Forty-Eighth Annual Scientific Meeting

Southeastern Society of Plastic and Reconstructive Surgeons

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

Please bring this program to the meeting.

FORTY-EIGHTH ANNUAL MEETING

Southeastern Society of Plastic and Reconstructive Surgeons

THE ATLANTIS
PARADISE ISLAND, THE BAHAMAS
JUNE 4-8, 2005

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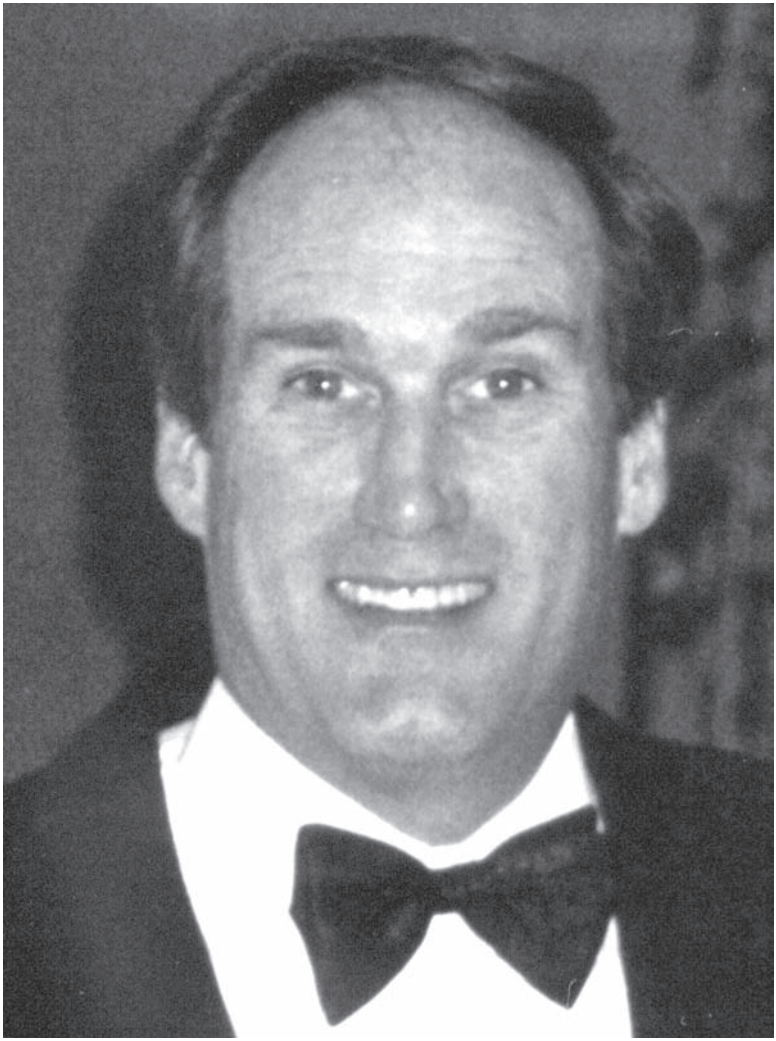

Michael E. Beasley, President
2004-2005

IN MEMORIAM

George E. McLean
Columbia, South Carolina

SESPRS Life Member George E. McLean was a native of Darlington, South Carolina. He graduated from medical school at Emory, interned in the United States Navy at Charleston, South Carolina, and returned to Emory for training in general surgery. George then moved west to Latter Day Saints Hospital in Salt Lake City, Utah, for his residency in plastic surgery before returning to his native state and opening his practice in Columbia, South Carolina, in 1962. George was a regular presence at SESPRS meetings for many years, and will be missed.

