

**RECONSTRUCTIVE BREAST SURGERY
ALBANY MEDICAL CENTER HOSPITAL
ALBANY, NY
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DIMITRI KOUMANIS, M.D.: Hello, I'm Dr. Koumanis and here I'm with my partner, Dr. Jerome Chow, and we're here at Albany Medical Center today and we are discussing today a patient, Mrs. H we'll call her, who's a 51-year old lady who had come to my practice a few months ago seeking a left breast reconstruction after mastectomy. She had a little bit of history about her. She had had a mastectomy back in 2002 which had node positives also in the axillary region which were taken out and she was given radiation to the axilla and part of the chest wall and also she was given chemotherapy. It was ER positive, but she opted not to go with Tamoxifen. At that point in time she did not want to get a reconstruction, but now that she's winding down in her work and she's more comfortable with her time, she said she wanted to pursue the breast reconstruction. So here we are today. We are planning to do a left breast reconstruction, so lift up the flaps here and go underneath the pectoralis muscle and do tissue expanders and today we are also going to show you how we use the Veritas Collagen Matrix sling in order to help support the expansion because there is possible radiation damage to the skin and also to provide us with a good way of reforming our inframammary fold and also to be able to keep our pocket stable. Another little tidbit of history with this lady is that she was offered autologous reconstruction first and wanted to try the implant, understanding the tissue could be compromised. However, with the Veritas, what we have been finding is that we are able to support the expansion a little bit better as it integrates into the skin. So just to go over the markings real quick here with Dr. Chow, we have our left side with the mastectomy site and the old incision where the mastectomy was made. We have our midline here. I usually like to draw it with the patient standing preoperatively in the preoperative holding area. We draw the IMF on the normal side here and mimic it. If it is difficult to draw it freehand, I have been known to use a stencil and to superimpose it by dropping a line off the midclavicular line, which you can also do, so that these look fairly symmetrical in the superior aspect and in the inferior aspect. Also we have our line going down the anterior axillary line, which we will put some sutures in there and then to secure our Veritas Collagen Matrix. So I guess we could begin by making our incision across the chest. Could we have a 15 blade? This patient is coming in for a secondary breast reconstruction. In this case, we would usually lift the skin flap and the pectoralis major muscle off the chest wall without separating the two. But for her we needed to do it in a dual plane to better facilitate her skin closure or else it would close too tight over the implant and compromise the skin flaps, so the Veritas will bode well for this case. Then, we will be lifting up

the pectoralis muscle. Now this patient, as I said, did not have another implant before this or a failed implant. This is her first time getting this surgery. So we're getting down into our subcutaneous tissue.

00:04:16

JEROME CHOW, M.D.: You can see how thin the skin is.

00:04:20

DIMITRI KOUMANIS, M.D.: Yup. We just release all this subcutaneous attachments and you can see her pectoralis muscle, which is quite thin actually, just peeking through our incision here. Can we get some pick-ups please? Some [unclear]. One for me and one -- so maybe we should use the ...

00:04:56

JEROME CHOW, M.D.: Double prong skin hooks?

00:04:57

DIMITRI KOUMANIS, M.D.: What's that?

00:04:58

JEROME CHOW, M.D.: Double prong skin hooks.

00:04:59

DIMITRI KOUMANIS, M.D.: Yeah, maybe some double prong skin hooks would be better, Brian. Now do we have our Bovie set up? What's the Bovie set up, Betty? Is that 30? Thank you. So we will begin by lifting our skin flaps here. It's very thin, so we have to always be weary of our -- not to buttonhole her skin, but also to leave our pectoralis muscle intact onto the chest to allow us to lift this up a little later. And I make my way down all the way to the IMF that we are trying to reconstitute here in this patient as it has been obscured do to the flatness of the chest, with the breast having been excised in 2002. Just making our way down here.

00:06:25

JEROME CHOW, M.D.: Want me to adjust your light for a second?

00:06:27

DIMITRI KOUMANIS, M.D.: Sure.

00:06:28

JEROME CHOW, M.D.: Actually it's behind your head.

00:06:29

DIMITRI KOUMANIS, M.D.: Is it behind my head? We'll do this one.

