rhBMP-2 as a viable alternative.

Methods: A literature search of PubMed, Ovid, and Web of Science (2008–2023) identified studies utilizing rhBMP-2 in pediatric craniofacial reconstruction. Randomized controlled trials, prospective or retrospective case series, and case reports were included. Reviews, animal, and basic science studies were excluded. Primary outcomes were efficacy, adverse events, and cost.

Results: Of 211 screened articles, 21 met inclusion criteria (6 RCTs, 2 prospective, 10 retrospective, 3 case reports). rhBMP-2 was used for alveolar cleft repair (18 studies), calvarial defect reconstruction (2), and mandibular continuity defect reconstruction (1). In alveolar cleft repair, 4 of 12 studies favored rhBMP-2 for bone formation, 1 favored ICBG, and 7 found no significant difference. Of 12 studies describing complications, 2 reported more adverse effects with rhBMP-2, 5 with ICBG, and 4 found no difference. Facial edema was the most common rhBMP-2 complication; donor-site morbidity was most common with ICBG. All 5 studies outlining operative time favored rhBMP-2. Of 8 studies reporting length of stay, 7 reported shorter stays with rhBMP-2. Cost analysis was mixed across 4 studies.

Conclusion: rhBMP-2 appears comparable, if not favorable, to ICBG for alveolar cleft repair with cost potentially offset by reduced operative time and hospital stay. Long-term follow-up is needed to confirm efficacy and safety.

MONDAY - S. ANTHONY WOLFE RESIDENT ABSTRACT COMPETITION. 2:50 – 3:30 PM

3 The Impact of Medicaid Expansion on State-Level Medicaid Reimbursement for Orthodontic Care: A Cost Analysis

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Background: Presurgical orthodontia enhances outcomes for cleft lip and palate (CL/P) patients undergoing alveolar bone grafting and orthognathic surgery. The average cost is \$2,692.42 for Phase 1 and \$5,369.51 for Phase 2 orthodontia. Medicaid Expansion reduces costs by improving access and benefits for low-income families. This study analyzes state-level Medicaid reimbursement rates for presurgical orthodontia in CL/P.

Methods: State websites were reviewed for 2024 provider reimbursement rates of CPT codes for CL/P orthodontia: D8020 (Phase 1/Orthodontia of Transitional Dentition) and D8080 (Phase 2/ Comprehensive Orthodontia of Adolescent Dentition). Reimbursement rates were averaged and categorized into Expansion and Non-Expansion states. States without coverage or missing data were excluded. Independent t-tests and ANOVA assessed significance ($p < 0.05$).

Results: Medicaid Expansion was not adopted by 20% of states (AL, GA, ID, KS, MS, NE, SC, TN, TX, WY). 97.5% of expansion states and 60% of non-expansion states cover D8080. The mean-adjusted reimbursement rates for D8080 were significantly higher for expansion vs. non-expansion states ($\$2,139.34 \pm \1465.92 vs $\$1,196.91 \pm \467.57 ; $p = 0.005$). 62.5% of expansion states and 50% of non-expansion states covered D8020, however, these rates did not differ between groups.

Conclusion: A disparity exists in Medicaid reimbursement for D8080 in which coverage favors expansion states. Out-of-pocket costs remain high making presurgical orthodontia unaffordable for low-income families. Addressing low reimbursement for orthodontia is necessary to lower financial barriers and improve surgical outcomes for Medicaid patients with CL/P.

MONDAY - S. ANTHONY WOLFE RESIDENT ABSTRACT COMPETITION. 2:50 – 3:30 PM

4 Differing Levator Veli Palatini Reposition Techniques in Primary Palatoplasty and the Impact on Incidence of Velopharyngeal Insufficiency Revisional Surgeries

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Background: Various techniques to reorient the levator veli palatini (LVP) muscles during primary palatoplasty exist including intravelar veloplasty (IVV) and myo-mucosal flaps. Bilateral nasal myo-mucosal flaps (NMMF) are a seldomly used technique. This study aimed to compare the LVP muscle repair techniques (IVV vs. NMMF) and their influence on the incidence of speech surgery.

Methods: A retrospective review was conducted. Variables included age, palatoplasty type, LVP muscle repair technique, and VPI surgery. A chi-square test of independence was conducted to examine the relationship between the type of LVP muscle repair (IVV vs. NMMF) during primary palatoplasty and the need for revision VPI speech surgery.

Results: 264 patients met inclusion criteria. The median age at primary palatoplasty was 9.43 months (IQR 9.07- 10.2). The Two-Flap technique was used in 71.3% of cases, while Von Langenbeck was used in 28.3%. 61.9% underwent IVV while 38.1% underwent NMMF. 20.8% of the sample required VPI surgery. The median age that speech surgery was performed was 4.4 years (IQR 3.4– 5.8). No statistically significant association between the type of LVP repositioning (IVV vs NMMF) and the likelihood of needing speech surgery was observed across palatoplasty types, $\chi^2(3, N=264)= 5.38, p= 0.146$.

Conclusion: Patients did not show a significantly higher likelihood of requiring speech surgery (VPI), regardless of the palatoplasty technique used (IVV vs NMMF). When comparing muscle repositioning methods, the NMMF modification offers outcomes comparable to the traditional IVV, with the added potential benefits of easier dissection, better muscle volume preservation, and reduced scarring.

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5 Variability in Delivery of Orthodontic Care Across ACPA-Approved Teams in the United States

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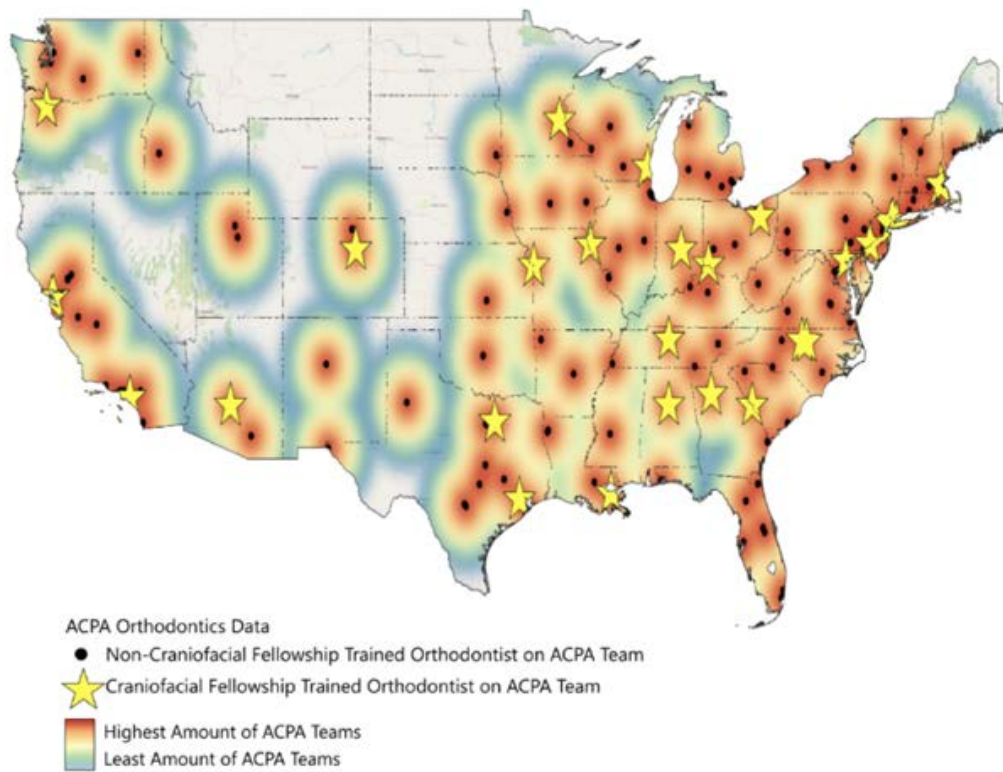
Purpose: American Cleft Palate and Craniofacial Association (ACPA)-approved teams are composed of trained professionals who work together to optimize outcomes for patients with cleft palates. Orthodontic care plays a critical role in correcting malocclusion, guiding maxillary growth, and improving surgical results. While ACPA approval requires the inclusion of an orthodontist on each team, the methods of care delivery often vary and are not always clearly defined. This study aims to explore how orthodontic care is integrated within ACPA-approved teams.