PAST UPCHURCH LECTURERS

Thomas Cronin, M.D.
1977

Sal Castanares, M.D.
1978

Kenneth Pickerell, M.D.
1979

Robert Goldwyn, M.D.
1980

Richard Stark, M.D.
1981

William Hamm, M.D.
1982

Reed Dingman, M.D.
1983

Clifford Snyder, M.D.
1984

John Mustarde, M.D.
1985

Fernando Ortiz-Monasterio, M.D.
1986

Jack Sheen, M.D.
1987

Jacques van der Meulen, M.D.
1988

Thomas D. Rees, M.D.
1989

Paul M. Weeks, M.D.
1990

Frederick J. McCoy, M.D.
1991

Simon Fredricks, M.D.
1992

John Hoopes, M.D.
1993

J.B. Lynch, M.D.
1994

M.J. Jurkiewicz, M.D.
1995

Milton T. Edgerton, M.D.
1996

Carl R. Hartrampf, M.D.
1997

John B. McCraw, M.D.
1998

D. Ralph Millard, Jr., M.D.
1999

Burton D. Brent, M.D.
2000

Jacques Baudet, M.D.
2001

Leonard T. Furlow, Jr., M.D.
2002

Norman M. Cole, M.D.
2003

Michael E. Jabeley, M.D.
2004

SPECIAL ACHIEVEMENT AWARD WINNERS

William J. Pitts, M.D.
1977

Robert C. Reeder, M.D.
1979

John R. Lewis, M.D.
1981

Bernard L. Kaye, M.D.
1982

Joel Mattison, M.D.
1985

McCarthy DeMere, M.D.
1987

Greer Ricketson, M.D.
1994

Allen Hughes, M.D.
1995

Richard Hagerty, M.D.
1997

Erle Peacock, M.D.
2001

PICKRELL AWARD WINNERS

Andrew M. Moore, M.D.
1985

Charles E. Horton, M.D.
1986

James W. Davis, M.D.
1987

James H. Hendrix, M.D.
1988

M. J. Jurkiewicz, M.D.
1989

Carl R. Hartrampf, M.D.
1990

Leonard T. Furlow, Jr., M.D.
1992

Hal G. Bingham, M.D.
1993

Norman Cole, M.D.
1994

John McCraw, M.D.
1996

Robert F. Hagerty, M.D.
1997

John B. Lynch, M.D.
1998

Joel Mattison, M.D.
1999

John Bostwick, III, M.D.
2001

Milton T. Edgerton, M.D.
2002

GLANCY AWARD WINNERS

Foad Nahai, M.D.
Emory University
1977

H. Louis Hill, M.D.
Emory University
1978

E.D. Newton, M.D.
University of Tennessee
1979

E.D. Newton, M.D.
University of Tennessee
1980

Dan H. Shell, M.D.
University of Tennessee
1981

Donato Viggiano, M.D.
University of Tennessee
1982

Larry Nichter, M.D.
University of Virginia
1983

Leonard Miller, M.D.
Emory University
1984

Richard Sadove, M.D.
Eastern Virginia Medical School
1984

Mason Williams, M.D.
Eastern Virginia Medical School
1986

David Hurley, M.D.
University of Virginia
1987

J.D. Stuart, M.D.
University of Virginia
1988

James H. Schmidt, M.D.
University of Florida
1989

Paul A. Watterson, M.D.
Emory University
1990

Michael G. Kanosky, M.D.
University of Mississippi
1991

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

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

Scott N. Oishi, M.D.
University of Kentucky
1994

Gregory Mackay, M.D.
Emory University
1995

R. C. High, M.D.
Bowman Gray School of Medicine
1996

Henry F. Garazo, M.D.
Medical College of Georgia
1997

Kim Edward Koger, M.D.
Duke University
1998

J. Timothy Katzen, M.D.
Vanderbilt University
1999

Richard Rosenblum, M.D.
Vanderbilt University
2000

Colin Riordan, M.D.
Vanderbilt University
2001

Julia MacRae, M.D.
University of Virginia
2002

Julia MacRae, M.D.
University of Virginia
2003

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

RECREATIONAL EVENTS AND SPOUSE PROGRAM

Saturday, June 4

6:00 p.m. - 7:30 p.m.	Welcome Reception

*Dinner on your own — reservations highly recommended**

Sunday, June 5

6:45 a.m.	3 Mile Fun Run
8:00 a.m. - 11:00 a.m.	Spouse Hospitality
1:30 p.m. - 4:00 p.m.	Tennis Tournament**
1:30 p.m. - 5:00 p.m.	Scuba & Snorkel
6:30 p.m. - 10:00 p.m.	Theme Dinner

Monday, June 6

8:00 a.m. - 11:00 a.m.	Spouse Hospitality
2:00 p.m. - 6:00 p.m.	Golf Tournament**
1:30 p.m. - 4:00 p.m.	Tennis Tournament**

*Dinner on your own — reservations highly recommended**

Tuesday, June 7

8:00 a.m. - 11:00 a.m.	Spouse Hospitality
1:30 p.m. - 4:00 p.m.	Men's Doubles Tennis**
7:00 p.m. - 7:45 p.m.	Reception
7:45 p.m. - 11:30 p.m.	Dinner and Dancing (black tie optional)***

Wednesday, June 8

8:00 a.m. - 11:00 a.m.	Spouse Hospitality

** The dinner hours are a very busy time at the restaurants on property at Atlantis and reservations are sometimes fully booked several days in advance. Please make your dinner reservations early.*

*** Optional Activities/Ticket required. Sign up at the SESPRS registration desk by 12:00 noon on Sunday, June 5 for the golf tournament.*

**** Please Note: Only children ages 16 and older will be allowed to attend the Black Tie Event.*

Week At A Glance

Sunday, June 5

7:00 a.m. - 8:00 a.m.	Continental Breakfast/ Exhibits Open	**Grand Ballroom C**
8:00 a.m. - 8:05 a.m.	Invocation Ronald Johnson, M.D.	**Grand Ballroom A**
8:05 a.m. - 8:10 a.m.	Presidential Welcome: Michael Beasley, M.D.	
8:10 a.m. - 8:50 a.m.	Resident Competition Papers 1-4, with discussion	
8:50 a.m. - 9:50 a.m.	Keynote Address - Archie Manning	
9:50 a.m. - 10:20 a.m..	Break - Visit the Exhibits	**Grand Ballroom C**
10:20 a.m. - 11:20 a.m.	Upchurch Lecture - P.G. Arnold, M.D.	
11:20 a.m. - 1:00 p.m.	Difficult/ Secondary Rhinoplasty Symposium - Jack Gunter, M.D.	

Monday, June 6

7:00 a.m. - 8:00 a.m.	Continental Breakfast/ Exhibits Open	**Grand Ballroom C**
8:00 a.m. - 8:35 a.m.	Resident Competition Papers 5-8, with discussion	**Grand Ballroom A**
8:35 a.m. - 9:15 a.m.	Member Papers, with discussion	
9:15 a.m. - 10:00 a.m.	Reports from ASPS, ABPS, ASAPS, PSEF	
10:00 a.m. - 10:30 a.m.	Break - Visit the Exhibits	**Grand Ballroom C**
10:30 a.m. - 11:30 a.m.	Member Papers, with discussion	
11:30 a.m. - 1:00 p.m.	Facial Rejuvenation Symposium Foad Nahai, M.D.	

Tuesday, June 7

7:00 a.m. - 8:00 a.m.	Continental Breakfast/ Exhibits Open	**Grand Ballroom C**
8:00 a.m. - 10:00 a.m.	"Body Contour Surgery After Massive Weight Loss" Dennis Hurwitz, M.D.	**Grand Ballroom A**
10:00 a.m. - 10:10 a.m.	Research Grant Paper Jorge de la Torre, M.D.	
10:10 a.m. - 10:15 a.m.	Discussion	
10:15 a.m. - 10:45 a.m.	Break - Visit the Exhibits	**Grand Ballroom C**

Week At A Glance

10:45 a.m. - 11:45 a.m.	"J" Lecture Luis Vasconez, M.D.	**Grand Ballroom A**
11:45 a.m. - 12:15 p.m.	"Audit Controls for the Plastic Surgeon" - Karen Zupko	
12:15 p.m. - 1:15 p.m.	SESPRS Annual Business Meeting	
12:15 p.m. - 1:15 p.m.	Resident's Luncheon	**TBA**
1:15 p.m. - 4:00 p.m.	Private Consultations with Karen Zupko - by appointment*	**Neptune Room**

Wednesday, June 8

8:30 a.m. - 9:00 a.m.	Continental Breakfast	**Ballroom Foyer**
9:00 a.m. - 10:00 a.m.	Member Papers, with discussion	**Grand Ballroom A**
10:00 a.m. - 11:00 a.m.	Patient Safety Panel Felmont Eaves, M.D.	
11:00 a.m.	Adjournment	

*Sign up for consultations will take place at the registration desk of the meeting. A limited number of appointments will be available on a first come, first served basis.

***Unless otherwise noted, all events will take place in Grand Ballroom A.**

SCIENTIFIC SESSIONS

DESCRIPTION

The Southeastern Society of Plastic and Reconstructive Surgeons' 48th Annual Meeting is designed to continue the high quality of scientific presentations which has been the hallmark of this society's educational offerings since its inception. This program is meant primarily for plastic surgeons. Others with significant involvement in rhinoplasty, facial rejuvenation and body contouring will benefit from this meeting. Plastic surgeons interested in aggressive but scientifically sound approaches to the management of plastic surgery patients will benefit from this meeting.

