researched type of stem cell, with the advantage that the harvest is easier to obtain, by using adipose cell aspirates collected during body contouring procedures, in relation to bone marrow stem cells. Knowing mesenchymal stem cells proliferative properties, we are going to evaluate the use of autologous fat transfer as an alternative for augmentation mammoplasty and gluteal reshaping.

**MATERIALS AND METHODS:** In this 5:00 minute video presentation we show the technique of autologous fat transfer for augmentation mammoplasty and gluteal reshaping in a patient. It starts with showing the marking of the breast, gluteal and abdominal area where the fat will be transferred. Afterwards dorsal liposuction takes place and decantation of the fat occurs in the canister. Then the fat is transferred to 60ml syringes where it is decanted for a second time and injected in the gluteal area with a total volume of approximately 300cc per side.

When autologous fat transfer to the gluteal area is finished, the patient is turned. Infiltration of the ventral abdominal area and liposuction is performed collecting and decanting the adipose tissue as explained. Before infiltration to the breast, fat is transferred from the 60ml syringes to 10ml syringes. Infiltration takes place using microcanulas (1.5 - 1.7mm in diameter) to inject the fat in a multilayered tunneling process into the subcutaneous and retroglandular areas of both breasts. The total volume of fat transferred to each breast in this patient was approximately 300cc.

**RESULTS:** Photos are shown comparing the preoperative and immediate postoperative results in the patient. Also, preoperative and postoperative follow-up photos of some patients are shown at 7, 14 and 36 months.

**CONCLUSIONS:** Adipose derived stem cells have demonstrated proliferative properties used to repair and substitute damaged cells or missing tissue. Autologous fat transfer is a technique used to fill and model tissues thus promoting a volumetric increase and a restoration of the tissues adjacent to the transfer site in a significant, reliable, long-lasting and safe way.

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**INTRODUCTION:** Blepharospasm is part of a spectrum of facial dystonia which can result in significant psychological and social distress to patients. Currently, mainstay treatment of blepharospasm is botulinum A.¹ Myectomy is reserved for patients with poor responses to botulinum toxin. Myectomy for benign essential blepharospasm decreases the morbidity, botulinum toxin treatment frequency, and long-term expense associated with this disabling condition.² However, myectomy can result in hollowing appearance and unpleasant cosmetic outcomes.³ We use a modified surgical method of preseptal orbicularis oculi myectomy and orbital orbicularis myotomy in situ for patients with benign essential blepharospasm to achieve satisfying outcomes in function and aesthetics.

**MATERIAL AND METHODS:** Between January, 2012 to October, 2014, we enrolled patients with benign essential blepharospasm who had poor response to botulinum toxin. Associated ptosis and dermatochalasis were assessed preoperatively. We performed upper and lower eyelid preseptal orbicularis oculi myectomy with orbital orbicularis myotomy in situ on these patients under general anesthesia. Simultaneous upper blepharoplasty and levator aponeurosis plication were also performed to correct dermatochalasis and ptosis.

**RESULTS:** There were eleven patients underwent upper and lower eyelid myectomy with myotomy in situ. Three were male and the other was female. Average age is sixty-one. Mean follow-up time was 27.25 months. Treatment interval of botulinum toxin injection before surgery was 10.2 weeks in average, which increased to 16.4 months after surgery. Subjective improvement in average was 75%. Blepharospasm function disability score was 12 in average, and improved to 6 in average.

**CONCLUSIONS:** This is a new surgical method for refractory benign essential blepharospasm. In comparison to previous limited upper myectomy, preseptal orbicularis oculi myectomy and orbital orbicularis myotomy in situ preserve the muscle volume and thus provide better aesthetic outcome without compromise of functional result in our experience.

**DISCLOSURE:** None of the authors has a financial interest in any of the products, devices, or drugs mentioned in this manuscript.