00:07:08

JEROME CHOW, M.D.: So the dissection is right on top of the pectoralis muscle right now and he's going to go down to his predetermined IMF. Do you want some Army-Navies?

00:07:23

DIMITRI KOUMANIS, M.D.: Yeah, let's use some Army-Navies now. The IMF region is obviously the most important because this is where we are going to later on take our bites to secure our Veritas Matrix for the sling, the breast sling, right at the IMF, so it's quite important just to make it there and not too much past it. Making our way all the way around and then -- can you see in here? Just release this lateral aspect, Dr. Chow. See where it's [unclear]. Can I have another skin hook please? So we're just releasing the lateral aspect where the pec rides up here and then we will start to move up onto our superior flap here in a little bit. So it looks like you can take a finger and you can verify here with my finger. As you can see that we're all the way down on our inframammary fold and now we're going to have to work up superiorly and more medially too because we're stuck about here too. Okay. Another one to me. Actually I think it's more amenable

for you. You're right-handed, right? Lift up until I get down here. Move this way. So the Veritas in just a little while will be spanned from the IMF and sewn into the chest wall and then it will span across to attach to the most inferior end of the pectoralis and then the implant will lie underneath both of those structures and lie in a pocket held back by the Veritas sling and the pectoralis muscle superiorly.

00:10:55

JEROME CHOW, M.D.: Muscle is stuck to the skin.

00:10:57

DIMITRI KOUMANIS, M.D.: Yeah, it's definitely from the radiation. As you can see, she's got some of the muscle is stuck right down to the skin as it was a thin flap probably to begin with back in 2002 and the radiation as well. The skin flaps are bleeding.

00:11:23

JEROME CHOW, M.D.: Pull back on it?

00:11:24

DIMITRI KOUMANIS, M.D.: Yup.

00:11:28

JEROME CHOW, M.D.: So, on thin skin like this it's not unlike a technique for lifting up the face lift flap, try not to buttonhole. Sometimes it might happen though, especially in the particularly thin skin that's been radiated. Her skin is very thin here as we trace the pec back. Can you get in here?

00:12:03

DIMITRI KOUMANIS, M.D.: Yup. I can get up in this area here now. Give me a little pull. So we probably don't have to lift too much of this stuff up here because we can lift it with the flap, you know?

00:13:11

JEROME CHOW, M.D.: Yup.

00:13:12

DIMITRI KOUMANIS, M.D.: So, okay. So, just to see where our pec is, so now we've got to find our inferior portion of the pectoralis muscle which -- can I have a pick up there, Brian? Sometimes this can be a tricky part due to the fact that there's been radiation. Can we get some...

00:13:31

JEROME CHOW, M.D.: [unclear], please.

00:13:37

DIMITRI KOUMANIS, M.D.: As it inserts. We can see a nice plane here where you can lift the pectoralis and then move upward and downward, inferiorly and superiorly. Sometimes even a little finger in here just gently to break up the areolar tissue until you find your good plane. Good starting point that we always told the residents is to start on top of a rib in case you get too deep you don't give the patient a pneumothorax. So, can I get another double prong? Yup. I'll take this one. Take that one. Okay, we're getting there. She has got a very thin muscle.

00:15:17

JEROME CHOW, M.D.: Yup.

00:15:18

DIMITRI KOUMANIS, M.D.: Thin skin flaps and muscle too. It's easy to buttonhole the muscle as well. It's got a little bleeder here that we can...

00:15:26

JEROME CHOW, M.D.: Army-Navy?

00:15:28

DIMITRI KOUMANIS, M.D.: I think it's up here. [whistles] A little finger fracture here. We're getting there. So because this can get tight, we usually release inferior portion of the pectoralis muscle all the way up even up a little bit to the medial aspect, which we can do now. Just working our way across along the IMF. There we go. Stopping along the way to get any major bleeders and continuing over here, so we're almost all the way up here. I can see with my finger we're up here. We're good here. But here we're going to have to release a little bit more of the pec muscle here because I can see that we're probably not going to be able to get this expander in here very easily without releasing that more medially. So we've got that there. We've got to release more medial.