OBJECTIVES

Upon completion of this meeting attendees will:

- Obtain a better understanding of surgical techniques and treatment options across a broad range of reconstructive and aesthetic surgery management issues with particular emphasis on difficult and secondary rhinoplasty, facial rejuvenation, body recontouring after massive weight loss and patient safety.
- Have an updated report concerning the research project the Society has funded and the potential impact of such research on improving plastic surgery patient care.
- Be informed regarding protection of monetary assets in the office.

ACCREDITATION

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

The Southeastern Society of Plastic and Reconstructive Surgeons designates this educational activity for a maximum of 16.5 category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

DISCLOSURE/CONFLICT OF INTEREST STATEMENTS

All faculty have been required to complete a statement detailing any and all conflicts of interest and/or industry support. We have printed and will verbally announce details as to any speaker who has made such a disclosure, and we will also affirmatively announce in writing and verbally with respect to any speaker who has refused to submit such conflict/industry support information. The absence of any such affirmative statement of disclosure means that the faculty member has submitted a complete disclosure statement, and has indicated that he/she has no conflicts/industry support to report.

All faculty/participants have been instructed that if any unapproved or off-label use of a product is to be referenced in a CME program presentation, the faculty member/participant shall be required to disclose that the product is either investigational or it is not labeled for the usage being discussed.

CERTIFICATES OF ATTENDANCE

To obtain your CME credit for this meeting, a completed evaluation form must be returned to the registration desk or mailed to the SESPRS Office. Upon receipt of this form, credit hours will be reported to ASPS automatically. An official certificate of attendance is available upon request from the SESPRS Office.

Scientific Sessions will be held in the Grand Ballroom A.

48th ANNUAL SCIENTIFIC MEETING
JUNE 4-8, 2005

Sunday, June 5

CHAIR: Mark Codner, M.D.
Atlanta, GA

SECRETARY: Galen Perdikis, M.D.
Jacksonville, FL

7:00-8:00 ***Continental Breakfast - Exhibits Open***

8:00-8:05 ***Invocation***
Ronald J. Johnson, M.D.
Memphis, TN

8:05-8:10 ***Presidential Welcome***
Michael E. Beasley, M.D.
Charlotte, NC

8:10-8:17 ***Resident Competition Paper #1***
"The Use of Hydrogel Sealant on Tendon Repairs to Reduce Adhesion Formation"
Robert E.H. Ferguson, Jr., M.D., Brian Rinker, M.D., Lexington, KY

A common complication of primary flexor tendon repair is loss of digital motion due to the formation of restrictive adhesions between the tendon and surrounding tissues. Early range of motion (ROM) decreases the incidence and degree of digital motion loss. A number of investigators have sought to decrease adhesion formation by placing a barrier between the repair site and the surrounding tissue. An ideal barrier should be easy to use, biocompatible, bioresorbale, move with the tendon, and remain intact long enough to allow tendon healing. A synthetic absorbable hydrogel sealant used in thoracic surgery appears to meet these criteria.

Thirty adult Leghorn chickens were randomized to undergo flexor tendon repair with or without sealant. The flexor profundus tendon of toes 2, 3, and 4 on one foot were divided then repaired using

a standard technique. The tendons in the sealant group were coated at the tendon repair site prior to closure of the skin. The repaired foot was immobilized in a fiberglass cast for 3 weeks. Each chicken was further randomized to have the repair site studied at 3, 6, or 12 weeks. Second and third toes were subjected to biomechanical analysis (work of flexion and breaking strength), while fourth toes were reserved for histological evaluation of the repair sites.

8:17-8:24 ***Resident Competition Paper #2***

"Office Surgery Safety and the Florida Moratoria"

Mark A. Clayman, M.D., Hollis H. Caffee, M.D., M. Brent Seagle, M.D., Jason Rosenberg, M.D.
University of Florida Health Science Center
Gainesville, FL

Background: Office-based surgery has become an important method of health-care delivery, but there is controversy about its safety. Since 2000, a series of articles were published in the lay media emphasizing the hazards of office surgery, leading to the Florida Board of Medicine restricting office procedures.

Objectives: To determine the nature and scope of deaths resulting from office surgery.

Methods: We reviewed the data on mandatory reporting by physicians to a central agency of all office surgical incidents that resulted in death, injury, or hospital transfer in the State of Florida from January 2000 to November of 2004. E-mail, internet, and telephone follow-up were used to determine physician's board status, office accreditation and hospital privileges. We reviewed data on medication interactions, anesthesia and monitoring.

Results: A total of 36 deaths related to office procedures were reported. Only 18 of those were related to surgical procedures that are within the realm of plastic surgery although surgeons of other specialties did 3 of these. When these 18 were reviewed by type of anesthesia, there were 12 who had general anesthesia, 10 with an anesthesiologist and 2 with a CRNA. Of those 18, only 7 died prior to discharge. Although all seven of them survived long enough to be transferred to a hospital, we classified them as office deaths. The other 11 died after appropriate discharge. Of the 7 office deaths, one developed bronchospasm during induction by an anesthesiologist. 5 were during deep sedation (Level III anesthesia) and 4 appeared to be related to excessive sedation and/or inadequate monitoring; the fifth

was probably related to illicit drug use and the sixth from a fat embolism. Of the 11 postoperative deaths, 7 were said to be due to thromboembolism and the others were from unknown causes.

Conclusion: Although the total number of office operations during the study period is unknown, the fact that only 7 deaths were reported would suggest that the location in which these procedures were done was not as much of a factor as the regulators have suggested. However, better patient screening, sedation management, DVG prophylaxis, and clinical judgment may have prevented some, if not most of these deaths. The most frequent cause of death after discharge was thromboembolism and some of these might have been prevented with better prophylaxis and post-op ambulation. More detailed findings and recommendations will be presented.

8:24-8:31 ***Resident Competition Paper #3***

"The Use of the Distal Radial Artery Perforator Flap in the Management of Chronic Hand Neuropathy"

Hisham Seily, M.D., John Seiffer, M.D., Houstan Payne, M.D., Robert Howell, M.D., Atlanta, GA

Purpose: The goal of this study is to report the use of the distal radial perforator fascial flap in the management of recurrent compression hand neuropathy. The anatomical injection study was designed to identify the fascial flap territory that could be based on the distal radial arter perforator.

Methods: 1) Anatomical Study: Ten upper extremity cadavers were dissected to identify the radial artery perforators. India Ink Injection was used to study the distal radial artery perforator. 2) Clinical Study: This study involves two groups – Group A retrospective study of twenty recurrent upper extremity compression neuropathy patients treated with neurolysis and fascial flap interposition. Average follow up is one year. Group B retrospective study of 20 patients who underwent neurolysis without fascial flap interposition.

