were given a diuretic which does not improve the condition. One-third of patients resided outside of our local referral area. The average time between onset of lymphedema and referral to our Lymphedema Program was 10 years (range, <1–62 years).

CONCLUSIONS: Patients presenting to a center with “lymphedema” often have another condition, and may be suboptimally managed prior to their referral. Patients with suspected lymphedema should be referred to specialists focused on this disease.

Applications of the Combined Transverse Upper Gracilis and Profunda Artery Perforator (TUGPAP) Flap

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INTRODUCTION: The transverse upper gracilis (TUG) and the profunda artery perforator (PAP) flaps have been described for breast and perineum reconstruction. However, the abdomen is considered one of the primary donor sites to reconstruct these areas. However, when abdominal tissue is not available, other donor sites such as the thighs or buttocks should be considered. The aim of this study is to describe our experience using the combined TUGPAP flap,1,2 for breast and perineum reconstruction.

MATERIALS AND METHODS: Between January 2011 and June 2013, all patients who required breast or perineum reconstruction using the TUGPAP were recorded. All patients with previous abdominal surgery or lack of adequate donor abdominal site tissue were excluded. All TUG-PAP flaps were based on two pedicles: the ascending branch of the medial circumflex femoral artery (TUG) component, and the profunda artery perforator itself for the (PAP) component. Demographics, etiology of reconstruction, flap harvest time and complications were analyzed.

RESULTS: A total of 13 combined flaps were performed: 10 free flaps for immediate unilateral breast reconstruction and 3 pedicle flaps for perineum reconstruction. There were 3 men and 10 women. The mean size of the harvested skin paddle was 28.6 x 8cm2 (range, 27 x 37 cm2 to 30 x 39 cm2). The average flap harvest time was 102 minutes (range, 95 to 120 minutes). The average pedicle length for the TUG flap was 7 cm (range: 6–8 cm) and for the PAP flap was 9 cm (range: 8.5–10 cm). The flap survival rate was 100% and no partial flap loss was reported. No major complications were seen. However, there was one case of persistent donor site seroma, which was managed conservatively.

CONCLUSION: When abdominal tissue is not available, the TUGPAP flap is an alternative flap for medium to large breast reconstruction and extensive perineum defects. The good pedicle length, large skin paddle and the versatility of design, makes this flap a good alternative. In addition, the TUGPAP flap can be used for other kind of reconstructions when there are limited soft tissue donor sites and large tissue volume is required. However, appropriate patient selection is important in order to obtain good results.

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Risk Stratification of Major Complications After Outpatient Abdominoplasty or Panniculectomy

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BACKGROUND: Ambulatory surgery centers offer the advantages of greater efficiency and overall patient experience. As more procedures are performed in the outpatient setting, reliably identifying patients at higher risk for major complications will be critical. Abdominoplasty and panniculectomy represent a large component of ambulatory plastic surgery procedures. While recent studies have identified risk factors for complications in the outpatient setting, there is no clinically actionable tool available for use currently.1,2 This study utilizes the ACS-NSQIP dataset to develop a
risk-stratification model for complications requiring secondary clinical intervention after outpatient abdominal surgery.

METHODS: Patients undergoing abdominoplasty or panniculectomy were identified from the NSQIP databases for 2012–2013. The primary outcome was need for secondary clinical intervention, defined as unplanned readmission or reoperation. Patient comorbidities and operative characteristics were correlated with complication risk. A step-wise multivariate logistic regression of all factors with p value < 0.1 was conducted and resulting significant factors were entered into a bootstrap technique. Adjusted multivariate beta-coefficients were used to generate weighted risk scores for each factor. Each patient was then assigned an aggregate complication risk score, yielding the risk-assessment tool.

RESULTS: 1,429 patients underwent outpatient abdominal surgery and were included for analysis. Unplanned reoperation or readmissions were observed in 4.1% of surgeries (n=59). Independent patient factors predictive of secondary clinical intervention included malnutrition (OR=8.1), male gender (OR=3.4), diabetes (OR=2.8), smoking (OR=2.5), BMI 35 or higher (OR=2.2), and age over 45 (OR=2.2). Regarding operative characteristics, patients undergoing concurrent breast implant insertion were at increased risk (OR=4.4), while those undergoing trunk liposuction were less likely to require secondary clinical intervention (OR=0.48). Patients were stratified into 4 groups according to complication risk: low risk (complication=1.7%), average risk (complication=2.7%), high risk (complication=8.8%), and extreme risk (complication=21.0%). The model demonstrated high sensitivity and specificity for discriminating need for secondary intervention with a C-statistic=0.76. It was also applicable to secondary outcomes, and accurately predicted surgical complications, overall complications, and prolonged hospital stay during the index procedure.

CONCLUSIONS: This study builds upon previous work by providing a quantifiable risk stratification system for clinically relevant complications experienced after abdominal surgery in the ambulatory setting. Malnutrition, male gender, and concurrent breast prosthetic implantation were strong independent predictors of risk. This tool may enhance preoperative counseling and improve patient selection in the ambulatory setting.

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In a Little While: Anticipating Changes in Bundled Payments for the Treatment of Patients with Acute, Life-threatening Dermatologic Emergencies, Through Prevention of Healthcare Associated Infections.

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INTRODUCTION: Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are part of the same clinical syndrome that represents a medication-induced desquamation disorder. In 1922 Drs. Stevens and Johnson first described SJS as an acute mucocutaneous syndrome presenting in two young boys. 1, 2 Patients admitted to a burn center suffering from the Stevens-Johnson syndrome to Toxic Epidermal Necrolysis (SJS-TEN) spectrum are typically considered to have high hospital morbidity and mortality. Little is known about patients admitted to a burn center suffering from non-bullous Skin Disorders (SD). This group includes severe rashes, non-healing wounds, erythema multiforme, and unknown skin lesions requiring hospitalizations. We compared these two group’s costs, mortality, and the effect of Healthcare-Associated Infections (HAI) on outcomes to better define this patient population.

METHODS: A post-hoc analysis of prospectively collected data was performed on 445 patients who had a diagnosis of a dermatologic condition requiring hospitalization who were admitted to our 36 bed ABA accredited burn center over the last 10 years. These charts, divided into SJS-TEN and SD, were cross-referenced with the hospital wide infectious control database to identify patients who suffered from HAIs that met the CDC National Healthcare Safety