

PROCEEDINGS OF THE
61st Annual Scientific Meeting
SOUTHEASTERN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS



Pearls of Wisdom

June 17–20, 2018

THE BREAKERS, WEST PALM BEACH, FL





The Breakers

One South County Road

Palm Beach, FL 33480

(877) 724-3188

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WEEK AT A GLANCE

SATURDAY, JUNE 16

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

SOCIAL EVENTS

6:00 pm	Welcome Reception
7:30 pm	Past Presidents Reception and Dinner

SUNDAY, JUNE 17

SCIENTIFIC SESSION

7:00 am	Registration Open—Continental Breakfast Visit Exhibits and Poster Viewing
8:00 am	Presidential Welcome Remarks
8:10 am	Resident Competition Papers
9:00 am	Special Guest Lecture
9:30 am	Special Guest Lecture
10:15 am	Break—Visit Exhibits and Poster Judging
10:45 am	Member Papers
11:15 am	Keynote Presentation
12:15pm	Resident Jeopardy Bowl

SOCIAL EVENTS

6:30 am	Past Presidents Breakfast
8:00 am	Spouse/Guest Hospitality Suite
12:30 pm	Toast to Trudie Luncheon Sponsored by Allergan
12:30 pm	Optional Dive Excursion
1:30 pm	Tennis Tournament
7:00– 9:30 pm	Theme Dinner

MONDAY, JUNE 18

SCIENTIFIC SESSION

6:30 am	Registration Open—Continental Breakfast Visit Exhibits and Poster Viewing
7:15 am	Problems and Pearls
8:00 am	Resident Competition Papers
8:45 am	Patient Safety Panel: Strategies and Controversies
9:45 am	Special Guest Lecture
10:30 am	Break—Visit Exhibits and Poster Judging
11:00 am	Member Papers
11:30 am	Upchurch Lecture
12:30 pm	Special Resident Session

SOCIAL EVENTS

1:30 pm	Golf Tournament Sponsored by TouchMD
6:00 pm	Special Resident Reception Sponsored by Allergan



WEEK AT A GLANCE

TUESDAY, JUNE 19

6:30 am	Registration Open—Continental Breakfast Visit Exhibits and Poster Viewing
7:00 am	MOC Accredited Course
8:00 am	Just The Facts Panel
9:00 am	Special Guest Lecturer
10:15 am	Break—Visit Exhibits and Poster Viewing
10:45 am	Member Papers
11:15 am	Special Guest Lecture
12:30 pm	SESPRS Annual Business Meeting
12:30 pm	Resident Luncheon “Business Tips You Should Know Before Starting Your Practice”

SOCIAL EVENTS

6:00 am	Fun Run
8:00 am	Spouse/Guest Hospitality Suite
6:30 pm	Cocktail Reception Sponsored by Galatea
7:00 pm	Black Tie Dinner Dance

WEDNESDAY, JUNE 20

7:00 am	Registration Open—Continental Breakfast
7:30 am	Research Grant Award & Report
8:15 am	Business and Legal Consultant Panel “What Every Plastic Surgeon Should Know to Run a Business”
11:30 am	Closing Remarks: Stephan J. Finical, MD Meeting Adjourns

SOCIAL EVENTS

8:00 am	Spouse/Guest Hospitality Suite
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The **SESPRS 61st Annual Scientific Meeting** is

Endorsed by

The American Society of Plastic Surgeons (ASPS)



AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS, INC.

PRESIDENTIAL WELCOME



On behalf of the Society, it is my pleasure to welcome you to The Breakers in picturesque Palm Beach, FL for the 61st Annual Meeting of the Southeastern Society of Plastic and Reconstructive Surgeons. Our immense gratitude goes to Dr. Mark Codner for assembling such a robust scientific program for this year's meeting. There will be ample "Pearls" for seasoned surgeons, new practitioners and resident plastic surgeons. These will enable you to take home practical knowledge that will be useful in your practices. We are proud to showcase the residents' efforts in

the Glancy award competition. A separate program, hosted by Dr. Michael Harrington, will be available to assist residents in preparing for their plastic surgery board examinations. Experienced surgeons will be well advised to stay for the Wednesday program to acquire some great practice management tools.

With the beach, Atlantic surf, and the five star Breakers Hotel, this is the year to bring your family to enjoy the many outdoor activities, as well as the planned social events during the meeting. For those who scuba dive, we are adding a two tank dive trip to the nearby Breakers Reef this year. Be sure to sign up online via our website and don't forget to bring your Scuba certification cards. Most of all, take some time to relax, recharge and spend some quality time with your families, friends and colleagues.

Thank you for allowing me to serve as your 2017–18 Southeastern President. Jeanne and I are looking forward to hosting you at the Breakers!

Sincerely,

Braun H. Graham, MD
President, 2017–2018

Southeastern Society of Plastic and Reconstructive Surgeons



OFFICERS AND TRUSTEES

PRESIDENT

Braun H. Graham, MD
Sarasota, Florida

PRESIDENT-ELECT

Stephan J. Finical, MD
Charlotte, North Carolina

VICE-PRESIDENT

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Atlanta, Georgia

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Lexington, Kentucky

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Atlanta, Georgia

HISTORIAN

Bruce A. Mast, MD
Gainesville, Florida

PARLIAMENTARIAN

John Lindsey, MD
Metairie, Louisiana

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Holly C. Wall, MD
Shreveport, Louisiana

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Lexington, Kentucky

Thomas J. Zaydon, Jr., MD
Miami, Florida

Lynn A. Damitz, MD
Chapel Hill, North Carolina

Robert Garza, MD
Nashville, Tennessee

***“Advancing professional excellence,
quality education, and regional collegiality”***

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



SOCIAL / RECREATIONAL / SPOUSE EVENTS

SOCIAL / RECREATIONAL / SPOUSE EVENTS

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

SATURDAY, JUNE 16

4:00–5:00 pm	Early Registration	
6:00–8:00 pm	Welcome Reception	Ponce de Leon Ballroom
7:30–10:00 pm	Past Presidents Reception and Dinner By Invitation Only. See Registration Desk for details.	Gulfstream 3,4

Dinner on your own. Reservations highly recommended.

SUNDAY, JUNE 17

8:00–10:00 am	Spouse Hospitality Suite Registered Spouse/family/guests welcome. Name badges required.	Gulfstream 1,2
12:00–1:00 pm	Resident Jeopardy Bowl Please Register.	Ponce de Leon Ballroom
12:30–2:30 pm	Toast to Trudie Special luncheon for Women in plastic surgery Registration preferred: Hosted by Holly Wall, MD; Lynn Damitz, MD; and Carmen Kavali, MD Support provided by Allergan	Gulfstream 4
12:30 pm	Drift Dive Excursion Registration is required. Transportation and details will be provided to registered guests. Very limited space available. Additional fees apply.	
1:30 pm	Annual Tennis Tournament Registration is required. Short walk to The Breakers tennis courts. Registered participants are responsible to make their way to the tennis facility by 1:15 pm. Additional fees apply.	Breakers Tennis Facility
7:00–9:30 pm	Theme Dinner Open to all paid registrants. Children of all ages welcome! It is a Jimmy Buffet Margaritaville themed event, dress cool and comfortably. Name badge required. See the Registration Desk for Details.	Ocean Lawn

SOCIAL / RECREATIONAL / SPOUSE EVENTS

MONDAY, JUNE 18

8:00–10:00 am	Spouse Hospitality Suite Registered Spouse/family/guests welcome. Name badges required.	Gulfstream 1,2
12:30–1:30 pm	Special Resident Session “Written and Oral Board Preparation” Michael Harrington, MD	Ponce de Leon Ballroom
1:30 pm	Annual Golf Tournament Registration is required—boxed lunch provided. Transportation to and from the Golf Course will be provided. Registered golfers are responsible to make their way to the transportation area at the front of the main building by 12:30 pm. Modified Shotgun start promptly at 1:30 pm. Additional fees apply. Support provided by TouchMD	Rees Jones Course
6:00 pm	Special Resident Reception Sponsored by Allergan	Magnolia Room

Dinner on your own. Reservations highly recommended.

TUESDAY, JUNE 19

6:00 am	Annual Fun Run Registration preferred but not required. No Charge. Participants should meet in the lobby of the main building at 5:45 am.	
8:00–10:00 am	Spouse Hospitality Suite Registered Spouse/family/guests welcome. Name badges required.	Gulfstream 1,2
12:30 pm	Resident Luncheon Registration Required. “Business Tips You Should Know Before Starting Your Practice”	Gulfstream 4
6:30 pm	Black Tie Cocktail Reception Support provided by Galatea Surgical	Circle Room
7:00–11:00 pm	Black Tie Dance and Dinner Open to paid registrants 16 and older. Separate registration required for exhibitors. Registrants MUST RSVP in advance of the meeting. Residents of the Glancy Award Competition (and spouses) are complimentary. All other Residents and Spouses, a separate registration is required. Name badge required. See the registration desk for details.	Mediterranean Ballroom

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

SPECIAL GUEST LECTURERS FOR 2018



James C. Grotting, MD

2018 Honorary Upchurch Lecturer has a long list of prominent accomplishments as President of The Southeastern in 2011, Past President of the American Society for Aesthetic Plastic Surgery (ASAPS), a clinical professor of plastic surgery at the University of Alabama at Birmingham and the University of Wisconsin-Madison, and operates a private practice in Birmingham, Alabama. Dr. Grotting is also a senior examiner and director of the American Board of Plastic Surgery and a fellow of the American College of Surgeons. In addition to being President of ASAPS, Dr. Grotting has served as chair of the Society's Education Commission, serves on multiple Society committees and is a board member of the Aesthetic Surgery Education and Research Foundation (ASERF), the nonprofit research and education arm of ASAPS. He serves on numerous editorial boards and is the author of five major textbooks in the specialty of plastic surgery. Dr. Grotting has provided free plastic surgery for children with facial deformities in developing countries, through Operation Smile, since 1987.

Our Upchurch Lecturers are a very special part of our Annual Meeting and we are honored to have Dr. Grotting present this special lecture entitled "Privilege, Planes, and Plans."



Joseph P. Hunstad, MD, FACS

Special Guest Lecturer, Resident lecturer and our 2018 ASAPS Visiting Professor, Joseph P. Hunstad, MD has been in practice in Charlotte North Carolina since 1987. He is on the Board of Directors of the American Society for Aesthetic Plastic Surgery and is an International Traveling Professor for the International Society of Aesthetic Plastic Surgery. He is an Assistant Consulting Professor at the University of North Carolina, Division of Plastic Surgery in Chapel Hill. He is Section Head of Plastic Surgery of Carolinas Medical Ctr., University Hospital Charlotte North Carolina.

He has authored the textbook *The Atlas of Abdominoplasty* published by Elsevier in 2009 in English, Spanish, and Chinese. He has also authored more than 70 peer-reviewed articles and textbook chapters in major plastic surgery publications. He is the president of the Hunstad Kortesis Centers in Huntersville and Charlotte North Carolina managing a three physician and 50 employee practice and surgical center. He has been active in teaching throughout the world and has had an active Aesthetic Society endorsed fellowship training program for over 17 years.

Dr. Hunstad's presentations titled "Pearls of Wisdom of Facial Rejuvenation" and "Pearls of Wisdom of Body Contouring" will highlight up to date tips and techniques in facial rejuvenation and body contouring.

SPECIAL GUEST LECTURERS FOR 2018



Maurice Nahabedian, MD

Special Guest Lecturer and MOC Course Presenter, Maurice Nahabedian, MD is a plastic and reconstructive surgeon in private practice in Northern Virginia at the National Center for Plastic Surgery. Dr. Nahabedian completed his Plastic Surgery residency at the Johns Hopkins Hospital in 1995 and remained on the full-time plastic surgery faculty until 2005. He transitioned to Georgetown University in 2005 and remained there until 2017 where he was a Professor and the Vice-Chairman of the Department of Plastic Surgery under the leadership

of Scott Spear, MD. Dr. Nahabedian has published over 200 scientific manuscripts, editorials, and discussions, as well as 70 book chapters that have focused primarily on aesthetic and reconstructive breast surgery. He has been the principal editor of 7 textbooks on breast and abdominal wall reconstruction and has been a visiting professor at over 100 hospitals and universities. Dr. Nahabedian was the Breast Section Editor for the Journal of Plastic and Reconstructive Surgery from 2009–2017 and remains on the editorial board of 4 other surgery journals. He has chaired 19 plastic surgery conferences throughout the United States and is the current Chairman for the 2018 annual meeting of the American Society of Plastic Surgeons. Dr. Nahabedian is certified by the American Board of Plastic Surgery and is a member of the American Society of Plastic Surgeons, American Society for Aesthetic Plastic Surgery, American College of Surgeons, American Association of Plastic Surgeons, and the American Society for Reconstructive Microsurgery.

Dr. Nahabedian's MOC presentation titled "Direct to Implant Breast Reconstruction, Drains, and Antibiotics" will provide a comprehensive review of current trends in breast reconstruction. Dr. Nahabedian's presentation titled "Pearls of Wisdom of Breast Aesthetic Surgery—Augmentation, Mastopexy and Reduction" will review the common and safe techniques in order to obtain predictable results after aesthetic breast surgery.



Michele Shermak, MD

Special Guest Lecturer Michele Shermak, MD earned her medical degree from the Johns Hopkins School of Medicine and continued on at Johns Hopkins for her combined training in general surgery and plastic surgery. She pursued advanced training in Nashville with Drs. Pat Maxwell, Jack Fisher and Mary Gingrass where she learned advanced techniques in body contouring surgery, reconstructive and cosmetic breast surgery, and facial aesthetic surgery. Dr. Shermak returned to Johns Hopkins to join faculty, and became chief of Johns Hopkins Bayview

Medical Center. While at Hopkins, Dr. Shermak worked closely with the bariatric medical and surgical groups, growing her practice and expertise in body contouring surgery after massive weight loss. She authored a surgical atlas focusing on breast and body contouring surgery published by McGraw Hill in 2010, and has written many scientific papers and book chapters focusing on technical innovation, safety and improving patient outcomes. After 11 years on faculty, Dr. Shermak transitioned into private practice in Baltimore, maintaining a part time faculty position and Associate Professorship at Hopkins. She continues to speak nationally and internationally about Breast and Body Contouring Surgery. She has served the ASPS in multiple leadership positions and is currently a Visiting Professor for the Plastic Surgery Foundation.

Dr. Shermak will be lecturing on Massive Weight Loss Body Contouring of the Trunk and Extremities, sharing pearls and her algorithmic approach to individualizing patient care, with a focus on optimizing perioperative experience, aesthetic outcomes and safety.

UPCHURCH LECTURER



Garrison Wynn, CSP

Keynote Presenter, Garrison Wynn with talents that established him as a Fortune 500 leader and professional stand-up comedian, Garrison Wynn, CSP, fuses comic timing and research to deliver motivational business expertise. For 20 years, he has given keynote presentations to clients (such as American Express, Wells Fargo, Oracle and NASA) at corporate and association events. He is the author of the Amazon bestseller *The Real*

Truth about Success, the Amazon #1 bestseller *The Cowbell Principle*, has been a weekly contributor to the *Washington Post* and featured in *Forbes* and *Inc. Magazines*. In his teens he debuted the world's first video gaming system (*Odyssey*) with baseball legend Hank Aaron and as a young man spent 6 years touring comedy clubs with the top names in the business. He went on to become the youngest department head in a Fortune 500 company's history where he researched and designed processes for 38 company locations nationwide and developed & marketed products still being sold in 30 countries.

Mr. Wynn's presentation titled "What the Most Influential People Do Differently" will emphasize how to utilize best practices from management and customer service fields to better communicate with staff and serve patients.

JURKIEWICZ LECTURER



Michael J. Yaremchuk, MD

Special Guest Lecturer, Michael Yaremchuk, MD received his MD from the Columbia College of Physicians and Surgeons and his BA degree from Yale College. After completing his plastic surgery training at the Johns Hopkins Hospital, Dr. Yaremchuk completed a craniofacial surgery fellowship at the Hospital of the University of Pennsylvania.

He is presently a Clinical Professor of Surgery at the Harvard Medical School, Program Director of the Harvard Plastic Surgery Training Program, and Chief of Craniofacial Surgery at the Massachusetts General Hospital.

Although Dr. Yaremchuk practices the entire range of plastic surgery, He has a special interest in both cosmetic and reconstructive surgery of the face and facial skeleton. Dr. Yaremchuk has authored four textbooks, 40 book chapters, and over 100 scientific articles. He has lectured to his surgical colleagues around the world.

His lectures will address aesthetic facial surgery: "How to Avoid the Operated Look" and "Designing Faces."

Program Chairman

Mark A. Codner, MD

Special Guest Lecturers

Bob Aicher, Esq.

Helen Daniell

James C. Grotting, MD

Joseph P. Hunstad, MD

Lawrence B. Keller

Ryan Miller

Maurice Nahabedian, MD

Michele Shermak, MD

Garrison Wynn

Michael J. Yaremchuk, MD

SESPRS Member Presenters

Sherry Collawn, MD

Kristopher M. Day, MD

Jarom N. Gilstrap, MD

Braun H. Graham, MD

Michael A. Harrington, MD

Daniel Haynes, MD

Scott B. Hollenbeck, MD

Adam J. Katz, MD

Timothy King, MD

Frank Lau, MD

John T. Lindsey, MD

Albert Losken, MD

Bruce A. Mast, MD

Gabriele Miotto, MD

Galen Perdakis, MD

Brian D. Rinker, MD

Christopher Runyan, MD

Henry B. Wilson, MD

Timothy Wilson, MD

Thomas J. Zaydon, Jr., MD

Glancy Competiton Presenters

Abdelaziz Atwez, MD

Patrick J. Buchanan, MD

Mathew T. Epps, MD

Alessandrina M. Freitas, MD

Alexandra M. Hart, MD

Shepard P. Johnson, MBBS

Salam A. Kassis, MD

Roberto A. Martinez, MD

Timothy M. Rankin, MD

Konrad Sarosiek, MD

Blair A. Wormer, MD

Resident, Non-Member & Student Presenters

Chiara Botti, MD

William H. Gazzola, DO

Anna Rose Johnson, MPH

Petros Konofaos, MD

Apoorve Nayyar, MBBS

Analise Thomas, MD

Al C. Valmadrid, BS

Zachary T. Young, MD

Session Moderators and Secretaries

Jorge de la Torre, MD

David B. Drake, MD

Stephan J. Finical, MD

Peter Haines, MD

Holly C. Wall, MD

PROGRAM OBJECTIVES

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

- Discuss presenters' research projects, the results, and the potential application to plastic surgeons' practice,
- Apply up to date techniques in the practice of forehead, brow, face, and implant use in facial rejuvenation,
- Utilize best practices from management and customer service fields to better communicate with staff and serve patients,
- Review problems that members are experiencing in their actual plastic surgery patients; develop strategies to manage the problems,
- Apply up to date strategies to maintain patient safety at the highest level in the office and the operating room with the latest recommendations for management of vasovagal episodes, toxicity, opioid abuse, injectables, DVT, and PE,
- Apply up to date and current techniques for surgical body contouring of the trunk after massive weight loss,
- Apply lessons learned from aviation safety to improve surgical safety in your practice,
- Utilize new knowledge in practice obtained from a comprehensive review of current trends in breast reconstruction,
- Identify and describe best evidence (the "facts") regarding various pertinent problems in plastic surgery,
- Apply up to date techniques in the practice of periorbital and eyelid rejuvenation and body contouring. Review recommendations of surgical techniques from experts in order to improve periorbital techniques and body contouring techniques,
- Discuss the latest online, SEO & website strategies and the potential application to plastic surgeons' practice. Discuss up to date income protection and wealth management strategies and the potential application to plastic surgeons' practice. Apply lessons learned on hiring and firing.