Results: The fascial flap was used in 20 patients. Average age 40 y (range 23-52). Average operative time 92 minutes. No reported flap necrosis. Patients who underwent fascial flap interposition (group A) showed improved pain, paresthesias and two point discrimination at 6 weeks follow up.

Conclusion: The distal radial arter perforator flap is a valuable tool in the management of recurrent compression hand neuropathy.

8:31-8:38 ***Resident Competition Paper #4***

"The Expression of Proinflammatory Cytokines in the Rat Muscle Flap with Ischemia-Reperfusion Injury"

Feng Zhang, M.D., Ph.D., Eric C. Hu, M.D., Jacob Gerzenshtein, M.D., Man-Ping Lei, M.D., Ph.D., William Lineaweaver, M.D., Division of Plastic Surgery, University of Mississippi, Jackson, MS

Ischemic-reperfusion injury mediated by free radicals and neutrophils are the principal pathway for tissue injury and death. Cytokines influence the activity of various cell types during inflammatory processes. In this study, expression of selected proinflammatory cytokines is examined in primary and secondary ischemia in a rat gracilis flap model. Sixty Sprague-Dawley rats were used in the study. The primary ischemia of the flap was induced by vascular pedicle clamping for 1 hour, after which the flap was replaced and allowed to reperfuse. After 24 hours, a secondary ischemia was induced by fascular pedicle clamping for 4 hours. The muscle flap was biopsied at 4 and 18 hours after primary ischemia, as well as at immediately, at 4, and 18 hours after secondary ischemia. Expression of tumor necrosis factor (TNF-alpha), interleukin (IL-1beta), and platelet derived growth factor (PDGF) mRNAs was determined by RT-PCR. The same number of muscle flaps without ischemia at different time interval was used for baseline gene expression. Results showed that TNF-alpha gene expression was significantly up-regulated at 18 hours after secondary ischemia. IL-1 gene expression was up-regulated at 4 hours after primary ischemia and greatest at 4 hours after secondary ischemia. PDGF expression was up-regulated immediately after secondary ischemia then at 4 hours after secondary ischemia ($p<0.05$), and down-regulated during reperfusion. This study delineated the changes of TNF-alpha, IL-1beta, and PDGF in both primary and subsequent secondary ischemia and reperfusion episodes at several critical time-points.

8:38-8:50 Discussion

8:50-9:50 ***Keynote Address***
Archie Manning
New Orleans, LA

9:50-10:20 ***Break – Visit the Exhibits***

10:20-11:20 ***Upchurch Lecture***
P.G. Arnold, M.D.
Rochester, MN

11:20-12:55 ***Difficult/ Secondary Rhinoplasty Symposium***
Jack Gunter, M.D.
Dallas, TX

Monday, June 6

CHAIR: Harold I. Friedman, M.D.
Columbia, SC

SECRETARY: E. Dwayne Lett, M.D.
Lebanon, TN

7:00-8:00 ***Continental Breakfast – Visit Exhibits***

8:00-8:07 ***Resident Competition Paper #5***
"Supermicrosurgical Replantation of Total Upper Eyelid Avulsion"
N.E. Soueid, M.D., K. Khoobehi, M.D., R. Allen, M.D., Louisiana State University, New Orleans, LA

Isao Koshima in 1997 advocated supermicrosurgery suggesting the future of microsurgery toward smaller vessels. He also discussed the lower patient's morbidity with the use of supermicrosurgery. We present and report the world's first case of successful total upper eyelid replantation on a 22-year-old female that sustained a traumatic avulsion of her upper eyelid by her dog. Upon an extensive literature review, we found that eyelid replantation has been previously performed using it as a composite graft posttraumatic avulsion.

We clearly demonstrate the clinical and photographic progress and improvement of this young Caucasian female and provide an algorithm to the practicing plastic surgeon of the preoperative and postoperative management of a traumatic eyelid avulsion/injury. In addition, we demonstrate the continued usefulness of medicinal leeches in cosmetic, plastic, and reconstructive surgery. The detailed eyelid microvascular anatomy is discussed and demonstrated within the content of our paper.

Our case clearly demonstrates the feasibility of Koshima's teaching in the future of microsurgery. Furthermore, the case expands the creative nature of plastic and reconstructive surgery.

8:07-8:14 ***Resident Competition Paper #6***

"The Development of Virtual Craniofacial Anthropometry"

Tracey H. Stokes, M.D., Sean R. Marshall, Roger W. Nightingale, Ph.D., Srinivasan Mukundan, Jr., M.D., Ph.D., Christopher R. Forrest, M.D., and Jeffrey Marcus, M.D., Duke University Medical Center, Durham, NC

Introduction: The assessment of craniofacial developmental morphology has been limited by a paucity of objective analytic techniques. Vector analysis has recently demonstrated comprehensive quantitative data in craniosynostosis. A balance must be struck between the practical derivation of objective data, and the ability of such data to illustrate visually complex clinical scenarios.

Purpose: 1. To develop a mathematical algorithm from volume craniofacial computed tomography (CT) for the construction of a three-dimensional (3D) cranial surface dataset that automatically derives a comprehensive set of objective craniofacial morphometric indices. 2. To validate the accuracy of the algorithm against a known radiographic skull phantom. 3. The demonstrate the practical application of multiple vector analysis in craniosynostosis.

Materials and Methods: Using the graphical computational programming language, MATLAB, an algorithm was created that displays craniofacial CT data as three reformatted orthogonal 2D images (axial, coronal, and sagittal planes). Anatomical landmarks (dorsum sella and glabella) define the coordinate system for performing index analysis. The algorithm automatically determines selected traditional indices as well as distances from the dorsum sella to the outer table at specified angular increments in all three dimensions. Thereby, 3D

Cartesian data is transformed into an array of spherical-coordinate rays and is displayed graphically as a "craniofacial fingerprint." A CT dataset of an adult skull phantom was acquired to verify the functionality of the algorithm. The algorithm was then applied to normal pediatric skulls and variations of single suture craniosynostosis.

Results: The cranial analysis tool is able to accurately and reproducibly measure distances in the test dataset as confirmed both by evaluation of the numerical values in the data array and by graphic superimposition of measured data onto the CT dataset. In automated fashion, traditional craniofacial indices as well as selected vector analysis are produced. The quantitative analysis and graphic representation is highly demonstrative of cranial shape anomalies.

Conclusion: The results of testing the algorithm show that it is able to measure distances reliably, creating a coordinate set in three dimensions that may then be used to derive nearly any desired morphometic measure. Vector analysis continues to show advantages as a tool for objective assessment, with practical applications in clinical practice and research. The future of cranial vault analysis is utilization of an automated 3D craniofacial fingerprint to develop a normative database and to further objectively differentiate conditions of dysmorphology.

