Demographic data were collected for each group including gender, age, race, insurance status, mechanism, need for emergent surgery, day and time of presentation. Statistical analysis using chi squared and paired t-test was performed between groups.

**RESULTS:** Over the 3 year time period 444 patients with upper extremity injuries presented to our institution and 122 patients were transferred from an outside hospital. The average age of group 1 was 41, (73% M, 27% F); group 2 average age was 38, (77% M, 23% F). 43% of the patients in group 2 were uninsured compared to 16% for group 1. (**P <0.05**)

**CONCLUSION:** The data suggests that our institution is receiving a large proportion of uninsured patients transferred for emergent upper extremity care, compared to our current patient demographic (group 2 is 2.7 times more likely to be uninsured compared to group 1). Because this is a retrospective study, the precise reason for these discrepancies will remain unknown. Nonetheless, these data illuminate the need for adjustments to the current triage protocol in order to better utilize and distribute financial resources to care for patients with upper extremity injuries.

**DISCLOSURE/FINANCIAL SUPPORT:** None of the authors has any financial support or interest with any institutions mentioned in this paper.

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**PRACTICE MANAGEMENT SESSION 2**

**Postoperative Management After Total Pharyngolaryngectomy Using The Free Ileocolon Flap: A 5-year Surgical Intensive Care Unit Experience**

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**BACKGROUND AND PURPOSE:** Operative management after total pharyngolaryngectomy with free ileocolon flaps can be challenging and complex.1–3 Adequate postoperative surgical ICU guidelines are essential in order to avoid postoperative complications.4, 5 Additional factors such as agitation, hypotension or prolonged mechanical ventilation might compromise final outcomes. The purpose of this study is to describe our long-term experience in the early postoperative care of patients after total pharyngolaryngectomy with immediate reconstruction using free ileocolon flap transfer.

**METHODS:** During 2010 and 2015, all patients who underwent total pharyngolaryngectomy and immediate reconstruction using free ileocolon flap were analyzed. Etiology of resection, neo-adjuvant therapy, surgical time, method of sedation, postoperative episodes of hypotension (MAP <60 mm Hg) requiring vasopressors, length of ICU stay, time of extubation and complications were recorded.

**RESULTS:** During this 5-year period, a total of 34 free ileocolon flaps were performed. The most common cause of total pharyngolaryngectomy was cancer. 28 patients had neo-adjuvant therapy. The average surgical time was 11.5 hours (range: 8–14.5 hours). The most common sedatives during surgery and during the ICU period were Midazolam and Dexmedetomidine. The average length of ICU stay was 3 days (2–15 days) with an average time for extubation of 3 days (1–20 days). In terms of complications, 3 patients required vasopressors due to hypotension (MAP<60 mm Hg), 2 had none planned/attempt-self extubation, 2 presented with postoperative bleeding/hematoma, 1 had pneumonia, 4 required unplanned return to the OR, 2 had partial flap loss and 1 had complete flap loss. Univariate analysis showed that factors such as hypotension with vasopressor requirements (**p<0.05**) and none planned/attempt-self extubation (**p<0.04**) was associated with unplanned return to the operating room.

**CONCLUSION:** Our data suggests that episodes of hypotension and unplanned extubation could lead to irreparable
surgical complications. As other free enteric flaps, ileocolon flap tolerates only a short ischemia time. It also harbors a great amount of bacteria, which would initiate autolysis when the ischemia starts. Therefore, special attention should be given to these patients and rigorous postoperative guidelines are essential in order to minimize complications.

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Lymph Node Flap Transfer and Modified Charles Procedure for Advanced Lower Limb Lymphedema

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INTRODUCTION: Lymph node flap transfer (LNFT) is becoming a popular physiologic approach for treating lower limb lymphedema. However, in chronic and severe cases, the Charles’ procedure allows radical reduction of the lymphatic load of the limb and should only be considered when other procedures are not feasible due to its potential complications as infection and poor cosmesis. The aim of this study is to present our experience combining tissue transfer procedures (LNFT) and excisional operations (the modified Charles procedure) for the surgical treatment of advanced lower limb lymphedema.

MATERIALS AND METHODS: From July 2010 to May 2015, 45 patients who were diagnosed and treated for advanced lower limb lymphedema with LNFT and a modified Charles procedure were analyzed. In addition, demographics, circumferential limb measurements, lymphoscintigraphy, skin tonicity and postoperative complications were recorded. The reduction rate was described by the percentage of improvement on skin tonicity and limb circumference. Postoperative follow-up was performed every 3 months during the first year and subsequently every 6 months.

RESULTS: After a 4-year follow-up, a total of 45 patients were analyzed. Twelve were male and thirty-three were female. During the follow-up period, all patients exhibited dramatic improvement in lower limb skin tonicity 35.0 % (range 12.5 to 78.0%) (p<0.05). In addition, the average reduction of limb circumference was 60.0% (range 40.0 to 90.0 %) (p<0.05). Moreover, the incidence of cellulitis exhibited a significant reduction in the postoperative period. Only five patients experienced superficial site infection after the operation, which was treated with antibiotics. No major complications were reported postoperatively. However, there were 6 patients with partial skin graft loss requiring re-grafting at the dorsum of the foot. Ten patients required revision and regrafting to improve the cosmesis. Postoperative lymphoscintigraphy displayed improved drainage of the affected limb. In addition, all patients were satisfied with their functional outcomes.

CONCLUSION: In cases of severe lower limb lymphedema, the combination of LNFT with the modified Charles procedure can be a good surgical option. This procedure may prevent some potential complications such as recurrence, infection, and aggravation of the disease due to the physiological properties of the transferred lymph nodes. However, further long-term studies are needed in order to rule out recurrence and long-term complications.

Laparoscopic Harvest of an Extended Right Gastroepiploic Lymph Node Flap With Double Level Inset in Patients With Extremity Lymphedema

Pedro Ciudad, MD, PhD; Oscar J. Manrique, MD; Ketan M. Patel, MD; Federico Lo Torto, MD; Mouchammed Agko, MD; Hung-Chi Chen, MD, PhD

INTRODUCTION: Lymph node flap (LNF) transfer has shown promising results and its becoming one of the