**Association for Transgender Health** criteria, and many were advised to have a preoperative mammogram. Demographics and outcomes data were collected and analyzed. Aesthetic results were evaluated by a blinded plastic surgeon.

**RESULTS:** From 2010–2015, 97 patients were identified who met our criteria, for a total of 194 mastectomies. The average age was 29 years (range 15–61), average BMI was 30 (range 20–54), and average specimen weight was 708 grams per breast (range 86–2702). The vast majority received full thickness nipple grafts (170/194). Eighty (82%) patients were on perioperative Testosterone. The average follow up was 98 days (range 0-1288). The aesthetic outcomes improved with surgeon experience. We had a total of 5 major complications which led to secondary surgical procedures: 2 hematomas requiring operative evacuation, and 3 seromas necessitating drain placement. One patient was diagnosed with breast cancer on screening mammography and was excluded. Minor complications included hypertrophic scarring, standing cone deformities, and pigmentation changes of the nipple grafts. There were no deaths or perioperative venous thrombosis.

**CONCLUSION:** Despite the recent increase in mastectomies performed annually, there is still no consensus on surgical method. With appropriate preoperative screening, patient selection and surgical technique, bilateral subcutaneous mastectomies for female to male gender confirmation surgery can be a safe, highly satisfying procedure. We wish to share our pearls (preoperative marking, patient positioning, DVT prophylaxis, surgical approach, nipple placement, etc.) to attain functional and cosmetically appealing outcomes.

**DISCLOSURE/FINANCIAL SUPPORT:** We have nothing to disclose.

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**Revisiting Buttock Implant Placement-Tilt Your Implants, Enhance Your Shaping Results**

**Alexander Aslani, MD, PhD**

**SUMMARY:** Most surgeons with clinical interest in buttock surgery will favour fat grafting as the gold solution in buttock surgery. While we share this view, in our experience good results are reserved to patients with favourable buttock shapes before surgery and BMI values around 26–30.

If patients are thin good fat grafting results are still possible but surgeons may often encounter some disappointment with the size achieved. For those patients, implants ideally supplemented by moderate volume fat grafting may yield more patient satisfaction. We present our modification in implant placement with supplementary fat grafting as a pearl to get more impressive results out of buttock surgeries on female patients.

**METHODS:** Our gold standard for patients with a BMI less than 26 is to combine intramuscular placement of anatomical implants supplemented by fat grafting wherever possible.

During the last years, we have modified our technique from vertical placement of the implants, as recommended by the manufacturer, towards a rotation paralleling the gluteus muscle fibres. The technical challenge in comparison to vertical implant placement is to avoid violation of the lateral gluteus muscle border.

In all cases presented, Waterjet assisted fat transfer was added before placement of the implants, with focus on the midbuttock area.

**DISCUSSION:** This is an adjustment with a learning curve, but the result is a much more pronounced enhancement of the hip area and widening of the inferior frame, a feature highly desired by most patients seeking buttock augmentation surgery.

**CONCLUSION:** Standard industry recommended vertical placement of anatomical buttock implants does not exhaust the potential of these devices, since the volume addition to the hips is limited. We have found that our adjustment with rotation of the implant rewarded us with much more rewarding results on the hips of operated patients.

**Autologous Fat Transfer for Augmentation Mammoplasty and Gluteal Reshaping, a Video Presentation**

**Alberto M.L. Caldeira, MD, PhD; Walter Marrou, MD**

**INTRODUCTION:** Autologous fat transfer is a procedure that has attracted many surgeons in the last few years. Adipose cell aspirate is a source of mesenchymal stem cells which are similar to those within the bone marrow, the most
researched type of stem cell, with the advantage that the harvest is easier to obtain, by using adipose cell aspirates collected during body contouring procedures, in relation to bone marrow stem cells. Knowing mesenchymal stem cells proliferative properties, we are going to evaluate the use of autologous fat transfer as an alternative for augmentation mammoplasty and gluteal reshaping.

**MATERIALS AND METHODS:** In this 5:00 minute video presentation we show the technique of autologous fat transfer for augmentation mammoplasty and gluteal reshaping in a patient. It starts with showing the marking of the breast, gluteal and abdominal area where the fat will be transferred. Afterwards dorsal liposuction takes place and decantation of the fat occurs in the canister. Then the fat is transferred to 60ml syringes where it is decanted for a second time and injected in the gluteal area with a total volume of approximately 300cc per side.

When autologous fat transfer to the gluteal area is finished, the patient is turned. Infiltration of the ventral abdominal area and liposuction is performed collecting and decanting the adipose tissue as explained. Before infiltration to the breast, fat is transferred from the 60ml syringes to 10ml syringes. Infiltration takes place using microcanulas (1.5 - 1.7mm in diameter) to inject the fat in a multilayered tunneling process into the subcutaneous and retroglandular areas of both breasts. The total volume of fat transferred to each breast in this patient was approximately 300cc.

**RESULTS:** Photos are shown comparing the preoperative and immediate postoperative results in the patient. Also, preoperative and postoperative follow-up photos of some patients are shown at 7, 14 and 36 months.

**CONCLUSIONS:** Adipose derived stem cells have demonstrated proliferative properties used to repair and substitute damaged cells or missing tissue. Autologous fat transfer is a technique used to fill and model tissues thus promoting a volumetric increase and a restoration of the tissues adjacent to the transfer site in a significant, reliable, long-lasting and safe way.

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**INTRODUCTION:** Blepharospasm is part of a spectrum of facial dystonia which can result in significant psychological and social distress to patients. Currently, mainstay treatment of blepharospasm is botulinum A.¹ Myectomy is reserved for patients have poor responses to botulinum toxin. Myectomy for benign essential blepharospasm decreases the morbidity, botulinum toxin treatment frequency, and long-term expense associated with this disabling condition.² However, myectomy can result in hollowing appearance and unpleasant cosmetic outcomes.³ We use a modified surgical method of preseptal orbicularis oculi myectomy and orbital orbicularis myotomy in situ for patients with benign essential blepharospasm to achieve satisfying outcomes in function and aesthetics.

**MATERIAL AND METHODS:** Between January, 2012 to October, 2014, we enrolled patients with benign essential blepharospasm who had poor response to botulinum toxin. Associated ptosis and dermatochalasis were assessed preoperatively. We performed upper and lower eyelid preseptal orbicularis oculi myectomy with orbital orbicularis myotomy in situ on these patients under general anesthesia. Simultaneous upper blepharoplasty and levator aponeurosis plication were also performed to correct dermatochalasis and ptosis.

**RESULTS:** There were eleven patients underwent upper and lower eyelid myectomy with myotomy in situ. Three were male and the other was female. Average age is sixty-one. Mean follow-up time was 27.25 months. Treatment interval of botulinum toxin injection before surgery was 10.2 weeks in average, which increased to 16.4 months after surgery. Subjective improvement in average was 75%. Blepharospasm function disability score was 12 in average, and improved to 6 in average.

**CONCLUSIONS:** This is a new surgical method for refractory benign essential blepharospasm. In comparison to previous limited upper myectomy, preseptal orbicularis oculi myectomy and orbital orbicularis myotomy in situ preserve the muscle volume and thus provide better aesthetic outcome without compromise of functional result in our experience.

**DISCLOSURE:** None of the authors has a financial interest in any of the products, devices, or drugs mentioned in this manuscript.

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