8:14-8:21 ***Resident Abstract Paper #7***

"A Simple and Inexpensive Method of Preoperative Computer Imaging for Rhinoplasty"

Christopher J. Ewart, M.D., Christopher J. Leonard, D.O., Jack C. Yu, M.D., Medical College of Georgia, Augusta, GA

Goals/Purpose: Despite concerns of legal liability, preoperative computer imaging has become a popular tool for the plastic surgeon. The ability to project possible surgical outcomes can facilitate communication between the patient and surgeon. It can be an effective tool in the education and training of residents. Unfortunately, these imaging programs are expensive and have a steep learning curve. The purpose of this paper is to present a relatively inexpensive method of preoperative computer imaging with a reasonable learning curve.

Materials/Methods: The price of currently available imaging programs was acquired through an online search and inquiries made to the software distributors. Their prices were compared to Adobe Photoshop CS which has a special feature called "liquefy." This

"liquefy" feature was used in the preoperative computer planning of two patients who presented for rhinoplasty at our institution (Figure 1 and 2). In addition, the "photocopy" filter in Adobe Photoshop CS was used to visualize subtle changes in facial shadows to help define the nose (Figure 3).

Results: Adobe Photoshop CS can be purchased for approximately $300 while an upgrade from previous versions is less than $200. The most commonly used preoperative imaging software is the Mirror Imaging System by Canfield which has a minimum purchase price of nearly $6,000. Figure 1 demonstrates the ability of Adobe Photoshop CS to create effective preoperative computer manipulated images. The patient in figure 2 received preoperative computer imaging and was pleased with the correlation between her projected and actual results. In addition, the "photocopy" filter was an effective educational tool in surgical planning by defining the shadow changes that would result from different surgical techniques.

Conclusions: Preoperative computer imaging can be a very effective tool for the plastic surgeon by providing improved physician-patient communication, increased patient confidence, and enhanced surgical planning. Adobe Photoshop CS is a relatively inexpensive program that can provide these benefits using only one or two features.

8:21-8:28 ***Resident Competition Paper #8***

"Impact of Significant Weight Loss on Outcome of Body Contouring Surgery"

Claire Sanger, M.D., Lisa David, M.D.
Wake Forest University, Winston-Salem, NC

Morbid obesity has become a major public health problem associated with significant morbidity and mortality. There are numerous options available for patients seeking assistance with weight loss including diet control, exercise, and in some cases, bariatric surgery. It is estimated that in 2001, there were 47,000 surgeries performed for morbid obesity, 63,000 in 2002 and an estimated 98,000 in 2003. As the number of patients undergoing bariatric surgery increases, it is expected there will be an increase in the number of patients presenting to plastic surgery offices for body contouring after weight loss. It is imperative that plastic surgeons prepare patients with extreme weight loss as to the risks and complications as compared to the general population undergoing body contouring.

A chart review was conducted of 26 patients undergoing body contouring from May 2001 to November 2004. The patients who had extreme weight loss, defined as losing greater than 50 pounds, were included in this study. Information concerning age, gender, weight lost, comorbidities, tobacco use, and weight loss method was assessed from the medical records. Additionally, the type of body contouring procedure and presence of complications were collected from the records.

Eighteen patients met inclusion criteria. A total of 31 procedures were performed by the same surgeon on these patients after weight reduction. The average weight loss was 135 pounds. There were 16 females and 2 males. The average age was 44 with the minimum 28 and maximum 62 years of age. The 31 procedures were composed of abdominoplasty (11), panniculectomy (6 and 3 with simultaneous hernia repair), breast reduction/augmentation (4), thigh reduction (5), brachioplasty (3), liposuction (1), and face lift (1). Twenty-seven percent (5 patients) had wound complications which included seromas, hematoma, infection and fat necrosis. All of the patients who had complications had undergone an abdominoplasty or a panniculectomy. Three of the five patients who had a wound complication had undergone gastric bypass for weight reduction.

The percentage of complications in our patient population is significantly higher than reported in the literature for the general population undergoing an abdominoplasty. We believe the increased wound complications seen in our patients can be attributed to the inherent complications seen with obese patients. There were no other comorbid factors in the study patients and all of the patients had ceased tobacco use three or more months prior to surgery. It is virtually impossible to correct the excess skin left after extreme weight loss by diet or exercise. There is no doubt that there is an improvement in the quality of life after body contouring, as measured subjectively, evaluated and reported by patients. As the number of patients increase who seek body contouring after extreme weight loss, surgeons must be able to inform patients of the risks and complications of body contouring surgery as they relate to the specific comorbidities of the particular patient. Likewise, surgeons will need to alter the aggressiveness of the procedure according to the risk versus benefit in patients who fall into the higher risk groups.

8:28-8:35 Discussion

Member Papers

8:35-8:42 *"A Reconstructive Approach to the Nasal Tip"*
S. Anthony Wolfe, M.D., Miami, FL

After the work of Burget and Menick in fabricating a facsimile of the missing alar cartilages beneath a forehead flap in total nasal reconstruction, the author described a similar method for the nasal deformity of bilateral cleft patients, (*PRS*, July, 2004): the native, deficient alar cartilages are completely ignored, and a new set of anatomically correct alar cartilages are constructed from conchal cartilage over the existing cartilages, fixed centrally to a columellar strut, and laterally, after creation of the desired tip projection, to the existing alar cartilages with transvestibular sutures. Once created, the whole panoply of tip sutures (transdomal, interdomal, etc.) can be applied to the newly created alar arches.

This method, the "Golden Arch procedure," has proved exceedingly useful in providing increased tip projection in not only patients with cleft nasal deformities, but also in other secondary rhinoplasties and even in primary rhinoplasties with significant tip projection deficiency. The procedure requires an open approach, and has completely replaced Peck and Sheen type grafts in our hands.

8:42-8:49 *"High Septal Osteotomy in Rhinoplasty for the Crooked Nose"*
John J. Jameson, M.D. and Edmond F. Ritter, M.D.,
Medical College of Georgia, Augusta, GA

When attempting to correct a patient's crooked nose who does not require dorsal hump resection, medial and lateral osteotomies with infracture are routinely performed. Such osteotomies succeed in mobilizing the nasal sidewalls but not the central structure of the upper nose. This structure (which is somewhat flexible) may hinder the stable midline reduction of the bony nasal pyramid. Incomplete mobilization of the central structure is a common cause of post operative nasal drift. We describe ***High Septal Osteotomy*** to provide a controlled septal cut which mobilizes the central structure. This technique was utilized for twenty-six patients; twenty-five of whom had excellent results. This maneuver permitted stable midline reduction of the nasal pyramid without dorsal collapse.

