We describe a case where an extended version of the PTO flap was used to reconstruct a combined perineal and PVW defect, achieving the above principles.

**CASE:** A 60-year-old patient was diagnosed with anal squamous cell carcinoma invading the PVW. She had neo-adjuvant chemo-radiotherapy completed 5 weeks pre-operatively. An ELAPE was performed with en-bloc resection of the PVW creating a complex composite perineal and vaginal defect

**TECHNIQUE:** A perforator of the internal pudendal artery is identified with a handheld Doppler at the inferolateral part of the skin defect. A semilunar area of skin incorporating the perforator at its base is marked along one side of the perineal defect. The marked skin island is incised down to the suprafascial layer.

The inferior 5 cm of the skin flap is folded inwards and is sutured to the remaining anterior vagina wall in order to create an adequate vagina allowing for future intercourse.

The superior 15 cm of the skin flap is de-epithelised and turned over inwards towards the perineal defect with the perforator as pivot point. The free border of the inverted thick de-epithelised gluteal dermis is then secured to the cut edges of the pelvic muscles acting as an autologous dermal vascularized substitute for the excised muscular pelvic floor whereas the gluteal subcutaneous tissue is used to fill the pelvic dead space. The overlying gluteal skin on both buttocks is advanced by undermining suprafascially over the gluteal muscles and closed in layers.

**RESULTS:** Surgical time for the combined reconstruction was 69 minutes. There was no flap loss, no wound complications, no perineal pain or perineal hernia during a 28-month follow-up. The patient resumed normal sexual activity 6 months post-operatively.

**CONCLUSION:** The extended version of the PTO flap allows functional restoration of the vagina. It involves minimal dissection, can be performed in prone position and recreates the natal cleft. Its dermal component replaces the excised muscular pelvic floor preventing from perineal hernias, whereas its subcutaneous component obliterates dead space with no donor site morbidity. The versatility of the PTO flap and its extension can be utilised in the reconstruction of other perineal defects.

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**The Impact of the 2010 NY State Breast Cancer Provider Discussion Law on Rates of Discussion and Reconstruction at Public NYC Hospitals**

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**PURPOSE:** In 2010, New York State (NYS) passed the Breast Cancer Provider Discussion Law mandating that breast cancer surgeons discuss insurance coverage of reconstruction and refer to a plastic surgeon, two significant factors found to affect reconstructive rates. Previously, we examined the impact of this law using the NYS Statewide Planning and Research Cooperative System (SPARCS) database, a comprehensive all payer patient data record that was established in 1979 to document patient characteristics, outcomes, and use of the NYS healthcare system. Our results demonstrated an increase in reconstruction rates across all groups and a reversal of previously documented racial and economic disparities. Herein, we analyzed data from four of the largest public New York City (NYC) Health and Hospital Corporation (HHC) hospitals to determine if the same increase in reconstruction rates is reflected in a diverse urban populace with high percentage of publicly insured patients, and whether discussion of breast reconstruction was affected by enactment of the law.

**METHODS:** This study was approved by the Columbia University Medical Center and Biomedical Research Alliance of New York (BRANY) IRBs. We analyzed breast cancer-related surgery data from four NYC HHC hospitals: Bellevue Hospital Center, Jacobi Medical Center, Lincoln
Hospital, and Metropolitan Hospital Center. Using these datasets, we examined breast reconstruction rates four years before (2007–2010) and three years after (2011–2013) the law came into effect. We further evaluated documentation of reconstructive discussion and referral and other variations in hospital care by subgroup.

RESULTS: All four hospitals reported that their breast surgeons were made aware of the law shortly after passage. We analyzed 603 patients who underwent mastectomies with a 50.9% reconstruction rate before law enactment and 50.0% after. Hospital-based subgroup analysis at Lincoln and Bellevue demonstrated 398 patients who underwent mastectomies with a 47.52% reconstruction rate before the law and a 57.65% after (OR 1.503, p-value = 0.0434). Jacobi patients were analyzed separately due to a reported breast surgeon preference shift favoring lumpectomies over mastectomies post-law enactment. 173 patients were analyzed demonstrating a 56.58% reconstruction rate before the law and a 38.14% rate after (OR 0.473, p-value = 0.0164). At Jacobi, discussion rate before the law was 71.05% and 94.85% after (OR 7.496, p-value < 0.0001).

CONCLUSION: Our results suggest that enactment of the law was correlated with a slight increase in reconstruction rates after mastectomy at Lincoln and Bellevue and an increase in discussion rates at Jacobi. Decrease in reconstruction rates at Jacobi may be explained by reported breast surgeon preference for lumpectomies over mastectomies post-law enactment. 173 patients were analyzed demonstrating a 56.58% reconstruction rate before the law and a 38.14% rate after (OR 0.473, p-value = 0.0164). At Jacobi, discussion rate before the law was 71.05% and 94.85% after (OR 7.496, p-value < 0.0001).

Usefulness of Orbicularis Oculi Myocutaneous Flap in Periorbital Reconstruction

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PURPOSE: After removal of the cancer or mass from the periorbital region, reconstruction of the defect site is often performed. Since the eyelid skin is thin and functionally important, reconstruction using the surrounding eyelid tissue is superior in terms of color match or blood supply, rather than using tissue from other areas. We retrospectively analyzed 25 patients who underwent surgery using the Orbicularis oculi myocutaneous flap in the clinic of the authors, to demonstrate the usefulness of the OMC flap.

METHODS: From November 2001 to July 2017, we performed 36 OMC flaps in 30 defects in 25 patients who underwent OMC flap reconstruction for periorbital defect. The medical records of each patient were reviewed retrospectively, we analyzed age at the operation, sex, cause of the defect, location, surgical method and complications.

RESULTS: Of the 25 patients, 12 were males and 13 were females. The mean age was 64 years and the median age was 68 years. There were 8 upper eyelid, 15 lower eyelid, 5 medial canthal and 2 lateral canthal in 30 defects. There were 20 cases of basal cell carcinoma, 2 cases of squamous cell carcinoma, 6 cases of xanthoma and 2 cases of coloboma. As a surgical methods, there were 25 reconstructed defects with only OMC flap, 5 with composite graft with OMC flap, and 6 with OMC flap and FTSG. By type of OMC flap, there were 18 V-Y advancement flaps, 12 switch flaps, 4 pivot flaps, and 2 simple advancement flaps. There was no other complication or abnormality except 1 patient with recurrence of cancer and 1 patient with entropion.

CONCLUSION: The OMC flap can be used to reconstruct the periorbital defect by various methods regardless of the position or size of the lesion. We demonstrated the usefulness of the OMC flap with high patient satisfaction without any complications in reconstruction using 30 OMC flaps in 36 defects in 25 patients.

Autologous Engineered Skin for Coverage after Giant Congenital Melanocytic Nevi Resection

Presenter: Elena Garcia-Vilarino, MD