Methods: A comprehensive list of ACPA-approved teams (n=204) and orthodontists (n=374) was reviewed. Non-U.S. and duplicate teams were excluded. Each team's website was analyzed to identify the listed orthodontists, care delivery models (Hospital/University, Private Practice, Mixed, or N/A), and the presence of a Craniofacial Orthodontic Fellowship. Team geographic distribution was also examined across U.S. Census regions (West, Midwest, South, and Northeast).

Results: Of the 184 teams and 335 orthodontists included in the analysis, 46.7% listed orthodontists on their websites. Among these teams, 53.5% followed a hospital/university-based model, 39.5% were private practice-based, and 7% used a mixed model. Only 34.9% of teams included an orthodontist with craniofacial fellowship training. Notably, 53.3% of teams did not list an orthodontist on their website. Regional distribution revealed 25% of teams were in the West, 21.7% in the Midwest, 33.2% in the South, and 20.1% in the Northeast, indicating notable geographic variation.

Conclusion: The findings reveal significant variability in the visibility, delivery models, and specialization of orthodontic care within ACPA-approved teams. Less than half of the teams specifically listed an orthodontist on their website, with hospital/university models being most common. The absence of fellowship-trained craniofacial orthodontists and regional disparities in care models may affect coordination and accessibility, suggesting a need for further investigation into how these variations influence patient outcomes.

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6 Frontal Sinus Volume in Normocephalic Nonsyndromic Sagittal Craniosynostosis: A Multi-Institutional Comparative Study

Michael Lebharr, MD¹; Alexander Velazquez, BS¹; Todd Nichols, MD²; Timothy Booth, MD⁵; Rami Hallac, PhD⁴; Laura S. Humphries, MD, FACS¹; Alex Kane, MD³; Ian C. Hoppe, MD, FACS¹; Paymon Sanati-Mehrizi, MD³

1 University of Mississippi Medical Center – Division of Plastic and Reconstructive Surgery

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4 Children's Health at UT Southwestern – Analytical Imaging and Modeling Center

5 The University of Texas Southwestern Medical Center – Department of Radiology

Purpose: This study aimed to investigate frontal sinus volume as a potential indicator of cranial compensatory growth in unoperated normocephalic nonsyndromic sagittal craniosynostosis (NNSC) patients. Previous research has suggested that frontal sinus volume may be suppressed in unoperated craniosynostosis due to intracranial space conservation. This multi-institutional study combines patient cohorts from two institutions to further explore this phenomenon.

Methods: Head computed tomography (CT) scans from 49 unoperated NNSC patients (22 from our initial cohort and 27 new patients from UTSW) were analyzed and compared to age- and sex-matched controls. Frontal sinus volumes were measured using Syngo.via, and statistical analysis was performed. Inclusion criteria required the presence of a frontal sinus for volume measurement in both cases and controls. The presence or absence of frontal sinus pneumatization was compared between the groups.

Results: Out of 49 NNSC patients, 14 (28.6%) demonstrated the presence of a frontal sinus, compared to 100% of age- and sex-matched controls. Among the 27 newly included patients from UTSW, 8 (29.6%) had a frontal sinus, reinforcing prior findings of reduced frontal sinus development in this population. When compared with controls, Pearson correlation analysis continued to show a strong association between NNSC and decreased-to-absent frontal sinus volume ($r = 0.987$, $P < 0.001$).

Conclusion: The expanded dataset from two institutions confirms a strong correlation between NNSC and decreased frontal sinus volume, suggesting that the frontal sinus may serve as a radiographic marker of compensatory cranial growth restriction. This study provides further evidence that frontal sinus absence may be an indicator of altered skull development and potentially elevated intracranial pressure in these patients. Future studies should investigate the clinical implications of this finding, particularly in relation to surgical decision-making.

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7 A Single Institution's Experience with Posterior Vault Distraction Osteogenesis in a Low Resource Environment

Austin A. Lignieres, MD¹; Samantha D. Morin, BS, BA¹; Kendall C. Pitre, BS²; Ronald R. McCall, MS²; Holman Taylor, BA²; Laura S. Humphries, MD¹; Ian C. Hoppe, MD¹

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Background: Posterior vault distraction osteogenesis (PVDO) aims to increase intracranial volume in patients with craniosynostosis to prevent intracranial hypertension and improve head shape. However, limited access to healthcare can complicate treatment. The average complication rate reported in the literature is 30%, with cerebrospinal fluid leak and wound infection being most common. The purpose of this study is to describe a single institution's experience treating patients undergoing PVDO who face barriers to accessing healthcare.

Methods: A retrospective analysis of patients undergoing PVDO at our institution from 2014-2023 was conducted. Data collection included demographics, social vulnerability index (SVI), cranial sutures involved, intraoperative details, and complications. Descriptive statistical analyses were used to compare variables of interest.

Results: Twenty patients (9 females, 11 males) were included, with a mean U.S. SVI of 0.73. Patients with a syndromic diagnosis comprised 50% of the patient population (n=10). The median age at surgery was 8.5 months (range: 3 months-6 years). Patients with multi-suture craniosynostosis represented 85% of the cohort (n=17), with the coronal suture most frequently involved (n=13; 65%). Six patients (30%) developed postoperative infections and 1 of those patients required a return to the operating room for washout. Eight patients (40%) underwent multiple cranial vault surgeries.

Conclusions: This study highlights clinical outcomes in a vulnerable patient population undergoing PVDO. The average SVI highlights limited access to healthcare, and thus a higher risk for non-compliance and adverse outcomes. Despite facing socioeconomic barriers, the studied patients had similar complication rates to those reported in the literature.

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8 Longitudinal Observation of a Novel Technique for Excision and Reconstruction of a Nasal Mass in Pai Syndrome

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Abstract: Pai Syndrome is a rare frontonasal dysplasia characterized by midline central nervous system lipomas, medial facial clefts, and facial cutaneous polyps. Cutaneous polyps of the nose can disrupt normal anatomy and lead to nasal asymmetry. This presents a challenging problem for plastic surgeons to excise the excess tissue and re-establish the aesthetic nasal subunits. There is a paucity in the literature regarding Pai Syndrome, reconstructive techniques, and long-term follow-up.

The patient presented after birth with an occlusive nasal mass and a small intra-oral polyp fused to the frenulum. At 10 weeks of age, the intra-oral mass was completely excised, and the nasal mass was debulked to open the airway. During the follow-up period, the nasal mass grew disproportionately to the surrounding tissue, further distorting the nasal ala and sill. At 2.5 years of age, the patient underwent repeat nasal mass debulking with the remaining skin designed into a tri-lobed flap. Inset into a back cut between the nasal ala and tip, the superior lobe of the flap re-established alar height. The middle lobe of the flap lined the septal wall mucosal defect from the polyp. The lower flap, along with local tissue, formed a new nasal sill. Pin cushioning of the superior lobe of the tri-lobed flap was noted at follow-up appointments but resolved in the first postoperative year. At 3.5 years old, the nasal polyp dermis continues to outgrow and distort the surrounding nasal tissue. Future reconstruction efforts will be aimed at thinning and refining the flap closure.

Figure 1:



Figure 1: Initial procedure at 10 weeks old. Central oral mass removed, debulked nasal mass

Figure 2a:

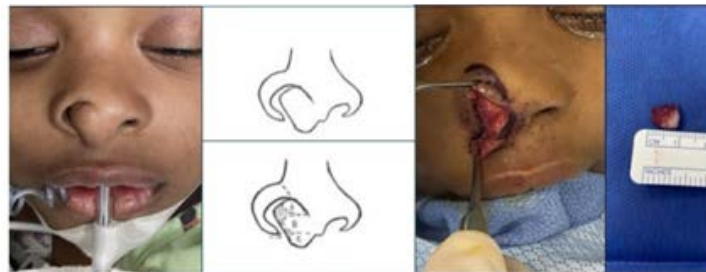


Figure 2a: Second procedure at 2.5 years-old. Tri-lobed flap designed of remaining nasal mass. (A) flap inset into nasal rim through a back-cut. (B) flap placed into septum. (C) flap inset into back cut of nasal sill. Excess cutaneous and subcutaneous fat discarded.

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Figure 2b:



Figure 2b: A. Trilobed flap after incision. B. Trilobed flap after removal of excess tissue. C. Nose after inset.

Figure 3:



Figure 3: Post-operative results at 3.5 years-old.