SESPRS DISCLOSURE POLICY

As a provider accredited by the ACCME, SESPRS must ensure balance, independence, objectivity and scientific rigor in all it's individually sponsored or jointly sponsored educational activities. All planners, presenters and faculty members are required to disclose all relevant financial relationships with commercial interests in advance of the activity. All individuals responsible for the content of any SESPRS educational activity must disclose. Anyone who refuses to disclose will be removed. All disclosures are reviewed by the SESPRS ACCME Committee, and conflicts of interest are identified and managed in advance of the activity.

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

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

Additionally, if any unapproved or off-label use of a product is to be referenced in a CME program presentation, the faculty member/participant is required to disclose that the product is either investigational or it is not labeled for the usage being discussed. SESPRS shall convey any information disclosed by the faculty member/participant to the CME program audience prior to the activity.

COMMERCIAL SUPPORT DISCLOSURE

Contributions have been received from more than one company. Commercial contributors acknowledge that the Accredited Provider (SESPRS) will make all decisions regarding the disposition and disbursement of contributions and/or commercial support and that the funding received from each company will in no way affect; the identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content of the CME, selection of educational methods, or evaluation of the activity. Per the ACCME Standards for Commercial Support, the SESPRS will ensure that no contribution or commercial support will be used to pay for travel, honoraria, or personal expenses for non-teacher or non-author participants associated with the CME activity. The SESPRS will, as requested, provide documentation detailing the receipt and expenditure of the commercial support. Commercial contributors also agree that it will provide no other support of any type, whether financial, travel, speaker's bureau funding for a particular faculty member, or in kind support for any speaker at the meeting to which this agreement pertains. We plan to acknowledge fully the contribution from all commercial contributors in conference materials in conjunction with the meeting, and in other ways as applicable according to the guidelines of our program.

ACCREDITATION

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

The Southeastern Society of Plastic and Reconstructive Surgeons designates this live activity for a maximum of 18 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the 18 credits, 2.50 have been identified as applicable to patient safety.



This symbol throughout the program identifies a safety credit.

COMMERCIAL SUPPORT RECEIVED FROM
Allergan
Mentor Worldwide, LLC

2018 ANNUAL MEETING DISCLOSURES

*Planner/Reviewer**

Bob Aicher	<i>Nothing to disclose</i>
Abdelaziz Atwez, MD	<i>Nothing to disclose</i>
Chiara Botti, MD	<i>Nothing to disclose</i>
Patrick Buchanan, MD	<i>Nothing to disclose</i>
Anthony Capito, MD*	<i>Nothing to disclose</i>
Mark Codner, MD*	<i>CRC Press & QMP Publishing; receives royalties</i>
Sherry Collawn, MD*	<i>Nothing to disclose</i>
Mark Craig, MD*	<i>Hallux stockholder; Allergan & Valeant advisory board member, receives honoraria; Inmode speaker and advisory board, receives consulting fees.</i>
Lynn Damitz, MD*	<i>Nothing to disclose</i>
Helen Daniell	<i>Nothing to disclose</i>
Kristopher Day, MD	<i>Nothing to disclose</i>
Jorge de la Torre, MD*	<i>Nothing to disclose</i>
David Drake, MD	<i>Nothing to disclose</i>
Mathew Epps, MD	<i>Nothing to disclose</i>
Stephan Finical, MD*	<i>Allergan consultant</i>
Alessandrina Freitas, MD	<i>Nothing to disclose</i>
William Gazzola, DO	<i>Nothing to disclose</i>
Jarom Gilstrap, MD	<i>Nothing to disclose</i>

Braun Graham, MD*	<i>Galatea Surgical, receives consulting fees and stipend</i>
James Grotting, MD	<i>Aesthetic Surgeons Financial shareholder & founder; Ideal Implant & Integrated Healing Technologies shareholder; Thieme Publishing, receives royalties</i>
Peter Haines, MD*	<i>Nothing to disclose</i>
Alexandra Hart, MD	<i>Nothing to disclose</i>
Daniel Haynes, MD*	<i>ASSI consultant, receives royalties</i>
Scott Hollenbeck, MD	<i>Nothing to disclose</i>
Joseph Hunstad, MD	<i>Becon Medical investigator, no royalties; Cohera, Mentor, Allergan, Covidien, Pfizer, RXI, Pacira research study coordinator and participant, receives study support; Elsevier, receives royalties; ASAPS Board of Directors</i>
Anna Rose Johnson, MPH	<i>Nothing to disclose</i>
Shepard Johnson, MBBS	<i>Nothing to disclose</i>
Salam Kassis, MD	<i>Nothing to disclose</i>
Adam Katz, MD	<i>Nothing to disclose</i>
Carmen Kavali, MD*	<i>Allergan consultant, receives consulting fees</i>

2018 ANNUAL MEETING DISCLOSURES

Timothy King, MD *Acelity consultant—receives consulting fees*

Peter Konofoas, MD *Nothing to disclose*

Frank Lau, MD *Nothing to disclose*

John Lindsey, MD *Nothing to disclose*

Albert Losken, MD* *RTI Surgical speaker and consultant, receives honorarium*

Roberto Martinez, MD *Nothing to disclose*

Bruce Mast, MD* *Axogen stockholder; Galatea Surgical, receives study fees; Thieme Publishing, receives royalties*

Thomas McFadden, MD* *Nothing to disclose*

Ryan Miller *Allergan, Merz Aesthetics and Suneva consultant, receives consulting fees*

Gabriele Miotto, MD *Nothing to disclose*

Kurtis Moyer, MD *Nothing to disclose*

Maurice Nahabedian, MD *Allergan consultant, receives consulting fees*

Apoorve Nayyar, MBBS *Nothing to disclose*

Galen Perdakis, MD *Nothing to disclose*

David Plank, MD* *Nothing to disclose*

Timothy Rankin, MD *Nothing to disclose*

Brian Rinker, MD* *Axogen researcher, receives research support*

Christopher Runyan, MD *Nothing to disclose*

Susan Russell* *Nothing to disclose*

Konrad Sarosiek, MD *Nothing to disclose*

Erin Schwarz* *Nothing to disclose*

Michele Shermak, MD *McGraw Hill Publishing, receives royalties*

John Sparrow, MD* *Nothing to disclose*

Analise Thomas, MD *Nothing to disclose*

AI Valmadrid, BS *Nothing to disclose*

Holly Wall, MD *Establishment Labs researcher, receives study fees; Integrated Health Technologies and Ideal Implant stockholder*

Henry Wilson, MD *Nothing to disclose*

Timothy Wilson, MD *Nothing to disclose*

Blair Wormer, MD *Nothing to disclose*

Cindy Wu, MD* *Nothing to disclose*

Garrison Wynn *Nothing to disclose*

Michael Yaremchuk, MD *Consultant with Matrix Surgical—receives consulting fees*

Zachary Young, MD *Nothing to disclose*

Thomas Zaydon, Jr., MD *Nothing to disclose*



SCIENTIFIC PROGRAM

SCIENTIFIC PROGRAM

SATURDAY, JUNE 16

All general sessions and exhibits located in the Ponce de Leon Ballrooms. Exhibits and poster facilities located in the Ponce de Leon Ballroom.

4:00–5:00 pm **Early Registration**

SUNDAY, JUNE 17

7:00 am **Registration Open**

*Ponce de Leon
Ballroom*

7:00–8:00 am **Continental Breakfast**
Visit Exhibits and Poster Viewing

*Ponce de Leon
Ballroom*

8:00–8:10 am **Welcoming Remarks:**
Braun H. Graham, MD
President, Southeastern Society of Plastic and
Reconstructive Surgeons

*Ponce de Leon
Ballroom*

8:15–9:00 am **Resident Paper Competition**
Moderator: Bruce Mast, MD
Secretary: Stephan Finical, MD

#1 “Reducing Expansion Visits in Immediate Implant-Based Breast Reconstruction: A Comparative Study of Prepectoral and Subpectoral Expander Placement” (Page 33)

Blair A. Wormer, MD—Vanderbilt University

#2 “Prospective Implementation of Enhanced Recovery After Surgery Protocol Following Ambulatory Breast Surgery: Reducing Opioid Consumption in Plastic Surgery” (Page 34)

Alexandra M. Hart, MD—Emory University

SCIENTIFIC PROGRAM

SUNDAY

#3 “The Mommy Makeover: Risk Factors of Combining Aesthetic Surgical Procedures for Female Patients Between the Ages of 25 and 55 Years” (Page 36)

Konrad Sarosiek, MD—Vanderbilt University

#4 “Quadruple Perforator Flaps for Primary Closure of Large Myelomeningoceles: An Evaluation of the Butterfly Flap Technique” (Page 37)

Timothy M. Rankin, MD—Vanderbilt University

#5 “Breast Pocket Irrigation During Reconstructive Surgery—ASPS Survey Directs In Vitro Study on Triple Antibiotic Solution” (Page 39)

Mathew Epps, MD—University of Tennessee

#6 “Outcomes of Digital Pulley Reconstruction with Sterile, Acellular Allograft: A Comparison with Tendon-Based Techniques” (Page 44)

Roberto A. Martinez, MD—University of Virginia

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

9:00–9:30 am **“Pearls of Wisdom of Facial Rejuvenation”**

Michael Yaremchuk, MD

9:30–10:00 am **“Pearls of Wisdom of Facial Rejuvenation”**

Joseph Hunstad, MD

10:00–10:15 am **Discussion and Audience Case Presentation**

Objective: Apply up to date techniques in the practice of forehead, brow, face, and implant use in facial rejuvenation.

10:15–10:45 am **Break**—Visit Exhibits and Poster Judging

*Ponce de Leon
Ballroom*

SCIENTIFIC PROGRAM

SUNDAY

10:45–11:15 am **Member Papers** (5 Minutes each)

Moderator: David Drake, MD

Secretary: Jorge de la Torre, MD

*Ponce de Leon
Ballroom*

#1 “Immediate Breast Reconstruction Enhanced with the ‘No-Touch’ Technique Significantly Reduces the Risk of Infection-Related Failure” (Page 45)

Henry B. Wilson, MD

#2 “Passot-type Immediate Breast Reconstruction Confers Cost Savings Compared to the Use of Acellular Dermal Matrix in Grades Two and Three Ptosis” (Page 47)

Kristopher M. Day, MD

#3 “A Reduction Mammoplasty NSQIP Analysis of 9110 Patients, Identifying Risk Factors Associated with Complications in Patients Over 60 Years of Age” (Page 49)

Zachary T. Young, MD

#4 “The Impact of Anxiety and/or Depression on Surgical Outcomes Following Breast Free Flap Reconstruction” (Page 50)

Analise Thomas, MD

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

11:15–12:15 pm **Keynote Presentation**

“What the Most Influential People Do Differently”

Mr. Garrison Wynn

Objective: Utilize best practices from management and customer service fields to better communicate with staff and serve patients.

12:15–1:00 pm **Resident Jeopardy Bowl**

Moderator: Bert Losken, MD

*Ponce de Leon
Ballroom*

SCIENTIFIC PROGRAM

MONDAY, JUNE 18

6:30 am **Registration Open**

*Ponce de Leon
Ballroom*

6:30–7:30 am **Continental Breakfast**
Visit Exhibits and Poster Viewing

*Ponce de Leon
Ballroom*

7:15–8:00 am **Problems and Pearls**
Moderator: Brian Rinker, MD

*Ponce de Leon
Ballroom*

Objective: Review problems that members are experiencing in their actual plastic surgery patients; develop strategies to manage the problems.

8:00–8:45 am **Resident Paper Competition**
Moderator: Bruce A. Mast, MD
Secretary: Thomas Zaydon, MD

#7 “In Vitro Comparison of Vashe[®], PhaseOne[®], and Mafenide[®] on Bacterial and Fungal Biofilms” (Page 52)
Salam A. Kassis, MD—Vanderbilt University

#8 “Trigger Finger Corticosteroid Injection with and without Local Anesthetic; A Double-blind Controlled Trial” (Page 53)
Shepard P. Johnson, MBBS—Vanderbilt University

#9 “Comparison of Complications Following Implant-based Breast Reconstruction Using Triple Antibiotic Solution versus Low Concentration Chlorohexidine Gluconate Solution” (Page 54)
Alexandra M. Hart, MD—Emory University

#10 “Preoperative Hypoglycemia Increases Infection Risk Following Trigger Finger Injection and Release” (Page 56)
Patrick J. Buchanan, MD—University of Florida

MONDAY

SCIENTIFIC PROGRAM

#11 “Success of Complicated Midline Sternotomy Closure Utilizing Minimal Dissection” (Page 57)

Abdelaziz Atwez, MD—Palmetto Health/USC School of Medicine

#12 “Pre-pectoral Wise Pattern Staged Implant-Based Breast Reconstruction for Obese or Ptotic Patients” (Page 58)

Alessandrina M. Freitas, MD—University of Virginia

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

8:45–9:45 am

Patient Safety: Strategies and Controversies



Current Office Safety Recommendations

“Vasovagal Episode, Lidocaine Toxicity, Chest Pain, Opioid Abuse”

Timothy Wilson, MD

“Filler Injection Tissue Ischemia, Avoiding Intravascular Anatomy, Loss of Vision after Filler, Filler Crash Cart”

Thomas Zaydon, MD

Current Operating Room Safety Recommendations

“Determining Risk of Pulmonary Embolus, Diagnosis and Management of DVT and PE, Intraoperative Fire”

Scott Hollenbeck, MD

“Marcaine Toxicity, Malignant Hyperthermia - Diagnosis and Treatment, Time Outs”

Galen Perdakis, MD

Objective: Apply up to date strategies to maintain patient safety at the highest level in the office and the operating room with the latest recommendations for management of vasovagal episodes, toxicity, opioid abuse, injectables, DVT, and PE.

9:45–10:15 am

“Pearls of Wisdom of Massive Weight Loss Surgery of the Trunk”

Michele Shermak, MD

MONDAY

SCIENTIFIC PROGRAM

10:15–10:30 am **Discussion and Audience Case Presentation**

Objective: Apply up to date and current techniques for surgical body contouring of the trunk after massive weight loss.

10:30–11:00 am **Break**—Visit Exhibits and Poster Judging

*Ponce de Leon
Ballroom*

11:00–11:30 am **Member Papers** (5 minutes each)

Moderator: Timothy Wilson, MD

Secretary: Peter Haines, MD

*Ponce de Leon
Ballroom*

#5 “Oil and Water: A Randomized, Blinded, Placebo-Controlled Study of Autologous Fat Grafting for Scar Prevention and Remodeling” (Page 60)

Adam J. Katz, MD

#6 “An Algorithm for Selecting Combined Hyaluronic Acid Agents of Different Physical Properties in Facial Rejuvenation” (Page 61)

Gabriele Miotto, MD

#7 “Developing a Lymphatic Surgery Program: A First Year Review” (Page 64)

Anna Rose Johnson, MPH

#8 “Comparison of Telfa Rolling and Revolve™ System Autologous Fat Processing Techniques in Postmastectomy Breast Reconstruction” (Page 67)

Al C. Valmadrid, BS

#9 “Midface Lift and Lateral Cantopexy in the Treatment of Scleral Show and Ectropion” (Page 68)

Chiara Botti, MD

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

MONDAY

SCIENTIFIC PROGRAM

11:30–12:30 pm **Upchurch Lecturer**
“Privilege, Planes, and Plans”

James C. Grotting, MD

Objective: Apply lessons learned from aviation safety to improve surgical safety in your practice.

12:30–1:30 pm **Special Resident Session**
“Written and Oral Board Preparation”

Michael Harrington, MD

MONDAY



SCIENTIFIC PROGRAM

TUESDAY, JUNE 19

6:00 am **Registration Open**

*Ponce de Leon
Ballroom*

6:00–7:00 am **Continental Breakfast**
Visit Exhibits and Poster Viewing

*Ponce de Leon
Ballroom*

7:00–8:00 am **MOC Accredited Course**
MOC-PS™
**“Direct to Implant Breast Reconstruction,
Drains, and Antibiotics”**
Maurice Nahabedian, MD

*Ponce de Leon
Ballroom*

Objective: Utilize new knowledge in practice obtained from a comprehensive review of current trends in breast reconstruction.

8:00–9:00 am **Just the Facts Panel**
Moderator: Bruce A. Mast, MD

Panel Members:

“Oral Antibiotics Should be Continued as Long as Drains are in Place”—Jarom Gilstrap, MD (University of South Carolina)

“NSAIDs Should be Avoided After Plastic Surgery Due to Risk of Hematoma” (ADHD)—Christopher Runyan, MD, PhD, (Wake Forest)

“Large Volume Fat Grafting to the Buttocks is Unsafe and Should Not be Done”—Frank Lau, MD (Louisiana State University)

“Early and Frequent Toxin Injections will Prevent Wrinkles”—
Petros Konofaos, MD, PhD (University of Tennessee, Memphis)

Objective: Identify and describe best evidence (the “facts”) regarding various pertinent problems in plastic surgery.

