P34.
THE ANTERIOR SMAS APPROACH TO FACELIFTING
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PURPOSE: To present an anterior approach to SMAS facelift.

METHODS: Two hundred consecutive facelifts were performed with an anterior SMAS flap approach often including buccal fat pad removal from the anterior approach.

RESULTS: No instances of neuropraxia, impressive mid-face vertical elevation, heart shaped face shaping due to fat repositioning and buccal fat pad removal when indicated along with improvement in the contour of the jawline.

CONCLUSION: The anterior SMAS approach to facelift is a safe approach to elevate the midface and contour the jawline as well as remove ptotic and or enlarged buccal fat pads.

P35.
FACIAL CONTOURING BY TARGETED RESTORATION OF FACIAL FAT COMPARTMENT VOLUME: THE MID-FACE
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PURPOSE: Recent anatomical findings have suggested that facial fat distribution is complex and changes with age. Here, we developed a grafting technique based on the physiological distribution and volume changes of facial fat compartments to achieve a youthful and natural-looking face.

METHODS: Forty cadaveric hemifaces were used for the dissection of fat compartments and neurovascular structures in the mid-face area. Seventy-eight patients were treated for cheek atrophy using our targeted restoration of mid-face fat compartment volume. The outcome was evaluated by a two-dimensional assessment, the malar lipo-atrophy assessment and a satisfaction survey.

RESULTS: The medial and lateral parts of the deep medial cheek fat compartment (DMC) were separated by a septum arising from the lateral border of the levator angularis muscle. The angular vein traveled between the DMC and the buccal fat pad, 12mm from the maxilla bone. A total volume of 29.3ml fat was grafted per cheek for each patient. A 12-month follow-up revealed an average volume augmentation rate of 27.1%. Pleasing and elevated anterior projection of the cheek and ameliorated nasolabial groove were still obvious by 12 months after the procedure. In total, 95.2% of the patients were satisfied with their results.

CONCLUSION: The present study provides the anatomical and clinical basis for the concept of compartmentally based fat grafting. It allows for the restoration of facial fat volume close to the physiological state. With this procedure, a natural and youthful facial contour could be rebuilt with a high satisfaction rate.

P36.
QUANTIFYING THE DEVELOPMENT OF BREAST CANCER SURGERY-ASSOCIATED LYMPHEDEMA IN HIGH-RISK PATIENTS UNDERGOING AXILLARY LYMPH NODE SURGERY IN CONSECUTIVE PATIENTS
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PURPOSE: Lymphedema represents a significant morbidity for patients after breast cancer surgery. However, there is no strong evidence on the predictors of breast cancer surgery-associated lymphedema (BCAL). We aim to evaluate predictors of BCAL in breast cancer patients undergoing surgical treatment.
METHODS: A retrospective review of all consecutive breast cancer patients undergoing lumpectomy and/or mastectomy with axillary lymph node surgery (>4 nodes removed) between 2010 and 2015 was undertaken. Primary outcome of interest was lymphedema development.

RESULTS: A total of 315 patients were identified, of which 34.3% underwent lumpectomy, 17.1% underwent mastectomy alone, while 48.6% underwent mastectomy and reconstruction. Lymphedema was diagnosed in 9.2% (n=19) of mastectomy patients and 27.8% (n=30) of lumpectomy patients. Removing >10 nodes in both the mastectomy (OR=11.4, p=.000) and lumpectomy (OR=5.51, p=.034) cohort was predictive for lymphedema development. Neoadjuvant radiotherapy was predictive for lymphedema in the mastectomy cohort (OR=6.15, p=.015). Age, BMI, adjuvant radiotherapy, chemotherapy and positive axillary nodes were not predictive of lymphedema development in either group.

CONCLUSION: Results suggest that patients are more at risk of post-operative lymphedema if they have more than ten axillary lymph nodes removed. As expected, patients undergoing mastectomy are at an increased risk for lymphedema if they have had neoadjuvant radiotherapy. These results may help clinicians pre-operatively identify patients at a greater risk of developing lymphedema and to take preventative, anti-lymphedema measures.

P37.

ANALYSIS OF SURVIVAL AND RECURRENCES FOR PATIENTS WITH BREAST CANCER RECEIVING MASTECTOMY WITH OR WITHOUT BREAST RECONSTRUCTION
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PURPOSE: Post-mastectomy breast reconstruction significantly improves quality-of-life among breast cancer survivors. However, some patients still report concerns over the impact of breast reconstruction on survival. This study aimed to estimate the association between breast reconstruction and overall survival among women who undergo mastectomy for breast cancer.

METHODS: We analyzed survival data from a prospectively-kept institutional breast cancer registry, comparing mastectomy-only patients to post-mastectomy breast reconstruction patients. We built Kaplan-Meier curves for both groups and compared unadjusted survival statistics using Logrank test. We used Cox Proportional Hazards to adjust for potential confounders.

RESULTS: 2,599 women underwent mastectomy for breast cancer during 2000–2014. Of these, 1,052 (40.5%) underwent mastectomy only and 1,547 (59.5%) also underwent breast reconstruction. Most reconstructions were autologous (65.1%), followed by implant-based (26.8%), and mixed (8.1%). Survival was significantly improved among women who underwent post-mastectomy breast reconstruction, compared to women who underwent mastectomy only (p<0.001). However, this was no longer significant after adjusting for stage, patient age, smoking status, radiotherapy, chemotherapy, hormone therapy, and axillary lymph node status (HR: 0.87; 95% CI: 0.67–1.13; p=0.320).

CONCLUSIONS: Breast reconstruction does not negatively impact patient survival. On the contrary, breast reconstruction patients showed improved survival in unadjusted analysis. Surgical oncologists and plastic surgeons should reassure breast cancer patients that breast reconstruction is a safe option for them with potential to improve their quality-of-life.