

XXXX. XXXXXXX, MD

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OPERATIVE NOTE

Patient:	First Last name
Date of Surgery:	x/xx/xxxx
Surgeon:	xxxx xxxxxx, M.D.
Anesthesia:	General
Anesthesiologist:	xxxx xxxxx, M.D.
Preoperative Diagnosis:	Bilateral Baker Grade 4 capsular contracture
Postoperative Diagnosis:	Same
Procedure:	Bilateral complete capsulectomy and implant removal and placement of new retropectoral McGhan Style 10 smooth silicone gel implants, 330 right, 300 left

INDICATIONS FOR OPERATION: In extensive discussion with the patient, I had them look in the photograph, and noting there is significant asymmetries in her nipple height, which means that I will invariably either have unequal inframammary folds or unequal nipple to fold distances. They understand this. They said for me to use my best judgment in creating what I think will be the best look appearance. I set nipple to fold distances at 8 on maximum stretch on the right, and it was a little bit longer on the left. I shortened it just a little bit, but I was afraid to completely even it, is that the fold would end up higher than the one on the right.

TECHNIQUES: I made a 5 cm incision in the right new proposed inframammary fold, which was just slightly above the old fold. I dissected down with the electrocautery to the capsule. On this side, there was an extremely thick capsule. It was a very easy dissection, coming around the capsule because it separated very easily from the surrounding tissue. Because of the spherical nature, I could not get around it, so I made a capsulotomy and removed the implant, which was an intact implant that appeared that to be an old implant. I then grasped the implant and continued to come around it with the electrocautery until it was completely removed. I irrigated. I stopped all bleeding with the electrocautery. There was not very much bleeding. I infiltrated Marcaine. I went on to the left. Everything was the same here, except the capsule is a little bit thinner than it was on the right. Neither was calcified. This implant also was nonruptured, intact Mam implant. The one on the left weighed 200 grams; the one on the right weighed 225 grams. The patient and everyone in the OR agreed, looking at her preoperatively, the left did look a little bit bigger than the right.

I then checked both sides again for hemostasis, irrigating, going back and forth until I was confident that there was no bleeding at all. I identified the lateral border of the pec major on the right. I dissected down with the electrocautery just under it and dissected a retropectoral pocket. Her serratus separated extremely easily from the chest wall and so I included that in the pocket, so that I ended up with a total submuscular pocket. I did not take down muscle along the inframammary fold, as her tissue was very thin. I felt it necessary to maintain coverage. I dissected to just below the level of the proposed folds in order to allow the implant

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Page 2

to sit at the level of the fold. I irrigated and stopped any bleeding with the electrocautery, but it was a very dry pocket. I performed an identical procedure on the left side. I checked that the pockets were symmetrical. I tried placing various sizes and various combinations from 250 up to 400; 330 on the right and 300 on the left looked like the best choice. The left still appeared larger than the right, but when I increased the gap to 60 cc. I changed gloves. I re-irrigated the pocket. I placed a 330 on the right and a 300 on the left. I sat her up. She looked excellent. I did feel, though, that both pockets were a little flat in the lower pole, so I created some vertical scores within the parenchyma to allow greater parenchymal stretch, and this helped. I tried closing the muscle to completely close off the pocket. But when I did so, I really flattened out the lower pole and the lower pole skin seemed to sag off of it, and so I took that repair out to allow better low pole expansion. I closed both sides with a layer of deep running 3-0 Vicryl, deep down interrupted 3-0 Vicryl, and subcuticular 4-0 Monocryl followed by Steri-Strips. She was placed in a bra.

I should have mentioned that I placed Blake drains prior to the placement of the implants, through the axilla and sewed them in place with a silk.

Estimated blood loss for the entire procedure was less than 25 cc. Complications were none. She went to recovery awake, comfortable and stable.

Xxxx Xxxxxx, M.D.

XXX:Exactrans:xxx