TUESDAY

SCIENTIFIC PROGRAM

9:00–9:30 am **“Pearls of Wisdom of Periorbital Rejuvenation”**
Michael Yaremchuk, MD

9:30–10:00 am **“Pearls of Wisdom of Body Contouring”**
Joseph Hunstad, MD

10:00–10:15 am **Discussion and Audience Case Presentation**

Objective: Apply up to date techniques in the practice of periorbital and eyelid rejuvenation and body contouring. Review recommendations of surgical techniques from experts in order to improve periorbital techniques and body contouring techniques.

10:15–10:45 am **Break**—Visit Exhibits and Poster Viewing

*Ponce de Leon
Ballroom*

10:45–11:15 am **Member Papers (5 Minutes Each)**

Moderator: Holly Wall, MD
Secretary: Peter Haines, MD

*Ponce de Leon
Ballroom*

#10 “A Clinical Comparison of Irrisept®, Triple Antibiotic, and Combination Breast Pocket Irrigation” (Page 69)
Daniel Haynes, MD

#11 “Social Media Preferences in Plastic Surgery: A Conjoint Analysis” (Page 70)
Apoorve Nayyar, MBBS

#12 “Regional Anesthetic Blocks for Plastic Surgery: You Can Do This!” (Page 71)
John T. Lindsey, MD, FACS

#13 “Meldown Poly-Lactic Acid Nano-Webs as a Tissue Engineering Scaffold” (Page 73)
William H. Gazzola, DO

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

SCIENTIFIC PROGRAM

11:15–11:45 pm **“Pearls of Wisdom of Massive Weight Loss Surgery of the Extremities”**

Michele Shermak, MD

11:45–12:15 pm **“Pearls of Wisdom of Breast Aesthetic Surgery—Augmentation, Mastopexy and Reduction”**

Maurice Nahabedian, MD

12:15–12:30 pm **Discussion and Audience Case Presentation**

Objective: Apply up to date and current techniques for surgical body contouring of the extremities after massive weight loss. Review the common and safe techniques in order to obtain predictable results after aesthetic breast surgery.

12:30 pm **SESPRS Annual Business Meeting**

Please register—lunch will be served

*Ponce de Leon
Ballroom*

12:30–3:00 pm **Resident Luncheon (Students, Residents & Fellows Only)**

Gulfstream 4

“Business Tips You Should Know Before Starting Your Practice”

1:00–1:30 pm **“Building Equity Online: 7 Opportunities in Your First Days of Practice to Maximize Value and Return Online”**

Ryan Miller

1:30–2:00 pm **“What Consultant Do I Need First?, Examples of How I Should Organize My Financial Statements What Type and How Much Insurance Do I need Before I Start?”**

Larry Keller

TUESDAY

SCIENTIFIC PROGRAM

2:00–2:30 pm **“How to Stay Out of Trouble with the ABPS
Regarding my Website and My Social Media.
How to Avoid Unintentional HIPAA Violations”**
Bob Aicher, Esq.

2:30–3:00 pm **“The Reports You Should See Before Signing a
Contract. What Employee Do I Hire First?”**
Helen Daniell



TUESDAY

SCIENTIFIC PROGRAM

WEDNESDAY, JUNE 20

7:30 am **Registration Open***Ponce de Leon
Ballroom*7:30–8:30 am **Continental Breakfast***Ponce de Leon
Ballroom*7:30–8:15 am **Research Grant Reports***Ponce de Leon
Ballroom***“Stromal Cell Interactions with Skin Cancer”**

2017 Research Grant Report—

Sherry Collawn, MD, PhD

“Development of a 3-D Bioprinter for Tissue Engineering”

2017 Research Grant Report—Timothy King, MD

8:15–11:30 am **Don't Miss This! Very Valuable Practice Advice
Business and Legal Consultant Panel****“What Every Plastic Surgeon Should Know to Run A Business”**

Moderator: Mark A. Codner, MD

8:15–9:15 am **“3 Online Marketing Mistakes That Are Costing You a Fortune”**

- Lead with strategy to take the reckless spending and guesswork out of your online marketing.
- Examine your lead handling to recover dropped leads and turn more prospects in to patients.
- Learn how to measure the value and return from each online investment.

Ryan Miller—CEO Etna Interactive—Medical Marketing Agency

SCIENTIFIC PROGRAM

- 9:15–10:00 am **“Hiring With Background Checks and Firing Without Legal Consequences”**
- How to Prevent and Recognize Embezzlement
 - Bad Taste or Illegal Social Media and ABPS Policies
 - The Legal Policies Regarding HIPAA, Patient Photographs, and Patient Reviews

Bob Aicher, Esq.—ASAPS General Counsel

- 10:00–10:30 am **“Monthly and Annual Financial Reports Every Plastic Surgeon in Practice Should Review”**

Helen Daniell, Practice Management

- 10:30–11:30 am
- Income Protection & Wealth Accumulation Strategies
 - Tax Minimization Strategies, Retirement and Estate Planning
 - Insurance—Malpractice, Disability, Life Insurance and Trusts that I Need

Lawrence Keller, Certified Financial Planner, Physician Financial Services

NON-CME

Objective: Discuss the latest online, SEO & website strategies and the potential application to plastic surgeons' practice. Apply lessons learned on hiring and firing.

- 11:30 am **Closing Remarks**

Stephan J. Finical, MD

Meeting Adjourns

***“Advancing professional excellence,
quality education, and regional collegiality”***

#1 Reducing Expansion Visits in Immediate Implant-Based Breast Reconstruction: A Comparative Study of Prepectoral and Subpectoral Expander Placement

Blair A. Wormer, MD¹; Al Valmadrid, BS¹; Nishant Ganesh Kumar, MD²; Salam Al Kassis, MD¹; Timothy M. Rankin, MD, MS¹; Christodoulos Kaoutzanis, MD¹; Kent K. Higdon, MD, FACS¹

¹ Department of Plastic Surgery, Vanderbilt University, Nashville, TN, USA

² Department of Plastic Surgery, University of Michigan Health System, Ann Arbor, MI, USA

PURPOSE: The numerous office visits required to complete expansion in implant-based breast reconstruction (IBBR) impacts patient satisfaction, office resources, and time to complete reconstruction. This study aimed to determine if prepectoral IBBR offers expedited tissue expansion compared to subpectoral IBBR without affecting complication rates.

METHODS: Consecutive patients who underwent immediate IBBR with tissue expanders from January 2016 to July 2017 by a single-surgeon were grouped into subpectoral (partial submuscular/partial acellular dermal matrix) or prepectoral (complete acellular dermal matrix coverage) and reviewed. The primary outcomes were total days and number of visits to expansion completion. Groups were compared by univariate analysis with significance set at $p < 0.05$.

RESULTS: In total, 101 patients (subpectoral=69, prepectoral=32) underwent 184 IBBR(subpectoral=124, prepectoral=60). There was no difference in age, body mass index, smoking or diabetes between the groups(all $p > 0.05$). Between prepectoral and subpectoral patients there was similar postoperative total morphine equivalents(22.6 ± 18.5 vs. 30.4 ± 19.6 ; $p = 0.062$). Prepectoral patients took fewer days to complete expansion(40.4 ± 37.8 days vs. 62.5 ± 50.2 days; $p = 0.032$), fewer office visits to complete expansion(2.3 ± 1.7 vs. 3.9 ± 1.8 ; $p < 0.001$), and were expanded to greater final volumes than subpectoral patients(543.7 ± 122.9 ml vs. 477.5 ± 159.6 ml; $p = 0.046$). Between prepectoral and subpectoral there were similar rates of minor complications(25% vs. 18.5%; $p = 0.311$), readmission(5% vs. 2.4%; $p = 0.393$), seroma(8.3% vs. 5.6%; $p = 0.489$), reoperation for hematoma(3.3% vs. 1.6%; $p = 0.597$), explantation(5% vs. 2.4%; $p = 0.393$), and length of follow up(179.3 ± 98.2 days vs. 218.3 ± 119.8 days; $p = 0.111$).

CONCLUSIONS: This novel analysis of the expansion abilities of prepectoral placement in immediate IBBR demonstrates it can facilitate expansion to higher total volumes in nearly half the office visits compared to similar populations with subpectoral placement, without increasing complication rates.

#2 Prospective Implementation of Enhanced Recovery After Surgery Protocol following Ambulatory Breast Surgery: Reducing Opioid Consumption in Plastic Surgery

Alexandra M Hart, MD; Connor Crowley, MD; Albert Losken, MD

PURPOSE: Increasing rates of opioid abuse coupled with improved outcomes with Enhanced Recovery After Surgery (ERAS) protocols have shown improved outcomes following inpatient surgery. This is the second report in a two-part series on pain control in outpatient breast surgery. The purpose of this study is to analyze the first documented implementation of an opioid-sparing ERAS protocol for ambulatory breast surgery patients and to compare ERAS patients to a historical opioid-only control.

METHODS: This is a prospective analysis of a consecutive series of patients (n=50) undergoing ambulatory breast surgery by a single surgeon. Patients were counseled pre and postoperatively on expectations for surgery. Postoperative pain regimen was:

- Neurontin 300mg three times daily
- Ibuprofen 200-400mg every 6 hours
- Acetaminophen 650mg every 6 hours
- 5 tablets, 5mg oxycodone for breakthrough pain

Pre and postoperatively patients were queried on pain level, medication usage, and satisfaction with pain management. ERAS patients were compared to a historical opioid-only control group (n=95) that received 30 tablets of 325mg acetaminophen/5mg oxycodone.

RESULTS: Most patients (>70%) reported being compliant with the prescribed pain regimen. Less than half (44.4%) of patients took one oxycodone. Of those patients, the majority took 2.44 tablets total. The most common reason for discontinuing pain medication was pain was adequately controlled (66.7%) followed by side effects (33.3%). The majority of side effects were related to oxycodone use and included drowsiness and nausea. Patients denied needing any other supplemental pain medication. There was no significant difference in pain scores between groups for all time points. Comparisons between ERAS patients and historical control are in Table 1.

Table 1: Comparison of Pain Scores and Satisfaction for ERAS-protocol versus Historical Opioid-only Patients.

	ERAS Group	Opioid Group	p-value
Mean Pain Score: (1-10)			
Preoperative	2.75	2.81	0.938
Postoperative Day 3-5	4.80	4.81	0.994
Postoperative Day 8-10	3.40	3.59	0.875
Postoperative Day >/30	1.83	3.00	0.641
Mean Change in Pain Score	-0.92	-0.19	
Took One Tablet of Oxycodone	44.4%	74.0%	
Number of Oxycodone Leftover	2.6/5.0	13.5/30.0	
Satisfaction with Postoperative Pain Management	(%)	(%)	
Dissatisfied	11.1	0.0	
Somewhat Dissatisfied	0.00	6.8	
Somewhat Satisfied	44.4	13.7	
Very Satisfied	44.4	79.5	
Satisfaction with how long after surgery it took to feel normal again	(%)	(%)	
Dissatisfied	0.00	5.5	
Somewhat Dissatisfied	11.1	2.7	
Somewhat Satisfied	11.1	28.8	
Very Satisfied	77.8	63.0	

CONCLUSION: The ERAS protocol decreases narcotic use over traditional opioid regimens while both treating patients’ pain appropriately and maintaining patient satisfaction with pain management.

#3 The Mommy Makeover: Risk Factors of Combining Aesthetic Surgical Procedures for Female Patients Between the Ages of 25 and 55 Years

Konrad Sarosiek, MD¹; Steven Schneeberger, BS¹; Christodoulos Kaoutzanis, MD¹; Christopher Tokin, MD¹; Blair Wormer, MD¹; Varun Gupta, MD²; Galen Perdakis, MD¹; Kent K. Higdon, MD¹

¹ Department of Plastic Surgery, Vanderbilt University, Nashville, TN

² Prima Center for Plastic Surgery, Duluth, GA

PURPOSE: This study examined the incidence and risk factors of major complications in female patients undergoing multiple aesthetic procedures commonly grouped and described as the “Mommy Makeover.”

METHODS: A prospective cohort of female patients aged 25 to 55 years undergoing cosmetic surgery between 2008 and 2013 were identified from the CosmetAssure™ database. Primary outcome was occurrence of a major complication requiring emergency room visit, hospitalization, or reoperation within 30 days of surgery. Multivariate regression analysis was performed controlling for age, gender, body mass index (BMI), procedure, and type of surgical facility.

RESULTS: Of the 120,650 women, 48,832 aged 25 to 55 years underwent abdominoplasty, breast augmentation, mastopexy, liposuction, or a combination. Of these procedures, abdominoplasty had significantly higher overall complication rates when compared to breast augmentation (2.9% vs. 1.5%; $p < 0.01$), mastopexy (2.9% vs. 1.3%; $p < 0.01$), and liposuction (2.9% vs. 0.7%; $p < 0.01$) individually. When single procedures were compared to combinations of two, three, or four concurrent operations increasing rates of major complications were noted (2.9% vs. 3.6% vs. 4.2% vs. 4.6%; $p < 0.01$). On multivariate analysis, independent predictors of major complications included increasing age (RR 1.01; $p < 0.01$), increasing BMI (RR 1.03; $p < 0.01$), and combined procedures (RR 1.36; $p < 0.01$). When looking specifically at deep vein thrombosis rates, combined procedures (RR 3.07; $p < 0.01$) was the only significant risk factor.

CONCLUSIONS: Age, BMI, and the combining of procedures under the “Mommy Makeover” concept significantly increases the overall complication rate for these patients. Deep vein thrombosis risk is also higher when combining procedures, which warrants individualized risk stratification and appropriate venous thromboembolism prophylaxis.

#4 Quadruple Perforator Flaps for Primary Closure of Large Myelomeningoceles: An Evaluation of the Butterfly Flap Technique

T.M. Rankin¹, C. Tokin¹, C. Kaoutzanis¹, B.A. Wormer¹, S. Al Kassis¹,
J.C. Wellons III², S.A. Braun¹

¹ Department of Plastic and reconstructive surgery, Vanderbilt University Medical Center

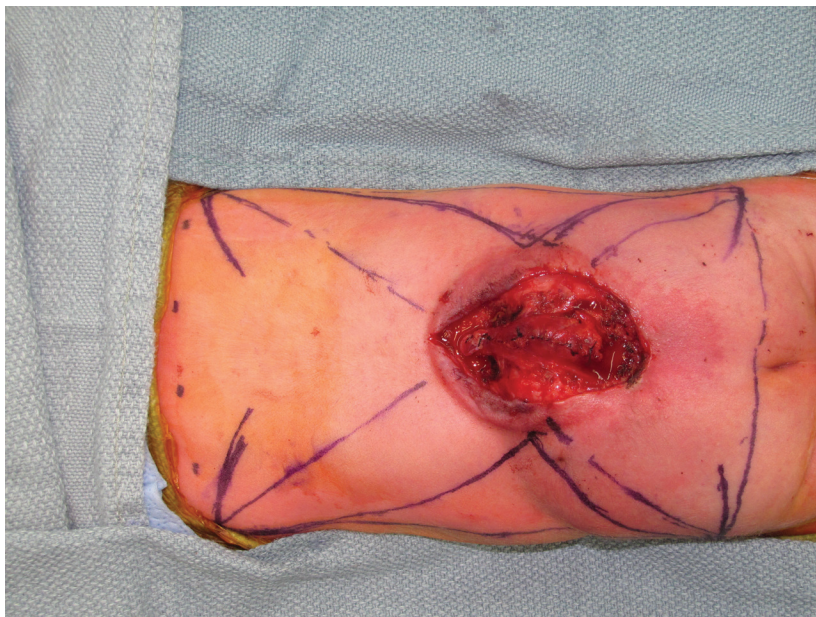
² Department of Neurosurgery, Vanderbilt University Medical Center

INTRODUCTION: Myelomeningocele is the most common open neural tube defect. A quadruple rotation-VY advancement flap (butterfly flap) was recently reported for closure of large myelomeningocele defects; however, no series has been reproduced to evaluate this technique. The objective of this study was to describe our experience with this technique.

MATERIALS AND METHODS: We reviewed all infants born with large myelomeningocele defects who underwent butterfly flap closure over a two-year period. Demographics, defect size, operative details, and complications were used to generate descriptive statistics.

RESULTS: From June 2015 to January 2018, 7 infants met inclusion criteria. Average defect width was 52% +/- 0.11 of the back, representing 21% +/- 0.09 of the total back area. Only 1 child had central breakdown. All patients had some peripheral skin dehiscence that occurred on postoperative day 12 +/- 7 and these were treated with outpatient wound care. 4 patients returned to the OR for dehiscence electively. There were no incidences of total flap loss. There were no cases of meningitis or myelomeningocele dehiscence. All patients had successful closure of their myelomeningocele without the use of skin grafts.

CONCLUSIONS: The butterfly flap is able to close large myelomeningocele defects and has the potential to improve contour. We had minor wound healing complications, but in the rare event of central dehiscence, quadruple rotation-VY advancement flaps can be re-advanced. In all cases, a large myelomeningocele was successfully reconstructed with robust full-thickness flaps and there was no need for skin grafting of donor sites.



#5 Breast Pocket Irrigation During Reconstructive Surgery—ASPS Survey Directs In Vitro Study on Triple Antibiotic Solution

Mathew T. Epps¹, Todd E. Thurston¹, Victoria Noyes², David F. Levine², Henry G. Spratt², Mark A. Brzezienski¹

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

² University of Tennessee at Chattanooga, Division of Microbiology

INTRODUCTION: Expander-to-implant is the most common breast reconstruction procedure in the US. A survey of American Society of Plastic Surgery (ASPS) members assessed antimicrobial breast pocket irrigation and dwell time preferences during implant-based reconstructive surgery. A pilot in vitro study was conducted to determine antibacterial efficacy of the survey respondent's most preferred irrigation at preferred dwell times against bacterial species linked to breast pocket contamination.

METHODS: The survey represented a random cohort of 2488 ASPS members. During in vitro studies, bacteria were exposed to Triple Antibiotic Solution (TAS) versus saline control (SAL) at 1, 2, and 5 mins in a simulated "cavity". Viable plate counts were used to assess cell viability.

