BAPRAS

British Association of Plastic
Reconstructive and Aesthetic Surgeons

Summer Scientific Meeting

19–21 June 2013
East Midlands Conference Centre, Nottingham

Contents

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We are grateful to Sytner Nottingham for their generous sponsorship of this meeting

PRESIDENT'S FOREWORD

Dear Members and Guests,

It is a great honour to host you all in Nottingham for the first Association visit.

"Collaboration" is the thread of our meeting and we hope that you will come to share in this. BAPRAS has agreed to closer ties with GeoPRAS, the Georgian Association, and we welcome their President to the UK for the first time. We are also privileged to welcome the Presidents of the Pakistan Association of Plastic Surgeons and German Society of Plastic, Reconstructive and Aesthetic Surgeons.

Other Invited faculty from Russia, China, Chile and Australia blend a mix of new and old contacts. All come with a microsurgical pedigree and generosity of spirit second to none. They will enrich our professional and personal lives.

Wednesday sees a celebration of overseas and charitable work and we learn how this is a two way experience. Funding perspectives on aid will be presented by a former ophthalmology trainee-turned-financier.

It is entirely appropriate that the Wednesday evening reception BBQ follows seamlessly on from the meeting, in the grounds adjacent to the conference centre. This is designed to facilitate one most important aspect of the summer meeting: chance meetings and serendipitous friendships.

Thursday debates changes following the Keogh review of cosmetic interventions, with learning from the plastic surgeon at "at the right hand" and one of the country's top medical negligence lawyers. We spend that afternoon focussed on local and international trainees, training, leadership and organising work in private practice.

The Association dinner is being held in the Senate Chamber of Nottingham University.

Friday morning's guest lecturer is the Chairman of the Cochrane Collaboration Skin Group, Nottingham University's Professor of Dermato-epidemiology, while the afternoon sees the launch of the Major Trauma special interest group and a symposium on major trauma with local, national and international speakers.

Around the keynote speakers we have an impressive array of free papers, which we hope will provoke debate but not discord!

I feel sure that you will leave Nottingham after this summer meeting with a new vigour, perspective and above all new friends.

Graeme Perks
President, 2013–2014

OUTLINE PROGRAMME

Wednesday 19 June 2013

09:00 Registration and refreshments

09:55 Welcome by the President

10:00 Introduction to the Georgian Society of Plastic Surgeons

10:10 Free papers: Vascular

11:00 Guest speaker: The use of locoregional flaps in head and neck reconstruction
Professor M Leung

11:20 Refreshments and exhibitions

11:40 Guest speaker session: International collaboration

13:20 Lunch and exhibitions

14:15 Guest speaker: Problems with nasal tip modelling: our point of view
Professor I Kuzanov

14:35 Free papers: Body contouring, breast and aesthetic surgery

15:35 Refreshments and exhibitions

16:00 Free papers: Body contouring, breast and aesthetic surgery (cont)

17:00 Guest speaker: Measuring patient-reported outcomes in body-contouring patients and the BODY-Q
Dr S Danila

17:10 Guest speaker: Breast reconstruction: my perspective
Dr L Mu

17:40 BAPRAS EGM
Open to all members

18:00 Drinks reception and BBQ

Thursday 20 June 2013

08:30 Registration and refreshments

09:00 Free papers: Face

10:10 John Potter Lecture *(in association with the University of Newcastle upon Tyne)*
- Introduction
  Professor T Lennard
- Smile restoration in developmental facial paralysis
  Dr M Novikov

10:40 Refreshments and exhibitions

11:10 Panel discussion: Reflections on the cosmetic surgery regulation review

12:20 Lunch and exhibitions

12:30 Introduction to the sKINship Project
(Conference Suite 3)

