PREOPERATIVE DIAGNOSES,1. Acquired absence of bilateral breast status post previous bilateral DIEP flap reconstruction.,2. Bilateral breast asymmetry.,3. Right breast macromastia.,4. Right abdominal scar deformity.,5. Left abdominal scar deformity.,6. A 1.3 cm lesion right inferior breast.,7. Lesion measuring 0.5 cm right inferior breast lateral.,POSTOPERATIVE DIAGNOSES,1. Acquired absence of bilateral breast status post previous bilateral DIEP flap reconstruction.,2. Bilateral breast asymmetry.,3. Right breast macromastia.,4. Right abdominal scar deformity.,5. Left abdominal scar deformity.,6. A 1.3 cm lesion right inferior breast.,7. Lesion measuring 0.5 cm right inferior breast lateral.,PROCEDURES,1. Left breast flap revision.,2. Right breast flap revision.,3. Right breast reduction mammoplasty.,4. Right nipple reconstruction.,5. Left abdominal scar deformity.,6. Right abdominal scar deformity.,7. Excision of right breast medial lesion enclosure.,8. Excision of right breast lateral lesion enclosure.,ANESTHESIA:, General.,COMPLICATIONS:, None.,DRAINS:, None.,SPECIMENS:, Right breast skin and lesions x2.,COMPLICATIONS:, None.,INDICATIONS:, This patient is a 54-year-old white female who presents for a revision of her previous bilateral breast reconstruction. The patient had asymmetry as well as right breast hypertrophy, and therefore, the procedures named above were indicated. The patient was informed about the possible risks and complications of the above procedures and gave an informed consent.,PROCEDURE:, The patient was brought to the

operating room, placed supine on the operative table. After adequate endotracheal anesthesia was established and IV prophylactic antibiotics were given, the chest and abdomen were prepped and draped in standard surgical fashion.,Attention was first turned to the left breast where liposuction was performed laterally to allow for better contour and minimize the outer quadrant. The incision was made for this and was then closed with 5-0 Prolene interrupted suture.,Attention was then turned to the right breast where liposuction was also performed to reduce the medial superior and lateral quadrants. Once this was performed, the vertical reduction mammoplasty was outlined. Prior to that, the nipple reconstruction was performed with a keyhole pattern flap. The flap was elevated with 15-blade and hemostasis was then obtained with the Bovie. The flap was then sutured onto itself and secured with 5-0 Prolene interrupted sutures. Then the lateral and medial limbs were undermined to close the defect and this was performed with 3-0 Monocryl interrupted sutures. Subsequently, the reduction mastectomy skin was then excised sharply and passed up the table marked and sent to Pathology. ,Hemostasis was then obtained with the Bovie and then undermining was performed in the medial, superior, and lateral skin to allow for closure of the reduction incisions. Once this was performed, a 3-0 Monocryl interrupted sutures were used to close the inferior limb. Subsequently 2-0 PDS continuous suture was then placed in the periareolar area to close the defect, with a diameter that equaled the new nipple areolar complex. Once this was performed, the remaining

incision was then closed with 3-0 Monocryl followed by 4-0 Monocryl subcuticular sutures. Subsequently, the 2 lesions were excised, the larger one which was medial and the lateral one that was smaller that were excised sharply, passed up the table and sent to Pathology. They were closed in 2 layers using 3-0 Monocryl followed by 4-0 Monocryl subcuticular suture.,Attention was then turned to the abdominal scars where liposuction and tumescent solution of diluted epinephrine were used to minimize the amount of excision that was required. Subsequently the extra skin was excised sharply in an elliptical fashion on the right side measuring approximately 10 x 3 cm, this was the superior and inferior skin, was when undermined and closure was performed after hemostasis was obtained with 3-0 Monocryl followed by 4-0 Monocryl subcuticular suture.,Attention was then turned to the contralateral left side where there was a larger defect. There was a larger excision required measuring approximately 15 x 3 cm. The superior and inferior edges of skin were undermined and closed primarily using 3-0 Monocryl followed by 4-0 Monocryl subcuticular sutures. Steri-Strips were placed on all incisions followed by surgical bra.,The patient tolerated the procedure well and was extubated without complications and transferred to the recovery room in stable condition. All instruments, needle counts, and sponges were correct at the end of the case.