RESULTS: The survey response rate was 16% (n=388). TAS was the favored irrigation (76% of users preferring dwell times of ≤ 2 min). Bacteria added to the "cavity" survived a 2 min dwell time with TAS as follows: 51%-*Staphylococcus epidermidis*, 69%-*Escherichia coli*, 88%-*Enterococcus faecalis*, 88%-*Pseudomonas aeruginosa*, and 80%-methicillin resistant *S. aureus*. Across all dwell times, bacterial survival in TAS and SAL did not differ significantly.

DISCUSSION: Our survey data demonstrates significant variability in practice and a lack of consensus among ASPS members regarding antimicrobial irrigation during implant-based reconstructive breast surgery. Our in vitro data further underscores the importance of relating clinical practices with lab studies of microorganisms potentially linked to breast pocket contamination, and suggests TAS requires either dwell times >5 min and/or the inclusion of efficacious antimicrobial/antiseptic agents. This finding has the potential to influence current antibiotic/anti-infective techniques during breast reconstruction.

Figure 1. American Society of Plastic Surgery Survey—Antimicrobial Techniques and Preferences during Implant-Based Reconstructive Breast Surgery. Survey respondents preferred TAS (35%), TAS and Betadine® +/- Bacitracin (14%), a Betadine® variant (11%), or Other (7%) which included Bacitracin alone variants. Strikingly, 16% of respondents reported the preference of no irrigation at all. Irrigations with >5 survey responses are listed in bold.

Breast Pocket Irrigation during Reconstructive Surgery	Frequency	Percentage
Normal Saline	14	3.5
TAS (Adam's Solution: Ancef®, Gentamycin, Bacitracin)	140	35
TAS + Betadine®	56	14
TAS, without Bacitracin, + Betadine®	10	2.5
Dilute Betadine® 1:20 ratio of stock solution (10% Povidone-Iodine)	12	3
Dilute Betadine® 1:10 ratio of stock solution (10% Povidone-Iodine)	1	0.2
Dilute Betadine® 1:1 ratio of stock solution (10% Povidone-Iodine)	23	6
Betadine® (10% Povidone-Iodine)	3	0.7
Dakin's® solution (0.25% Sodium hypochlorite)	1	5.7
Clorpactin wcs-90® (0.4% Sodium oxychlorosene; Hypochlorous acid derivative; Dakin's solution alternative)	2	0.5
PhaseOne® wound irrigation (0.025% Hypochlorous acid)	0	0
Irrisept® (0.05% aqueous Chlorhexidine gluconate)	2	0.5
Dilute Hibiclens® (0.05% Chlorhexidine gluconate soap)	3	0.7
Bactisure™ wound irrigation (Benzalkonium chloride)	0	0
Prontosan® wound irrigation (Polyhexanide/Betaine soap)	1	0.2
50,000 units Bacitracin (1amp) in 1 liter of saline	20	5
50,000 units Bacitracin (1amp) in 500cc saline + 500cc Betadine® solution	0	0
50,000 units Bacitracin (1amp) in 1 liter of saline + 50cc Betadine® solution	1	0.2
Vancomycin	1	0.2
Gentamycin	3	0.7
Ancef®	2	0.5
Hydrogen peroxide	0	0
Other	28	7
N/a	65	16.2

Figure 2. American Society of Plastic Surgery Survey—Antimicrobial Techniques and Preferences during Reconstructive Breast Surgery. Approximately 35% of respondents preferred traditional Triple Antibiotic Solution (TAS), outlined by the vertical box, with a cumulative total of 45%, 60%, and 75% of TAS users preferring dwell times of less than 30sec, 1min, and 2min, respectively. Similar dwell time preferences were observed across all variants of TAS.

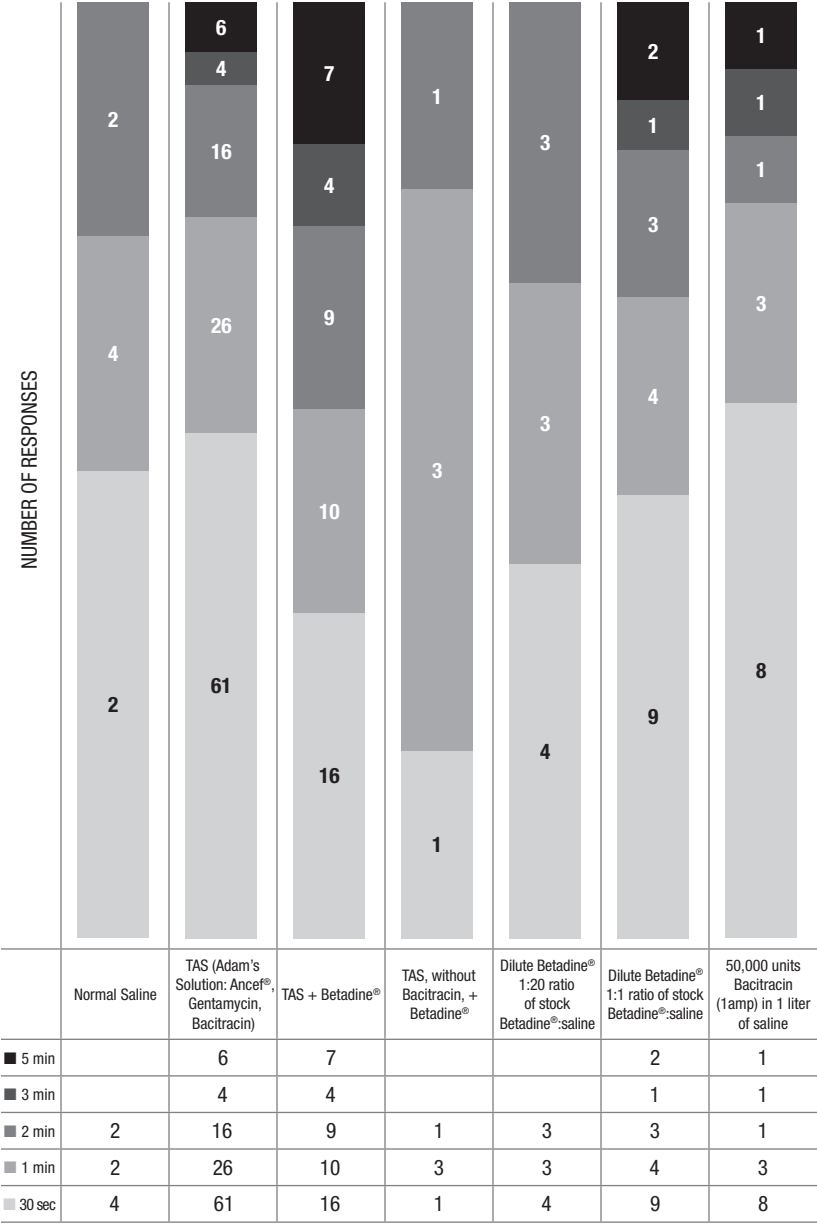


Figure 3. The Protocol Developed to Test the Efficacy of Different Surgical Irrigation Solutions in Killing Target Bacterial Cultures. In this study, two irrigation solutions were considered: Triple Antibiotic Solution (TAS: Ancef, Gentamycin, and Bacitracin; Adams 3AB in figure) and a sterile saline control (SAL). Cultures tested using this technique included the following: *E. faecalis*, *E. coli*, methicillin resistant *S. aureus* (MRSA), *P. aeruginosa*, and *S. epidermidis*. Note that all petri dishes (in gray) were incubated a minimum of 24hrs and often 48hrs for manual colony counts to enumerate either the starting culture or the surviving cultures after the exposures in the “cavity” (i.e. – a simulated bacteria colony within the breast pocket). Culture studies were conducted in triplicate for each bacterium at 1, 2, and 5mins to simulate respective dwell times.

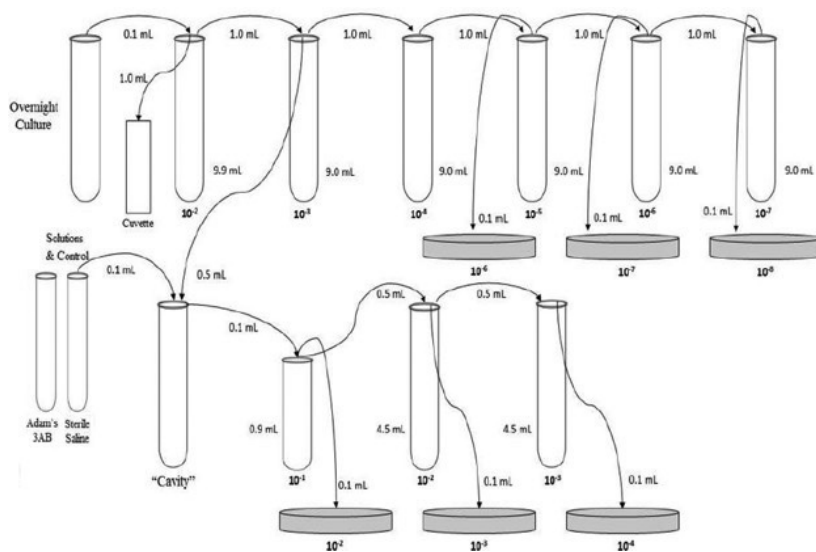
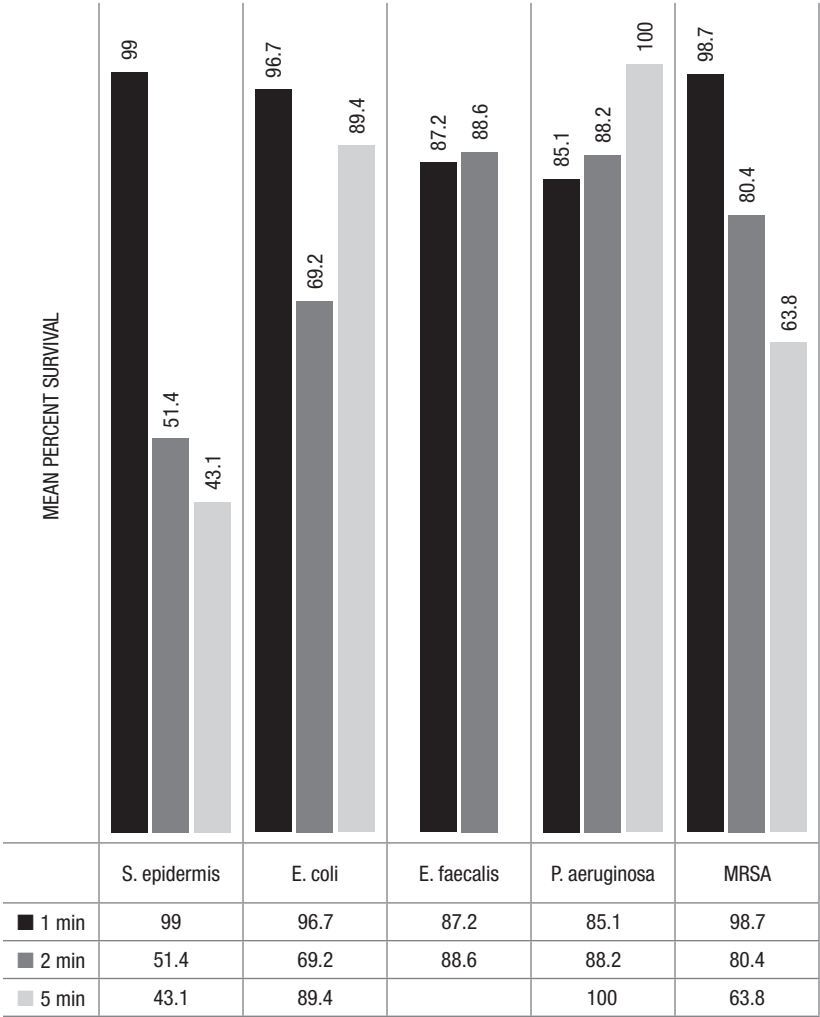


Figure 4. In Vitro Microbiology Data demonstrating Bacterium Survival following Exposure to Triple Antibiotic Solution (TAS) Normalized to a Saline Control (SAL) Across Dwell Times of 1, 2, and 5 mins. A 2min dwell time conferred a bacterial survival rate of 51%, 69%, 88%, 88%, and 80% for *S. epidermidis*, *E. coli*, *E. faecalis*, *P. aeruginosa*, and methicillin resistant *S. aureus* (MRSA), respectively. Across all dwell times (1,2, and 5mins), bacterial survival between TAS and SAL treatment groups did not differ significantly.



#6 Outcomes of Digital Pulley Reconstruction with Sterile, Acellular Allograft: A Comparison with Tendon-Based Techniques

Brent DeGeorge, MD, PhD; Roberto A. Martinez, MD; Anthony Archual, MD; Jane Gui, BS; A. Bobby Chhabra, MD; David Drake, MD

HYPOTHESIS: We previously demonstrated the safety and feasibility of sterile, acellular pulley allografts for reconstruction of injuries with symptomatic bowstringing. Comparison to traditional tendon-based techniques has not been reported. We hypothesized the use of allograft would result in reduced procedural time with equivalent clinical outcomes.

METHODS: After institutional approval, all cases of pulley reconstruction using either sterile, acellular allograft or autograft tendon between November 2013 and November 2015 were reviewed. Patients who underwent multiple procedures were excluded. Patient demographics, co-morbidities, operative details, post-operative complications, DASH scores and follow-up were recorded. A p-value of <0.05 was considered statistically significant.

RESULTS: Fifteen pulleys in 10 fingers of 10 patients were included. Five tendon and 5 allograft based reconstructions were performed. There was no difference in demographics or co-morbidities between groups. The most common indication for surgery was trauma. Both total operative and tourniquet times were significantly reduced in the allograft group (46 ± 5.5 vs. 89 ± 12.9 minutes, 34 ± 6.8 vs. 63 ± 5.3 minutes; $p=0.015$ and 0.014 , respectively). Four of 5 patients in the allograft group had multiple pulleys reconstructed versus 1 in the tendon-based group. No patients in the allograft group required re-operation versus 1 in the tendon-based group required re-operation for persistent bowstringing. Post-operative DASH scores were lower in the allograft group (56.8 vs 3.6 , $p=0.11$). There was no difference in post-operative range of motion. Average follow-up was 12.5 ± 2.9 months.

CONCLUSIONS: Pulley reconstruction with allograft is efficient, technically feasible and eliminates donor site morbidity. Total operative and tourniquet times were significantly decreased without increased complication rate.

#1 Immediate Breast Reconstruction Enhanced with the “No-Touch” Technique Significantly Reduces the Risk of Infection-Related Failure

Henry B. Wilson, MD, FACS

PURPOSE: Infection rates in prosthetic breast reconstruction after mastectomy vary widely, ranging from 1% to 35%, with meta-analyses reporting average infection rates of over 5%. In an attempt to reduce infectious events, the author developed a “no-touch” protocol for the procedure, utilizing a transparent barrier drape and self-retaining retractor system patterned after similar orthopedic and urologic techniques.

MATERIALS and Methods: An IRB-approved retrospective study was performed of patients who underwent immediate breast reconstruction with tissue expanders and acellular dermis (ADM) from 2010 to 2017 by the author. The cohort prior to the institution of a no-touch protocol in 2014 was compared to the cohort after the enhancement was instituted. Demographic and outcome data were analyzed.

RESULTS: Sixty-nine patients (113 breasts) underwent reconstruction from 2010 to 2014 utilizing the traditional technique, and 64 patients (104 breasts) underwent reconstruction from 2014 to 2017 using the new no-touch enhancement (Figures 1 and 2). Patients in both groups had similar demographics and comorbidity profiles. The only significant technique variable besides the addition of no-touch was the trend toward the use of larger sizes of ADM in the later group (154 cm² vs 108 cm²). The rate of reconstructive failure due to infection dropped from 11.5% (13/113) to 1.9% (2/105) ($p=0.002$) after institution of the no-touch protocol.

CONCLUSION: Institution of a specific no-touch protocol to immediate breast reconstruction with tissue expanders and ADM lowered the risk of reconstructive failure due to infection six-fold—11.5% to 1.9%. Comparative studies from other surgeons are encouraged.

Figure 1: Right breast reconstruction showing no-touch system in place before tissue expander and acellular dermis are placed. The submuscular pocket has been created and the inferior edge of the muscle is visible. Preoperative markings are visible through the drape.

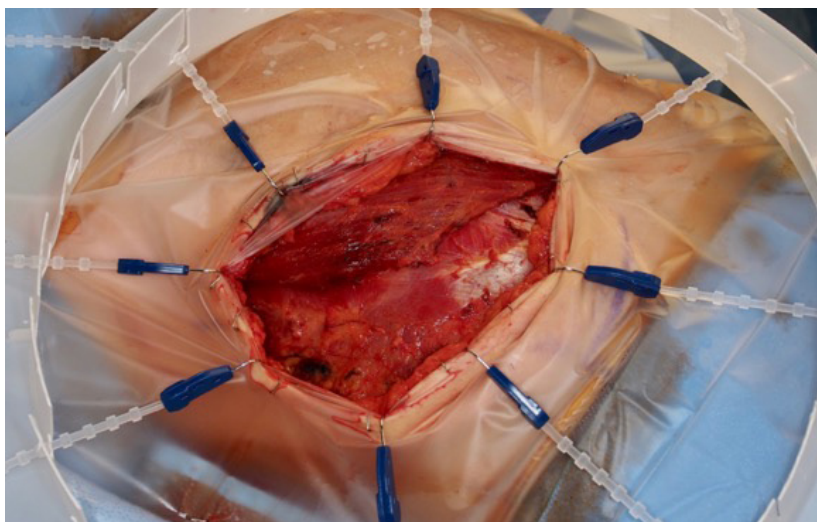
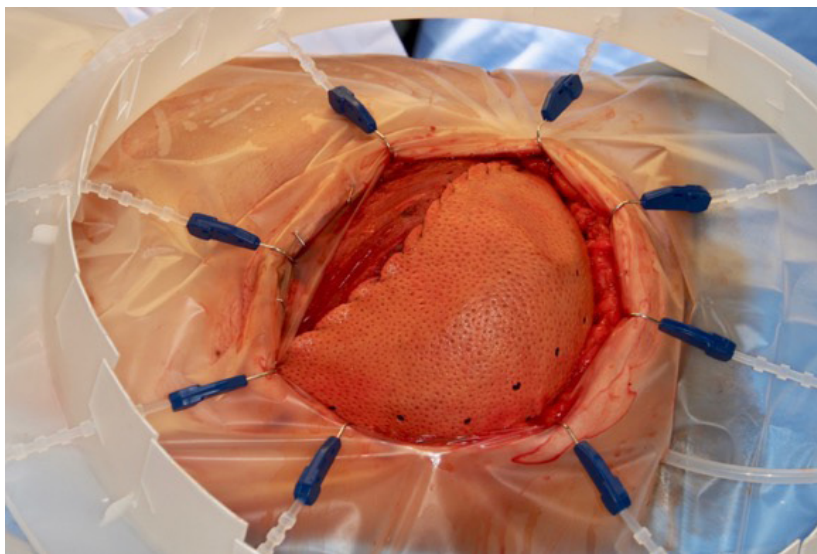


Figure 2: Right breast reconstruction showing no-touch system in place after placement of tissue expander and acellular dermis prior to final closure.



