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PURPOSE: Underrepresented minority (URM) patients are often systematically disadvantaged in their ability to access care. Of these, lesbian, gay, bisexual and transgender (LGBT) patients are subjected a unique set of healthcare disparities not faced by other URMs. To better understand how this specific URM population faces novel difficulties in their access to care within plastic surgery, this study aimed to delineate the demographics of and attitudes toward the LGBT population within the plastic surgery academic community.

METHODS: An anonymous survey was distributed to faculty and residents in every plastic surgery residency within the United States. Respondents were asked their training status or faculty position, gender identity and sexual orientation. Subsequent questions targeted perceptions of and attitude towards the impact of sexual orientation and gender identity on plastic surgery training and work experiences.

RESULTS: We received 385 responses from 201 residents (52.5%) and 179 attending surgeons (46.5%). Thirty respondents self-identified as LGB, none as transgender. Of LGB respondents, 59% were open about their sexuality to all residents, 36% to some, and 4% to none. Only 21% were open to all attendings, most (68%) were open to some, and 10% to none. While 65% did not fear rejection/reprisal following disclosure of their sexuality, the overwhelming majority (95.6%) were not open during the application/interview process. Some (13%) were advised not to disclose their sexual orientation while applying or interviewing. During training, 17% of LGB respondents experienced homophobic remarks from residents and 26% experienced such remarks from attendings. However, 90% did not report the incident. Many respondents reported witnessing transphobic and/or homophobic remarks made by hospital staff including nurses (34.3%), other residents (24.1%), and attendings (23.8%). Only 7.3% of respondents admitted making transphobic or homophobic statements and only 7.9% reported witnessing discriminatory care toward LGBT patients and patients’ partners. Only 6.9% felt that homosexuality was immoral while 5.5% felt that being transgender was immoral. 32.7% of respondents reported teaching medical students awareness and sensitivity to the health concerns of LGBT patients while 18.9% disagreed in doing so.

CONCLUSION: Our data suggests that despite recent social progress towards the acceptance of the LGBT community, there exists ongoing discrimination within both the plastic surgery and healthcare community. Though a majority of LGB respondents did not fear rejection/reprisal following disclosure of their sexuality, it is significant that a third still did, reflecting ongoing fears of the community. That over a quarter of respondents overheard transphobic/homophobic remarks speaks to the need for ongoing education/training. That training/education on the health concerns of LGBT patients is opposed by large percentage of respondents speaks to the acuity of this need. There is also, however, clear evidence of support and tolerance within academic plastic surgery, as evidenced by the majority of LGB residents who are open to some or all residents and attendings and only a small percentage of LGB respondents were advised not to disclose their sexuality during interviews. While more progress is needed to ensure equitable access to care, academic plastic surgery is increasingly tolerant of the LGBT community.

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Acellular Dermal Matrix Sterility: Does it Affect Microbial and Clinical Outcomes Following Implantation for Breast Reconstruction

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INTRODUCTION: There has been much debate regarding the use of Acellular Dermal Matrices (ADM) in breast reconstruction and the risk for postoperative infectious complications. Recent literature has further investigated the effects of ADM sterilization on these complications, although with varying conclusions. Previous work by our group examining the microbiological profile of sterile and aseptic ADM showed no significant difference between aseptic and sterilized products immediately out of the package. In this study we investigate the microbiologic profiles of these agents after implantation.
**METHODS:** In this prospective study we sampled previously implanted samples of ADM. These ADMs were implanted during the first stage of tissue expander based immediate breast reconstruction, and a 1 cm squared sample was excised during the stage II expander-implant exchange procedure. Samples were incubated and cultured for 48 hours in tryptic soy broth. Those samples which showed growth were further cultured on tryptic soy broth and blood agar plates. Patient records were also analyzed, to determine if ADM sterilization and microbial growth were correlated with infectious complications following the stage I and stage II operations.

**RESULTS:** A total of 51 samples of ADM were collected from 32 patients. Six samples were from aseptic ADM (Alloderm), 27 were collected from ADM sterilized to $10^{-3}$ (Alloderm RTU), and 18 samples were from products sterilized to $10^{-6}$ (Allomax). None of the samples demonstrated bacterial growth. Only 3 of the patients experienced postoperative cellulitis between the initial implantation of ADM and the second stage of reconstruction. Two of these patients also developed deep space infections. There was no statistically significant correlation between the ADM used and the degree of ADM sterility.

**CONCLUSIONS:** Our findings showed no discernible difference in microbial presence and clinical outcomes when comparing the varying degrees of ADM sterility. Furthermore, patients experiencing postoperative infections did not show bacterial growth when the ADM was cultured during the expander-implant swap procedure. Our study did not demonstrate a clinical microbiological difference between aseptic or sterile ADM products when used for tissue expander based breast reconstruction.

**METHODS:** A retrospective review was conducted of UBC patients treated between 2006 and 2010 with UM and BM in a large healthcare system. Institutional billing data was investigated for 5 years postoperatively to determine the immediate and subsequent charges of all breast-related care associated with the initial diagnosis.

**RESULTS:** During the study period, 450 subjects undergoing UM (n=286) or BM (n=164) were eligible for review. At 1 year, physician charges were significantly lower following UM versus BM (median $26,399 vs. $36,367; p<0.0001), and there was a trend toward lower hospital (median $88,427 vs. $96,412; p=0.9509) and total (median $125,230 vs. $138,467; p=0.6075) charges in this group as well. However, during years 2–5, physician (median $6,030 vs. $3,322; p=0.0338), hospital (median $14,596 vs. $8,019; p=0.0023) and total (median $22,128 vs. $13,478; p=0.0116) charges were significantly higher following UM.

**CONCLUSIONS:** Charges following UM at 1 year were lower as compared to BM. However, the UM group experienced higher charges during years 2–5. It is essential to explore this topic further given that information on costs is valuable to patients and may exhibit some influence on the decision-making process. Short-term and long-term physician and hospital charges by mastectomy type after propensity score matching.

**PURPOSE:** The purpose of this study was to determine costs following unilateral mastectomy (UM) and bilateral mastectomy (BM) for patients with unilateral breast cancer (UBC). We hypothesized that BM may be associated with fewer costs over time.

**RESULTS:** A total of 51 samples of ADM were collected from 32 patients. Six samples were from aseptic ADM (Alloderm), 27 were collected from ADM sterilized to $10^{-3}$ (Alloderm RTU), and 18 samples were from products sterilized to $10^{-6}$ (Allomax). None of the samples demonstrated bacterial growth. Only 3 of the patients experienced postoperative cellulitis between the initial implantation of ADM and the second stage of reconstruction. Two of these patients also developed deep space infections. There was no statistically significant correlation between the ADM used and the degree of ADM sterility.

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**IQR, interquartile range**

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