00:19:00

JEROME CHOW, M.D.: Now, a lot of plastic surgeons would be concerned about detaching this muscle here and some will actually advocate lifting up their rectus fascia, but because we're using the sling, we can be more complete here in terms of the dissection medially. We are counting on the Veritas to do the work of what the rectus fascia would be doing inferiorly and in terms of that continuity of the muscle.

00:19:32

DIMITRI KOUMANIS, M.D.: Just need some traction up here so we can get that little bleeder. It's not too big. So, how do we look here? Let's run our finger along again, always to verify. So we're a little bit still stuck in this little area here. Actually we're not too bad. You don't want to go too far medially because you don't want to get symmastia-type symptoms. That's good. There you see the pec minor and there's the pec major on top, right?

00:20:14

JEROME CHOW, M.D.: We're good.

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DIMITRI KOUMANIS, M.D.: I think we're good. Okay, so a little wash, please, Brian.

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JEROME CHOW, M.D.: Betadine?

00:20:21

DIMITRI KOUMANIS, M.D.: Betadine. So we like to use a little Betadine, a very dilute tea which has been shown not to ruin the tissues or any sort of growth factors.

00:20:33

JEROME CHOW, M.D.: There's a good paper by William Lineaweaver that shows that it is effective without being detrimental to wound healing. But we do irrigate with clear as well because of the tissue expander that we're replacing.

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DIMITRI KOUMANIS, M.D.: We like to use -- whatever tissue expander you like to have, I recommend people bring a few extras just because even though we use the base width of the other breast to estimate and compare it to the base width we'll need here for our tissue expansion, I like to go sometimes a size above and a size below and get one of each. Whatever you don't use you can always send back. We also like to dip our tissue expanders in the triple-antibiotic solution as described by Adams in the paper in PRS last year or the year before if I remember correctly, which showed a decrease in capsule contracture and in infection rate. We also change our gloves right before we handle the implants. I think sterility is a foreign object and I think it's very important that you keep those rules close to heart. Okay, I think we're ready for our...

00:22:05

JEROME CHOW, M.D.: So then we take a look at our templates.

00:22:08

DIMITRI KOUMANIS, M.D.: Yup. So Betty, if you could show us our templates again and then we'll choose. The nice thing about Veritas, just to go into the history of how we started to use it is that we started using it first for abdominal wall reconstruction and it boded so well for us that we cut down our seroma rate anecdotally that we decided to start using it in our breast reconstruction cases and it did very well. It's easy to use. It revascularizes very quickly. We have some histology that we'll show at some of our conferences that show that there is vascular regeneration and in-growth within the Veritas and it provides a very nice, easy to use, sling across where you can meet the pectoralis and you're newly-formed IMF with the Veritas sling. So here are the templates over here and it looks like we'll probably need a 10 by 16 over here that we'll be able to cut. So Betty, if you could open the 10 by 16 for us. Could you fix my earpiece and just put it back in? Thanks. Yup, there we go. That's good. Perfect.

00:23:25

JEROME CHOW, M.D.: Indicator's white.

00:23:31

DIMITRI KOUMANIS, M.D.: Thank you. So we're just verifying with our nurse Betty that the expiration dates are good and the good thing also about the Veritas is that it's right off the shelf. We keep it in the shelf right here next door. It does not need to be frozen or refrigerated and you do not need to call blood bank. It comes right out of its own pocket and sleeve in a sterile form.

00:23:55

JEROME CHOW, M.D.: No reconstitution.

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DIMITRI KOUMANIS, M.D.: No reconstitution with water. Although we just rinse it really quick with just a little bit of saline, but it's kind of more our own little voodoo that we do. You do not need to do that. It is a sterile piece of bioprosthetic.

00:24:09

JEROME CHOW, M.D.: Here you see the inner envelope that Betty is giving to Brian and that inner envelope is sterile and the Veritas is packaged right in that envelope. Again, no reconstitution is necessary, which makes this one of those situations where we can figure out what size we want and get it within minutes, rather than figuring out what size we want or trying to predict what size we want, which is sometimes what you have to do with some of the other products that need to come down from blood bank and be reconstituted, and reconstitution time, as you know, can vary. We don't reconstitute this.