8:49-8:56 *"The Use of Biomedical Sensors to Monitor Capsule Formation Around Soft Tissue Implants"*
H.I. Friedman, M.D., Ph.D., J.W. Bender, Ph.D., V. Giurgiutiu, Ph.D., C. Watson, M.D., M. Fitzmaurice, M.D. and M.L. Yost, Ph.D., Columbia, SC

Capsule formation around implantable devices, particularly breast implants, has been well documented clinically and histologically. In the past there has not been good correlation between microscopic observations and clinical findings of capsule firmness or contraction. In the current investigation, we have studied capsule formation around two types of biomedical sensors in rats. Histological observations were correlated with sensor derived data at varying time intervals after implantation. Twenty Sprague Dawley rats were implanted sub-muscularly with both small piezsoacoustic and strain gauge devices. The formation of a dense mechanically tough capsule reduces the vibration amplitude of the former, and contractile forces change the electrical resistance of the latter. Initial recordings were made at the time of implantation and then at timed intervals 2, 4, 8, 12, and 16 weeks later. At the time of the second recording, the animals were sacrificed (four animals at each time interval) and the histology of the capsule was correlated with biomedical sensor data. The results demonstrated that the capsule toughness and contractile force as measured by the sensors did correlate with their microscopic appearance. Future experiments will evaluate inhibition of capsule formation and the ability of these biomedical sensors to measure perturbations in capsule formation. Wireless sensors for intermittent noninvasive measurements are also being developed.

8:56-9:03 *"Palatal Fistula Repair Using Acellular Dermal Matrix: The University of Florida Experience"*
Matthew H. Steele, Brent M. Seagle. PLEASE SEE PAGE 191 FOR ABSTRACT.

9:03-9:15 Discussion

9:15-10:00 ***Report from ASPS***
Scott Spear, M.D.
Washington, DC

Report from ABPS
John A. Persing, M.D.
New Haven, CT

Report from PSEF
Scott Spear, M.D.
Washington, DC

Report from ASAPS
Foad Nahai, M.D.
Atlanta, GA

10:00-10:30 ***Break – Visit the Exhibits***

Member Papers

10:30-10:37 *"The Reversed Hemisoleus Flap and Its Role in Reconstruction of an Open Tibial Wound in the Lower Third of the Leg"*
Lee L.Q. Pu, M.D., Ph.D., University of Kentucky, Kentucky Clinic, Lexington, KY

The usefulness of a reversed medial hemisoleus muscle flap as a local reconstructive option for soft tissue coverage of an open tibial wound in the lower third of the leg has never been acknowledged. In the past 2 years, 8 patients (5 males, 3 females; age: 12 to 52 years) underwent soft tissue reconstruction of an open tibial wound (3 x 3 to 10 x 6 cm) in the lower third of the leg with a reversed medial hemisoleus muscle flap and a skin graft. The flap was elevated with emphasis on the preservation of several perforators from the posterior tibial vessels to the flap as possible while allowing adequate turnover of the flap to cover the exposed tibia and/or hardware. In this series, there was no total flap loss and limb salvage was achieved in all patients. Only two patients (one paraplegic, another heavy smoker) developed insignificant distal flap necrosis and were treated subsequently with debridement and flap re-advancement. All patients healed their tibial wounds with reliable soft tissue coverage and good cosmetic outcome during the follow-up. A reversed medial hemisoleus muscle flap, therefore, can be a good choice for soft tissue coverage of a sizable open tibial wound in the lower third of the leg, especially when a free tissue transfer is not an option. It offers a cost-effective

approach for managing this complex clinical problem and can be performed in non-university teaching hospitals. Detailed knowledge of the flap anatomy and meticulous flap elevation are the keys for such a success.

10:37-10:44 *"Reconstruction of Dorsal Foot and Ankle Wounds with the Extensor Digitorum Brevis Muscle Flap"*
Deowall Chattar-Cora, M.D. and William C. Pederson, M.D., University of Texas Health Science Center, San Antonio, TX

Wounds of the dorsal foot and ankle region are difficult to treat given the paucity of regional flaps. Commonly used methods are unreliable, multi-staged, have significant donor site morbidity, or are technically complex requiring specialized training and expensive equipment to perform. The extensor digitorum brevis muscle flap has minimal morbidity, is easy to elevate, and does not require expensive equipment to perform. We report the largest series of patients (18) treated with this flap. Eighty-three percent (15/18) of the wounds were successfully treated with minimal morbidity. The extensor digitorum brevis muscle flap is useful for dorsal foot and ankle wounds, and should be considered in patients potentially requiring a free flap.

10:44-10:51 *"Microsurgical Muscle Flap Coverage of Traumatic Injuries of the Hand and Wrist"*
William C. Lineaweaver, M.D., University of Mississippi Medical Center, Jackson, MS

Recent studies have emphasized advantages of cutaneous flaps (including perforator flaps) in treatment of hand and wrist defects. This author believes that muscle flaps have great utility in such injuries and reviewed his experience with 71 muscle flap cases done over 18 years.

93% of the flaps were technically successful. Rectus, latissimus and serratus flaps were specifically useful for different defect configuration and pedicle requirements. All flaps adapted well to secondary procedures. Muscle flaps offer consistent anatomy, favorable donor sites remote from the injured extremities, flexible shapes, large caliber vascular pedicles with flexible lengths and the potential to contribute specialized tissue components such as nerve grafts.

10:51-11:00 Discussion

11:00-11:07 *"Restoration of Fecal Continence After Functional Gluteoplasty: Long-Term Results, Technical Refinements and Donor Site Morbidity"*
C. Scott Hultman, M.D., Michael R. Zenn, M.D., Tripti Agarwal, M.D., Christopher C. Baker, M.D., Mark Koruda, M.D., University of North Carolina, Chapel Hill, NC

Purpose: For patients with severe fecal incontinence, reconstruction of the anal sphincter, via gluteoplasty, may improve quality of life, but little is known about long-term functional results. We present our comprehensive experience with gluteoplasty, highlighting technical refinements, donor site morbidity, and functional outcomes.

Methods: We performed a retrospective analysis of 25 consecutive patients (22 female, 3 male; mean age 42 years) undergoing gluteoplasty for fecal incontinence, at a university teaching hospital, from 1996-2004. Etiology of incontinence was as follows: obstetrical injury (n=13), irritable bowel syndrome (n=3), previous rectal surgery (n=3), Crohn's disease (n=3), impalement (n=1), rectocele (n=1), and idiopathic (n=1).