#2 Passot-Type Immediate Breast Reconstruction Confers Cost Savings Compared to the Use of Acellular Dermal Matrix in Grades Two and Three Ptosis

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SOURCE OF FUNDS: No funds were used for this retrospective review.

CONFLICTS OF INTEREST: The authors declare they have no conflicts of interest of any kind.

KEY WORDS: Passot, breast reconstruction, breast cancer.

PURPOSE: Acellular dermal matrices (ADM) are commonly used for immediate breast reconstruction after skin-sparing mastectomy (SSM). The cost of ADM is significant. Larger ptotic breasts allow surgeons to use the patient's de-epithelialized dermal pedicle, avoiding the use of ADM.

METHODS: All consecutive SSM macromastia patients with Regnault grades two or three ptosis who received immediate breast reconstruction (IBR) with tissue expanders (TE) and Passot-type dermal pedicle without ADM were included.

RESULTS: Thirty-eight patients with an average age of 52.7 years, weight 210.5 pounds, and BMI of 35.1 were treated (36 bilateral, two unilateral; 74 breasts). Average mastectomy specimens weighed 912.9 grams. TE's were filled to 265.0 cc (42.1% capacity) intraoperatively, and final implant volume averaged 710.9 cc. Operative times for Passot reconstruction was 109.4 ± 36.2 versus 92.5 ± 27.9 minutes ($p = 0.043$) for submuscular TE placement with ADM. There were seven (18.4%) implant-related infections, five cases (13.2%) of mastectomy flap necrosis, and four (10.5%) capsular contractures. Thirty-five patients (92.1%) successfully completed Passot reconstruction. Total cost savings in this case series was \$89,724.23 ($\$2360.96 \pm \$3528.98/\text{case}$).

CONCLUSION: Passot-type IBR after SSM is safe, demonstrates acceptable rates of successful breast reconstruction, and confers cost savings in ptotic macromastia patients.

Table 1. Demographics

Age (years)	52.7
Weight (pounds)	210.5
BMI (mean)	35.1
DM (%)	13.2
Smoking (%)	13.2
Hypertension (%)	31.6
Radiation (%)	34.2
Chemotherapy (%)	34.2

Table 2. Clinical Course and Outcomes

Intraoperative Expansion (cc)	259.1
Final Expansion (cc)	628.6
Duration of Expansion (days)	180.0
Implant Size (cc)	710.9
Flap Necrosis (%)	23.7
Implant Infection (%)	18.4
Capsular Contractures (%)	10.5
Secondary Latissimus Dorsi (n)	10.5
Successful Reconstruction (%)	92.1

Table 3. Cost Analysis

	Acellular Dermal Matrix	Passot
Cost Per Procedure*	\$14,070 ± \$7415.17	\$11,709.04 ± \$3886.19
Total Cost for Case Series	\$534,667.75 ± \$281,776.38	\$444,943.52 ± \$147,675.22
Total Cost Savings	-	\$89,724.23

* Considers biomaterials and operative room time charges

Figure 1. Intraoperative Dermal Pedicle



The inferiorly-based, horizontal, de-epithelialized dermal pedicle is sewn to the inferior edge of the pectoralis major muscle. This native tissue therefore performs similar to a piece of acellular dermal matrix by reinforcing the soft tissue envelop and stabilizing the tissue expander.

#3 A Reduction Mammoplasty NSQIP Analysis of 9110 Patients, Identifying Risk Factors Associated with Complications in Patients Over 60 Years of Age

Zachary T. Young, MD; Michaela Close, BS; Fernando Herrera, MD

PURPOSE: The purpose of this study was to identify patients older than 60 years of age undergoing reduction mammoplasty to identify complications and associated risk factors.

METHODS: The ACS NSQIP data from years 2013–2015 was searched using cpt code 19318 to identify all patients undergoing isolated reduction mammoplasty. Patient demographics and 30day complications were analyzed. Comparative analysis was performed between patients younger than 60 to patients 60 and over identifying risk factors associated with complications in the geriatric population.

RESULTS: 9110 patients undergoing reduction mammoplasty were identified. Of these 1442 (15.83%) were patients older than 60 years of age. Mean Geriatric age was 65.94 years of age (range 60–85). Mean age of all patients was 42.01 (range 18–85). 859 patients were active smokers. 140 patients were diabetic. The geriatric population showed a higher risk for cerebral vascular accidents (p value <0.00006), myocardial infarction (p value <0.02), and readmission (p value <0.03).

Smoking was found to be a statistically significant risk factor for superficial surgical site infection (SSI), and deep space infection. Diabetes was found to be a statistically significant risk factor for superficial SSI, transfusion, reoperation, and readmission.

CONCLUSION: Reduction mammoplasty is a common surgical procedure. It is not uncommon for patients over 60 years of age to undergo elective reduction mammoplasty (15.83% incidence). Resulting in a cumulative complication rate of 11.65% in the geriatric population compared to 8.89% in the under 60 group.

#4 The Impact of Anxiety and/or Depression on Surgical Outcomes Following Breast Free Flap Reconstruction

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BACKGROUND: Prior studies have demonstrated that psychological factors affect surgical outcomes. Specifically, with certain general and orthopedic surgical procedures, the diagnoses of anxiety and depression have been correlated with increased complications and repeat operations. Within the plastic surgery literature, there is a paucity of data regarding the potential detrimental influence of these mental health co-morbidities. This study aims to examine the impact of baseline mental health status on patients undergoing breast cancer-related autologous reconstruction.

METHODS: Patients admitted to our institution from 2011–2016 for breast reconstruction with a free flap were retrospectively reviewed. Those with a pre-operative diagnosis of anxiety and/or depression were compared against those without such a diagnosis. Demographics (age, mean BMI, and co-morbidities including diabetes and hypertension), number of surgical revisions, complications (surgical site infection, urinary tract infection, and flap loss), length of stay (LoS), and 60-day re-admission were examined between these groups. Categorical variables were analyzed using Pearson's chi-squared test and continuous variables with two-way student's t-tests.

RESULTS: 275 patients (A/D: n=126; no-A/D: n=149) met inclusion criteria. Patients without anxiety or depression underwent fewer revisionary procedures than those with a psychiatric diagnosis ($p=0.025$). This finding seemed to be driven by the diagnosis of anxiety. Specifically, patients with anxiety underwent significantly more revisions than those without anxiety ($p<0.001$). There were no significant differences in demographics, complications, mean LoS, or readmission rate.

CONCLUSION: Patients without anxiety and/or depression undergo significantly fewer revisions following breast free flap reconstruction. As such, it is essential that patients undergoing breast reconstruction are appropriately counseled as well as psychologically screened and supported.

Table 1. Demographics, number of revisions, length of stay, readmission rate, and complications compared between patients with and without anxiety and/or depression. * $p=0.025$, ** $p<0.001$

	Anxiety	Depression	Anxiety and Depression	Anxiety or Depression	No Psychiatric Diagnosis
Total patients	91	79	44	126	149
Age (SD)	49.98 (7.85)	50.31 (7.73)	49.38 (8.09)	50.39 (7.68)	49.91 (8.30)
BMI (SD)	29.12 (4.17)	29.85 (4.28)	29.03 (4.19)	29.60 (4.24)	28.86 (5.02)
Diabetes	10	12	5	17	12
HTN	24	27	12	39	49
SSI	8	5	3	10	9
UTI	3	1	1	3	11
Flap Loss	3	2	1	4	5
Revisions (SD)	1.63 (0.96)**				
	1.29 (0.88)	1.43 (0.87)	1.49 (0.96)*	1.24 (0.86)*	
LoS (SD)	4.77 (1.44)	4.61 (1.59)	4.61 (1.06)	4.72 (1.64)	4.58 (1.24)
60-day Readmission (SD)	0.25 (0.59)	0.25 (0.59)	0.32 (0.67)	0.23 (0.55)	0.14 (0.37)

#7 In Vitro Comparison of Vashe[®], PhaseOne[®], and Mafenide[®] on Bacterial and Fungal Biofilms

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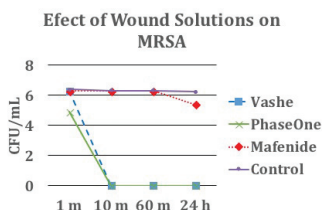
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BACKGROUND: Biofilms are a complex milieu of matrix-enclosed populations of microorganisms contributing to chronic wound states. In this study we compared the activity of three antimicrobial wound-care solutions (Vashe[®] (HOCL), PhaseOne[®] (HOCL), and Mafenide[®] (mafenide acetate) on in vitro bacterial and fungal biofilms.

METHODS: Laboratory and clinical isolates of 6 gram negative bacteria (36 strains), 3 gram positive bacteria (21 strains), and 9 candida species were used to create biofilms. A total of 66 biofilms were created and confirmed both microscopically and macroscopically. Working concentrations of the 3 antimicrobials were incubated with the biofilm plates and monitored at 1, 10 and 60-minute intervals to compare bacterial and fungal viability with the colony forming unit (CFU) assay.

RESULTS: Vashe and PhaseOne displayed excellent bactericidal and fungicidal activity whereas Mafenide demonstrated minimal activity against the biofilms tested. With the exception of *C. albicans*, all biofilms were eliminated at either 1 or 10 minutes using Vashe and PhaseOne solutions. In most cases, Mafenide was unable to eliminate both bacterial and fungal species, even with 24 hours of treatment as demonstrated in Figure 1 below in methicillin resistant *Staphylococcus aureus* (MRSA) biofilm.

CONCLUSIONS: Biofilms represent an unsolved problem with no clear consensus on the treatment in chronic wounds or prosthetic devices. Our results suggest that hypochlorite-based wound solutions are more efficacious than Mafenide in eliminating bacterial and fungal biofilms. Further studies are necessary to investigate the in vivo efficacy of hypochlorite-based antimicrobial solutions on biofilms.



#8 Trigger Finger Corticosteroid Injection with and without Local Anesthetic; A Double-blind, Randomized Controlled Trial

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PURPOSE: First line treatment for trigger finger is a corticosteroid injection. Although the injectable is often prepared with a local anesthetic, we hypothesize that patients receiving an injection without local anesthesia will experience no difference in pain.

METHODS: Patients with trigger finger were prospectively randomized into two cohorts to receive triamcinolone (1mL, 40mg) plus 1% lidocaine (1mL) or triamcinolone (1mL, 40mg) plus normal saline (1mL). Both patient and surgeon were blinded to treatment arm. Pain was measured using a visual analog scale (VAS) immediately following the injection, then 6, 24, and 72 hours post-injection. Failure of treatment was defined by the need for a repeat injection at six weeks.

RESULTS: Forty-one patients were enrolled with a total of 54 trigger fingers (26 lidocaine injections and 28 normal saline injections). Immediate post-injection pain scores were significantly higher for injections containing lidocaine versus normal saline (VAS 2.96 vs 1.82, $p = 0.03$), but there was no significant difference in pain scores at 6 hours (1.61 vs 1.59, $p = 0.97$), 24 hours (0.45 vs 0.47, $p = 0.67$), and 72 hours (0.79 vs 0.63, $p = 0.73$). Additionally, there was no difference in need for repeat injection (33% vs 20%, $p = 0.45$) or adverse outcomes at six weeks.

CONCLUSIONS: For corticosteroid treatment of trigger finger, there is no difference in immediate or acute pain reported by patients receiving an injection with or without lidocaine. We recommend administering the injectable solution without an anesthetic, thereby minimizing the cost and risk associated with an additional medication.

#9 Comparison of Complications Following Implant-based Breast Reconstruction Using Triple Antibiotic Solution versus Low Concentration Chlorohexidine Gluconate Solution

Alexandra Hart, MD; Tyler Merceron, MD; Udayan S. Betarbet, BS; Albert Losken, MD

PURPOSE: Infection and capsular contracture prevention remain a primary goal of implant-based breast reconstruction (IBBR). Previous reports have shown improved outcomes using triple antibiotic solution (TS), but ready-to-use products have gained popularity. The purpose of this analysis is compare outcomes following IBBR between TBS and low concentration chlorohexidine gluconate (LCCG) solution.

METHODS: This is an analysis of IBBR patients (2010-2016) from a single center from a prospectively maintained database. The TS group's (n=99) implant pocket was irrigated with 1 g/cefazolin, 80mg/ gentamicin, 50,000IU/bacitracin in 500mL of normal saline and the LCCG group's (n=144) with Irrisept® (Irrimax Corp., Lawrenceville GA, USA). Comparisons were made between demographic and clinical variables. Complications were recorded and compared. Multivariate regression analysis was performed.

RESULTS: The TS group had significantly more skin-sparing mastectomy's, adjuvant radiotherapy, preoperative chemotherapy, and less direct to implant reconstructions. Follow up time was similar between groups (TS: 13.6mo. vs. LCCG: 13.0mo). On univariate analysis, TS had significantly higher incidence of infections. This remained true on binomial logistic regression models controlling for group differences which showed that the odds of infection were 4.7 times lower with the use of LCCG. There was not a significant change in the odds of any of the other complications.

	P-Value	Odds Ratio	95% Confidence Interval	
			Lower	Upper
Any Complication	0.910	1.05	0.474	2.314
Major	0.575	1.31	0.509	3.371
Minor	0.873	0.91	0.265	3.093
Infection	0.026	4.77	0.054	0.828
Implant Failure	0.137	5.03	0.598	42.31
Capsular Contracture	0.805	1.27	0.189	8.591

CONCLUSION: The use of LCCG may reduce the incidence of postoperative infections in immediate BR but does not change the overall risk of implant failure.

#10 Preoperative Hypoglycemia Increases Infection Risk Following Trigger Finger Injection and Release

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BACKGROUND: Diabetes mellitus is a well-known risk factor for infection following trigger finger (TF) injection and/or release. However, the effect of preoperative hypoglycemia prior to TF injection or release is currently unknown. The purpose of this study is to determine the effects of pre-operative hypoglycemia on infection incidence following TF injection or release.

METHODOLOGY: A retrospective cohort review between 2007 and 2015 was conducted using a national private payer database within the PearlDiver Supercomputer. Preoperative, fasting, glucose levels were collected for each patient and these ranged from 20 mg/dL to 219 mg/dL. Surgical site infection (SSI) rates were determined using ICD-9 codes.

RESULTS: The query of the PearlDiver database returned 153,479 TF injections, of which 3,479 (2.27%) and 6,276 (4.09%) had infections within 90-day and one-year post-procedure, respectively. There were 70,290 TF releases identified, with 1,887 (2.68%) SSI captured within three months after surgery and 3,144 (4.47%) within one-year post-surgery. There was a statistically significant increase in SSI rates in patients with hypoglycemia within 90-days ($p=0.006$) and one-year ($p<0.001$) time intervals post-TF injection. Likewise, a statistically significant increase in SSI rate in patients with hypoglycemia undergoing TF release within one-year post-release was seen, $p=0.003$.

CONCLUSIONS: Hypoglycemia prior to TF injection or release increases the risk for SSI. Tight glycemic control may be warranted to mitigate this risk. Further studies are needed to investigate the effect of hypoglycemia as an independent risk factor for SSI.

#11 Success of Complicated Midline Sternotomy Closure Utilizing Minimal Dissection

Abdelaziz Atwez, Harold Friedman, Jarom Gilstrap, Mirsad Mujadzic, Elliott Chen

BACKGROUND: Median sternotomy wound breakdown after cardiac surgery has a reported incidence of 0.3-5%. Devascularization of the sternum by utilization of the internal mammary artery partially explains this phenomenon along with a high rate of comorbidities in this patient population. Ideal operative treatment should minimize surgical dissection while eliminating sternectomy dead space in these already compromised patients. We present a technique for sternal wound closure that minimizes the dissection while optimizing results.

METHODS: 29 consecutive patients with midline breakdown after CABG and/or valve replacement underwent bilateral pectoralis major myocutaneous advancement flap from 2009-2017. A limited dissection technique was used to harvest both pectoralis major myocutaneous flaps by undermining to the level of the pectoralis minor without the need for extensive lateral dissection or division of humeral insertion.

RESULTS: Of the 29 patients there were eight complications, five of them including three hematomas, and two seromas did not require more than drainage and usual wound care. The other three were wound complications from continued osteomyelitis. Only these three required debridement for source control. Two of these three were treated by re-closure and only one required omental flap closure.

CONCLUSION: The vast majority of patients presenting with wound dehiscence after sternotomy for cardiac disease can be managed safely with minimal pectoralis muscle advancement over the sternal bone and without division of the humeral insertion. Strategies to minimize complications include post-operative continuous wall suction to obliterate sternectomy dead space and a thorough debridement to remove sources of osteomyelitis.

#12 Pre-pectoral Wise Pattern Staged Implant-Based Breast Reconstruction for Obese or Ptotic Patients

Alessandrina M. Freitas, MD, MPH; Chris A. Campbell, MD

BACKGROUND: Autologous breast reconstruction can be arduous in the obese while large or ptotic breasts create difficulties with skin envelope tailoring for implant reconstruction. An incision on the breast mound apex can blunt the contour. Conversely, a Wise pattern closure can increase projection.

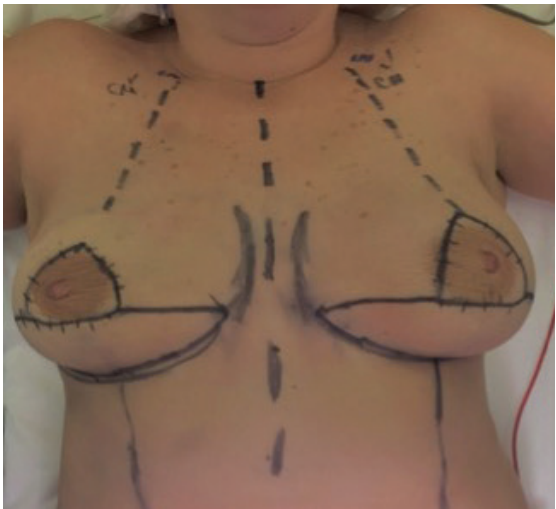
METHODS: A retrospective review identified overweight and/or ptotic patients who underwent immediate staged pre-pectoral implant reconstruction. Demographics, risk factors, and relevant outcome measures were reported.

