Hospital, and Metropolitan Hospital Center. Using these datasets, we examined breast reconstruction rates four years before (2007–2010) and three years after (2011–2013) the law came into effect. We further evaluated documentation of reconstructive discussion and referral and other variations in hospital care by subgroup.

RESULTS: All four hospitals reported that their breast surgeons were made aware of the law shortly after passage. We analyzed 603 patients who underwent mastectomies with a 50.9% reconstruction rate before law enactment and 50.0% after. Hospital-based subgroup analysis at Lincoln and Bellevue demonstrated 398 patients who underwent mastectomies with a 47.52% reconstruction rate before the law and a 57.65% after (OR 1.503, p-value = 0.0434). Jacobi patients were analyzed separately due to a reported breast surgeon preference shift favoring lumpectomies over mastectomies post-law enactment. 173 patients were analyzed demonstrating a 56.58% reconstruction rate before the law and a 38.14% rate after (OR 0.473, p-value = 0.0164). At Jacobi, discussion rate before the law was 71.05% and 94.85% after (OR 7.496, p-value < 0.0001).

CONCLUSION: Our results suggest that enactment of the law was correlated with a slight increase in reconstruction rates after mastectomy at Lincoln and Bellevue and an increase in discussion rates at Jacobi. Decrease in reconstruction rates at Jacobi may be explained by reported breast surgeon preference for lumpectomies over mastectomies post-law enactment. The relatively modest increase in discussion and reconstruction rates seen in this urban populace as compared to the SPARCS database may suggest that there can be a saturation point wherein patients who are made aware of options still choose not to see a plastic surgeon or undergo reconstruction. Limitations to this study are its retrospective design and potential under-reporting of patient outcomes by data collection methods. Further study is ongoing to determine the patient, provider, and healthcare environment factors that impact breast reconstruction.

Usefulness of Orbicularis Oculi Myocutaneous Flap in Periorbital Reconstruction

**Presenter:** Yong Chan Bae, MD, PhD

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**PURPOSE:** After removal of the cancer or mass from the periorbital region, reconstruction of the defect site is often performed. Since the eyelid skin is thin and functionally important, reconstruction using the surrounding eyelid tissue is superior in terms of color match or blood supply, rather than using tissue from other areas. We retrospectively analyzed 25 patients who underwent surgery using the Orbicularis oculi myocutaneous flap in the clinic of the authors, to demonstrate the usefulness of the OMC flap.

**METHODS:** From November 2001 to July 2017, we performed 36 OMC flaps in 30 defects in 25 patients who underwent OMC flap reconstruction for periorbital defect. The medical records of each patient were reviewed retrospectively, we analyzed age at the operation, sex, cause of the defect, location, surgical method and complications.

**RESULTS:** Of the 25 patients, 12 were males and 13 were females. The mean age was 64 years and the median age was 68 years. There were 8 upper eyelid, 15 lower eyelid, 5 medial canthal and 2 lateral canthal in 30 defects. There were 20 cases of basal cell carcinoma, 2 cases of squamous cell carcinoma, 6 cases of xanthoma and 2 cases of coloboma. As a surgical methods, there were 25 reconstructed defects with only OMC flap, 5 with composite graft with OMC flap, and 6 with OMC flap and FTSG. By type of OMC flap, there were 18 V-Y advancement flaps, 12 switch flaps, 4 pivot flaps, and 2 simple advancement flaps. There was no other complication or abnormality except 1 patient with recurrence of cancer and 1 patient with entropion.

**CONCLUSION:** The OMC flap can be used to reconstruct the periorbital defect by various methods regardless of the position or size of the lesion. We demonstrated the usefulness of the OMC flap with high patient satisfaction without any complications in reconstruction using 30 OMC flaps in 36 defects in 25 patients.

**Autologous Engineered Skin for Coverage after Giant Congenital Melanocytic Nevi Resection**

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BACKGROUND: Giant Congenital Melanocytic Nevus (GCMN) is a proliferation of melanocytic cells present at time of birth with an expected diameter >20 cm by the time of adulthood. GCMN has been associated with malignant melanoma, rhabdomyosarcomas and other tumors. Nevertheless, its resection in order to reduce the risk of malignancy is still controversial. Surgical excision is in most cases performed for aesthetic purposes, therefore, the need for techniques that minimize surgical sequelae.

Coverage of the wound bed can be challenging, specially with nevi that involve more than 20% of total body surface area (TBSA). Serial extirpation after tissue expansion is the gold standard treatment for nevi located in the trunk, scalp and face. However, for lesions located in the buttocks or limbs skin grafts are the elective treatment, involving important aesthetic sequelae at donor site.

We present our long-term results with autologous engineered skin (AES) for coverage after GCMN resection.

METHODS: We performed a retrospective review of the medical records of a series of 5 pediatric patients suffering from Giant Congenital Melanocytic Nevius, operated in our department. Nevus resection was performed in one or more surgical procedures depending on nevus extension. A maximum of 15% TBSA was removed on each procedure and the defect was then covered with artificial dermal matrix. A skin biopsy of an uninfected area was obtained from the patient and sent for culture to the Tissue Engineering Unit. After 3 weeks, which allowed for dermal matrix neovascularization and for keratinocytes expansion; AES was grafted over a well vascularized homogeneous wound bed.

RESULTS: The average take percentage per grafting procedure was 46% SCT (15 – 95%). The major cause for graft loss was wound bed infection in early stages. Average follow-up period was 11 years with a range of 2 – 14 years. Patient’s degree of satisfaction was evaluated with EQ-5D-Y health questionnaire, showing a health status evaluated between 95–100%. Results were evaluated with Modified Vancouver Scar Scale (MVSS) and Patient Observer Scar Assesment (POSAS). MVSS showed a total score of 6,25, being 14 the worst result. POSAS global evaluation was a 4,25, being 1 equal to normal skin, and 10 very different to normal skin.

CONCLUSION: GCMN management needs to be individualized. We can conclude that AES is a good surgical resource for coverage of defects after GCMN resection when tissue expansion might not be an option, avoiding or limiting donor sites and acting as a stable coverage with growth potential over time.

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What Are the Applicants Thinking? A Longitudinal Assessment of Integrated Plastic Surgery Program Attributes during the Interview Season

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PURPOSE: Integrated plastic surgery residency positions continue to grow at a soaring rate. From 2013 to 2017, the number of available positions rose from 116 to 159. Despite this increase, the caliber of applicants has remained competitive. While numerous publications highlight the attributes of a successful applicant, few look at program characteristics that appeal to applicants. Our study aims to elucidate program attributes are attractive to applicants at the beginning and end of their interview season, and how the importance of these attributes may change during the process.

METHODS: An ASPS endorsed survey was distributed to applicants applying for an integrated plastic surgery