PREOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,POSTOPERATIVE DIAGNOSES:,1. Deformity, right breast reconstruction.,2. Excess soft tissue, anterior abdomen and flank.,3. Lipodystrophy of the abdomen.,PROCEDURES:,1. Revision, right breast reconstruction.,2. Excision, soft tissue fullness of the lateral abdomen and flank.,3. Liposuction of the supraumbilical abdomen.,ANESTHESIA: , General.,INDICATION FOR OPERATION:, The patient is a 31-year-old white female who previously has undergone latissimus dorsi flap and implant, breast reconstruction. She now had lateralization of the implant with loss of medial fullness for which she desired correction. It was felt that mobilization of the implant medially would provide the patient significant improvement and this was discussed with the patient at length. The patient also had a small dog ear in the flank area on the right from the latissimus flap harvest, which was to be corrected. She had also had liposuction of the periumbilical and infraumbilical abdomen with desire to have great improvement superiorly, was felt to be a candidate for such. The above-noted procedure was discussed with the patient in detail. The risks, benefits and potential complications were discussed. She was marked in the upright position and then taken to the operating room for the above-noted procedure.,OPERATIVE PROCEDURE: , The patient was taken to the operating room and placed in the supine position. Following adequate induction of general LMA

anesthesia, the chest and abdomen was prepped and draped in the usual sterile fashion. The supraumbilical abdomen was then injected with a solution of 5% lidocaine with epinephrine, as was the dog ear. At this time, the superior central scar was then excised, dissection continued through the subcutaneous tissue, the underlying latissimus muscle until the capsule of the implant was reached. This was then opened. The implant was removed and placed on the back table in antibiotic solution. Using Bovie cautery, the medial capsule was released and undermining was then performed with release of the muscle to the level of the proposed medial projection of the breast. The inframammary fold medially was secured with 2-0 PDS suture to create greater takeoff point at this level which in the upright position and using a sizer produced a good form. The lateral pocket was diminished by series of 2-0 PDS suture to provide medialization of the implant. The implant was then placed back into the submuscular pocket with much improved positioning and medial fullness. With this completed, the implant was again removed, antibiotic irrigation was performed. A drain was placed and brought out through a separate inferior stab wound incision and hemostasis was confirmed. The implant was then replaced and the wound was then closed in layers using 2-0 PDS running suture on the muscle and 3-0 Monocryl Dermabond subcuticular sutures. The 2.5 cm dog ear was then excised into and including the subcutaneous tissue, even contouring was achieved and this was closed with two layers using 3-0 Monocryl suture. Using a #3 cannula, a superior umbilical

incision, liposuction was carried out into the supraumbilical abdomen, removing approximately 40 to 50 mL of fat with improved supraumbilical contours. This was closed with 6-0 Prolene suture. The patient was placed in a compressive garment after treating the incision with Dermabond, Steri-Strips and antibiotic ointment around the drain site and umbilicus. A Kerlix dressing and a surgical bra was placed to the chest area. A compressive garment was placed. The patient was then aroused from anesthesia, extubated, and taken to the recovery room in stable condition. Sponge, needle, lap, instrument counts were all correct. The patient tolerated the procedure well. There were no complications. The estimated blood loss was approximately 25 mL.