TECHNIQUE: The inferior flap was de-epithelialized. Meshed ADM was secured to the medial, superior, and lateral aspects of the breast pocket. The pre-pectoral expander was placed and the ADM was sutured to the de-epithelialized flap. Wise pattern closure was completed by inseting the superior flap over the inferior.

RESULTS: Twenty-one reconstructions were performed in eleven patients. Mean follow-up was 364 days. Mean BMI was 35.2. There was one smoker and two diabetics. Three breasts received radiation with tissue expander in situ. We observed no implant exposures. Six breasts exhibited delayed healing. One infection was treated with oral antibiotics/drainage and one infection required IV antibiotics. All patients who completed expansion reported aesthetic satisfaction. Seven patients have completed reconstruction with exchange to final silicone implants and all report excellent satisfaction.

CONCLUSIONS: Delayed wound healing can be managed due to the de-epithelialized inferior skin flap buttressing the wise pattern closure. All patients who reached final expansion were pleased with their aesthetic outcome. All patients who have final implant(s) are satisfied with their reconstructive result, noting the natural contour of the wise pattern closure.

Picture 1. Design/Marking



Picture 2. Left—Preoperative; Right—Postoperative with final implants



#5 Oil and Water: A Randomized, Blinded, Placebo-Controlled Study of Autologous Fat Grafting for Scar Prevention and Remodeling

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BACKGROUND: It is widely accepted that autologous fat transfer (AFT) is able to alter the appearance and quality of overlying skin and scar tissue. However, the majority of supporting literature is either retrospective or anecdotal; and, those studies that do provide objective and quantitative analyses are limited in scope by their measurement methods and statistics. We performed a multi-center, double-blinded, randomized placebo controlled trial to subjectively and objectively evaluate the effect of AFT on overlying scar tissue.

METHODS: Subjects with cutaneous scars were enrolled in the study, with one site randomized to treatment with experimental therapy (AFT) and one site to treatment with saline (control). Outcome metrics were measured at baseline (pre-treatment), 6 months, and 12 months post-treatment. Scars were evaluated using: subjective scar quality assessment (POSAS), hardness (durometer), elasticity (cutometer), color/pigment (colorimeter) and histological analysis. Graft samples were analyzed for cellular quality. Statistics were completed using SPSS.

RESULTS: Although AFT demonstrated a few statistically significant benefits in treated scars over time, these changes were not significantly different than scars treated with saline.

CONCLUSION: Although many in our specialty endorse and promote the therapeutic effects of fat grafting, our placebo controlled study results suggest that any putative improvements in scar quality related to fat grafting are also achieved using saline. We will discuss limitations of our study as well as potential mechanisms that may explain our findings. Further objective, randomized trials including a control treatment group are required to confirm the therapeutic effects of autologous fat grafting for scar remodeling.

*Funded by AFIRM/U.S. Army Medical Research and Materiel Command (USAMRMC).

#6 An Algorithm for Selecting Combined Hyaluronic Acid Agents of Different Physical Properties in Facial Rejuvenation

Gabriele Miotto

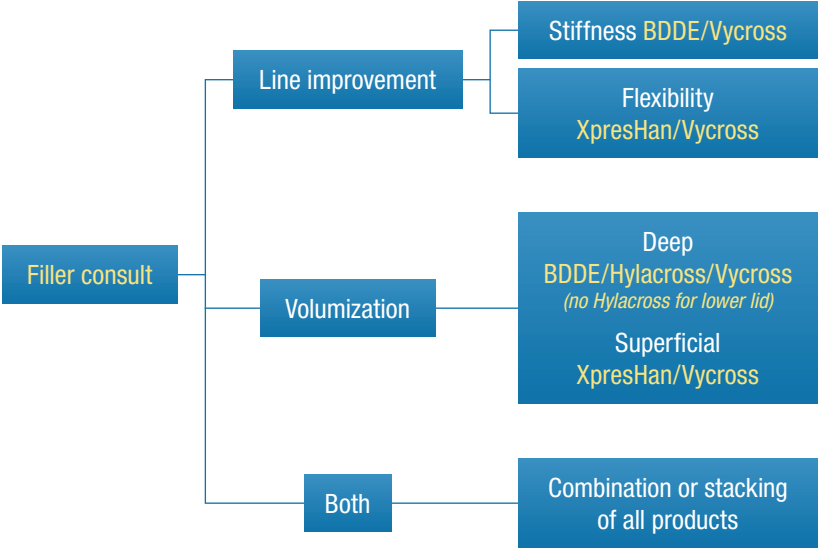
BACKGROUND: The advancement of hyaluronic acid (HA) technologies has resulted in products of varying stiffness, elasticity, and durability. Combining products with different physical characteristics has the potential to maximize the clinical effectiveness of filler treatments.

MATERIALS and Methods: Over a one-year period, an algorithmic approach to facial rejuvenation treatments with filler placement was applied in 100 consecutive patients. The injections were performed in an office setting using a combination of specific fillers injected with needles and blunt cannulas under topical and/or local anesthesia to improve facial aging. Four different crosslinking technologies were used: BDDE, Vycross, Hylacross and XpresHan.

RESULTS: Ninety six percent of patients were females. Forty four percent of patients had a combination of at least two different specific fillers for line improvement and/or facial volumization and forty one percent of the patients received 3 or more syringes of fillers per treatment. There were no cases of intravascular injection, infection or need for filler reversion. There were two cases of persistent swelling in the lower eyelid. Combination therapy allowed target-specific improvement in areas such as the tear trough/lid-cheek interface, nasolabial fold, malar area, temporal recess, upper eyelid, and in the lower face/perioral areas. Specific patient analysis, treatment planning, results, and complications are discussed.

CONCLUSIONS: Combination therapy with HA products of different technologies is safe and effective non-invasive option for global facial rejuvenation. An algorithmic approach to filler selection can help facilitate decision making for different clinical findings with consistent results, having the potential to drive practice growth.

Figure 1. Filler selection algorithm for the filler consultation and treatment.



Case 1. Pre and post procedure pictures of a 35-year old female with midface deficiency, negative lower lid vector and tear trough deformity. She was treated with stacking technique of 2cc of Restylane-L and 1cc of Restylane Silk (BDDE technology) distributed into to midface, malar areas and tear troughs.



Case 2: Pre and post procedure pictures of a 59-year old female with midface and malar deflation, Deep nasolabial folds (NLFs), marionette lines and jowls. She was treated with stacking technique of 1cc of Juvederm Voluma (Vycross) to deep prejowl sulci and 0.6cc of Restylane Defyne (XpresHan) to superficial prejowl sulci and marionette lines and chin, 0.4cc of Restylane Defyne to deep NLFs and 0.6cc of Restylane Refyne (XpresHan) to superficial NLFs and 0.4cc of Restylane Refyne into upper eyelids.



#7 Developing a Lymphatic Surgery Program: A First Year Review

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BACKGROUND: Lymphedema is a chronic condition which carries a significant physical, psychosocial, and economic burden. Our program was established in 2017 with the aims of preventing lymphedema in high-risk patients and optimizing treatment for patients with chronic lymphedema. The purpose of this study is to describe our clinical experience in the first year.

METHODS: A retrospective review of our clinical database was performed on all individuals presenting to our institution for lymphatic surgery consideration. Patient demographics, clinical characteristics, surgical management, and referrals were reviewed.

RESULTS: A total of 142 patients presented for lymphatic surgery evaluation. Patients had a mean BMI of 30.4 and median L-Dex of 32. The most common etiology of lymphedema was breast-cancer related (n=47). Chronic lymphedema patients were more likely to be referred from an outside facility compared to patients seeking preventative surgery ($p<0.001$). Most common complaints were: swelling (94%), tightness (81%), and heaviness (80%). Patients spent a median 56 hrs./week managing their disease. Symptom duration was greater for patients with non-cancer related lymphedema ($p<0.001$). Patients were more likely to receive preventative procedures compared to chronic ($p<0.001$). 28% of patients underwent a lymphatic procedure (32 preventative, 1 chronic LVB, 6 lymph node transplants, and 1 debulking).

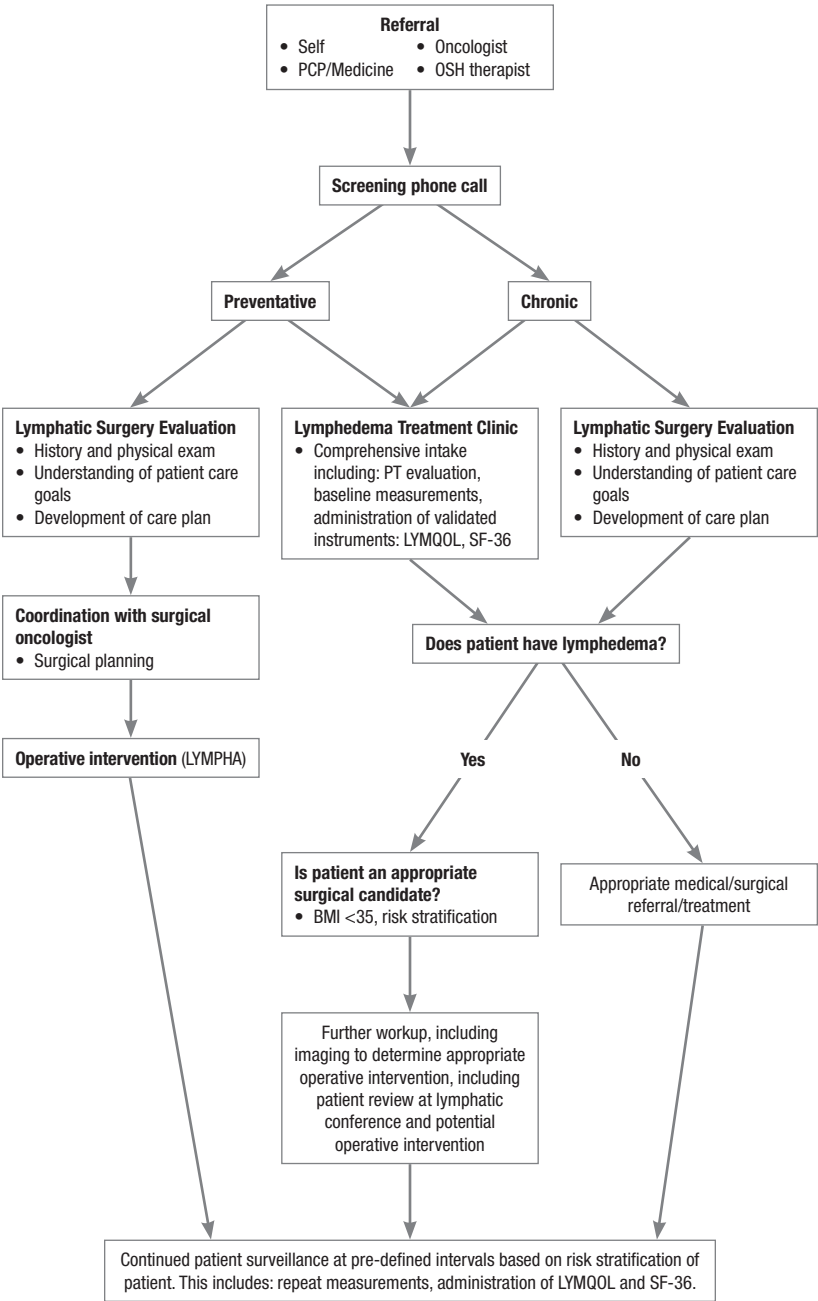
CONCLUSION: First year review of our lymphatic surgery experience has demonstrated clinical need evidenced by the number of patients and high percentage of outside referrals. As a program develops, lymphatic surgeons should expect to perform more time-sensitive preventative procedures, as evaluation of chronic lymphedema requires a more robust workup and review.

Table 1: Demographics at Initial Evaluation

**one patient did not report their ethnicity*

	Overall	Breast Cancer		Cancer, Non-Breast		Non-Cancer
		Preventative	Chronic	Preventative	Chronic	
	n = 142	n = 38	n = 47	n = 2	n = 22	n = 33
Age, mean (sd)	54.8 (13.6)	50.7 (12.2)	60.8 (10.7)	67.3 (22.1)	58.7 (13.6)	47.7 (13.8)
BMI, mean (sd)	30.4 (7.3)	27.9 (6.9)	31.5 (6.7)	26.1 (6.8)	29.1 (7.6)	32.9 (7.8)
Sex, n (%)						
Female	127 (89.4)	38 (100)	47 (100)	1 (50)	15 (68.2)	26 (78.8)
Male	15 (10.6)	0 (0)	0 (0)	1 (50)	7 (31.8)	7 (21.2)
Race, n (%)						
White	119 (83.8)	29 (76.3)	41 (87.2)	2 (100)	19 (86.4)	28 (84.8)
Black	10 (7.0)	6 (15.8)	2 (4.3)	0 (0)	0 (0)	2 (6.1)
Asian	6 (4.2)	3 (7.9)	3 (6.4)	0 (0)	0 (0)	0 (0)
Other	3 (2.1)	0 (0)	1 (2.1)	0 (0)	1 (4.5)	1 (3.0)
Unknown	4 (2.8)	0 (0)	0 (0)	0 (0)	2 (9.1)	2 (6.1.)
Ethnicity, n (%)*						
Hispanic	2 (1.4)	0 (0)	1 (2.1)	0 (0)	0 (0)	1 (3.0)
Non-Hispanic	139 (98.6)	38 (100)	45 (95.7)	2 (100)	22 (100)	32 (97.0)
Referred from an outside facility, n (%)	60 (42.3)	8 (21.1)	24 (51.1)	0 (0)	12 (54.5)	16 (48.5)
Distance traveled to clinic, miles, median (min-max)	29.9 (1–1150)	95 (1–1150)	58 (6–712)	28 (18–38)	32 (2–88)	26 (2–99)

Figure 1: Current Patient Flow at Our Institutional Lymphatic Center



#8 Comparison of Telfa Rolling and Revolve™ System Autologous Fat Processing Techniques in Postmastectomy Breast Reconstruction

Al C. Valmadrid, BS; Christodoulos Kaoutzanis, MD; Blair A. Wormer, MD; Angel Farinas Chopite, MD; Salam Al Kassis, MD; Galen Perdikis, MD; Stephane A. Braun, MD; Kent K. Higdon, MD

PURPOSE: The purpose of this study was to compare the different autologous fat grafting (AFG) techniques Telfa Rolling (TR) and REVOLVE™ System (RS) in patients undergoing postmastectomy breast reconstruction.

METHODS: Consecutive post-mastectomy breast reconstruction patients who underwent AFG were retrospectively reviewed and grouped by processing technique (TR or RS). Patients with less than 180 days of follow-up were excluded. Demographics, operative details, and postoperative complications were compared between the techniques using univariate analysis with significance set at $p<0.05$.

RESULTS: Between January 2013 and September 2017, 186 women (TR=76, RS=110) underwent a total of 319 breast reconstructions (TR=131, RS=188) with AFG following postmastectomy breast reconstruction. There was no difference in demographics, number of AFG procedures done, volume of fat grafted, and the number of days after reconstruction that AFG was performed between TR and RS. TR patients had longer operative times for second AFG procedures than RS patients (99.5 ± 32.0 mins vs. 83.7 ± 29.5 mins; $p=0.04$). Breasts reconstructed with TR had more palpable masses requiring imaging compared to RS (24.4% vs. 14.4%; $p=0.02$). Additionally, TR breasts had more fat necrosis than RS breasts (22.1% vs. 9.6%; $p<0.01$). There was no difference in surgical excision of fat necrosis, cancer recurrence, or days after first AFG that cancer recurred between the two groups.

CONCLUSIONS: In this analysis of different AFG processing techniques in postmastectomy breast reconstruction, RS is associated with a decreased incidence of fat necrosis and need for subsequent imaging compared to TR, without an increase in other complications or cancer recurrence.

#9 Midface Lift and Lateral Cantopexy in the Treatment of Scleral Show and Ectropion

Chiara Botti, MD; Giovanni Botti, MD

The presentation illustrates how subperiosteal midface lift coupled with lateral cantopexy can be a useful tool in the correction of iatrogenic lower eyelid deformities. This technique allows to recruit tissue from the midface area to be brought into the lower eyelid, where the anterior lamella is deficient, while re-establishing a good stability of the eyelid suspension system.

#10 A Clinical Comparison of Irrisept®, Triple Antibiotic, and Combination Breast Pocket Irrigation

Daniel F. Haynes, MD

BACKGROUND: Infection around breast implants and expanders can result in additional surgeries, delays in reconstruction, and is implicated in the long-term development of capsular contracture. Multiple irrigation regimens have been used, including triple antibiotic and povidone-iodine, with the recent addition of dilute chlorhexidine (Irrisept®) as a pre-mixed, FDA approved surgical irrigant. (Preliminary data from this study was presented at the SESPRS annual meeting in 2015. The data now include similar subject numbers in all three arms, and are statistically significant.)

PATIENTS and Methods: A retrospective, IRB approved review was performed of breast reconstruction surgeries (CPT codes 11970, 19340, 19342, 19357) performed by a single surgeon over a 5 year period, encompassing 522 patients and 899 breasts. Breast pockets were irrigated with triple antibiotic alone, Irrisept® alone, or a combination of the two, in three sequential time periods.

RESULTS: Three hundred and seventy-five expanders were placed, and 524 permanent implants. Chlorhexidine and triple antibiotic irrigation had similar rates of infection, but chlorhexidine showed less implant loss (Table 1). A combination of chlorhexidine and triple antibiotic had the lowest rate of infection, and only one implant loss, a statistically significant difference compared to triple antibiotic alone ($p=0.0053$).

CONCLUSIONS: Chlorhexidine is superior to triple antibiotic in preventing implant loss. The combination of chlorhexidine and triple antibiotic provides the best protection against both infection and implant loss, when compared to either regimen alone.