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1 Patient Reported Outcomes After Surgical Treatment for Neurogenic Thoracic Outlet Syndrome with at least 1 Year Follow Up

Joshua Bell, MD, Syeda Hoorulain Ahmed, MD, Mohammed Mumtaz, BA, Ramin Shekouhi, MD, Rachel Safeek, MD, MPH, Harvey Chim, MD

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Objectives: This study analyzes functional and patient-reported outcomes following surgical decompression for Neurogenic Thoracic Outlet Syndrome (NTOS).

Methods: Forty-four consecutive patients who underwent surgery for NTOS were reviewed. Patients were contacted at least one year postoperatively and assessed using standardized patient reported outcome measures (PROMs), including Visual Analog Scale (VAS) for pain, Patient Satisfaction Scale (PSS), Derkash classification, Disabilities of the Arm, Shoulder, and Hand (DASH) score, Michigan Hand Outcomes Questionnaire (MHQ), and Cervical Brachial Symptom Questionnaire (CBSQ). Data was analyzed using t-tests and linear regression models.

Results: The NTOS site of involvement was supraclavicular (SC) in 12 (27.3%) patients, infraclavicular (IC) in 16 (36.4%), and both (SC and IC) in 16 (36.4%). A distal compression site was treated in 20 (45.5%) patients. Overall success rate, as assessed through Derkash classification, was 87.5%. Mean postoperative VAS score (2.6 ± 3.2) was significantly improved from preoperative VAS score (8.0 ± 2.9). Mean postoperative DASH, MHQ, and CBSQ scores were 32.8 ± 21.8 , 68.1 ± 26.5 and 39.2 ± 32.6 , respectively. Postoperative VAS scores were significantly ($p < 0.05$) correlated with worse Derkash classification, DASH, MHQ, and CBSQ scores. Multiple linear regression analysis showed that a longer duration of symptoms before surgery was the most significant factor for a higher mean postoperative VAS pain score.

Conclusions: Longer time to surgery was associated with higher postoperative VAS pain scores, suggesting that earlier surgical intervention in NTOS patients may be beneficial. Higher VAS scores were significantly correlated with poorer postoperative mid-term outcomes as assessed through the DASH, MHQ, CBSQ scores, and Derkash classification.

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Table 1. Characteristics and outcome measures of patients.

Variable	Value
Patients (n, %)	44 (100.0%)
Sex	
Male (n, %)	19 (43.2%)
Female (n, %)	25 (56.8%)
Age (mean $\pm$ SD)	47.1 $\pm$ 17.5
BMI (mean $\pm$ SD)	27.4 $\pm$ 6.2
EANS nTOS classification	
Class I (n, %)	22 (50.0%)
Class II (n, %)	1 (2.3%)
Class III (n, %)	21 (47.7%)
TOS site	
SC (n, %)	12 (27.3%)
IC (n, %)	16 (36.4%)
Both (SC + IC) (n, %)	16 (36.4%)
Presence of distal nerve compression (n, %)	20 (45.5%)
Preoperative symptoms	
Sensory deficits (n, %)	42 (95.5%)
Motor deficits (n, %)	32 (72.7%)
Pain (n, %)	40 (90.9%)
Symptom duration before surgery (mean $\pm$ SD, months)	34.0 $\pm$ 46.3
Improvement in symptom severity	
Sensory deficits (n, %)	41 (93.2%)
Motor deficits (n, %)	30 (93.8%)
Pain (n, %)	38 (95.0%)
Preoperative VAS score (n= 8 patients, mean $\pm$ SD)	8.0 $\pm$ 2.9
Postoperative VAS score (n= 8 patients, mean $\pm$ SD)	2.6 $\pm$ 3.2
PROMs completed (n, %)	32 (72.7%)
Survey follow-up duration (mean $\pm$ SD, months)	10.5 $\pm$ 9.8

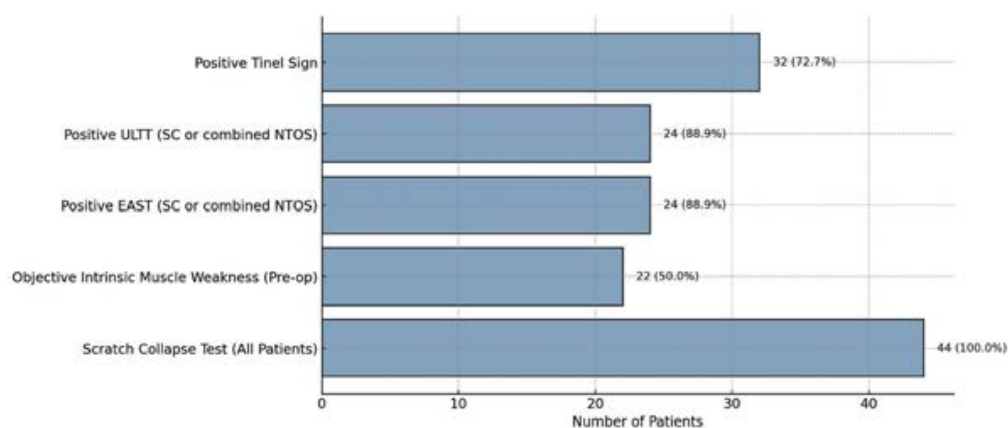
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VAS score (mean ± SD)	3.2 ± 2.5
PSS (mean ± SD)	3.5 ± 1.4
Very dissatisfied (n, %)	5 (15.6%)
Somewhat dissatisfied (n, %)	4 (12.5%)
Neither satisfied nor dissatisfied (n, %)	4 (12.5%)
Somewhat satisfied (n, %)	9 (28.1%)
Very satisfied (n, %)	10 (31.3%)
Derkash classification (mean ± SD)	2.2 ± 0.9
Excellent (n, %)	6 (18.8%)
Good (n, %)	16 (50.0%)
Fair (n, %)	6 (18.8%)
Poor (n, %)	4 (9.1%)
DASH score (mean ± SD)	32.8 ± 21.8
CBSQ score (mean ± SD)	39.2 ± 32.6
MHQ score (mean ± SD)	68.1 ± 26.5

Table 2. Multiple linear regression model of mean VAS score and study variables.

Variables	Coefficient	Standard error	95% CI	P-value
Age	0.03	0.03	-0.05, 0.06	>0.05
BMI	0.06	0.07	-0.08, 0.21	>0.05
Surgical delay	0.03	0.01	0.003, 0.02	<0.05
Follow-up duration	0.03	0.05	-0.07, 0.14	>0.05
Site of nTOS	-0.31	0.53	-1.40, 0.80	>0.05
nTOS classification	-0.40	0.50	-1.40, 0.65	>0.05

Figure 1. Distribution of preoperative diagnostic physical examination findings.



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Figure 2. Representative patient before (left) and after (right) right supraclavicular brachial plexus neurolysis with anterior and middle scalenectomies (SA: scalene anterior muscle; PN: phrenic nerve; UT: upper trunk; MT: middle trunk; LT: lower trunk; SA: subclavian artery)

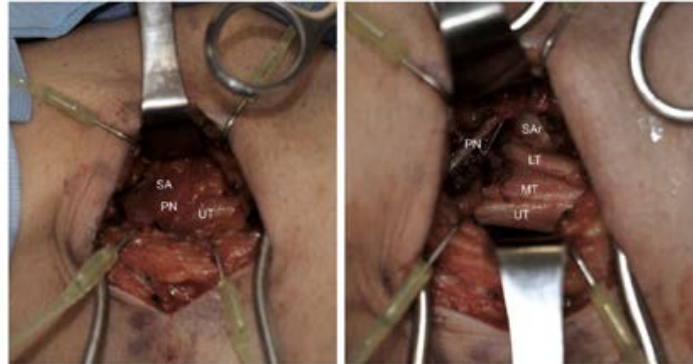


Figure 3. Representative patient before (left) and after (right) right infraclavicular brachial plexus neurolysis with pectoralis minor tenotomy (PM: pectoralis minor muscle; LC: lateral cord of infraclavicular brachial plexus).

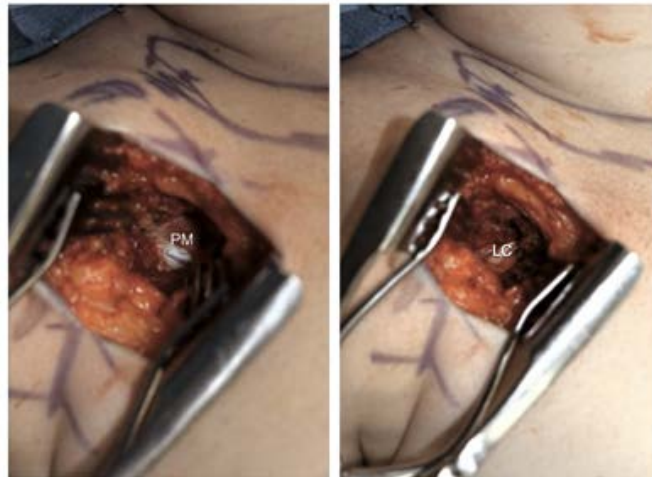


Figure 4. Box plot comparing preoperative and postoperative VAS scores.