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DIMITRI KOUMANIS, M.D.: So, the first thing that we do is actually we lay down our Veritas in the inferior portion inside and we do it to the chest wall. Other people with other techniques, using acellular cadaver skin or so forth have been published where they do it against the skin flap. She's very thin. I've always liked to do it against the chest wall here. I find it to be a little bit more accurate and it gives me a nice pocket that goes from chest to the pectoralis muscle.

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JEROME CHOW, M.D.: Do you find a particular type of suture is important.

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DIMITRI KOUMANIS, M.D.: I like to use usually a PDS. I don't think you need a permanent type of suture in this situation. This Veritas within three weeks will start to in-grow, as you'll see when we take these out and we put in our permanent implants. We've been using this a little bit, basically exclusively for the past little while. We did this again, Dr. Chow will corroborate this, is through

trial and error of using other things like acellular cadaver skin and other things. The sling that the Veritas uses is excellent. It's easy to handle. It's easy to take bites in, and it does not, I repeat, need to be reconstituted. So we like it very much and I've had very good success at expanding with it. It expands very well.

00:26:06

JEROME CHOW, M.D.: One nice thing is how it doesn't expand too much on the table. Once it stretches out to that length, it's not going to stretch any more, unlike some other products that we used.

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DIMITRI KOUMANIS, M.D.: So, we'll start medially. I'll start sewing medially and then Dr. Chow will take over laterally. You can do this in -- I like to sometimes, if it's a difficult sort of geometry, I like to actually put in a tacking suture in the corner to just to get my length and then you put your tacking suture so you know where you're stretched out in the other corner and you always need to verify where your IMF is. Now, if this patient had a lot more adipose tissue, the way sometimes I verify is by taking a 25 gauge needle and just piercing the skin to show my residents where exactly you need to line up the IMF, because that's the most important part of the operation, if you ask me, because your IMF is where your implant is going to settle, and so we take a piece at the end of the Veritas here. Can I get an [unclear]? Thank you. So I verified that it's down here, so you want to go over right into this area here and take a good bite, as you can see here. I'm actually toggling with this and it's a nice bite into the chest wall, not too deep to cause pain, but just deep enough to grab a good bite and secure bite. We'll just march along here. Some people like to do a continuous suture and that's okay too. I don't see how any of that would make a difference. I think it's more preference than anything else. We'll just march across down our -- I think this one is quite easy that I will be able to -- she's very thin -- that I'll be able to do this in a continual fashion with my bites. You want to put the Veritas under a little bit of stretch like Dr. Chow said. You don't have to overstretch it. Can I get a little bit more here? Sorry. Yup. Okay, and then my IMF is down here. It's got the skin. There we go. So now we've got the chest wall. It's important to get the chest wall. Doing that. Lift up. There, yeah, perfect. There we go. So as you get down here, you'll be able to -- a lot more evident where you've got to take your bites. So, reconstituting our inframammary fold. It's working along, as you can see, making sure this lies down right at the IMF. Taking a bite right into the chest wall, as you can see. You might have to take over here, Dr. Chow. Just go laterally up to here. Lift for you. So Dr. Chow is now going to continue laterally. It's important to -- we've all heard of implants before this technique, slipping into the axilla, which is bad form, obviously. With this technique, the good thing is you can actually take some bites just in front of the anterior axillary lines so that the implant can't move laterally and -- right there. Can we fit those in? It might be. Sure. That'd be great. That's got to go there.

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JEROME CHOW, M.D.: I'm not in a good position.

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DIMITRI KOUMANIS, M.D.: What's that?

00:31:31

JEROME CHOW, M.D.: It's not a good position. I think I'm going to go over there.

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DIMITRI KOUMANIS, M.D.: Okay. So, Dr. Chow is just repositioning so he can be accurate. That's an important point. If you're not happy with it, this is your shot to make this very accurate along the IMF, and so he's moving into a better position to get a better look. As I lift up I'm kind of

