and 4 beard) and 14 cleft lip repair (6 unilateral, 8 bilateral) were included in the study. Firstly the recipient areas were assessed for scar width and maturity, the number of needed donor grafts, the angle and direction of the existing hair around scar. The occipital and post auricular scalp area were selected as donor sides for scalp, sideburn and eyebrow scars. If there were adequate follicular unit in the submental beard region, it was selected as donor side for moustache and beard scar; if were not, scalp was selected again. Two teams that extraction and implantation worked together for shortening the duration of ischemia. 

Çeviri hatası: All patients were discharged on the same day with analgesics and antibiotics. The patient was called for control at the 2nd week, 1st, 3rd, 6th, 12th months and digital photographs were taken. Graft survival and patient satisfaction were assessed with Photoshop program and the patient satisfaction scale (1: not satisfied, 0: neutral, 1: moderate, 2: good, 3: very satisfied) at post-operative 1 year.

RESULTS: There were no major complications in the early postoperative period, transient edema due to tumescence infiltration and pain responding to simple analgesia. In the late period, one epidermal inclusion cyst developed, treated with excision. Mean survival rate of grafts was 86%. 20 patients were very-well satisfied (3), 7 were good (2).

CONCLUSION: The scarring alopecia is a challenging problem to deal with affects the social and psychological condition of the patient in the aesthetic units. Focal unit extraction technique (FUE) hair and beard transplantation is an easy, low cost, minimally invasive and alternative treatment with high success and satisfaction rate in scar camouflage.

Reference Citations:
1. Umar S. Use of beard hair as a donor source to camouflage the linear scars of follicular unit hair transplant. J Plast Reconstr Aesthet Surg. 2012 Sep;65(9):1279–80.
2. Barr L, Barrera A. Use of hair grafting in scar camouflage. Facial Plast Surg Clin North Am. 2011 Aug;19(3):559–68.
3. Epstein J. Facial hair restoration: hair transplantation to eyebrows, beard, sideburns, and eyelashes. Facial Plast Surg Clin North Am. 2013 Aug;21(3):457–67.
4. Barrera A. The use of micrografts and minigrafts in the aesthetic reconstruction of the face and scalp. Plast Reconstr Surg. 2003 Sep;112(3):883–90.

RECONSTRUCTIVE SESSION 1

Posterior Sheath Repair in Abdominal Wall Reconstruction: Achieving Retromuscular Mesh Placement

Presenter: Charles A. Messa, BS

Co-Authors: Martin J. Carney, BS; Jason M. Weissler, MD; Sameer Shakir, MD; Fabiola A. Enriquez, BA; Stephen J. Kovach, MD; John P. Fischer, MD, MPH

Affiliation: University of Pennsylvania, Philadelphia, PA

INTRODUCTION: Ventral hernia repair (VHR) remains a difficult surgical problem to manage. Retromuscular sublay mesh placement in VHR consistently provides favorable outcomes regardless of mesh type utilized, presumably highlighting the importance of the posterior rectus sheath. We hypothesized that posterior sheath repair to achieve retromuscular closure demonstrates improved outcomes compared to intraperitoneal repair as well as comparable recurrence and complication profiles to retromuscular sublay repair.

METHODS: We performed a single-institution retrospective review over three-years of consecutive hernia repairs for two surgeons. Included patients were grouped according to repair-type: A) sublay placement with reconstructed posterior sheath, B) retromuscular repair with unaltered posterior sheath, and C) intraperitoneal or underlay repair. Primary outcome measures included hernia recurrence and surgical site occurrence (SSO). Analysis included multivariate logistic regression and descriptive statistics.