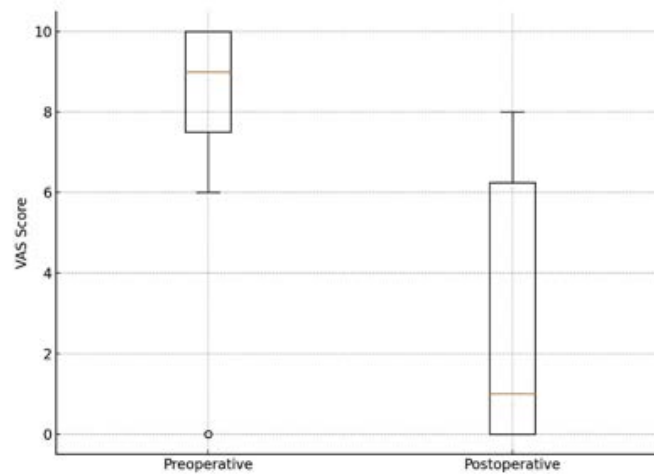


Figure 5. Changes in symptoms following surgical intervention.

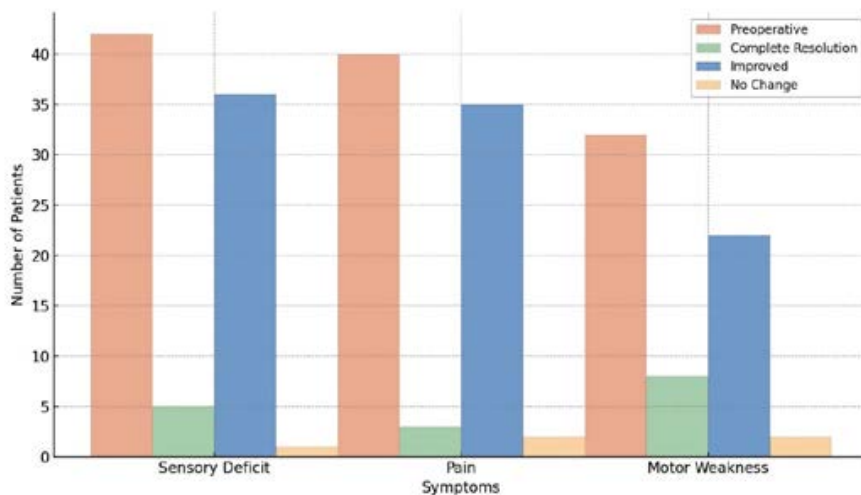


Figure 6. Box plots of patient-reported outcome measures in patients with and without a secondary distal compression site.

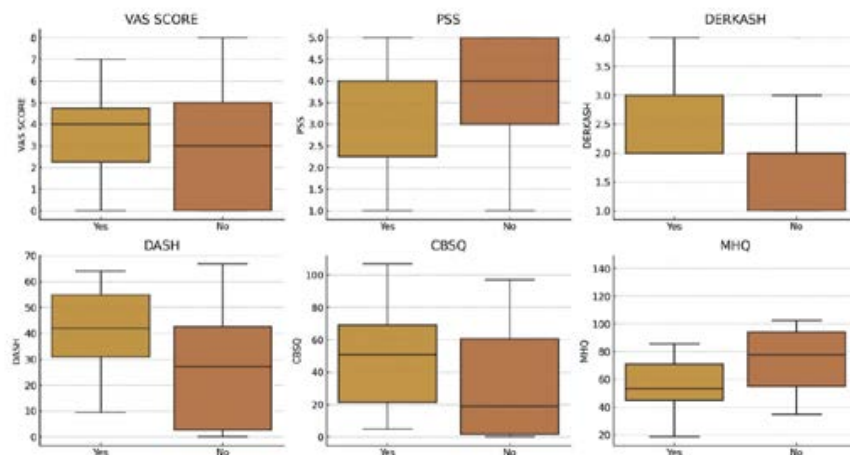
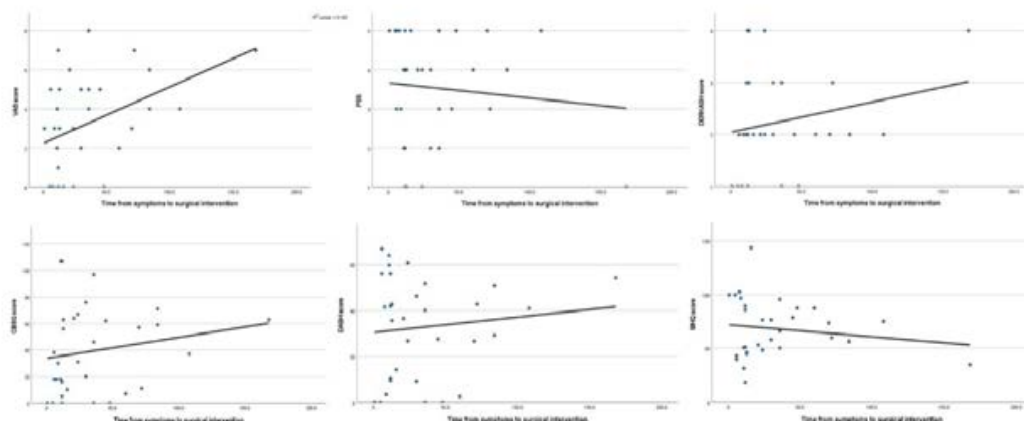


Figure 7. Linear regression model of the mean PROM scores versus duration from symptoms to surgical intervention.



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2 Novel 3D Printed Simulator to Teach Metacarpal Fixation with Kirschner Wires

Michael K. Boyajian MD, Michael K. Boyajian MD, Eric Zeng BS, Michael F. Reynolds MD, Christopher M. Runyan MD, PhD, Kyle E. Robinson MD.

Wake Forest Department of Plastic and Reconstructive Surgery

Purpose: The purpose of this project was to create a novel simulator to teach metacarpal fixation with Kirschner wires. Using this simulator, we held workshops for junior residents, and validated the curriculum via objective pre- and post-workshop assessments on a cadaver model.

Methods: A novel hand simulator was created using 3D printing and silicone casting. Cost of materials was \$25. The beginner model has a transparent silicone skin envelope, and the more advanced model is opaque. A two-hour simulation workshop was held for PGY1 and PGY2 plastic surgery residents (n=5). Survey data was collected.

For objective validation, the participants underwent pre- and post-workshop assessments on cadaveric hands. Their task was to drive K-wires through intact cadaver metacarpals 2-5. X-rays were taken of each attempt, and success or failure was judged on ability to drive K-wires through the entire length of the bone. They got 3 attempts per metacarpal, for a total of 12 attempts. Two fellowship-trained Hand Surgery attendings served as the control group.

Results: Survey data indicated that participant confidence significantly improved, and simulator feedback was resoundingly positive. Additionally, the participants' objective skill significantly improved. Comparing objective pre- and post-assessments on cadavers, the participants' successful K-wire placement rate improved from 11.7% to 71.7% ($p < 0.001$), compared to the attending control group's 87.5%.

Conclusions: Exposure to this novel training tool significantly improved junior resident confidence and objective metacarpal fixation skill. Because it can be mass produced and shared, the device potentially has wide applicability within hand surgery training.

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 1..... 7:30 - 8:20 AM

3 Sarcopenia in Autologous Breast Reconstruction with DIEP Flaps: A Propensity Score Matched Analysis

Jesse Chou, MD; Robert DeVito, MD; Hibo Weheliye, BS; Amanda Silva, MD; Scott Hollenbeck, MD; Christopher Campbell, MD; JT Stranix, MD

University of Virginia

Background: Sarcopenia, characterized by progressive loss of skeletal muscle mass and strength, has been associated higher rates of postoperative complications across various surgical disciplines. However, its impact on microsurgical breast reconstruction remains unclear. This study investigates the relationship between preoperative sarcopenia and outcomes in patients undergoing autologous breast reconstruction.