obscuring his, so it's always good to lift up and down to try to let him know where -- you can also take some gentian violet or some methylene blue and kind of tattoo along the IMF on the inside. It gets a little bit messy but that works as well. Then, two weeks from now, she will start to get expanded in the clinic. Now, just a note, the number one thing obviously with this type of procedure, complication, is infection rates, which we try to reduce with our triple-antibiotic and our sterile technique, like everyone does. And another thing, to reduce seromas, because seromas can be a nuisance with breast reconstruction, with any sort of prosthetic that you're using. The way to reduce it in studies that have shown case series by Dr. Spears and other things happening at Brigham Hospital with using other products has been to inflate the implant if you can and it doesn't compromise your skin flaps a little bit to decrease the dead space. You'll see we will be putting two JP drains, one in the lower pole along the IMF in between the skin and subcutaneous tissue and the Veritas, and then one in the superior aspect as well, in the same plane. There is also a technique that people like to use, whether keeping the Veritas taut against when it meets the pectoralis muscle, or you can actually leave it almost like an accordion and the theory behind that is as you expand the Veritas stretches out. I like to leave it a little loose but not in an accordion fashion and I've had good results with that in the clinic when expanding. I think it's a preference.

00:34:24

JEROME CHOW, M.D.: Just going to tie that down?

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DIMITRI KOUMANIS, M.D.: Tie that and then we'll just do some interrupteds up the lateral aspect. Scissors, Brian, to Dr. Chow. Just put a few, want to put a few interrupteds here. So we're going to put a few interrupteds up the lateral aspect here.

00:34:57

JEROME CHOW, M.D.: We should probably trim it.

00:34:58

DIMITRI KOUMANIS, M.D.: What's that. We're going to trim it. So we're going to trim it first and then we'll put a few, which will go to here. Can I have the curved Metzenbaums, please? So, we do have excess amount here so we can trim some of it. I think we should be able to trim about this much. Agreed? It's quite easy to sculpt and cut. It looks very well. We'll have to clean that up a little bit. I think that'll bode well down there. So right here in the corner sometimes you've got to round it out just so it sits nicely. Can I have that suture again, Brian? So, bring it to there. Are you in the right spot now, Jerry?

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JEROME CHOW, M.D.: Yup.

00:36:53

DIMITRI KOUMANIS, M.D.: Okay. Scissors, Brian, please. Okay. Can I get somebody to put my earpiece back in? Can you put my earpiece back in? My earpiece, just put it back in. It keeps slipping out. There we go. Okay. Can I get a new one, please, Brian? So a few more on the lateral aspect. We can put one more here, just to pin it down. Scissors. Then one more up the lateral aspect and we should be done that part. Okay. We should be good there. Scissors. Okay. All right, so now we've got our lateral aspect. We've got our medial aspect here. This will have to be trimmed because you can see it's quite long once we get our implant in. So now what I'd like to do is just tuck this in, put a little bit of wet, some saline in there to keep everything moist. We'll moist it all and then we use the triple-antibiotic as well. So first we put a little bit of that in there, into the pocket, just douse it with some triple antibiotic on top of your skin flaps, below, and in the gutters. Then we let that sit with a little sponge there and then we work on our implants. We need to change

our gloves and we need to measure to see what kind of implant we're actually going to use, sorry, before we do that. Can I get a ruler please, Brian? So I've had -- Betty, can you show me the implants please? It looks like we're at about 13 and a half base width, so probably go a little bit smaller than that and we try to match the other side, but you can over expand, so we'll probably use the -- 11, 12 centimeter -- so we'll probably use the 300 cc implant for that, please, if you could open that up. That should be plenty for this, and then we will change our gloves. Yup. The importance, as everybody knows, for tissue expansion, is making sure that your pocket is formed well and the implant doesn't flip around or move around so that you get good expansion at all poles of the breast, especially in your lower pole, where you want to reconstitute that natural ptosis of the breast as best you can, even though you're doing an implant. So we're just waiting for our implant to get put into our triple-antibiotic. We'll take the air out of the implant and then place it in and then see if we can inflate it with a little bit, as I've said, if you can inflate it a little bit on the table without compromising your skin flaps, it will reduce the dead space and most likely your seroma.

00:42:03
JEROME CHOW, M.D.: Thank you.

00:42:04
DIMITRI KOUMANIS, M.D.: Thank you very much.

00:42:15
JEROME CHOW, M.D.: So, Brian's pouring the triple-antibiotic into the container and that's the implant that's been chosen. It's 300 cc?

