income, and insurance status likely exist. To our knowledge, no study has assessed the effect of patient socioeconomic status on clinical decision-making in facial fracture repair. Thus, the objective of this project was to assess if socioeconomic factors impact whether patients obtain open versus closed treatment of mandibular fractures.

METHODS: Data were extracted from the 2012 and 2013 National Inpatient Sample (NIS). Patients that had either open or closed treatment were included for analysis. Patients who had a length of stay longer than three days or died during their inpatient stay were excluded. These criteria were used to exclude patients with polytrauma as well as complicated fractures. Chi-squared tests were performed to test for univariate associations between race, sex, insurance payer and procedure done. A logistic model was then used to test for these factors simultaneously.

RESULTS: Initial data provided a total of 2481 patients who underwent open and 933 patients who underwent closed treatment. Statistically significant differences were present within the race, sex and insurance payer status groups (p < 0.05). Patients of black and Hispanic race had decreased odds of undergoing closed treatment (OR = 0.775, 0.725 respectively) compared to patients of white race. Further, self-paying patients had decreased odds of undergoing closed treatment (OR = 0.818) compared to privately insured patients. Finally, we found that female patients had increased odds of undergoing closed treatment (OR = 1.511).

CONCLUSION: Our results reveal that certain socioeconomic factors do affect the management of mandibular fractures. Specifically, patients who are female, white or have private insurance have a higher likelihood of being treated with closed treatment. Further analysis will be needed to determine the underlying etiology of these socioeconomic and sex disparities.

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PURPOSE: Depression prior to breast cancer and its effect on post-diagnosis quality of life in women undergoing breast reconstruction is relatively unknown. The BREAST-Q has become widely used to assess pre- and post-operative patient-reported outcomes. There are no studies evaluating the impact of a pre-cancer diagnosis of depression or anti-depressant use on BREAST-Q scores. We investigated if depression or anti-depressant use may alter the results of the BREAST-Q.

METHODS: This study is a single-center, retrospective analysis of 300 patients with completed BREAST-Q data who underwent breast reconstruction from November 2013 to 2016 following a diagnosis of breast cancer. Patients completed the BREAST-Q at four time points: pre-operatively, 6-weeks following tissue expander insertion, and 6- and 12-months following final reconstruction. We reviewed medical records to identify patients who had a pre-cancer diagnosis of clinical depression and anti-depressant medication use. Patients were stratified into a depression and no depression group. The depression group was defined as a pre-cancer diagnosis of depression. The no depression group was defined as no pre-cancer clinical diagnosis of depression and no anti-depressant use. BREAST-Q scores were compared between depression (n=50) and no depression (n=250) patients; the depression group was further stratified by anti-depressant (n=36) and no anti-depressant (n=14) use. The Mann-Whitney U test was used for continuous variables, based on the non-parametric distribution of the data. The same statistical guidelines were used for the sub-group analysis.

RESULTS: Sexual well-being scores at the 6-week tissue expander follow up for patients in the depression group (median=37, IQR = 25–47) were significantly lower (p<0.01) than scores for patients in the no depression group (median=47, IQR = 39–60). Patients in both groups showed a decrease from baseline in BREAST-Q scores across all domains at the 6-week tissue expander follow-up. However, the scores after final reconstruction (6 and 12-month follow-ups) were higher than baseline for both groups of patients. There were no statistically significant differences in BREAST-Q scores in other domains. The sub-group analysis comparing the depression group on anti-depressant medication (n=36, 72%) to those on no anti-depressant medication (n=14, 28%) did not show any statistically significant differences in BREAST-Q scores.
across all domains. Six (17%) of the 36 patients with a prior diagnosis of depression were currently taking either bupropion or mirtazapine, two medications that have shown to have minimal effects on sexual function. These patients had clinically higher sexual well-being BREAST-Q scores at baseline (median=61) compared to patients taking anti-depressants that cause sexual dysfunction (median=53).

CONCLUSION: Patients with a diagnosis of depression prior to breast cancer had lower BREAST-Q sexual well-being scores at the 6-week tissue expander follow-up, regardless of anti-depressant medication use. While at 6-weeks there is a difference in scores between the patients with depression and no depression, by 12 months no other differences are noted.

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How Patient Decision Making Characteristics Affect Satisfaction in Facial Plastic Surgery: A Prospective Pilot Study

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PURPOSE: The main objective of this study was to prospectively analyze which personality traits, clinical psychiatric states, and patient decision-making characteristics predict who will be less-satisfied after facial plastic surgery

METHODS: This prospective study enrolled 60 adult subjects into one of three groups: aesthetic, functional, and reconstructive facial plastic surgery procedures, n=20 in each group, from November 2011 to February 2016. Self-report surveys of personality traits (NEO-PI-R), psychiatric state (PHQ-9, GAD, HAI-S), and decision-making characteristics (Maximizer/Satisficer Survey) were given during the pre-operative clinic visits. In post-operative follow-up, satisfaction questionnaires at three, six and twelve months were administered. Data analysis examined associations between patient satisfaction, decision-making characteristics, and psychiatric variables.

RESULTS: Bivariate analyses showed that Max/Sat decision-making style was significantly related to patient satisfaction scores in the year following surgery. This difference reached statistical significance at 6 months and remained a strong trend at 12 months. Patients who were “less than extremely satisfied” at both post-operative time points were more likely to portray the Maximizer decision-making style. No other variables were associated with patient satisfaction at any time point. Max/Sat Survey scores were not associated with self-reports of depression, anxiety, or illness anxiety. Mean scores on the Max/Sat Survey did not differ between the aesthetic, functional and reconstructive groups.

CONCLUSION: The Max/Sat survey captures an aspect of patient care not traditionally measured by standard clinical psychometric screening tools to help predict satisfaction. A short questionnaire targeting consumer decision-making may be a helpful tool for preoperative counseling.

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The Effect of Intraoperative Temperature on Microvascular Thrombosis

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PURPOSE: The trauma literature provides evidence of a correlation between hypothermia and mortality. Anesthesia guidelines require intraoperative temperature monitoring and prevention of hypothermia (T < 36 C). There has been less concern with mild intraoperative hyperthermia for plastic surgery patients. However, previous data from our institution suggest that intraoperative hyperthermia is associated with increased rates of microvascular thrombosis in free tissue transfer. We present a series of free tissue transfers to further assess for correlation between intraoperative hyperthermia and microvascular thrombosis.

METHODS: A retrospective chart review was conducted of 416 consecutive patients with 686 free flap breast