Table 1.

Triple Antibiotic Irrigation	# patients	# breasts	# infections	implant loss
	179	292	17	10
			5.8%	3.4%
Irrisept®	# patients	# breasts	# infections	implant loss
	173	306	18	5
			5.9%	1.6%
Triple Antibiotic + Irrisept	# patients	# breasts	# infections	implant loss
	170	301	9	1
			3.0%	0.3%

#11 Social Media Preferences in Plastic Surgery: A Conjoint Analysis

Apoorve Nayyar, MBBS¹; Stephen Tyler Elkins-Williams, MD²;
Kristalyn K. Gallagher, DO, FACOS^{1,3}; C. Scott Hultman, MD; MBA²; Cindy Wu, MD²

¹ Lineberger Comprehensive Cancer Center, University of North Carolina at Chapel Hill

² Plastic and Reconstructive Surgery, University of North Carolina at Chapel Hill

³ Department of Surgery, University of North Carolina at Chapel Hill

BACKGROUND: Social media has become an indispensable tool for patients to learn about aesthetic surgery. Currently, minimal information exists about patients' preferred social media platform when researching for an aesthetic surgeon.

METHODS: We utilized a choice-based conjoint analysis survey to analyze the preferences of patients seeking three common aesthetic procedures—breast augmentation (BA), facial rejuvenation (FR) and breast/abdominal surgery (BAB). Participants were asked to choose among social media platforms (Facebook, Twitter, Instagram, Snapchat, Pinterest, Tumblr, YouTube), information extent (basic, moderate, comprehensive), delivery mechanism (pre-recorded video, live-video, photographs, text description), messenger (surgeon, nurse/clinic staff, patient) and option for interactivity (Yes/No). The survey was administered using an Internet crowdsourcing service (Amazon Mechanical Turk®).

RESULTS: A total of 564 participants were recruited: 168 in BA, 247 in FR and 149 in BAB. Amongst the attributes surveyed, participants in all three groups (BA, FR, BAB) valued social media platform as the most important (30.9%, 33.3%, 31.6%), followed by information extent (23%, 22.6%, 21.3%), delivery mechanism (19%, 17.5%, 18.8%), messenger (16.2%, 16.9%, 17%) and interactivity (10.9%, 9.7%, 11.2%). Within these attributes, Facebook ranked as the preferred platform, comprehensive information extent, live-video as the delivery mechanism and surgeon as the messenger.

CONCLUSION: The choice of social media platform is the most important factor for patients, with a preference for comprehensive information delivered by the surgeon via live-video on Facebook. Our study elucidates social media usage in common aesthetic populations, which can help improve aesthetic patient outreach.

#12 Regional Anesthetic Blocks for Plastic Surgery: You Can Do This!

John T. Lindsey, MD, FACS

BACKGROUND: Attention is increasingly focused on patient comfort, decreased opioid usage, and ERAS protocols. Regional anesthetic blocks for plastic surgery procedures accomplish these goals but do require new skills and knowledge of new technologies.

METHODS: PEC1 + Serratus Anterior Plane (SAP) Blocks: 33 patients undergoing cosmetic breast augmentation or implant-based reconstruction received ultrasound-guided PEC1 + SAP blocks after induction of anesthesia but before the prep and drape over the past 10 months by the operating surgeon with liposomal bupivacaine. (Fig. 1 and 2)

Transversus Abdominis Plane (TAP) Blocks: 50 patients undergoing abdominoplasty or DIEP flap reconstruction received intraoperative ultrasound-guided TAP blocks over the past 20 months by the operating surgeon with liposomal bupivacaine. (Fig. 3)

RESULTS: Anatomic planes, which are the target of regional anesthetic techniques, were clearly visualized with this high-resolution, latest-technology, highly-portable ultrasound device. Successfully targeted planes were between the pectoralis major and minor muscles, beneath the serratus anterior muscle, and between the internal oblique and transversalis muscles. Patients experienced good to excellent analgesia with less reliance on opioid medications and decreased need for refills. For hospitalized patients, length of stay in some cases was decreased up to 1 day, and PCA pumps were eliminated. There were no complications or adverse sequelae observed in any of these patients related to the regional blocks.

CONCLUSIONS: Incorporation of regional anesthetic techniques in this single surgeon experience confirm reports of effectiveness in the anesthesia literature and may be of benefit to plastic surgery patients.

Figure 1. Ultrasound image of the upper anterior chest wall. PEC1 block showing the targeted plane between the pectoralis major and minor muscles. Arrow marks the tip of the needle in the correct plane.



Figure 2. Ultrasound image of the lateral chest wall. Targeted SAP plane marked by the arrow superficial to the rib and deep to the serratus anterior muscle.

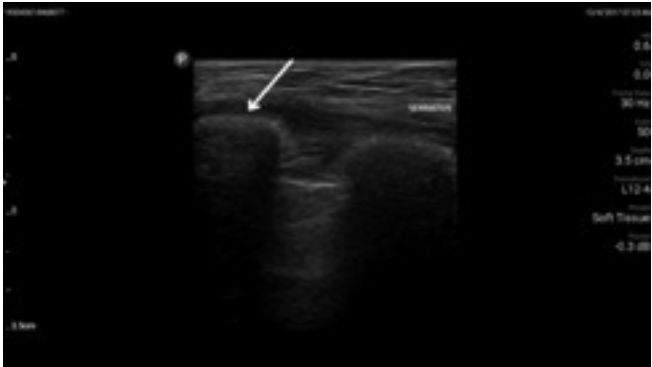
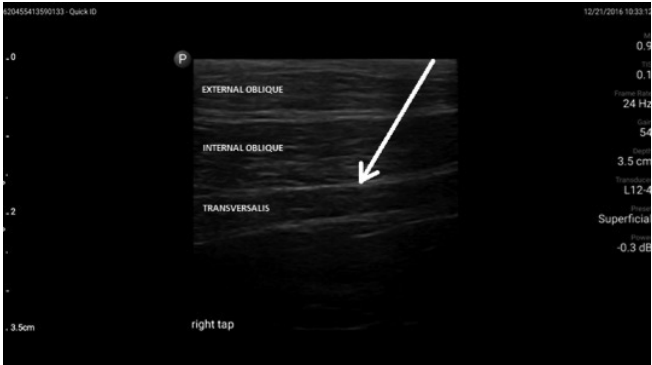


Figure 3. Ultrasound image of the three abdominal wall layers. Arrow indicates targeted TAP plane.



#13 Meltblown Poly-Lactic Acid Nano-Webs as a Tissue Engineering Scaffold

William H. Gazzola, DO, MSE^{1,2}; Roberto S. Benson, PhD³; Wayne Carver, PhD¹

¹ University of South Carolina School of Medicine

² Palmetto Health Richland

³ The University of Tennessee, Knoxville

ABSTRACT: Polylactic acid (PLA) nanofiber non-wovens have recently come under more vigorous investigation for their use as tissue engineering scaffolds due to its ability to mimic the physical properties of naturally occurring human extracellular matrix in a variety of host tissues. Currently, the majority of available research on PLA nano-webs has focused on their creation through electrospinning. The goal of this study was to evaluate meltblown non-woven webs made of nano-diameter PLA fibers for their application as a tissue engineering scaffold. Meltblown PLA fabrics were produced with a variety of different crystallinities, tensile moduli, and pore diameters. One fabric with mechanical properties similar to human dermis was selected as a scaffold to study attachment, proliferation and migration of human dermal fibroblasts over 1, 3, 7 and 14 days without the use of additional cell adhesion molecules. MTT assay showed good proliferation from day 1 to 3 ($p=0.026$) and up to 7 days of culture ($p=.005$), but without increase from day 7 to 14. Electron microscopy demonstrated adequate cellular attachment and surface migration at 1, 3, 7 and 14 days. Finally confocal microscopy was used to investigate cellular penetration into the scaffolds. The investigation found that cells were able to penetrate fully through the thickness of the scaffold. The successes of this initial experiment are promising, and confirm that meltblown nano-fiber non-woven are a viable avenue for tissue engineering scaffolds. Hopefully these conclusions will open the door for others to pursue research in this exciting field.

Figure 1. MTT assay results from cellular cultures at days 1, 3, 7 and 14

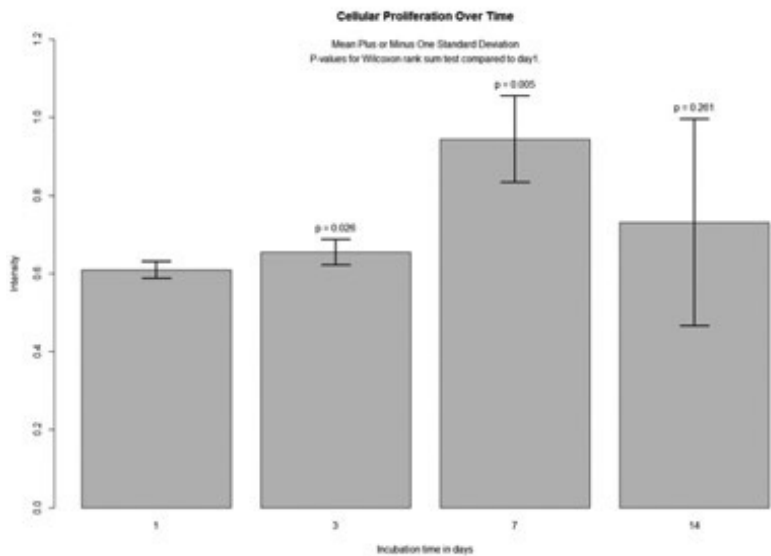


Figure 2. Scanning electron microscopy of cellular migration across the surface of the scaffolds. Notice the preferential migration on the longitudinal axis of the fibers, with cellular confluence taking place between 7 and 14 days. (A) 24h, (B) 3 days, (C) 7 days, (D) 14 days

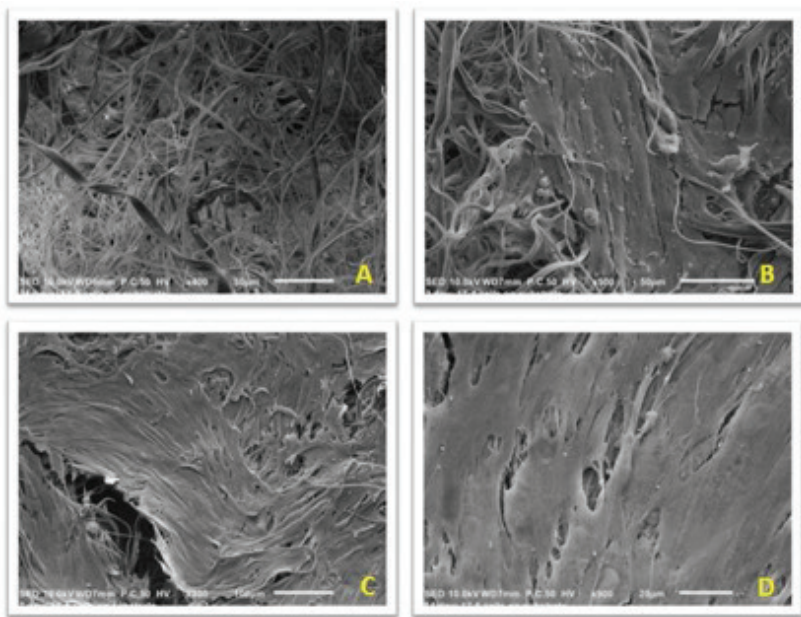


Figure 3. Scanning electron microscopy of fibrous ECM seen between cells at 14 days of culture

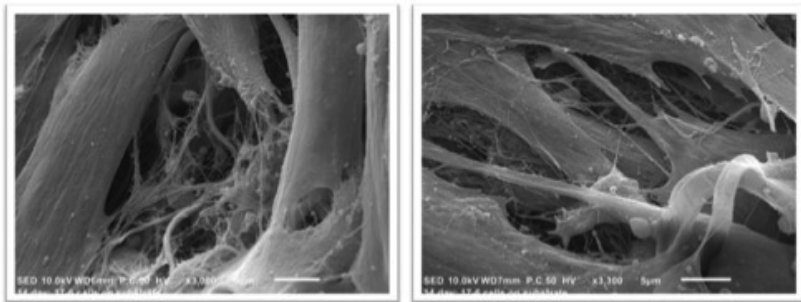


Figure 4. Scanning electron microscopy of single cell attachment to nano-fibers

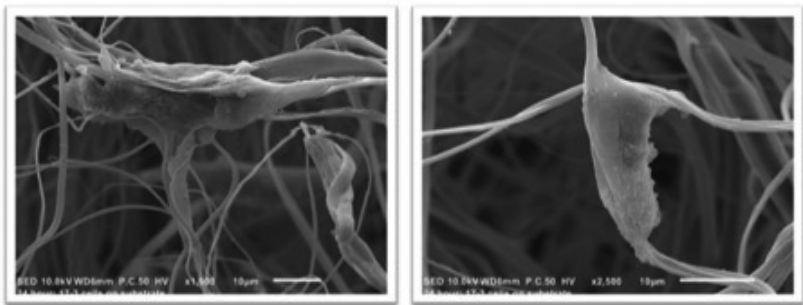
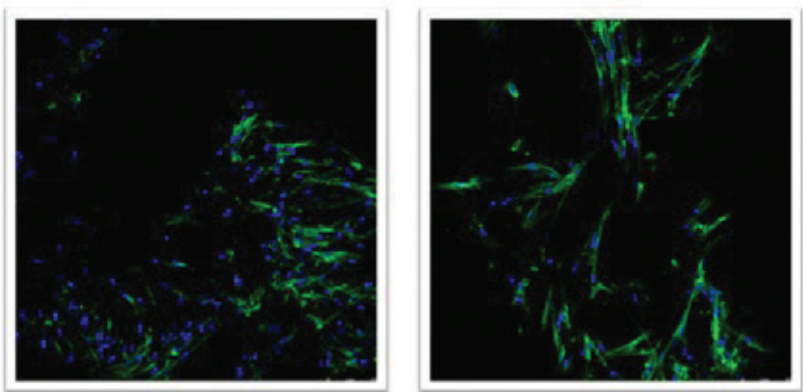


Figure 5. Cellular penetration at 14 days into the center of the scaffold



POSTERS FOR PRESENTATION

- #1 “The Hidden Cost of Post-Operative Complications Associated with the Use of Ready-to-Use Human Acellular Dermal Matrices”**
Craig M. Forleiter, MD; Jonathan Cook, MD; Jonathan R. Sarik, MD;
Martin I. Newman, MD, FACS
- #2 “Breast Upper Pole Autologous Augmentation with Poly-4-hydroxybutyrate (P4HB) Mesh Fixation”**
Yoav Barnavon, MD; Craig M. Forleiter, MD
- #3 “The Effect of Smoking in the Cosmetic Surgery Population: Analysis of 129,007 Patients”**
Christodoulos Kaoutzanis, MD; Julian Winocour, MD; Varun Gupta, MBBS, MPH;
Max Yeslev, MD, PhD; Nishant Ganesh Kumar, MD; Blair Wormer, MD;
James C. Grotting, MD, FACS; Kye Higdon, MD, FACS
- #4 “Feasibility of Sensate Profunda Artery Perforator Flaps”**
Bin Song, MD; Katherine Chiasson, MD; Jobe Fix, MD; Jorge de la Torre, MD
- #5 “A Novel Free Flap for Breast Reconstruction: the Posterior Intercostal Artery Perforator (PICAP) Flap”**
Katherine Chiasson, MD; Robert J. Allen, MD
- #6 “The Use of a Novel Local Flap Trainer in Plastic Surgery Education”**
Amy Kite, MD; Morgan Yacoe; Jennifer Rhodes, MD
- #7 “Analysis of Cranial Base Suture Fusion Patterns”**
Jose J. Rodriguez, MD; Caroline Reist, BS; James T. Thompson, MD
- #8 “A Classification System and Treatment Algorithm for Mastectomy Flap Ischemia”**
Stephanie Koonce, MD; Martin Newman, MD
- #9 “Development of a Novel Suture-less Nerve Coaptation Device”**
Angel F. Farinas, MD; Kevin Saladino; Alonda C. Pollins, MLI;
Nancy L. Cardwell, BS; Wesley P. Thayer MD, PhD

POSTERS FOR PRESENTATION

- #10 “Multi-stage Fat Grafting for Total Breast Reconstruction After Mastectomy”**
Jonathan S. Lam, MD; David S. Nguyen, BS; Charles Patterson, MD;
Jules Walters, MD; Kamran Khoobehi, MD
- #11 “Ocular Trauma; A Review of the Association Between Facial Fractures and Traumatic Mechanism”**
Riley A. Schlub, MD; Elliott H. Chen, MD
- #12 “Optimizing Cost and Time Efficiency in Intermaxillary Fixation”**
Riley A. Schlub, MD; Elliott H. Chen, MD
- #13 “A Novel Procedure for Chronic Sagittal Band Rupture, Permitting Immediate Active Motion and Hand Use During Recovery”**
Lauren Nigro, MD; Andrea Pozez, MD; Wyndell Merritt, MD
- #14 “Oncoplastic Breast Reduction: A Case Series Showcasing a Novel Technique for Immediate Areolar Reconstruction”**
Patrick J. Buchanan, MD; Mark M. Leyngold, MD
- #15 “Pre-pectoral Breast Reconstruction with Circumferential Acellular Dermal Matrix Wrap and Double Port Expander after Nipple Sparing Mastectomy”**
Mateo de Acosta Andino David, Thorburn Ashley, Makwana Shreyas,
Gatlin Lawson, Cohn Alvin B
- #16 “Quantifying Burn Injury-Related Disability and Quality of Life in the Developing World: A Primer for Patient-Centered Resource Allocation”**
Heather A. McMahon, MD; Alessandrina M. Freitas, MD; Idorenyin Ndem, BA;
Thomas J. Gampper, MD; Brent R. DeGeorge Jr., MD, PhD
- #17 “Temporal Trends in Immediate Post-Mastectomy Breast Reconstruction”**
Karishma G. Reddy, MD; Apoorve Nayyar, MBBS; Paula D. Strassle, MSPH;
Michelle C. Roughton, MD; Kristalyn K. Gallagher, DO, FACOS;
Kandace P. McGuire, MD, FACS

POSTERS FOR PRESENTATION

#18 “The Regular Use of Stacked Perforator Flap Techniques in Breast Reconstruction”