00:42:22
DIMITRI KOUMANIS, M.D.: Mm-hmm. Okay. Let's mix that in there a little bit and we'll take the air out. Most of it's out but we can get the -- what we need is -- yeah, we need that syringe so we can take the air out. So, just drawing back and releasing that air, drawing back until you get enough resistance. You can see it deflating. It's usually two or three times, and then you get a good deflation of the implant. You know, the orientation of different implants can be different, so I always verify with the box, even though it is usually quite evident on which way the implant should sit. Betty, could you show me that box, please? Usually the port is at the top, so, and that's what the box is showing. So, these are moderate height implants and it's all a matter of preference. So we just tuck now, if you can look in here, the implant into our pocket, and that should sit in there quite nicely, which it does, with no issues whatsoever. The implant is sitting flat. We have now reconstituted our lateral border so the implant cannot slip laterally into the axilla and we'll probably add one more stitch in here when we're done, being mindful of the implant, not taking a bite into the implant, and we will set our medial border now, which I can do right now. If I could have some retractors for Dr. Chow and then I'll have my PDS again, my 30 PDS. Then we will start to marry the two ends, the inferior end of the pectoralis and the superior end of the Veritas.

00:45:12
JEROME CHOW, M.D.: So, placement of the implant can be done at any point. For the faint of heart like myself, I tend to sew in the Veritas all the way and then slip it in through the lateral aspect as if we had a pectoralis muscle all the way.

00:45:29
DIMITRI KOUMANIS, M.D.: Yup. That's an appropriate way of doing things, obviously. In this case, the implant went in so nicely that I'm able to actually suture around it without having to fear, but as Dr. Chow is quite correct in saying that sometimes the safer way to go is to take a -- do all your bites before the implant goes in and that way you don't run the fear of catching your implant. Although in this case, it's quite easy to see our boundaries. That tore through, so we know that's not

a good enough bite. That's a better bite. That was a better bite.

00:46:41

JEROME CHOW, M.D.: You see how the stitch didn't tear through the Veritas. The stitch broke when the knot got caught. The Veritas is very strong. In fact, in these situations, you'll very rarely see the Veritas tear? You want me to get that out?

00:47:07

DIMITRI KOUMANIS, M.D.: Yeah, let's cut that up. The tissue is not the greatest in the midline so I have to go deeper. It felt solid, but it was not obviously and that tests how solid you have it, so that feels more solid. Cut the end of that. Yup, go ahead. That feels much more solid. A few more up the side. Here. Here we go. Okay. So let's see now how our Veritas -- so, as you can see, we're able to -- and we won't need to trim too much, but we'll need to trim a little of it, but maybe not hardly any at all. All right. To bring this together. So you see the implant underneath. There's your Veritas. There's your implant and there's your pectoralis that we will marry along with this. I think that leaving it about this loose is fine. It's not too loose. It's not too tight. So we'll take the PDS again and could you put my earpiece in? This thing keeps falling out. Okay. Just press it in there. You won't hurt me. There we go. Wonderful. Okay? So, we'll go all the way and find our lateral edge here. These superior ones I like to do interrupted. Some people also would run these, I think it's less traumatic, if you do interrupted, I think, on the muscle. You're not crushing it. Then we will place our drains in. We'll possibly inject a little bit. I'll inject a little bit of fluid in through here before I put that stitch in here. So we'll leave a little window from here to here where we can see the port. She should be quite easy to expand post-operatively because she's quite thin and there will be no guessing of where the port is with our magnet. If they do have a thicker subcutaneous tissue, I sometimes make notes in my charts, kind of measuring from the midline to here and then honing in on where the magnet would be, so that post-operatively, if I have to verify, if I'm getting mixed signals, which sometimes can happen, I can verify my notes by taking measurements. The implant doesn't move too much because we've got it in a sling inferiorly and superiorly. So we'll leave that little space there for a port. We'll come back and close that after. As I said, we start expanding approximately two weeks after this surgery. As you can see, these type of bioprosthetic slings have done very well for placing that implant in a stable place. Instead of -- I was trained, and I'm sure Dr. Chow was too, on lifting up serratus. Serratus can be quite thin inferiorly and quite difficult to keep strength and you get these buttonholes everywhere, whereas this is a much nicer technique. That's why it's become popular among surgeons, because it's quite satisfying to do. Okay. Then we will tack down one more up here. Then, Brian, if you can get the stopcock ready so we can fill this a little bit, just to reduce the dead space. We won't fill a lot. Anywhere from 40 to 60 or whatever we see that -- sometimes you have these big skin flaps there and then you can fill more just to reduce the dead space and hence your seroma, post-operatively. You might want to put one a little bit lateral here. See if we can get that. Yup. I may just put an extra one laterally here just to -- Can you cut this, Brian? Don't want to jab myself here. It tore through. Can I get another suture, please? There we go. That's it for that. So that's our sling. That sits nicely as you can see. It's nice and taut. Just loose enough for us to be able to make our expansion possible and it's right, if you feel the implant, it is basically right here along the edge, which all the way across you can feel it. We've reset our inframammary fold. So let's see how much we can -- so check your skin hooks. We probably won't be able to put much in this lady. Possibly, maybe 40 cc's, if that. You know, because she is somewhat tight. So we won't put much in this one. In others I've put up to 80 to 100. All right. You're drawing now. Thank you. The stopcock's not all the way down yet. There we go. So, make sure your air bubble is obviously as important with the expansion. It's still enough to --