Results: Gluteoplasty was successful in restoring fecal continence in 18 patients (75%) and was partially successful in 4 patients (16%). Two patients required permanent ostomy because of refractory incontinence. Donor site morbidity and perirectal complications were observed in 16 patients (64%) and included dysthesias (n=7), cellulitis (n=5), irregular contour (n=3), abscess (n=2), seroma (n=2), fistula (n=1), but no hip dysfunction or altered gait. Mean length of follow-up was 20.6 months (range: 3-68 months).

Conclusions: Despite a high incidence of donor site and perirectal complications, unilateral functional gluteoplasty was successful in restoring long-term fecal continence in most patients.

11:07-11:14 *"Implant Breast Reconstruction Using Acellular Dermal Matrix: Clinical Outcome"*
G. Mabel Gamboa-Bobadilla, M.D.
Medical College of Georgia, Section of Plastic Surgery, Augusta, GA

Purpose: The purpose of this study is to introduce our experience of saline implant breast reconstruction using the acellular

dermal matrix. The author examined the effect of the acellular dermal matrix in a prosthetic breast reconstruction, in high-risk individuals with deficient soft tissue coverage.

Materials and Methods: Thirteen breast reconstructions were evaluated in eleven consecutive patients at the Medical College of Georgia. All patients who underwent saline implant breast reconstruction with total or partial coverage with allogenic acellular dermal matrix (Alloderm) were identified. The medical record database was reviewed for demographic data, medical history, surgical procedure and clinical outcome.

Results: Thirteen breast reconstructions in eleven consecutive patients with an average age of 58 years underwent mastectomies. The technique uses a saline implant totally or partially covered with human acellular dermal matrix. The mean postoperative follow-up was eight months. Ninety percent of the patients were considered high risk, with more than three systemic diseases. The thickness of the human acellular dermal matrix used was an average of 1.3 millimeters with an average area per breast of 121 centimeters square. There were twelve successful breast reconstructions (ninety-two percent) providing stability, increasing the soft tissue padding allowing more resemblance to the teardrop breast shape, decreasing the rippling of the saline implant. Alloderm was also successfully used as a filler in some atrophic, scarred areas of the chest wall. The graft was used in an only fashion, or as an extension of the pectoralis major muscle covering the implant. A representative histologic cross-section demonstrates a full incorporation and proliferation of blood vessels throughout the thickness of the human acellular dermal matrix.

Conclusions: The use of human acellular dermal matrix in breast reconstruction as a complete or partial periprosthetic coverage is an excellent alternative used in high-risk patients with minimal increase in the operative time and a decrease in the morbidity of more extensive procedures. The advantages observed in more than ninety percent of the patients are the increase in soft tissue padding, serving as a soft tissue filler, decrease of the rippling and implant visibility.

11:14-11:21 *"Do Progressive Tension Sutures Really Decrease Complications in Abdominoplasty?: A Single Surgeon's Experience"*
Sami Khan, M.D., Sumeet S. Teotia, M.D., William Mullis, M.D., William E. Jacobs, M.D., Michael E. Beasley, M.D., Kevin L. Smith, M.D., Felmont Eaves, III, M.D., Stephen J. Finical, M.D., and Paul A. Watterson, M.D., Charlotte Plastic Surgery, Charlotte, NC

Some authors have reported decreased complication rates with the use of progressive tension sutures (PTS) in abdominoplasty.

We retrospectively identified all patients who had undergone abdominoplasty procedures by the senior author (PAW) from 2000-2004. Patients were divided into Group I (abdominoplasty) and Group II (abdominoplasty with PTS). Groups were compared for complications.

One hundred and one patients satisfied the inclusion criteria. Forty-nine (48.5%) patients had placement of PTS. The overall incidence of complications in Group I versus Group II was 42.3% and 19.4%, respectively (p=0.01). The seroma rate for Group I versus Group II was 13.5% versus 6.1% (p=0.21). The wound complication rate for Group I and Group II was 13.5% and 2.0%, respectively (p=0.03).

Our results suggest that progressive tension sutures decrease wound complications in abdominoplasty.

11:21-11:30 Discussion

11:30-1:00 ***Facial Rejuvenation Symposium***
Foad Nahai, M.D.
Atlanta, GA

Tuesday, June 7

CHAIR: William Lineaweaver, M.D.
Jackson, MS

SECRETARY: Kevin Hagen, M.D.
Nashville, TN

7:00-8:00 ***Continental Breakfast – Visit the Exhibits***

8:00-10:00	***"Body Contour Surgery After Massive Weight Loss"*** Dennis Hurwitz, M.D. Pittsburgh, PA
10:00-10:10	**Research Grant Paper** ***"Secondary Endoscopic Forehead Lift"*** Jorge de la Torre, M.D. Birmingham, AL
10:10-10:15	Discussion
10:15-10:45	***Break – Visit the Exhibits***
10:45-11:45	***"J" Lecture*** Luis Vasconez, M.D. Birmingham, AL
11:45-12:15	***"Audit Controls for the Plastic Surgeon"*** Karen Zupko Chicago, IL
12:15-1:15	SESPRS Annual Business Meeting *Active and Life Members Only*
12:15-1:15	Residents' Luncheon
1:15-4:00	Private consultations with Karen Zupko, by appointment

Wednesday, June 8

CHAIR:	Henry Vasconez, M.D. Lexington, KY
SECRETARY:	Bruce A. Mast, M.D. Gainesville, FL

8:00-9:00 *Continental Breakfast*

Member Papers

9:00–9:07 *"Integrating the DIEP and Free TRAM Techniques Optimizes Surgical Outcomes: Presentation of an Algorithm for Microsurgical Breast Reconstruction Based on Perforator Anatomy"*
John T. Lindsey, M.D., Metairie, LA

One hundred and twenty patients who underwent breast reconstruction with the DIEP or modified (muscle sparing) free TRAM techniques were retrospectively reviewed over a 5 year period. All patients before 1/04 (group I, N=91) received the DIEP flap. Patients after 1/04 (group II, N=29) were approached using an integrated technique and received either the DIEP or the modified (muscle sparing) free TRAM based on the perforator anatomy identified at the time of surgery. Average follow-up for group I was 27 months (5.2-43 months) and 8 months for group II (3-12 months).

By applying the surgical technique according to the algorithm presented, we have increased our success rate to 100% (29/29 cases, $p<0.039$, group II) over the past 12 months without increasing donor site morbidity. This compares to a success rate of only 90% (82/91 cases, group I) when the DIEP was attempted indiscriminately in every case.

