multivariate regression analysis. Alpha level was set to 0.05 for statistical significance.

Results: Four hundred and forty patients were recruited, of which 214 (49%) received an opioid prescription. The following factors were independently associated with receiving an opioid prescription: surgery of the upper limb (OR 4.0 [1.7-9.3], p=0.001), breast and abdomen (OR 11.1 [1.2-101.1], p=0.032), dermatologic surgery (OR 0.2 [0.1-0.5], p=0.001), and surgery in the main operating room (OR 23.6 [10.0-55.2], p<0.001). Patients consumed more opioid tablets if they were on pain medications prior to surgery (p=0.03), and if they scored higher on the PHQ-4 (p=0.001), but not the PCS (p=0.732). Plastic Surgeons prescribed significantly less opioids over time in minor procedures (p<0.001), without an increase in pain crises. The mean number of tablets per opioid prescription was 22, and the mean number of tablets consumed per specific procedures were: 15.9 opioid tablets over 8.6 days after bilateral breast reduction, 8 tablets over 2.5 days after carpal tunnel release, 6.4 tablets over 3.3 days after palmar fasciectomy, 2.6 tablets over 5 days after trigger finger release, 2.1 tablets over 1.2 days after subcutaneous cyst or mass excision, and 1.2 tablets over 1.2 days after skin cancer surgery. The number of unused tablets were: 888 Tylenol 3, 156 Tylenol 2, 46 Oxycodeone, 30 Percocet, and 24 hydromorphone. Only 18% of patients who received opioid prescriptions were instructed on proper disposal of unused tablets.

Conclusions: The patterns of opioid prescription and consumption patterns after outpatient Plastic Surgery are elucidated. Plastic surgeons globally over-estimate opioid requirements across all procedures studied. Surgeons could potentially prescribe less opioids in the minor procedure room without an increase in pain crises. Large sample, procedure-specific studies are required to determine opioid requirements. The lack of patient information on proper disposal of unused tablets represents a gap in knowledge which needs to be addressed.

Purpose: As health care costs become an increasingly large share of the U.S. economy while millions remain uninsured, a single payer alternative has been increasingly espoused, even by leading presidential candidates. We examine the views of U.S. plastic and reconstructive surgeons on a single payer healthcare system and its implications for patients and practice.

Methods: 3,431 U.S. plastic and reconstructive surgeons were sent a 28-item Qualtrics survey from September 1st to November 1st, 2019. Demographic and opinion data were analyzed.

Results: There was a 11.16% response rate (n=383). The majority of respondents were male (84% compared to 85% of plastic surgeons nationally) with an average age of 55.2; 64% of respondents were in private practice (significantly lower than the 80% national proportion, p < 0.0001), and 17% in academic practice (significantly higher than the 4% national proportion, p < 0.0001). Among survey respondents, there is a significant relationship between respondents’ practice region and practice type (p=0.0005), with the Northeast having the highest percentage of academic practitioners (29.7%), and the Southeast having the highest percentage of private practitioners (100%). There is also a significant relationship between political affiliation and practice type (p = 0.0085). Among private practitioners, 43.3% identify as Republican and 16.2% Democrat, compared to 24.6% Republican and 33.9% Democrat among academic practitioners. Forty three percent believe it is the government’s responsibility to ensure that care is provided for all. The proportion of plastic surgeons that chose single payer as the most optimal health care system is significantly different between academic (41.5%) and private practice (24.6%, p=0.011). Among academic plastic surgeons, 22% would consider leaving if single payer were enacted and 59.5% would decrease the reconstructive portion of their practice (p <0.01). Seventy percent of all respondents, regardless of practice type, agreed that losing the economic incentive of doing more cases would adversely affect how hard they work, with 63 percent saying they would not work the same number of hours under single payer (p<0.05). Thirty four percent are willing to give up income in order to reduce their paperwork and administrative burden.