Methods: A single-center, retrospective cohort study was designed, including patients undergoing DIEP flap breast reconstruction from 2017 to 2024. Patients with preoperative computed tomography angiography (CTA) were included. Sarcopenia was determined by obtaining psoas muscle mass index (L3-PMI, cm^2/m^2) at the L3 vertebra derived from cross-sectional area of psoas muscles normalized to height. Sarcopenia was defined as $\text{PMI} < 408.7 \text{ cm}^2/\text{m}^2$, determined via receiver operating characteristic (ROC) analysis. Patients were propensity score matched (PSM) for age, BMI, medical comorbidities, reconstruction laterality, timing, and adjuvant treatments.

Results: 203 patients with mean age 51.7 years, (range 27–77) were included. 64 (31.5%) were sarcopenic and 139 (68.5%) were non-sarcopenic. Sarcopenic patients were older (69.76 vs. 71.6 years, $p = 0.01$) but had no significant differences in BMI, comorbidities, reconstruction laterality, timing, or adjuvant treatments. After PSM, sarcopenia remained associated with higher rates of breast revision ($p = 0.026$), donor site infection ($p = 0.0109$), recipient site wounds requiring intervention ($p = 0.0015$), and hematoma ($p = 0.0027$).

Conclusions: Preoperative sarcopenia is independently associated with increased postoperative morbidity following autologous breast reconstruction. These findings highlight the need for preoperative risk stratification and optimization strategies in sarcopenic patients.

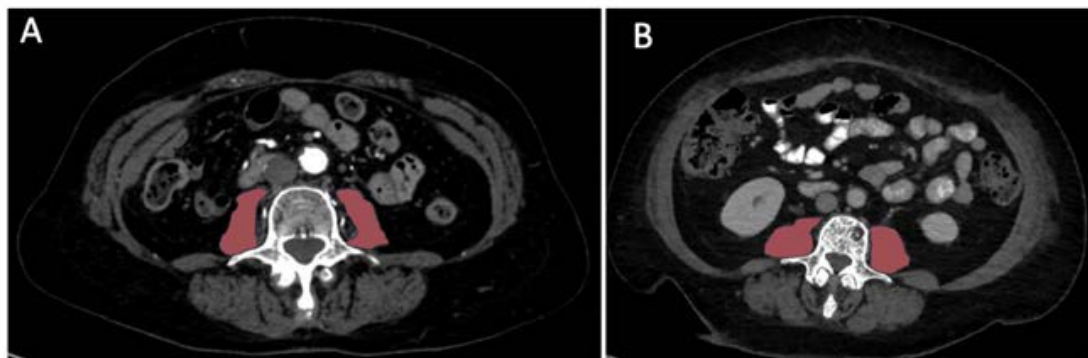


Figure 1: CTA assessment of psoas muscle cross-sectional area (CSA) at L3 level. *Highlighted: Bilateral psoas CSA*
A: Patient with low psoas CSA consistent with sarcopenia.
B: Patient with nonsarcopenic psoas CSA.

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4 The Impact of S-Code versus CPT Code Utilization for DIEP Flaps: A Reimbursement Analysis in an Underserved State

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Purpose: The purpose of this project was to create a novel simulator to teach metacarpal fixation with Kirschner wires. Using this simulator, we held workshops for junior residents, and validated the curriculum via objective pre- and post-workshop assessments on a cadaver model.

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TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 1..... 7:30 – 8:20 AM

5 Keep Your Friends Close and Your Teammates Closer: The Impact of Consistent Team Staffing in Microsurgical Breast Reconstruction

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Division of Plastic, Maxillofacial, and Oral Surgery, Department of Surgery, Duke University Health System, Durham, North Carolina.

Background: Microsurgical breast reconstruction is intraoperatively complex. Evidence of standardized workflows improving outcomes exists, but the impact of staffing with consistent personnel is not documented.

Methods: All microsurgical breast reconstructions (07/2021–06/2024) at our institution were analyzed for staff familiarity at granular time-intervals (T0: setup to incision and T1-T3: each third of procedure). Staff were deemed “unfamiliar” if they staffed <2 microsurgical breast reconstructions with the attending in past four months.(Figure 1) Intraoperative setbacks included anastomotic revisions, vessel damage, switching recipient vessels, or mastectomy flap defect. Major complications included operative takeback or flap loss.

Results: Among 291 surgeries (5 attendings, 2 hospitals), 34.3% were immediate, 77.2% used standard hemiabdominal DIEP flaps, 59.1% were bilateral, and 50.0% had prior radiation. Intraoperative setbacks occurred in 19.6%, major complications in 7.2%, average duration was 628 minutes, and supply costs averaged \$5,216. Unfamiliar scrub-techs correlated with increased intraoperative setbacks (RR:1.84, $p<0.05$), particularly in early time-intervals (T1:1.69, $p=0.06$; T2:1.82, $p=0.03$). Unfamiliar circulators correlated with increased supply costs (+\$591, $p<0.05$), especially in later time-intervals (T2:+\$592, $p<0.05$; T3:+\$757, $p<0.05$).(Figure 2) Multivariate analysis confirmed unfamiliar scrub-techs and circulators were significantly correlated with increased intraoperative setbacks and higher costs ($p<0.05$), with a trend toward longer duration ($p=0.06$). In addition to staff familiarity, intraoperative setbacks also correlated with prior radiation ($p<0.05$), duration correlated with laterality, immediate reconstructions, mastectomy type, and anastomoses ($p<0.05$), and costs correlated with anastomoses ($p<0.05$).

Conclusion: Unfamiliar teams correlated with increased intraoperative setbacks, costs, and durations. The demonstrated medical, financial, and logistical benefits can be used to justify the need for consistent staffing in microsurgical breast reconstruction.

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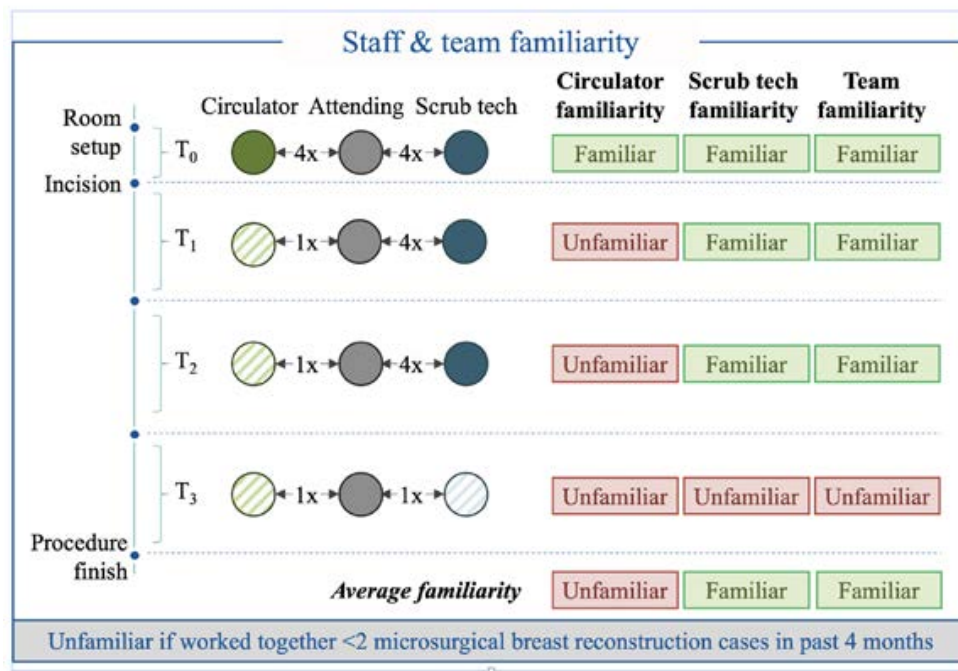


Figure 1: Schematic depicting methodology for assessing team familiarity at individual staff level (scrub tech, circulator) within granular time-interval (T0-T3) for each case. In schematic above, staffing at T0 (room setup to incision) includes a circulator and scrub tech who each worked with the attending on microsurgical breast reconstruction 4 times in the past 4 months. As such, both would be classified as familiar. At T2, a different circulator is present who has only worked on 1 case with the attending in the past 4 months, and as such the case would be classified as having an 'unfamiliar' circulator at T2. Average familiarity is calculated by averaging the staff familiarity across all time points.