By integrating DIEP and free TRAM surgical techniques and selectively applying the surgical technique according to the perforator anatomy, microsurgical reconstruction can be more reliably offered to patients while still minimizing donor site morbidity.

9:07 – 9:14 *"Algorithm for Autologous Breast Reconstruction for Partial Mastectomy Defects"*
Joshua L. Levine, M.D. and Robert J. Allen, M.D., New Orleans, LA

The use of lateral thoracic skin and fat for breast reconstruction is advantageous because it does not require the use of muscle transfer, and the donor site incision is well hidden under the arm. In patients with redundant skin at the thoracic flank, use of this tissue has the added benefit of removal of an unsightly roll. The lateral thoracic

skin and fat flap can be harvested using microsurgical technique based on three different pedicles: the thoracodorsal artery perforators (TDAP); a direct cutaneous branch of either the thoracodorsal, axillary or lateral thoracic arteries; and the lateral thoracic intercostals perforating vessel. In this report we review these options, present a case illustrating each option, and suggest an algorithm for deciding which pedicle to use.

9:14 – 9:21 *"Maximizing Latissimus Dorsi Breast Reconstruction Utilizing Functional Muscle Transfer and Tissue Expansion"*
Bruce A. Mast, M.D. and Donna K. Simoneau, PA-C, Gainesville, FL

Latissimus dorsi breast reconstruction with implants has been criticized for Baker III or IV capsular contractures in 15% to 30% of patients. Also criticized is muscle atrophy and loss of breast volume and definition. This study evaluated two modifications of the classic latissimus reconstruction: muscle transferred as an innervated functional unit and tissue expansion posterior to the latissimus, but anterior to the pectoralis muscle. After expansion, a permanent prosthesis was placed (47 silicone gel and 3 saline). Fifty such reconstructions were done in 33 patients (17 bilateral and 16 unilateral), with average follow up of 18 months. Only 4 Baker III capsular contractures (8%) and no Baker IV contractures occurred. All patients demonstrated excellent retention of breast shape/definition. This study demonstrates that functional muscle transfer and tissue expansion results in low capsular contracture rates and excellent retained breast shape.

9:21-9:30 Discussion

9:30 – 9:37 *"The Role of MRI in Diagnosis and Management of Glomus Cell Tumor"*
Wyndell H. Merritt, M.D., Richmond, VA

Glomus cell tumors are renowned for maximum symptomology with minimal findings, but are still primarily diagnosed clinically. The intraoperative tumor size is difficult to assess, but if inadequately resected, they usually recur.

Two patients are presented with digital glomus cell tumors diagnosed on MRI. One MRI was useful to characterize the tumor for accurate resection. The other patient had atypical symptoms (only

point pain) with no other clinical findings to make the diagnosis. We conclude that MRI proves a useful tool for both diagnosis and treatment of glomus cell tumor.

9:37 – 9:44 *"Latissimus Dorsi Flap Remains an Excellent Choice for Breast Reconstruction"*
E. Sternberg, G. Perdikis, S. McLaughlin, M. Freeman, J. Waldorf, S. Terkonda, Jacksonville, FL

Latissimus dorsi flap has been unfairly relegated to a second option in breast reconstruction. 100 consecutive latissimus dorsi muscle flaps with tissue expander (LDMF) reconstruction were studied, mean follow up 34.5 months (range 1 - 175); 50 immediate, 50 delayed. With attention to a few technical details, overall excellent aesthetic, soft, reconstructions were achieved. Complications included 1 partial flap loss, 2 patients required inframammary fold revision, and 6 patients developed capsular contracture. Donor site seroma occurred in 34 patients; 6 required operative revision. Results were similar in the immediate versus the delayed groups.

LDMF remains an aesthetic, reliable, safe reconstructive choice.

9:44 – 9:51 *"Breast Reduction as an Alternative Treatment Option for Early Breast Cancer in Women with Macromastia"*
Brian P. Thornton, Daniel H. Stewart, Patrick McGrath, Lee L.Q. Pu, Lexington, KY

Introduction: Macromastia has been considered a contraindication to breast conservation therapy because of difficulties with postoperative radiation therapy. Furthermore, cosmetic results and oncologic cure following breast-conserving surgery and radiation therapy are generally poorer in women with larger breasts. However, breast reduction carried out at the time of surgical resection of breast cancer might potentially allow this group of women to undergo breast-conserving surgery with better cosmetic outcomes and possibly improved oncologic results. This study evaluates the feasibility of reduction mammoplasty as a component of breast conservation therapy for early breast cancer in patients with macromastia.

Methods: A retrospective review of the database from the

University of Kentucky Breast Care Center in the past 3 years identified 6 patients with significant macromastia receiving oncologic treatment for early breast cancer and simultaneous breast reduction. The mean patient age was 43.5 +/- 8.7 (mean +/- SD) years with 3 patients being Caucasian and 3 African-American. These patients with early breast cancer were initially seen by the surgical oncology service and referred to plastic surgery service for breast reduction as an alternative treatment option. All patients underwent a Wise pattern inferior pedicle breast reduction after surgical extirpation of the cancer with adequate surgical margin. Post-operatively, all patients received postoperative radiation as a part of the treatment and were evaluated for complications after breast reduction, aesthetic outcome and local recurrence after such a breast-conserving surgery.

Results: The average weight of the reduction mammoplasty specimen on the cancerous side was 827.2 +/- 130.9 g and 987.7 +/- 141.8 on the noncancerous sides. All breast cancers were Stage I or IIA averaging 2.3 +/- 1.5 cm in size with the adequate surgical margin prior to reduction. Subsequent pathologic examination of the reduction specimens revealed no further tumor specimen but cellular atypia was noted on 3 specimens from the cancerous side. All patients were followed for an average of 20.3 months with no major postoperative complications or recurrences. Breast reduction incisions healed primarily and necessary adjuvant radiation was not delayed. All patients were pleased with the aesthetic result and had improvement of their symptoms related to macromastia.

Conclusions: We believe that bilateral reduction mammoplasty is a reasonable and safe option for early breast cancer patients with macromastia who desire breast conservation therapy. A Wise pattern inferior pedicle technique offers a versatile preoperative design of breast reduction for this group of patients since the tumor is commonly located in the superior or lateral part of the breast. Our combined oncological and reconstructive approach would give women an important boost, both physically and psychologically, during management of their breast cancers by creating symmetric, aesthetically pleasing breasts.

9:51-10:00 Discussion

10:00-11:00	***Patient Safety Panel*** Felmont Eaves, M.D. Charlotte, NC
11:00	Adjourn – The Cloisters, Sea Island, Georgia June 3 - 7, 2006