okay, so we will be injecting 30 cc's into the implant. And after every 30 cc's, you should check your skin flaps again. Make sure that your skin flaps are not compromised. If they are, it's not worth it to try and push the envelope.

00:57:12

JEROME CHOW, M.D.: Literally.

00:57:13

DIMITRI KOUMANIS, M.D.: Yup. Literally, right. Okay, so let's check our flaps again. Is that tight? I think that's about it.

00:57:23

JEROME CHOW, M.D.: I would say so, yup.

00:57:24

DIMITRI KOUMANIS, M.D.: I would say so. That just gives you a little bit of room to expand after trying to find that. See, there's not too much dead space here so she should do fairly well with the seromas. So I will take two more sutures here just to complete our line here over top of the magnet, with the [unclear], please. I think it's important to make sure you have -- some people like to use one drain. I like to use two. One up top and one at the bottom. I keep them on antibiotics while they have the drains. We do have an implant in there. Usually within the week, both of those drains can come out. But I wait just as in other types of surgeries, abdominal reconstruction and so forth. We wait until they have less than 20 cc's on at least two consecutive full days in order that they're dry so we do not get a seroma buildup. By expanding them in the office, too, you're reducing that dead space where the seroma can build up and decreasing your chances of a seroma happening. So we will take our JP drains, and again so now we have just a recap. If you look in here, we have our IMF with the implant sitting very nicely, all the way medially, right to our line so we do not get any symmastia, and if you bring this in, over here you can see that we will be able to insufflate her in order for her to have some cleavage area there and also, it's coming all the way up top here to our other line here, so that not only was the Veritas sling correct, but our measurements on what type of implant we used fit the pocket perfectly at this time, so it's very important to have implants, like I say, size above, size below, just so there's no room for error. Actually, there is room for error and then you can accommodate. So, we'll just do our last part of our operation as I like to go lateral here to put in our two JPs. I set these to bulb suction. If she's going to stay in the hospital due to pain or any sort of other issues, then we would make sure that this patient gets her bulbs are always on suction. If they can't seal for the first 24 hours, we put them on low wall suction. We lay these ones down right at the IMF here and just tuck it in like this. It's perfect. Here's our superior drain, well-hidden in the shadows of the axilla. We just place this one on top of this. So that is the operation and we are now just going to close the skin in a two-layered fashion. We do deep dermals with a Monocryl 3-O to line up the skin very well and then we just usually run a subcuticular 4-O Monocryl and then that would be the end of the operation. Hemostasis was checked for. The implant was in perfect condition. I don't know if you have anything else to add, Dr. Chow.

01:01:20

JEROME CHOW, M.D.: No. I think it was great.

01:01:22

DIMITRI KOUMANIS, M.D.: So, again we'd like to thank Albany Medical Center and the Albany Medical College for allowing this to happen where we work. We'd like to thank our OR staff here, Betty and Brian and our anesthesiologists. From Dr. Chow and myself, we'd like to extend our gratitude towards Synovis and the Veritas product, which we've been happy to use and

happy to endorse. Until next time, thank you very much.

01:01:45

JEROME CHOW, M.D.: Thank you.

01:01:49

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