specialty services such as reconstructive surgery. In January 2014, the Affordable Care Act (ACA) took effect, allowing states to expand Medicaid eligibility. Concurrently, Maryland also launched statewide global budgeting of hospitals, intended to control healthcare costs. However, the impact of such reform on utilization of reconstructive procedures has not been characterized. This study evaluated the impact of Medicaid expansion and global hospital budgeting on utilization of 3 common reconstructive procedures (reconstructive breast surgery, maxillofacial surgery, and hand surgery) by marginalized populations (Medicaid/uninsured patients).

MATERIALS AND METHODS: Adults in New Jersey (Medicaid expansion state), Maryland (expansion state with global hospital budgeting), and Florida (non-expansion state) undergoing the selected reconstructive procedures between 2012-2016 were tabulated using Healthcare Costs and Utilization Project State Ambulatory Surgery and Services and State Inpatient Databases. Interrupted time-series analyses were used to evaluate the impact of policy reform on reconstructive surgery utilization by marginalized patients.

RESULTS: During the study period, 96,662 Medicaid/uninsured patients underwent the selected reconstructive procedures in the 3 states. The likelihood of Medicaid being listed as the primary payer for patients undergoing reconstructive surgery significantly increased in expansion states (Maryland absolute policy effect: 0.02% per quarter, 95% confidence interval: 0.01% to 0.02% per quarter; New Jersey absolute policy effect: 0.04% per quarter, 95% confidence interval 0.02%–0.05%) when compared to Florida (non-expansion state). There was also an immediate policy effect: within 1 year of ACA implementation, there was a significant increase in the proportion of Medicaid beneficiaries undergoing the reconstructive procedures (Maryland, 0.03%, 95% CI, 0.01%–0.05%; New Jersey, 0.01%, 95% CI, 0.01%–0.02%), whereas there was a significant decline in the proportion of uninsured patients (Maryland, −0.01%, 95% CI, −0.01% to 0.0%; New Jersey, −0.008%, 95% CI, −0.01% to −0.006%). Trends in Maryland versus New Jersey were compared with understand the impact of global hospital budgeting. Global budgeting did not significantly impact overall utilization of reconstructive procedures amongst Medicaid beneficiaries, though there was an increase in utilization of emergent/urgent reconstructive procedures that reached borderline significance (0.03% per quarter; 95% CI, 0.0%–0.05%).

CONCLUSIONS: Medicaid beneficiaries experienced an increased utilization of reconstructive surgery post-ACA in expansion states when compared with nonexpansion states, mirroring trends in other areas of healthcare. Increased utilization by Medicare beneficiaries was not completely offset by decreases in utilization by uninsured patients, suggesting that the ACA expanded access to reconstructive surgery. It was encouraging that global hospital budgeting did not limit utilization of reconstructive procedures by Medicaid beneficiaries. In fact, utilization of emergent/urgent procedures among marginalized patients in globally budgeted hospitals increased, perhaps as a result of greater incentives for hospitals to connect vulnerable/high-risk patients to the care they need under this system.

REFERENCE:
1. Rajkumar R, Patel A, Murphy K, et al. Maryland’s all-payer approach to delivery-system reform. N Engl J Med. 2014;370:493.

Should Antiplatelet Therapy Be Held Perioperatively? The First Study Examining Outcomes in Patients Receiving Dual Antiplatelet Therapy in the Lower Extremity Free Flap Population

Presenter: Jenna C. Bekeny, BA
Co-Authors: Elizabeth G. Zolper, BS; Mark Mishu, BA; Christopher M. Fleury, MD; Kenneth L. Fan, MD; Christopher E. Attinger, MD; Karen Kim Evans, MD

Affiliation: MedStar Georgetown University Hospital, Washington, DC

BACKGROUND: Antiplatelet agents are typically held in the perioperative period due to intraoperative bleeding concerns. Dual antiplatelet therapy regimens, such as aspirin and clopidogrel, have significant morbidity and mortality benefit in patients with a history of ischemic heart disease or peripheral vascular disease making these therapeutic regimens commonly encountered in patients with chronic wounds requiring free tissue transfer (FTT). Emerging evidence suggests holding platelet antagonists for surgical therapy may lead to high thrombotic risks such as perioperative myocardial infarction. Furthermore, our institution has found favorable outcomes in patients on dual therapy receiving skin grafts. The objective of our study is to evaluate the impact of aspirin and platelet antagonist on FTT outcomes and need of the transfusion in the setting of copious hemostasis.
METHODS: A retrospective review of lower extremity FTT at our institution from 2011 to 2019 was performed. Data collected included demographics, comorbidities, administration of antiplatelet agents, and FTT characteristics. Outcomes of interest were blood transfusion volume, postoperative hematoma, and flap success.

