did not receive either pre- or postmastectomy radiation therapy. Patients with premastectomy radiation had higher rates of seroma (14.3% versus 0.2%; \(P < 0.001\)), minor infection (10.7% versus 1.2%; \(P = 0.009\)), implant loss (21.4% versus 3.4%; \(P = 0.001\), and local recurrence (7.1% versus 1.0%; \(P = 0.049\)), when compared with those without radiation. Patients receiving premastectomy radiation also had a capsular contracture rate 3 times that of nonradiated patients (10.7% versus 3.2%; \(P = 0.075\), although the difference was not significant. Patients with postmastectomy radiation had higher rates of major infection (8.4% versus 2.4%; \(P = 0.017\)), capsular contracture (19.7% versus 3.2%; \(P < 0.001\), implant loss (9.9% versus 3.4%; \(P = 0.022\), and local recurrence (5.6% versus 1.0%; \(P = 0.018\), when compared with patients without radiation. Outcomes after prepectoral implant-based breast reconstruction were comparable between pre- and postmastectomy radiation therapy groups, respectively, with regard to major infection (7.1% versus 8.4%; \(P = 1.000\), dehiscence (3.6% versus 1.4%; \(P = 0.488\), major mastectomy skin flap necrosis (7.1% versus 2.8%; \(P = 0.317\), capsular contracture (10.7% versus 19.7%; \(P = 0.382\), implant loss (21.4% versus 9.9%; \(P = 0.184\), and local recurrence (7.1% versus 5.6%; \(P = 1.000\). However, patients with premastectomy radiation had a higher rate of seroma compared with those receiving postmastectomy radiation therapy (14.3% versus 0%; \(P = 0.005\).

CONCLUSIONS: In prepectoral implant-based breast reconstruction, both pre- and postmastectomy radiation therapy were associated with higher rates of infection and implant loss compared with nonradiated patients. However, premastectomy radiation was associated with a higher rate of seroma compared with nonradiated and postmastectomy radiation therapy groups. Postmastectomy radiation was associated with a higher rate of capsular contracture when compared with nonradiated patients and a comparable rate of capsular contracture when compared with premastectomy radiation therapy patients.

Outpatient Microsurgical Breast Reconstruction

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**BACKGROUND:** The extensive nature of perforator-based breast reconstructions, combined with the need for postoperative flap monitoring, often leads to long hospitalizations. We presented an early report demonstrated the feasibility and advantages of a modified operative technique and recovery protocol, allowing us to perform outpatient breast reconstructions with the deep inferior epigastric artery perforator (DIEP) flap.¹ This follow-up comprises the experience gained, expanded to other perforator-based flaps, and not limited to DIEP breast reconstructions.

**PATIENTS AND METHODS:** We have implemented a general protocol in patients undergoing breast reconstruction with autologous flaps, promoting early mobilization and discharge by improving postoperative pain and decreasing opioid requirements. This protocol includes intraoperative local anesthesia, a microfascial incision for DIEP harvest with rib preservation, along with prophylactic anticoagulation.

**RESULTS:** Ninety-two consecutive patients underwent autologous tissue-based breast reconstruction with DIEP, IGAP, SGAP, and PAP flaps. No intraoperative complications were reported. All patients were discharged within 23 hours, without evidence of flap compromise. One patient required operative takeback for evacuation of a hematoma on postoperative day 4. No partial or total flap losses were documented.

**DISCUSSION:** The aim of any procedure should be to get the patient back to the preoperative status as quickly as possible, as prolonged hospitalizations are associated with higher incidences of infection, deep venous thrombosis, overall dissatisfaction, and higher overall costs of care. By using a modified operative technique, multimodal pain control and postoperative anticoagulant therapy, outpatient perforator flap-based breast reconstructions can be performed with high success and low complication rates.

**REFERENCE:**
1. Martinez CA, Reis SM, Rednam R, et al. The outpatient DIEP: safety and viability following a modified recovery protocol. *Plast Reconstr Surg Glob Open.* 2018;6:e1898.

Breast Reconstruction in Inflammatory Breast Cancer: An Analysis of Predictors, Trends, and Survival from the National Cancer Database

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