Conclusion: Most U.S. plastic and reconstructive surgeons in 2019 do not support the enactment of a single payer health care system, and the majority believe that losing the economic incentive associated with doing

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Plastic & Reconstructive Surgeons’ Views On A Single Payer Health Care Alternative: Implications For Patients And Practice

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more cases will adversely affect their incentive to perform non-fee-for-service surgery. While the majority of plastic surgeons are private practitioners, those in academia will likely be disproportionately affected by sweeping health care reform because academic medical centers with nonprofit status typically treat a higher percentage of Medicaid and Medicare patients than do private practices. Surgeon reimbursement rates for these patients stand to decrease if single payer were enacted. Given this reduction in incentive to perform cases including complex reconstruction, there is a strong likelihood that implementation of universal coverage will in fact decrease access to these procedures due to limited availability of providers willing to perform them, in addition to the possibility of driving an even fewer number of trainees into academic practice.

**QS10**

**Zygomaticomaxillary Complex Fractures Associated With Naso-orbito-ethmoid Fractures In Pediatric Patients: A 25-year Experience At The Johns Hopkins Children’S Center**

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**Purpose:** Naso-orbito-ethmoidal (NOE) fractures associated with ipsilateral ZMC fractures are more challenging injuries than ZMC fractures alone. However, there is a paucity of information on this complex fracture pattern in the pediatric population. Because of differences in the craniofacial skeleton between children and adults, it is important to characterize combined ZMC-NOE fractures in children specifically, especially given that this injury pattern in adults leads to poorer long-term outcomes. This study investigated the etiology, treatment, and outcomes of combined ZMC and NOE fractures versus isolated ZMC fractures in pediatric patients.

**Methods:** This was a 25-year retrospective cohort study of pediatric patients who presented to a single institution with ZMC fractures. Patient data/outcomes were derived from the medical record and comparatively investigated between (1) combined ZMC-NOE and (2) isolated ZMC fracture cohorts.

**Results:** Forty-nine patients had ZMC fractures in our 25-year study period, of whom forty-six had adequate clinical documentation and follow up. Seventeen of these patients had ipsilateral NOE injuries associated with their ZMC fracture. Both patient groups (isolated ZMC fractures versus combined ZMC and NOE fractures) were similar in terms of demographics. However, patients with combined ZMC-NOE fractures had longer median hospital lengths of stay than patients with ZMC fractures alone (9 vs. 5.5 days), and a greater proportion of patients with combined ZMC-NOE fractures required more extensive surgical approaches with coronal incision (57.1% vs. 11.8%, p=0.007). Approximately 88.2% of patients with combined ZMC-NOE fractures suffered complications versus 31.0% of patients with isolated ZMC fractures. Furthermore, patients with combined ZMC-NOE fractures had greater incidence of postoperative facial deformity than those with ZMC fractures alone (adjusted odds ratio 6.72, p=0.032). Enophthalmos (41.2%), orbital dystopia (29.4%) and midface growth restriction (35.3%) were the most common postoperative deformities in patients with combined ZMC-NOE fractures, and were observed disproportionately in these patients compared to patients with isolated ZMC fractures. In fact, midface retrusion was seen exclusively in patients with combined ZMC-NOE fractures who had deciduous dentition.

**Conclusion:** This is the largest longitudinal study of combined ZMC-NOE fractures in pediatric patients. Our results demonstrate that high impact trauma can cause NOE fractures in association with ZMC fractures relatively commonly in this patient population. This injury pattern was found to cause significantly greater postoperative complications and deformity than isolated ZMC fractures alone, possibly due in part to inadequate surgical reduction in the context of a more complex fracture. Thus, pediatric patients presenting with this facial fracture pattern require greater attention at the time of operative repair to ensure adequate bony reduction, possibly through use of low-dose intraoperative imaging and custom splints. Furthermore, these patients require more extensive clinical follow-up and monitoring given a greater risk for long-term morbidity.