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 – 9:10 AM

6 Understanding Macromastia-Associated Headache and the Impact of Reduction Mammoplasty: A Pilot Prospective Cohort Study

Elizabeth Laikhter MD¹, Kristyn Spera Pocock MD², Joseph Rigdon PhD, MS³, Adam J. Katz MD, FACS¹, Bennett Calder MD¹, Ivo Pestana MD, FACS, FAAPS¹, Richard B. Lipton MD, FAHS, FAAN⁴, Lauren Doyle Strauss DO, FAHS⁵, Liza Smirnoff MD⁶, Sandhya Kumar MD², Rebecca Erwin Wells MD, MPH, FAHS, FAAN², Lisa R. David MD, MBA, FACS¹

1. Department of Plastic Surgery, Atrium Health Wake Forest Baptist, Winston-Salem, NC
2. Department of Neurology, Comprehensive Headache Program, Wake Forest University School of Medicine, Atrium Health Wake Forest Baptist, Winston-Salem, NC
3. Department of Biostatistics and Data Science, Wake Forest University School of Medicine, Winston-Salem, NC
4. Department of Neurology, Montefiore Headache Center, Albert Einstein College of Medicine, Bronx, NY
5. Department of Neurology, Virginia Commonwealth University, Richmond, VA
6. Department of Neurology, University of Miami School of Medicine, Miami, FL

Background: Despite the reported association between macromastia and headache, the macromastia-related headache is not clearly defined, often called “tension-type” in surgical literature. Together with the Department of Neurology Comprehensive Headache Program, our study aimed to identify macromastia-related headache according to International Classification of Headache Disorders (ICHD) criteria and determine response to surgical intervention in women with macromastia-associated headache undergoing reduction mammoplasty (RM).

Methods: A prospective observational cohort study was performed (3/16/23-2/24/24). Adult cisgender women with symptomatic macromastia, headache, and insurance approval for RM were recruited from Plastic Surgery Clinic. Pre- and postoperative surveys were administered, including validated ID Migraine, Migraine Disability Assessment Score (MIDAS) and sleep apnea risk (Berlin) scores. Eligibility criteria: English speakers, >18 years, >4 headache days/month. Exclusion criteria: brain or C-spine surgery within two years, history of breast malignancy, or use of >50mcg estradiol.

Results: Of 34 patients (median age 33.5, 62% White, 32% Black), most (97%) screened positive for migraine. Pre- to postoperative improvement occurred in monthly headache-days (13.4 to 3.6, -9.8, 95% CI -12.8, -3.8; $p<0.0001$), average headache severity (6.1 to 2.5, -3.8, CI -4.8, -2.4; $p<0.0001$), and disability (16.3 to 5.4, -9.6; CI -16.3, -5.4; $p=0.0003$). Most patients (26/33, 79%) reported a $\geq 50\%$ improvement in monthly headache-days. Over 1/3 (36%) experienced improvement in sleep apnea risk score.

Conclusions: Most women with headache pursuing RM experience migraine, contrary to the prevailing assumption that macromastia-associated headache is tension-type. Further collaborative research is necessary to elucidate migraine pathophysiology and the role macromastia may play.

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 – 9:10 AM

7 Exploring Indications for Nerve Pedicle Transfer in the Distal Hand: The Impact of Injury Mechanism and the Timing of Surgery on Long-Term Pain and Functional Hand Outcomes

Evan B. Lynch MD, PhD; E. Abi Recktenwald MD; Elizabeth G. McCauley, BA; Morgan S. Brgoch, MD

University of Kentucky, Department of Surgery, Division of Hand Surgery

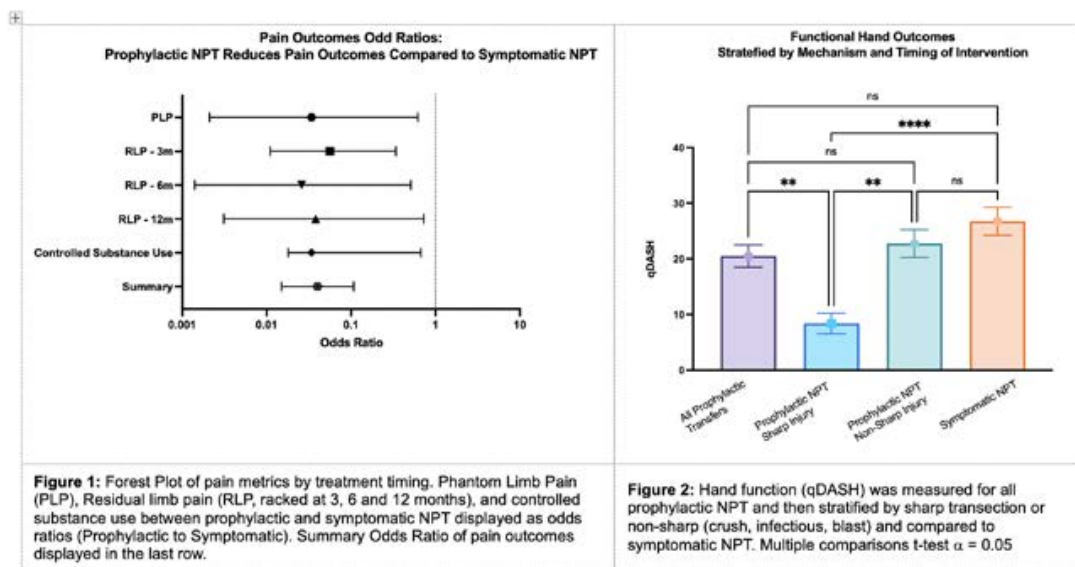
Introduction: Prophylactic Nerve Pedicle Transfer (NPT), with regenerative peripheral nerve interface (RPNI) or targeted muscle reinnervation (TMR) reduces the incidence of symptomatic neuromas and residual limb pain after amputation. The impact of NPT on distal hand amputations has been incompletely studied. Our study investigates pain-related and functional outcomes in prophylactically-treated or symptomatically-treated patients with distal hand amputations, stratified by mechanism.

Methods: This is a retrospective review on patients undergoing phalangeal or ray amputations and subsequent NPT over a 3-year period. Patients were stratified by mechanism (sharp, infectious, crush or blast) and surgery timing. Prophylactic NPT was compared to NPT for treatment of symptomatic neuromas. Pain and functional hand outcomes (qDASH) were assessed over 1 year of follow-up.

Results: 39 patients (mean age 44, 65% male) who underwent 104 total procedures met inclusion criteria. Prophylactic NPT outperformed Symptomatic NPT in both phantom pain (PLP) (OR 0.034) and residual limb pain (RLP) (OR 0.05, 0.034, 0.026 at 3, 6 and 12 months, respectively). Controlled substance use was similarly decreased (OR 0.076). There were no significant differences in hand function between all prophylactic NPT and all symptomatic NPT. However, when stratified by mechanism, sharp transections had better prevention of residual limb pain (OR 0.036), return to work (OR 6.15) and hand function (8.38 ± 1.86 vs. 22.74 ± 4.07 , $p < 0.0006$).

Conclusions: These data suggest in sharp amputation, prophylactic NPT may improve pain and functional hand outcomes in paired symptomatically-treated cohorts. These data work to inform indications for prophylactic NPT in distal hand amputations.

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 - 9:10 AM



TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 – 9:10 AM

8 Use of Topical Arista™ and Intravenous Tranexamic Acid in Breast Reduction Patients Reduces Hematoma Rates

Anjali Om, Allen Kong, Orr Shaul, Daniel Cuzzone, Gabriela Garcia Nores, Albert Losken

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

Introduction: Bleeding complications are not uncommon after breast reduction. Several studies have evaluated the effects of tranexamic acid (TXA), an antifibrinolytic agent, to minimize hematoma. Arista™, a microporous polysaccharide derived from plant starch, can be used as an adjunctive hemostatic agent but its efficacy is less well studied.

Methods: This is a retrospective chart review of patients who underwent reduction mammoplasty by three plastic surgeons at Emory University Hospital or affiliated Aesthetic Center January 1, 2020, to October 1, 2024. Our institution implemented use of 1g intravenous (IV) intraoperative TXA in June 2021 and Arista™ in July 2024. Outcomes include postoperative hematoma (major requiring operative intervention, minor managed nonoperatively), seroma, infection, and delayed wound healing rates.