Charles Patterson, MD; Radbeh Torabi, MD; Mark Stalder, MD; Oren Tessler, MD; Stephen Delatte, MD; Robert Allen, MD; Hugo St. Hilaire, DDS, MD

#19 “Designer Microsurgery: An Evolution of Perforator Flap Breast Reconstruction”

Charles Patterson, MD; Mark Stalder, MD; Radbeh Torabi, MD; Oren Tessler, MD; Stephen Delatte, MD; Robert Allen, MD; Hugo St. Hilaire, DDS, MD

#20 “Patient Demographics and Factors Influencing Cosmetic Procedures at an Academic Medical Center”

J. Simon Ivey, MD; Anna Skochdopole, BS; Rupak D. Mukherjee, PhD; Fernando Herrera MD

#21 “Total Plantar Reconstruction in the Pediatric Population”

Thomas Gallagher, MD; Mark Feldmann, MD

#22 “Adipofascial Flap for Single-Stage Nasal Reconstruction”

Thomas Gallagher, MD; Anthony Capito, MD

#23 “Historical Roots of Modern Plastic Surgery: A Cited Reference Analysis Prior to 1960”

Mustafa Chopan, MD; Lohrasb Sayadi, MD; Patrick J. Buchanan, MD; Adam J. Katz, MD; Bruce A. Mast, MD

#24 “Modified Abdominal Wall Reconstruction in the Orthotopic Liver Transplantation Patient”

Jorge de la Torre, MD; Srikanth Kurapati, MD; Brad Denney, MD

#25 “Alar Base Reduction Using Cinch Suture and Nasal Sill Excision”

Gaurav Bharti, MD; Turkia Abbed, MD

#26 “‘Is it Time for FaceTime?’ Advances in Plastic Surgery Telehealth Policy”

Tony L. Weaver, DO; Ricky P. Clay, MD; Benjamin McIntyre, MD

POSTERS FOR PRESENTATION

#27 “Creativity of Healthcare Students and Providers: A Subjective and Objective Analysis”

Timothy Stoddard, Adam J. Katz

#28 “Phentermine: A Systematic Review for Plastic & Reconstructive Surgeons”

Frank Lau, MD; Soobin Lim, MD

#29 “Massive Localized lymphedema: Analysis of Intraoperative Care”

Evan Moore, MD; Henry Vasconez, MD; Lesley Wong, MD

#30 “A Simplified Procedure for the Correction of Vertical Orbital Dystopia”

Erin Wolfe, BS; S. Anthony Wolfe, MD; Nicole Cabbad, MD

#31 “Trading Pills for Needles: The Impact of House Bill 1 on Upper Extremity Soft Tissue Infections in IV Drug Users in Kentucky”

S. Covey; R. DeCoster; M. Shrout; J. Burns; D. Davenport; L. Wong; A. Duggal; H. Vasconez

#32 “The Use of Microporous Polysaccharide Hemospheres (Arista®) to Prevent Seroma Formation in Post-Mastectomy Prosthetic Breast Reconstruction”

Olga A. Schuth, MD; Amy C. Kite, MD; Nadia P. Blanchet, MD

#33 “Regional Variations in Use of Post-Mastectomy Breast Reconstruction for Breast Cancer Patients”

Apoorve Nayyar, MBBS; Paula D. Strassle, MSPH; Jonathan A. Black, MD; Karishma G. Reddy, MD; Francisco Schlottmann, MD; Michelle C. Roughton, MD; Kandace P. McGuire, MD, FACS; Kristalyn K. Gallagher, DO, FACOS

#34 “Internet Crowdsourcing: A Reliable Tool for Aesthetic Surgery Research?”

Apoorve Nayyar, MBBS; Jihane Jadi, BS; Stephen Tyler-Elkins, MD; Kristalyn K. Gallagher, DO; C. Scott Hultman, MD; Cindy Wu, MD

#35 “The Reversed Flow MS�D FLAP for Secondary Breast Reconstruction”

A. Sakharpe; J. Cook; M. Newman; Y. Barnavon

POSTERS FOR PRESENTATION

- #36 “Upper Extremity Soft Tissue Infections in IV Drug users: A Cost Analysis”**
Max Shrout; Ryan DeCoster; Sarah Covey; Jack Burns; Daniel Davenport;
Lesley Wong; Henry Vasconez; Senior Author Anil Duggal
- #37 “Female to Male Gender Confirming Drainless Mastectomy Is Safe in Obese Males”**
Eric Pittelkow, MD; Farrah Rhamani, BS; Steve Duquette, MD;
Corianne Rogers, MD; William Wooden, MD; Sidhbh Gallagher, MD
- #38 “Assessing the Impact of a TQIP Communications Package on Time-to-Operation for Facial Fractures”**
Patrick Keller; Steven Schneeberger; Brian Drolet; Salam Al Kassis;
F. Bennett Pearce; Galen Perdikis
- #39 “Hyperfibrinolysis and Inhalation Injury Predict Platelet Depletion in Burn Patients: A Prospective Study”**
Patrick R. Keller; Breanne H.Y. Gibson; Bryan Keller; Matthew T. Duvernay;
Emilie Amaro; Tanya Marvi; J. Blair Summitt; Jonathan G. Schoenecker
- #40 “The Effects of Obesity on Complication Rates after Breast Reduction”**
Kiandra B. Scott, MD; Milton B. Armstrong, MD

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 Owen, Dr. McCarthy 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 Stuckey, Dr. Grover Austin, Dr. Robert Hagerty, Dr. Robert Meade, Dr. Cliff Snyder, Dr. John Lewis, Dr. Charles Horton, Dr. Claude Coleman.



PAST PRESIDENTS AND LECTURERS

PAST PRESIDENTS

1958	Founding	1988	James H. Carraway
1959	Neal Owens	1989	John H. Hartley, Jr.
1960	Greer Ricketson*	1990	W. Michael Bryant
1961	Robert F. Hagerty*	1991	Allen H. Hughes
1962	Lorenzo H. Adams*	1992	Norman M. Cole
1963	Clifford C. Snyder*	1993	Edward A. Luce
1964	Samuel E. Upchurch*	1994	Benjamin H. Wofford
1965	McCarthy DeMere*	1995	William F. Mullis
1966	Charles Horton*	1996	Thomas W. Orcutt
1967	Francis Marzoni*	1997	J. Barry Bishop
1968	Andrew M. Moore*	1998	Kenna S. Given
1969	Carter P. Maguire*	1999	W. Howard Kisner
1970	James H. Hendrix*	2000	R. Cole Goodman
1971	John R. Lewis*	2001	L. Franklyn Elliott
1972	James G. Stuckey*	2002	Andrew M. Moore, II
1973	James B. Cox	2003	Ronald J. Johnson
1974	William M. Berkeley*	2004	William H. Wallace
1975	Henry T. Brobst*	2005	Michael E. Beasley
1976	John M. Hamilton*	2006	Anthony J. Pizzo
1977	Jerome E. Adamson	2007	R. Bruce Shack
1978	Byron E. Green	2008	Suman K. Das
1979	George W. Hoffman*	2009	James W. Wade
1980	William E. Hugher*	2010	James Moore
1981	Eugene F. Worthen	2011	James C. Grotting
1982	Joel W.L. Mattison*	2012	W. Byron Barber
1983	James H. Fleming*	2013	Ann Ford Reilley
1984	Robert C. Reeder*	2014	Harold I. Friedman
1985	Andrew W. Walker*	2015	Henry C. Vasconez
1986	John R. Reynolds	2016	Kevin F. Hagan
1987	John R. Royer	2017	Walter L. Erhardt, Jr.

*deceased

PAST UPCHURCH LECTURERS

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

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

PAST UPCHURCH LECTURERS

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

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

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, MD	2017

UPCOMING EVENTS

FUTURE ANNUAL SCIENTIFIC MEETINGS

June 8–12, 2019	The Ritz-Carlton, Naples, FL
June 7–11, 2020	The Sanctuary, Kiawah Island, SC
June 14–17, 2021	The Westin, Hilton Head, SC
June 12–15, 2022	The Four Seasons, Orlando, FL

FUTURE ATLANTA BREAST SURGERY SYMPOSIUM

January 18–20, 2019	Intercontinental Hotel, Atlanta, GA
January 24–26, 2020	Intercontinental Hotel, Atlanta, GA
January 22–24, 2021	Intercontinental Hotel, Atlanta, GA



PAST ANNUAL MEETINGS

60th Annual Scientific Meeting

June 11-15, 2017
The Cloister; Sea Island, GA

59th Annual Scientific Meeting

June 11-15, 2016
Disney Grand Floridian Resort and Spa; Lake Buena Vista, FL

58th Annual Scientific Meeting

June 6-10, 2015
Omni Amelia Island Plantation;
Amelia Island, FL

57th Annual Scientific Meeting

June 8-12, 2014
Atlantis Resort; Paradise Island,
Nassau, Bahamas

56th Annual Scientific Meeting

June 1-5, 2013
Hyatt Regency Coconut Point
Resort and Spa; Bonita Springs, FL

55th Annual Scientific Meeting

June 2-6, 2012
Ritz-Carlton; Amelia Island, FL

54th Annual Scientific Meeting

June 4-8, 2011
Naples Grand Beach & Resort;
Naples, FL

53rd Annual Scientific Meeting

June 12-16, 2010
The Breakers; Palm Beach, FL

52nd Annual Scientific Meeting

June 6-10, 2009
Wyndham Rio Mar Beach Resort &
Spa; Puerto Rico

51st Annual Scientific Meeting

June 7-11, 2008
Boca Raton Resort and Club;
Boca Raton, FL

50th Annual Scientific Meeting

June 9-13, 2007
Sandestin Golf and Beach Resort;
Destin, FL

49th Annual Scientific Meeting

2006
The Cloister; Sea Island, GA

48th Annual Scientific Meeting

June 4-8, 2005
The Atlantis; Paradise Island,
Bahamas

47th Annual Scientific Meeting

June 5-9, 2004
The Homestead; Hot Springs, VA

46th Annual Scientific Meeting

2003
The Breakers; Palm Beach, FL

45th Annual Scientific Meeting

June 1-5, 2002
The Westin Resort;
Hilton Head, SC

44th Annual Scientific Meeting

June 9-13, 2001
Disney's Yacht & Beach Club
Resort; Orlando, FL

43rd Annual Scientific Meeting

June 4-8, 2000
Southampton Princess; Bermuda

42nd Annual Scientific Meeting

June 5-9, 1999
Boca Raton Resort and Club;
Boca Raton, FL

41st Annual Scientific Meeting

June 6-10, 1998
The Registry Resort; Naples, FL

40th Annual Scientific Meeting

June 7-11, 1997
The Lodge; Williamsburg, VA

39th Annual Scientific Meeting

June 1-5, 1996
The Breakers; Palm Beach, FL

38th Annual Scientific Meeting

June 3-7, 1995
Marriott at Sawgrass Resort;
Ponte Verde Beach, FL

37th Annual Scientific Meeting

June 5-9, 1994
Boca Raton Resort and Club;
Boca Raton, FL

36th Annual Scientific Meeting

June 6-10, 1993
Westin Resort; Hilton Head, SC

35th Annual Scientific Meeting

1992
Ritz-Carlton Amelia Island;
Amelia Island, FL

34th Annual Scientific Meeting

June 9-13, 1991
The Greenbrier;
White Sulphur Springs, WV

33rd Annual Scientific Meeting

June 3-7, 1990
Kiawah Island Resort;
South Carolina

32nd Annual Scientific Meeting

June 18-22, 1989
Southampton Princess; Bermuda

33rd Annual Scientific Meeting

1988
Innisbrook Resort;
Tarpon Springs, FL

34th Annual Scientific Meeting

1987
The Grand Hotel; Point Clear, AL

PAST ANNUAL MEETINGS

29th Annual Scientific Meeting

May 25-29, 1986
Boca Raton Hotel and Club;
Boca Raton, FL

28th Annual Scientific Meeting

May 5-9, 1985
Disney World; Lake Buena Vista, FL

27th Annual Scientific Meeting

April 29-May 3, 1984
Colonial Williamsburg Inn &
Lodge; Williamsburg, VA

26th Annual Scientific Meeting

May 8-12, 1983
Amelia Island Plantation;
Amelia Island, FL

25th Annual Scientific Meeting

June 20-24, 1982
Southampton Princess; Bermuda

24th Annual Scientific Meeting

May 30-June 4, 1981
The Cloister; Sea Island, GA

23rd Annual Scientific Meeting

May 25-29, 1980
The Greenbrier;
White Sulphur Springs, WV

22nd Annual Scientific Meeting

May 27-31, 1979
The Cloister; Sea Island, GA

21st Annual Scientific Meeting

May 14-18, 1978
Boca Raton Hotel and Club;
Boca Raton, FL

20th Annual Scientific Meeting

May 27-31, 1979
The Cloister; Sea Island, GA

19th Annual Scientific Meeting

April 25-29, 1976
Don Cesar Resort Hotel;
St. Petersburg, FL

18th Annual Scientific Meeting

May 25-29, 1975
The Grand Hotel; Point Clear, AL

17th Annual Scientific Meeting

March 10-14, 1974
The Marriott; Hilton Head, SC

16th Annual Scientific Meeting

1973
The Grand Hotel; Point Clear, AL

15th Annual Scientific Meeting

May 31-June 3, 1972
Williamsburg Lodge;
Williamsburg, VA

14th Annual Scientific Meeting

May 30-June 3, 1971
The Cloister; Sea Island, GA

13th Annual Scientific Meeting

April 1-4, 1970
Royal Orleans; New Orleans, LA

12th Annual Scientific Meeting

March 30-April 3, 1969
Velda Rosa Towers;
Hot Springs, AR

11th Annual Scientific Meeting

May 29-June 1, 1968
Broadwater Beach Hotel;
Biloxi, MS

10th Annual Scientific Meeting

1967
West End; Grand Bahama Island

9th Annual Scientific Meeting

1966
The Marriott; Atlanta, GA

8th Annual Scientific Meeting

May 20-22, 1965
Grand Hotel; Point Clear, AL

7th Annual Scientific Meeting

April: 1964
Imperial House Motel;
Lexington, KY

6th Annual Scientific Meeting

1963
The Peabody; Memphis, TN

5th Annual Scientific Meeting

1962
The Cloister; Sea Island, GA

4th Annual Scientific Meeting

November 6-9, 1961
Colonial Williamsburg Inn &
Lodge; Dallas, TX

3rd Annual Scientific Meeting

February 11-14, 1960
The Tides Hotel; St. Petersburg, FL

2nd Annual Scientific Meeting

March 20-21, 1959
Fort Sumter Hotel; Charleston, SC

1st Annual Scientific Meeting

April 17-18, 1958
International House;
New Orleans, LA



AWARD WINNERS

AWARD WINNERS

SPECIAL ACHIEVEMENT AWARD

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

PICKRELL AWARD

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

Andrew M. Moore	1985
Charles E. Horton	1986
James W. Davis	1987
James H. Hendrix	1988
Maurice J. Jurkiewicz	1989
Carl R. Hartrampf	1990
Leonard T. Furlow	1992
Hal. G. Bingham	1993
Norman Cole	1994
John McCraw	1996

FOUNDERS AWARD

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

Albert Losken	2012
Wyndell Merritt	2013
Adam Katz	2014
C. Scott Hultman	2015
Galen Perdikis	2015
Brian R. Rinker, MD	2016
Bruce A. Mast, MD	2017
Joseph K. Williams, MD	2018

Robert F. Hagerty	1997
John B. Lynch	1998
Joel Mattison	1999
John Bostwick, III	2001
Milton T. Edgerton	2002
Luis Vasconez	2005
Michael E. Jabaley	2006
Wyndell Merritt	2012
Edward Luce	2015

AWARD WINNERS

GLANCY AWARD

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

Foad Nahai 1977
Emory University

Leonard Miller 1984
Emory University

H. Louis Hill 1978
Emory University

Richard Sadove 1985
Eastern Virginia Medical School

E.D. Newton 1979
University of Tennessee

Mason Williams 1986
Eastern Virginia Medical School

Dan H. Shell 1981
University of Tennessee

David Hurley 1987
University of Virginia

Donato Viggiano 1982
University of Tennessee

J.D. Stuart 1988
University of Virginia

Larry Nichter 1983
University of Virginia

James H. Schmidt 1989
University of Florida

AWARD WINNERS

Paul A. Watterson 1990 Emory University	Robert E.H. Ferguson 2005 Kentucky Clinic
Michael G. Kanosky 1991 University of Mississippi	Dean DeRoberts 2006 Wake Forest
Joseph M. Woods, IV 1992 Vanderbilt University	Howard Levinson 2007 Duke University
David Brothers 1993 University of N.C. at Chapel Hill	S. S. Tholpady 2008 University of Virginia
Scott N. Oishi 1994 University of Kentucky	Scott Hollenbeck 2009 Duke University
Gregory Mackay 1995 Emory University	Yvonne Pierpont 2010 University of South Florida
R.C. High 1996 Bowman Gray School of Medicine	Anthony Capito 2011 University of Virginia
Henry F. Garazo 1997 Medical College of Georgia	Matthew Blanton 2012 Duke University
Kim Edward Koger 1998 Duke University	Michael Lynch 2013 University of Kentucky
J. Timothy Katzen 1999 Vanderbilt University	Brent R. DeGeorge 2014 University of Virginia
Richard Rosenblum 2000 Vanderbilt University	Michael Lynch 2015 University of Kentucky
Colin Riordan 2001 Vanderbilt University	William D. North, MD 2016 University of Kentucky
Julia MacRae 2002 University of Virginia	Kristopher M. Day, MD 2017 University of Tennessee, Chattanooga
M.I. Okwueze 2004 Vanderbilt University	



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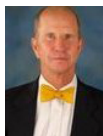
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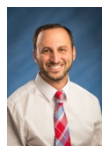
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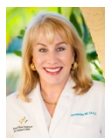
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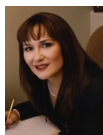
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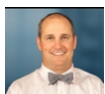
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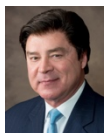
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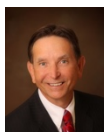
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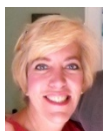
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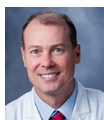
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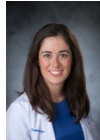
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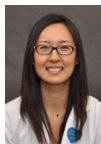


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