RESULTS: We identified 196 LE FTT procedures performed for lower extremity salvage in the chronic wound population. Median age at time of FTT was 57 years (interquartile range, 47–65). Median Charlson Comorbidity Index was 3.0 (interquartile range, 1.0–5.0). Comorbidities included diabetes 44.4%, peripheral vascular disease 20.4%. Thirty-five of these patients (17.9%) were taking dual antiplatelet therapy (aspirin and clopidogrel). Of these 35, clopidogrel was continued throughout the operative course in 14 patients (40.0%) while it was held on the day of surgery in 21 patients (60.0%). Comparisons were made between the dual antiplatelet group (DA, n = 35) and nonantiplatelet group (NDA, n = 161); the dual antiplatelet group was further analyzed by continued therapy (CT, n = 14) versus held therapy (HT, n = 21). The volume of intraoperatively transfused blood products was significantly higher for the DA versus NDA groups. Median Charlson Comorbidity Index was significantly higher in the CT versus HT groups (5.0 versus 3.0; P < 0.001). There was no significant difference in intraoperative transfusion volume for the CT (median, 438 ml) versus HT (median, 600 ml; P = 0.427) groups. Intraoperative thrombosis occurred in 2.5% of all FTT patients (n = 5/196). While the incidence was highest in the HT cohort (n = 2/21, 19.0%), it was not statistically significant. Incidence of postoperative hematoma (NDA: 7.5%, DA: 17.1%; P = 0.100) and flap success (NDA: 95.0%, DA: 91.4%; P = 0.418) was similar between the 2 groups. One patient in the HT group had a myocardial infarct on postoperative day 1.

CONCLUSIONS: Despite increases in the volume of blood products transfused, FTT can be performed safely and successfully with perioperative administration of dual antiplatelet therapy. Antiplatelet therapy can be given throughout the operative course; holding antiplatelet therapy may result in cardiovascular risk. Holding clopidogrel on the day of FTT was not associated with decreased intraoperative transfusion. A multidisciplinary approach to surgical bleeding versus thrombotic risk is necessary in this comorbid population.

REFERENCE:
1. Walters E, Naz I, Mehra S, et al. Chronic antiplatelet or anticoagulant therapy does not increase graft failure after split thickness skin grafting. J Vasc Surg. 2018;67:E213.

Hypertrophic Scars: A Retrospective Review of Etiologies, Treatments, and Outcomes

Presenter: Kevin M. Klifto, PharmD
Co-Authors: Pooja Yesantharao, MS; Andres Makarem, BS; Carisa M. Cooney, MPH; C. Scott Hultman, MD, MBA; Damon S. Cooney, MD

Affiliation: Johns Hopkins University, Baltimore, MD

PURPOSE: We conducted the current study to review our clinical experience managing hypertrophic scars. Our primary aim was to investigate the outcomes of nonsurgical and surgical treatments intended to remove or reduce hypertrophic scars. The secondary aim was to investigate anatomical locations and nonsurgical and surgical treatments between burn and nonburn etiologies of hypertrophic scars. Tertiary aims were to assess responses to therapy and recurrence rates associated with different laser settings.

METHODS: A retrospective analysis of a consecutive cohort of patients whose hypertrophic scars were managed and followed up in clinic from January 1, 2017 to January 1, 2019. Patients were included if they were ≥18 years of age and had a documented diagnosis of a hypertrophic scar. Patients were excluded if they did not follow-up after hypertrophic scar treatment or if they had a keloid scar diagnosis. Primary outcomes measured were hypertrophic scar treatment modalities and corresponding changes in pain scores, changes in pruritus scores, and recurrence rates following treatments. Secondary outcomes measured were scar locations, previous treatments, previous surgery in scar location, subsequent treatments, and postsurgical adjuvant therapy between burn and nonburn etiologies. Tertiary outcomes measured were responses to therapy and recurrence rates associated with laser types, settings and handpiece options.

RESULTS: One hundred forty-two patients (mean age, 40.6 ± 15.9 years) had 595 hypertrophic scars. Median length of follow-up was 10.1 months (interquartile range, 7.3–14.8 months). Surgery or lasers were associated with significant changes in pruritus scores compared to corticostroid injections or topical steroids alone (P = 0.01). Lasers or corticosteroid injections were associated with significantly lower recurrence rates compared to surgery or topical corticosteroids alone (P = 0.03). Lasers significantly increased