(OR 2.083, p=0.028), and longer follow-up (OR 1.021, p<.001) were independent predictors for complications.

**CONCLUSION:** Although a large implant size does not increase the rate of implant removal or IBR failure, reconstructions receiving a larger implant with respect to the mastectomy weight have an increased rate of capsular contracture in non-irradiated breast or breasts that do not receive SFG-TtE. Overall, beyond the final TE volume, the implant’s size, the nonuse of ADM’s and adjuvant radiotherapy or chemotherapy were found to be independent predictors for overall complications.

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**TRACK: RECONSTRUCTIVE**

**Intra-operative Methadone Decreases Post-operative Pain and Opioid Use in DIEP Flap Breast Patients: A New ERAS Protocol**

*Presenter: Jaime L. Bernstein, MD*

*Co-Authors: Marcos Lu Wang, Hao Huang, MD, David M. Otterburn, MD*

**BACKGROUND:** Post-operative pain relief is a significant problem for many patients, increasing the risk of surgical complications and chronic post-operative pain. Patients undergoing surgery can achieve better analgesia with just one dose of methadone (long acting μ-opioid) then with multiple doses of a short acting opioid, however this has never been evaluated in the plastic surgery literature. This purpose of this study is to evaluate the effectiveness of methadone for pain control following DIEP flap breast reconstruction in the setting of a newly instituted ERAS protocol.

**METHODS:** This is a prospective study of an ERAS protocol for all patients undergoing DIEP flap breast reconstruction at a single institution, which centered around the standardization of a single weight based intra-operative dose of methadone. Patients who were operated on after institution of the ERAS protocol were compared to those immediately prior to protocol implementation. Charts were reviewed for patient demographics, intra-operative analgesics, and postoperative medication, both during hospitalization and after discharge.

**RESULTS:** 83 women who underwent DIEP flap Breast reconstruction were identified, 54 patients in the ERAS cohort and 29 in our non-ERAS cohort. The two cohorts had comparable age, weight, BMI, and other medical co-morbidities (p>0.05). The ERAS cohort had significant reduction in opioid usage overall. During the first 12 hours following surgery, the morphine milligram equivalents (MME) was 11.18 versus 27.28 (p<0.001) in the ERAS versus the non-ERAS group, 24 hours following surgery it was 38.69 vs 77.40 MME (p<0.001), and in total during hospital admission it was 79.98 vs 146.7 MME,(p=0.002). The ERAS cohort also had a significant reduction in their overall daily patient rated pain score (P<0.05) and significantly lower heart rate throughout admission. Importantly, those in the ERAS cohort were less likely to be tachycardic throughout admission, defined as a heart rate greater than 100 bpm for at least 12 consecutive hours. There was no difference in length of stay (p>0.05) between the two cohorts. On average during the first week after discharge, patients in the ERAS cohort required 13.9 MME of narcotic pain medications per day. 25% of patients did not require any narcotics at home and after 1 week, more than 75% of patients did not require any narcotics at home.

**CONCLUSION:** In conclusion, after instituting our ERAS protocol with a single dose of intra-operative methadone, post-operative opioid analgesic usage and pain was significantly reduced. Methadone has the potential to be used for patients undergoing plastic surgery procedures, both inpatient and ambulatory, to decrease post-operative pain, opioid use, and increase overall patient comfort and satisfaction. Further work is ongoing to study the impact of our ERAS protocol on DIEP flap patients’ post-operative course.

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**TRACK: AESTHETIC**

**The Deep Fascia of the Infraorbital Region and the Suprafibromuscular Facelift: New Anatomical Concepts Applied in Midface Surgery**

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Contrary to what previous surgeons have described, the existence of a fibro-fatty fascial layer has been shown between the SMAS and Deep Fascia of the midface and lower face that protects the facial nerve and lines the expressive muscles of the face, including the zygomaticus, orbicularis oris, and lip elevators. The authors defined this plane in the mid-face and lower face, and described it as above the previously unrecognized ‘deep fascia’, dubbing it ‘Chiara’s fascia.’ The authors have correlated anatomical work to explain the new concepts linked to the description of