PREOPERATIVE DIAGNOSES,Breast hypoplasia, melasma to the face, and varicose veins to the posterior aspect of the right distal thigh/popliteal fossa area.,PROCEDURES,1. Bilateral augmentation mammoplasty, subglandular with a mammary gel silicone breast implant, 435 cc each.,2. TCA peel to two lesions of the face and vein stripping to the right posterior thigh and popliteal fossa area.,ANESTHESIA,General endotracheal.,EBL,100 cc.,IV FLUIDS,2L.,URINE OUTPUT,Per Anesthesia.,INDICATION FOR SURGERY,The patient is a 48-year-old female who was seen in clinic by Dr. W and where she was evaluated for her small breasts as well as dark areas on her face and varicose veins to the back and posterior aspect of her right lower extremity. She requested that surgical procedures to be performed for correction of these abnormalities. As such, complications were explained to the patient including infection, bleeding, poor wound healing, and need for additional surgery. The patient subsequently signed the consent and requested that Dr. W and associates to perform the procedure.,TECHNIQUE,The patient was brought to the operating room in supine position. General anesthesia was induced and then the patient was placed on the operating table in a prone position. The posterior thigh of the right lower extremity was prepped and draped in a sterile fashion. First, multiple serial small incisions less than 1 cm in length were made to the posterior aspect of the right thigh and sequential stripping of the varicose veins was performed. Once these varicose veins had been completely stripped and avulsed,

then next the wounds were then irrigated and were cleaned with wet and dry, and all the incisions were closed with the use of 5-0 Monocryl buried interrupted sutures. The incisions were then dressed with Mastisol, Steri-Strips, ABDs and a TED hose. Next, the patient was then flipped back over onto the stretcher and placed on the operating table in a supine position. The anterior chest was then prepped and draped in a sterile fashion. Next, a 10 blade was placed through previous circumareolar incisions from a previous augmentation mammoplasty. Dissection was carried out with a 10 blade and Bovie cautery until the pectoralis fascia was identified to both breasts. Once the pectoralis muscle and fascia were identified, then a surgical plane was created in a subglandular layer. The hemostasis was obtained to both breast pockets with the Bovie cautery and suction and irrigation was performed to bilateral breast pockets as well. A sizer was used to identify the appropriate size of the silicone implant to be used. This was determined to be approximately 435 cc bilaterally. As such, two mammary gel silicone breast implants were placed in a subglandular muscle. Additional dissection of the breast pockets were performed bilaterally and the patient was sequentially placed in the upright sitting position for evaluation of appropriate placement of the mammary gel silicone implants. Once it was determined that the implants were appropriately selected and placed with the 435 cc silicon gel implant, the circumareolar incisions were closed in approximately 4-layered fashion closing the fascia, subcutaneous tissue, deep dermis, and a running dermal

subcuticular for final skin closure. This was performed with 3-0 Monocryl and then 4-0 Monocryl for running subcuticular. The incisions were then dressed with Mastisol, Steri-Strips, and Xeroform and dressed with sample Kerlix. Next, our attention was paid to the face where 25% TCA solution was applied to two locations; one on the left cheek and the other one on the right cheek, where a hyperpigmentation/melasma. Several applications of the TCA peel was performed, and at the end of this, the frosting was noted to both spots. At the end of the case, needle and instrument counts were correct. Dr. W was present and scrubbed for the entire procedure. The patient was extubated in the operating room and taken to the PACU in stable condition.