the forehead region a micropore tape is placed for three days.

Stitches in front of the ears and alternate stitches in the hairline are removed at five days and the remaining sutures in the hairline at ten days.

We have been using the Round Mini-lift Technique since April 2005, in more than 500 patients from 39 to 83 years.

RESULTS: Once the undermining and dissection are very limited there are no expressive swellings or complications.

CONCLUSION: The operation is easy and fast to perform, accompanied by inconsiderable injury to the tissues and a short-term rehabilitation period.

INTRODUCTION: Pre-pectoral direct to implant (DTI) breast reconstruction has historically been fraught with complications including flap necrosis, implant extrusion, and capsular contracture as well as extremely high rates of operative revisions. This may result from a number of factors, including the lack of an algorithmic approach, failure to predict postoperative migration of the implant, use of improper implants, and unsuitable patient selection. Over the last 5 years, we have gained significant experience from the performance of DTI reconstructions at our institution and believe we have valuable knowledge and clinical pearls to offer to reconstructive surgeons.

VIDEO: Using video, technical aspects to achieving superior results will be demonstrated, including suture technique, application of acellular dermal matrix (ADM) and creation of the implant pocket, implant selection and placement, and post-operative dressings. Preoperative and postoperative video will be used to illustrate potentially avoidable mistakes.

TECHNIQUE: In our operative method, a tenting technique is utilized whereby a sheet of ADM is trimmed to cover the anterior surface of the implant and is circumferentially sutured into the mastectomy pocket. In comparison, techniques in the literature describe an off-label wrap or modified wrap technique. We will highlight technology that has led to superior results in our practice including ADM, fluorescence-based tissue perfusion technology, highly cohesive implants (anatomic, extra fill round), and evolutions in mastectomy operations with ideal incision placement.

PATIENT SELECTION: Patient selection is paramount. We will briefly review ideal and less suitable candidates with regards to the breast envelope. In addition, absolute contradictions such active smoking and relative contraindications including preoperative and postoperative radiation will be reviewed. Other criteria suggested in the literature will be discussed including BMI, breast size and significant medical comorbidities.

CLINICAL AND TECHNICAL PEARLS:

• Preoperative selection for prepectoral DTI
• Placement of ADM and pocket construction
• Implant selection based on mastectomy weight and pocket dynamics
• Anticipating postoperative implant migration and ADM stretch
• Casting technique for skin adherence and correction of ptosis

Fat Grafting Prior to Tissue Expander Exchange Can Optimize Results in Implant-Based Reconstruction in Irradiated Breast

Presenter: Han L. T. Hoang, MD
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INTRODUCTION: Radiotherapy is known to associate with increased risks of post-operative complications, especially in implant based breast reconstruction. In addition to vascular compromise and compromised wound healing, radiation also results in significant tissue atrophy. This complicates subsequent surgeries, including tissue expander exchange to implant, fat grafting, nipple reconstruction, and implant exchange. Fat grafting in radiated tissue has shown in vitro and vivo to improve tissue quality. However, fat grafting in the setting of radiated tissue expander/implants may increase implant related complications including infection, exposure, and implant loss. In this study we aim to evaluate the safety profile and outcomes of fat grafting before tissue expander exchange in radiated patients.

METHODS: All Patients with tissue expander based reconstruction post radiation therapy who received fat grafting either before or after tissue expander exchange between January 2014 to December 2016 were included. Demographics, intraoperative details and outcomes including surgical complications and revision surgeries were reviewed.

RESULTS: 8 consecutive patients with implant-based reconstruction who underwent fat grafting after radiation were included in the study. 5 patients had fat grafting before tissue expander exchange. 3 patients had fat grafting after permanent implant placement. Average injection volume is 40 cc per breast. There was no surgery-related complication from any of the stages, tissue expander placement, intermediate fat grafting, and tissue expander exchange. Patients who had fat grafting prior to exchange appeared to have a softer and thicker soft tissue envelope.

CONCLUSION: Fat grafting in irradiated breasts prior or after tissue expander exchange is safe and may improve the tissue quality of the mastectomy skin. As radiation induced tissue atrophy progresses over time, we recommend fat grafting prior to the tissue expander exchange to introduce new healthy cell to build up mastectomy flap prior to permanent implant exchange. This may decrease complications and optimize the result of the permanent implant placement.

A Practical Way for Deciding the New Location of the Nipple in Reduction Mammaplasty, Equilateral Triangle Concept

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INTRODUCTION: The concept of the ideal breast is questioned throughout the ages by the sculptors, painters and finally by the plastic surgeons. The most argued theory is an equilateral triangle joining the sternal notch and two nipples measuring 19–21 cms. Even though it is used in augmentation procedures, this concept is under-utilized in reduction mammoplasty or mastopexies. Breast reshaping procedures use different pedicles for carrying nipple areola complex (NAC) to its new position. Whichever pedicle we use the most important step is the new place of the NAC. In the standard marking we draw a meridian starting from midpoint of the line joining notch and AC(acromioclavicular) joint bisecting the breast. Then we move the nipple on that imaginary meridian to its new place. The problem is, on big sized breasts where nipples are more lateral then normal and in overweight patients, it is harder to correctly place that meridian confusing non-breast lateral tissue with the actual breast itself, drawing that line laterally then it should be. This can cause laterally placed nipples post-op. To overcome this problem, one can utilize equilateral triangle concept in reduction and place the nipples on an imaginary equilateral triangle which two sides are notch-new nipple and one side is between the new nipples.

METHODS: 12 patients with laterally placed nipples were operated by the author between January 2015 and September 2016. 2 inferior and 10 superomedial pedicled breast reductions were performed. New nipple-notch distances were between 21–23 cms. During the marking imaginary meridian line was drawn first then triangle was utilized and distance between the two possible nipple placements measured. The mean follow-up after the operation was 6 months (3–11 months)

RESULTS: The mean distance between two possible nipple placements was 2.1 cm (1–4 cms). 10 of the 12 patients were highly satisfied with the results. The reason for the dissatisfaction of the other patients were not related to placement of their nipples. None of the patients complained of a medially placed nipple.

CONCLUSION: Using the equilateral triangle concept is an quick way to doublecheck the new location for the new nipple.