Results: Eighty-seven consecutive breast reduction patients received both Arista™ and TXA, 133 patients received TXA only, and 211 controls received neither (Table 1). There was a significant total hematoma reduction in patients treated with both TXA and Arista™ (3.4%) compared to TXA alone (3.8%) and neither (10%) (Figure 1). Relative risk reduction was 62.2% with TXA and 65.4% with TXA and Arista™ compared to control. The number needed to treat to prevent one hematoma was 16.1 for TXA and 15.2 for TXA and Arista™. Delayed wound healing rates were also lower in the TXA and Arista™ treatment group (P=0.0020). There was no significant difference in seroma or infection rates.

Conclusion: The use of Arista™ in combination with IV TXA is a safe and effective way to reduce hematoma rates in patients receiving reduction mammoplasty.

Adverse Outcome	No TXA or Arista™ (n=211)	TXA Only (n=133)	TXA and Arista™ (n=87)	P-Value
Hematoma	21 (10.0%)	5 (3.8%)	3 (3.4%)	0.0219
Major Hematoma	8 (3.8%)	3 (2.3%)	2 (2.3%)	0.5547
Minor Hematoma	13 (6.2%)	2 (1.5%)	1 (1.1%)	0.0118
Seroma	10 (3.4%)	4 (3.0%)	1 (1.1%)	0.3498
Infection	6 (2.8%)	9 (6.8%)	1 (1.1%)	0.0722
Delayed Wound Healing	24 (11.4%)	22 (16.5%)	2 (2.3%)	0.0020

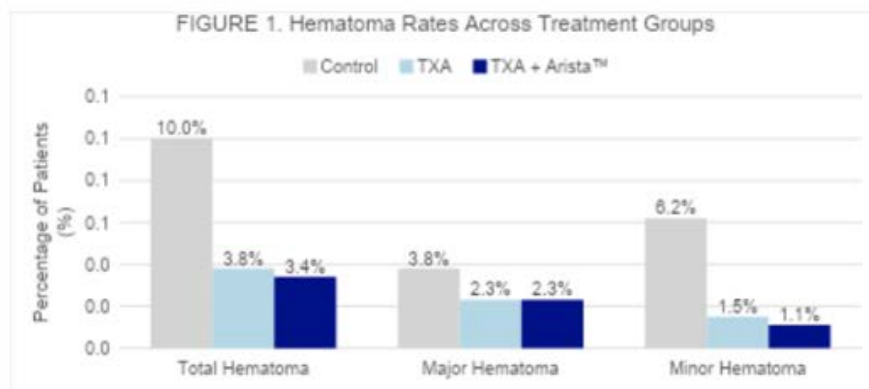


FIGURE 1. Hematoma rates in breast reduction patients across treatment groups. Control refers to patients given neither TXA nor Arista™. Major hematoma refers to cases requiring operative intervention while minor hematoma refers to cases managed nonoperatively.

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 – 9:10 AM

9 Reconstruction of Massive Ventral Hernias with Free Latissimus Dorsi Flap: Mid-Term Patient Reported Outcomes Analysis

Rachel Safeek, MD, MPH, Syeda Hoorulain Ahmed, MD, Ramin Shekouhi, MD, Rachel Safeek, MD, MPH, Joshua Bell, MD, Harvey Chim, MD

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

Purpose: This study evaluates the postoperative functional and quality of life outcomes associated with using the free noninnervated latissimus dorsi muscle flap in combination with transversus abdominis release (TAR) and retrorectus mesh for massive ventral hernia repair (VHR).

Methods: Eighteen patients who underwent VHR were reviewed. Patients were contacted at least two years postoperatively and assessed using standardized patient-reported outcome measures (PROMs), including Visual Analog Scale (VAS) for pain, Short-Form Health Survey (SF-12), Hernia-Related Quality-of-Life Survey (HerQLes), and Carolinas Comfort Scale (CCS). Data were analyzed using t-tests and linear regression models.

Results: Comorbidities included diabetes (27.8%), COPD (5.6%), smoking (5.6%), and immunosuppression for liver or kidney transplants (16.7%). Steroid use was noted in 11.1% of patients, and all had prior abdominal surgeries and hernia repairs. The mean clinic follow-up was 8.9 months, with no flap failures or hernia recurrences. Medical complications occurred in 3 patients, and 5 patients (27.8%) experienced 8 surgical complications. Two patients died of unrelated causes. Of 16 survivors, 8 (50%) completed phone surveys at a mean follow-up of 36.8 months. Increasing age was positively correlated with PCS-12 [0.70, $P<0.05$] and HerQLes scores [1.94, $P<0.05$]. Larger abdominal wall defects were associated with PCS-12 [-2.31, $P<0.05$] and HerQLes scores [-6.40, $P<0.05$], while CCS scores increased with defect size [8.20, $P<0.05$]. Higher body mass index (BMI) was linked to lower MCS-12 [-1.60, $P<0.05$].

Conclusions: Free LD flap is effective for repair of massive ventral hernias. Age positively impacted quality-of-life scores, while higher BMI and larger defects negatively influenced outcomes.

Keywords: Abdominal wall defects; abdominal wall reconstruction; free latissimus dorsi flap; ventral hernias

TUESDAY - GLANCY RESIDENT COMPETITION - SESSION 2 8:20 - 9:10 AM

10 The Paraspinous Muscle Deep Release Technique for Posterior Trunk Reconstruction: An Institutional Experience

Jenna R. Stoehr, MD; Nicole K. Le, MD, MPH; Lauren Kuykendall, MD; Jared S Troy, MDSA

Background: Paraspinous muscle (PSM) flaps are a useful tool for posterior trunk reconstruction after neurosurgical intervention. Avoiding subcutaneous undermining of the flaps and only performing a deep release may eliminate the need for drain use. The objective of this study is to present our institutional experience with deep release PSM flaps.

Methods: Data were retrospectively collected for patients who underwent posterior trunk reconstruction with PSM flaps from 2019 to 2024. Demographics, preoperative comorbidities, and postoperative outcomes were compared between different PSM flap techniques.

Results: A total of 111 patient cases were reviewed. The deep release was the most common technique (59%), followed by superficial and deep release (SD, 25%) and superficial release (16%). The average operative time of the deep release (272.92 minutes) was shorter compared to the superficial (309.56 minutes) or SD techniques (382.36 minutes, $p < 0.01$). Drains were utilized in only 26% of deep release cases, whereas they were used in 93% and 94% of SD and superficial release cases, respectively ($p < 0.01$). Complication rates were not significantly different between the techniques.

Conclusions: The deep release technique for PSM flaps has become standard practice at our institution. Our experience demonstrates its benefits for both cost savings by decreasing operating room time and improvement in patient experience by avoiding drain use, while providing an effective and durable reconstructive result.



**FOUNDERS
PAST PRESIDENTS
& ANNUAL MEETINGS**



FOUNDERS

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

JOHN T. LINDSEY

67th Annual Scientific Meeting
The Cloister, Sea Island, GA
June 8-12, 2024

ALBERT LOSKEN

66th Annual Scientific Meeting
The SLS, Nassau, Bahamas
June 18-22, 2023

JORGE DE LA TORRE

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

DAVID B. DRAKE

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

MARK A. CODNER*

63rd Virtual Scientific Meeting
June 6-7, 2020

STEPHAN J. FINICAL

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

BRAUN H. GRAHAM

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

WALTER L. ERHARDT JR.

60th Annual Scientific Meeting
June 11-15, 2017
The Cloister; Sea Island, GA

KEVIN F. HAGAN

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

HENRY C. VASCONEZ

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

HAROLD I. FRIEDMAN

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

ANN FORD REILLEY

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

W. BYRON BARBER

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

JAMES C. GROTTING

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

JAMES MOORE

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

JAMES W. WADE

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

SUMAN K. DAS

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

R. BRUCE SHACK

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

ANTHONY J. PIZZO

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

MICHAEL E. BEASLEY

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

WILLIAM H. WALLACE

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

RONALD J. JOHNSON

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

ANDREW M. MOORE II

45th Annual Scientific Meeting
June 1-5, 2002
The Westin Resort;
Hilton Head, SC

L. FRANKLYN ELLIOTT

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

R. COLE GOODMAN

43rd Annual Scientific Meeting
June 4-8, 2000
Southampton Princess; Bermuda

W. HOWARD KISNER

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

KENNA S. GIVEN

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

J. BARRY BISHOP

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

THOMAS F. ORCUTT

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

WILLIAM F. MULLIS

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

BENJAMIN H. WOODFORD

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

EDWARD A. LUCE

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

NORMAN M. COLE*

35th Annual Scientific Meeting
1992
Ritz-Carlton Amelia Island;
Amelia Island, FL