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Effectiveness of Lymphatic Microsurgical
Procedures in the Treatment of Primary
Lymphedema

Ming-Huei Cheng, MD, MBA, FACS; Ketan
M. Patel, MD

INTRODUCTION: Vascularized lymph node transfer
(VLNT) and lymphovenous bypass (LVB) procedures repre-
sent physiologic treatment options for symptomatic lymph-
edema. Secondary causes related to oncologic surgery and/ or radiation have been successfully treated using these sur-
gical procedures. Primary lymphedema represents a poorly
understood lymphedematous condition with equally poor
understanding of the benefits of microsurgical intervention.
The purpose of this study was to review our experience with
this patient population to better understand the effectiveness
of microsurgical procedures.

METHODS: A retrospective review of a prospectively
maintained database of patients who received microsurgi-
cal treatment for primary lymphedema was reviewed. Both
LVB and VLNT procedures were used in this patient cohort.
Outcomes related to demographics, circumference differ-
ences, and symptoms, and quality of life (QoL) changes
were evaluated. A validated questionnaire, the LYMQOL,
was used to assess QoL outcomes.

RESULTS: Thirteen patients were identified and met
inclusion criteria. All patients had primary lower extremity
lymphedema. Average age and symptom duration was 37.8
years and 162 months, respectively. The average lymph-
edema stage was classified as Stage II in 66.7% of patients.
Average followup was 12.2 months. VLNT was used in
most cases (69.2%) while LVB was used in the remainder
of patients. The average overall circumference reduction
was 3.6 cm with more improvement seen in patients who
received VLNT as compared to LVB (4.2 cm vs. 1.9 cm).
Improvements in body weight and cellulitis occurrence
was significantly improved in the VLNT cohort (p<0.05).
In addition, patient reported QoL domains related to func-
tion, appearance, symptoms, and mood were significantly
improved following VLNT (p<0.05 in all domains) as com-
pared to LVB (p>0.05 in all domains).

CONCLUSION: Lymphatic microsurgical procedures
are valuable treatment options for patients with primary
lymphedema. Vascularized lymph node transfer appears to
result in improved overall outcomes as compared to lympho-
venous bypass procedures in this specific patient population.
Improvements in objective clinical measures (limb circum-
ference, body weight, and cellulitis occurrence) correlate well
with improved patient reported quality of life parameters.

Nipple-Areolar Complex Reconstruction:
A Compilation of Techniques to Achieve
a Natural Result

Rachael M. Payne, BS; Jamie A. S. Spitz,
MD; Ramasamy Kalimuthu, MD

BACKGROUND: The nipple-areolar complex (NAC)
is a defining feature of a woman’s breast anatomy that is
often lost following mastectomy and breast reconstruc-
tion. Numerous methods of nipple-areolar reconstruction
have been described, yet 1 in 3 patients report dissatisfac-
tion with the final results.1 This may be due to the unnatural
appearance of the reconstructed NAC. We present a series
of techniques utilized to achieve optimal nipple-areolar
reconstruction aesthetics.

METHODS: A retrospective review of a single surgeon’s
practice was performed from January 2008 until Decem-
ber 2014. Patient follow-up ranged from 1 to 8 years. Pre-
mastectomy color evaluations of the native nipple-areolar
complex were performed. All patients that underwent recon-
struction had simultaneous nippleareolar tattooing utilizing
a blending method. The specific NAC local flap was deter-
mined based on the patient’s individual scar pattern.

RESULTS: There were a total of 342 patients included; 140
reconstructions were unilateral (41%) and 202 reconstruc-
tions were bilateral (59%). Sixty-eight patients (20%) had
fading of their tattoo, of which 34 patients (10%) underwent
nipple color retouching. The most common area that required
additional tattooing was the mastectomy scar. Thirty patients
(9%) underwent secondary nipple reconstruction due to loss
of nipple projection. One hundred and two patients (30%)
developed superficial epidermolysis of the reconstructed
NAC which was managed with local wound care alone.
There were no cases of full thickness necrosis of the NAC