RESULTS: One-hundred seventy-nine patients met inclusion criteria. There were 25 (14.0%) in Group-A, 89 (48.7%) in Group-B, and 65 (36.3%) in Group-C. Groups did not differ in average age 56.5 (p<0.298), BMI 32.4 (p<0.774), incidence of diabetes, hypertension, hyperlipidemia, COPD, tobacco use, OR time, or ostomy reversal. The majority of cases consisted of ASA class 3 (54.2%), Ventral Hernia Working Group (VHWG) class 2 (47.5%), and clean wound classification (63.7%). Prior hernia repairs were performed in 102 (57%) patients. Biologic mesh was used in 56 (31.3%) patients, synthetic in 103 (57.5%), and biosynthetic...
in 20 (11.2%). Patient post-operative follow-up averaged 15.5 months. Analysis of 11 recurrences yielded significant differences between Groups-B and C ($p<0.009$), a trend towards significance between Groups-A and C ($p<0.058$), and no difference between Groups-A and B ($p<0.608$). Retromuscular mesh placement and anterior components separation demonstrated protective effects on recurrence (OR: 0.148, $p<0.081$ and OR: 0.259, $p<0.067$). Postoperative mesh infection (OR: 72.03, $p<0.012$) and seroma (OR: 8.992, $p<0.036$) were significant predictors of hernia recurrence. BMI (OR: 1.052, $p<0.015$), VHWG (OR: 1.617, $p<0.036$), and hyperlipidemia (OR: 2.157, $p<0.049$) were significant predictors of SSO on multivariate regression. The posterior sheath was reconstructed primarily using absorbable suture for small defects, or biologic mesh for larger defects.

CONCLUSION: Initial analysis of posterior sheath repair to allow for retromuscular VHR suggests noninferiority, when compared to traditional sublay reconstruction. We present the first known description of discrete posterior sheath reconstruction to aid in retromuscular closure of complex ventral hernia.

Incisional Negative-Pressure Therapy Decreases Complications in Ventral Hernia Repair with Simultaneous Panniculectomy

Presenter: Silviu C. Diaconu, MD
Co-Authors: Colton H.L. McNichols, MD; Eseigboria Ikheoa, BS; Jennifer Bai, BA; Stephen S. Cai, BS; Jhade Woodall, MD; Michael P. Grant, MD, PhD; Arthur J. Nam, MD, MS; Yvonne M. Rasko, MD
Affiliation: R Adams Cowley Shock Trauma Center, Baltimore, MD

INTRODUCTION: Ventral hernia repair with simultaneous panniculectomy is associated with high wound complication rates. Some surgeons believe negative-pressure therapy (NPT) after primary closure of the surgical incision may lower wound complications. Although NPT has been shown to decrease complications in sternal and groin incisions, the benefit in ventral hernia repair is unknown and NPT in ventral hernia repair with simultaneous panniculectomy has not been studied. The purpose of this study is to retrospectively analyze if patients undergoing ventral hernia repair with simultaneous panniculectomy have improved outcomes with NPT.

METHODS: An eight-year retrospective study (2007–2015) was performed on patients undergoing ventral hernia repair with panniculectomy at University of Maryland Medical Center / R Adams Cowley Shock Trauma Center. Patients who underwent ventral hernia repair with simultaneous panniculectomy and incisional negative-pressure therapy using the Prevena V.A.C system (KCI, San Antonio, Tx) were compared to patients who underwent ventral hernia repair with simultaneous panniculectomy and standard sterile dressings (SSD). Patient characteristics and postoperative complications were compared between these groups. Wound complications were defined as skin dehiscence, skin necrosis, development of chronic wound, surgical site infection, seroma, and hematoma.

RESULTS: A total of 106 patients were analyzed; 64 in the NPT group and 42 in the SSD group. The two groups were similar in terms of BMI (39 kg/m² vs 37 ±8 kg/m², $p=0.288$), gender (84% female vs 79% female, $p=0.446$), and smoking status (30% vs 22%, $p=0.382$). Patients in the NPT group were older (56 vs 50, $p=0.013$), had larger hernia size (120 cm² vs 55 cm², $p=0.029$), were more likely to have a history of recurrent hernias (80% vs 55%, $p=0.006$) and required component separation at the time of VHR (80% vs 50%, $p=0.001$). Nevertheless, despite having higher risk factors, patients in the NPT group had less wound complications (45% vs 69%, $p=0.016$).

CONCLUSION: This study showed that incisional negative pressure therapy in ventral hernia repair with simultaneous panniculectomy decreases wound complications.

Reference Citations:
1. Koolen PGL, Ibrahim AMS, Kim K, et al. Patient selection optimization following combined abdominal procedures: analysis of 4925 patients undergoing panniculectomy/abdominoplasty with or without concurrent hernia repair. Plast Reconstr Surg. 2014;134(4):539e-50e.