ALLEN H. HUGHES

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

W. MICHAEL BRYANT

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

PAST PRESIDENTS & ANNUAL MEETINGS

JOHN H. HARTLEY JR.*

32nd Annual Scientific Meeting
June 18-22, 1989
Southampton Princess; Bermuda

JAMES H. CARRAWAY

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

JOHN R. ROYER*

23th Annual Scientific Meeting
The Grand Hotel, Point Clear, AL
1987

JOHN R. REYNOLDS*

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

ANDREW W. WALKER*

28th Annual Scientific Meeting
May 5-9, 1985
Disney World; Lake Buena Vista, FL

ROBERT C. REEDER*

27th Annual Scientific Meeting
April 29-May 3, 1984
Colonial Williamsburg 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
Southampton 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 Williamsburg Inn &
Lodge; Dallas, TX

GREER RICKETSON*

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

NEAL OWENS*

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

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

**deceased*

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	Burton D. Brent	2000
Thomas Cronin	1977	Jacques Baudet	2001
Sal Castanares	1978	Leonard Furlow	2002
Kenneth Pickrell	1979	Norman M. Cole	2003
Robert Goldwyn	1980	Michael E. Jabaley	2004
Richard Stark	1981	P.G Arnold	2005
William Hamm	1982	Luis O. Vasconez	2006
Red Dingman	1983	Edward A. Luce	2007
Clifford Snyder	1984	Wayne Morrison	2008
John Mustarde	1985	Gustavo Colon	2009
Fernando Ortiz-Monasterio	1986	T. Roderick Hester	2010
Jack Sheen	1987	William P. Magee, Jr.	2011
Jacques van der Meulen	1988	Thomas Biggs	2012
Thomas Rees	1989	R. Bruce Shack	2013
Paul Weeks	1990	Foad Nahai	2014
Frederick McCoy	1991	Wyndell Merritt	2015
Simon Fredericks	1992	Andrew Moore	2016
John Hoopes	1993	Kenna Given	2017
J.B. Lynch	1994	James C. Grotting	2018
Maurice J. Jurkiewicz	1995	Robert J. Allen	2019
Milton T. Edgerton	1996	William C. Lineaweaver	2021
Carl R. Hartrampf	1997	Renato Saltz	2022
John B. McCraw	1998	L. Franklyn Elliott	2023
D. Ralph Millard	1999	Jeffrey M. Kenkel	2024

PAST JURKIEWICZ LECTURERS

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

He received his plastic surgery training at Barnes Hospital in St. Louis under Drs. Brown and Byars. After completing his surgical training in 1959, he was appointed chief of plastic surgery at the University of Florida. He did not take his plastic surgery board exam until 1963. Thus, formal plastic surgery resident training did not occur until 1965 at the University of Florida. In 1971, Dr. Jurkiewicz moved to Atlanta and became the chief of plastic surgery at Emory University. His surgical skills coupled with excellent faculty recruitment and training resulted in Emory's residency training program becoming renowned

throughout the country. After years of national and international contributions to surgery, Dr. Jurkiewicz was selected as president of the American College of Surgeons in 1989. In 2001, the Jurkiewicz Society of Emory University honored him by providing funding for a biannual Jurkiewicz lecture to be presented on odd years during the annual SESPRS meeting. The first Jurkiewicz lecture was presented by Dr. Carl Hartrampf, Jr. on June 11, 2001 entitled "Plastic Surgery at Emory Before Jurkiewicz and Plastic Surgery at Emory, 1971–2001."

Carl R. Hartrampf	2001
Leonard T. Furlow	2003
Luis O. Vasconez	2005
T. Roderick Hester	2007
John McCraw	2009
John J. Coleman, III	2011
Jack Fisher	2013
Grant Carlson	2015
Joseph Williams	2017
Phillip G. Arnold	2019
David A. Staffenberg	2021
Foad Nahai	2023



AWARDS

AWARD WINNERS

SPECIAL ACHIEVEMENT AWARD

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

FOUNDERS AWARD: The Founders

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

Albert Losken	2012
Wyndell Merritt	2013
Adam Katz	2014
C. Scott Hultman	2015
Galen Perdikis	2015
Brian R. Rinker	2016
Bruce A. Mast	2017
Joseph K. Williams	2018
John T. Lindsey	2019
Grant W. Carlson	2020
Detlev Erdmann	2021
Bruce A. Mast	2022
Melinda Haws	2023
Simeon Wall, Jr.	2024

PICKRELL AWARD

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

Andrew M. Moore	1985	Robert F. Hagerty	1997
Charles E. Horton	1986	John B. Lynch	1998
James W. Davis	1987	Joel Mattison	1999
James H. Hendrix	1988	John Bostwick, III	2001
Maurice J. Jurkiewicz	1989	Milton T. Edgerton	2002
Carl R. Hartrampf	1990	Luis Vasconez	2005
Leonard T. Furlow	1992	Michael E. Jabaley	2006
Hal. G. Bingham	1993	Wyndell Merritt	2012
Norman Cole	1994	Edward Luce	2015
John McCraw	1996	Bruce Shack	2023

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, MD1977	Eastern Virginia Medical School
Emory University	
H. Louis Hill, MD1978	Mason Williams, MD1986
Emory University	Eastern Virginia Medical School
E.D. Newton, MD1979	David Hurley, MD1987
University of Tennessee	University of Virginia
Dan H. Shell, MD1981	J.D. Stuart, MD1988
University of Tennessee	University of Virginia
Donato Viggiano, MD1982	James H. Schmidt, MD1989
University of Tennessee	University of Florida
Larry Nichter, MD1983	Paul A. Watterson, MD1990
University of Virginia	Emory University
Leonard Miller, MD1984	Michael G. Kanosky, MD1991
Emory University	University of Mississippi
Richard Sadove, MD1985	Joseph M. Woods, IV, MD1992
	Vanderbilt University

GLANCY AWARD

David Brothers, MD1993 University of N.C. at Chapel Hill	Yvonne Pierpont, MD2010 University of South Florida
Scott N. Oishi, MD1994 University of Kentucky	Anthony Capito, MD 2011 University of Virginia
Gregory Mackay, MD1995 Emory University	Matthew Blanton, MD2012 Duke University
R.C. High, MD1996 Bowman Gray School of Medicine	Michael Lynch, MD2013 University of Kentucky
Henry F. Garazo, MD1997 Medical College of Georgia	Brent R. DeGeorge, MD2014 University of Virginia
Kim Edward Koger, MD1998 Duke University	Michael Lynch, MD2015 University of Kentucky
J. Timothy Katzen, MD1999 Vanderbilt University	William D. North, MD2016 University of Kentucky
Richard Rosenblum, MD 2000 Vanderbilt University	Kristopher M. Day, MD2017 University of Tennessee, Chattanooga
Colin Riordan, MD2001 Vanderbilt University	Alexandra Marie Hart, MD2018 Emory University
Julia MacRae, MD 2002 University of Virginia	Shepard P. Johnson, MD2019 Vanderbilt University
M.I. Okwueze, MD 2004 Vanderbilt University	Ronnie L. Shammas, MD 2020 Duke University
Robert E.H. Ferguson, MD 2005 Kentucky Clinic	John Heinemann, MD, MHP2021 University of Virginia
Dean DeRoberts, MD 2006 Wake Forest	Matthew E. Pontell, MD 2022 Vanderbilt University
Howard Levinson, MD 2007 Duke University	Ciara A Brown, MD 2023 Emory University
S. S. Tholpady, MD 2008 University of Virginia	Nicholas O'Sick, MD 2024 Vanderbilt University
Scott Hollenbeck, MD 2009 Duke University	

FUTURE MEETINGS

FUTURE ANNUAL SCIENTIFIC MEETINGS

69th Annual Scientific Meeting

June 14-18, 2026

JW Marriott - Marco Island, FL

71st Annual Scientific Meeting

June 10-14, 2028

The Cloister - Sea Island GA

70th Annual Scientific Meeting

June 20-24, 2027

Ponte Vedra & Club - Ponte Vedra FL

72nd Annual Scientific Meeting

June 17-21, 2029

The Breakers - Palm Beach FL



FUTURE ATLANTA BREAST SURGERY SYMPOSIUMS

41st Annual Atlanta

Breast Surgery Symposium

January 30 - February 1, 2026

The Intercontinental - Atlanta, GA

42nd Annual Atlanta

Breast Surgery Symposium

January 29-31, 2027

The Intercontinental - Atlanta, GA