13:20 Guest speaker session: My department

15:10 Refreshments and exhibitions

15:30 Guest speaker session: Training pathways and leadership

16:25 Guest speaker session: Financial management and private practice

17:05 Close

19:15 Association Dinner

OUTLINE PROGRAMME

Friday 21 June 2013

08:30 Registration and refreshments

09:00 Free papers: Skin

10:30 Guest speaker: How to cheat at clinical trials
Professor H Williams

11:00 Refreshments and exhibitions

11:30 Free papers: Flaps and burns

13:00 Lunch and exhibitions

14:00 Introduction to the BAPRAS Trauma SIG

14:05 Guest speaker: Major trauma networks in England: is it making a difference?
Mr C Moran

14:25 Free papers: Limbs

15:35 Refreshments and exhibitions

15:55 Guest speaker session: Major trauma

17:30 Close

GUEST SPEAKERS

Mr P Balen

Paul graduated with a first in law at Peterhouse, Cambridge. He qualified as a solicitor in 1977 and became a partner in what is now Freeth Cartwright LLP in 1980. He is now a consultant.

A Past President of both the Nottinghamshire Law and the Nottinghamshire Medicolegal Societies, in 2000 he was appointed one of the first three Senior Fellows of the Association of Personal Injury Lawyers. He is a referral panel solicitor for Action for Victims of Medical Accidents as well as Chief Assessor for the Law Society Clinical Negligence Specialist Panel and an accredited APIL clinical negligence specialist.

Paul is also an accredited mediator and a director of Trust Mediation, a not-for-profit company specialising in mediating clinical negligence and personal injury claims. He is General Editor of *Clinical Negligence* published by Jordans.

Paul has been involved in many medical product group claims such as Benzodiazepine, Norplant, MMR, ABG and 3M Hips as well as the cases involving Dow Corning, Trilucent, Hydrogel and PIP silicone breast implants in which litigation he currently serves on the steering committee.

Paul has given evidence on breast implants to the Silicone Breast Implants Review Committee (1997); the House of Commons Health Select Committee (2001) and on Cosmetic Surgery to the Keogh Review (2013). He has appeared widely on TV and radio and for some 20 years was the Radio Nottingham phone-in legal eagle!

- Reflections on the cosmetic surgery regulation review
  Thursday 20 June

Dr A Banerji

Dr Arnab Banerji is Chairman of Collabrium Capital. He is a non-executive director of the Qatar Financial Centre Authority. He is a non-executive director of Kames Capital, which is part of the AEGON group.

He has held a number of senior financial positions, including at Nomura Securities, Citibank and Foreign & Colonial where he was the group Chief Investment Officer. As CIO he was responsible for over US$100 billion of international investments. He was formerly a director of CDC, part of the Department for International Development. He has also served on the UK Government Export Credits Guarantees Advisory Board and on the Morgan Stanley Capital International Advisory Board.

From 2002 to 2005 Arnab worked in No 10 Downing Street as the Senior Policy Advisor on Economic Affairs to then-Prime Minister, Tony Blair. He also served as Economic Advisor to the UK-China Task Force Co-headed by Deputy Prime Minister John Prescott and State Councillor Tang. He accompanied the Prime Minster on his visit to China in 2003 when he served as his speech writer.

From 2004 to 2005 served as a member of Sir Peter Gershon's Whitehall Efficiency Review of all UK government activities.

In 1980 Arnab graduated from Oxford with degrees in Physiology and Medicine. He is a member of the university's Medical Sciences Advisory Board.

In 1982 Arnab was gratified and relieved to learn that he'd passed the Primary Fellowship of the Royal College of Surgeons. He naturally has a great respect for those who went on to complete their studies!

- International collaboration
  Wednesday 19 June

Dr S Danila

Stefan was born in Chile in 1979. He obtained his medical degree at the Universidad de los Andes in 2001. After he graduated with honours, he earned a Masters Degree in Clinical Epidemiology (University of Chile), starting his research career applying evidence-based medicine concepts to his work and teaching. In 2003, he started his general surgery training at the Military Hospital of Santiago (Universidad de los Andes) and finished his plastic surgery residency in 2009 at the Universidad de Chile. As a plastic surgeon and researcher, Dr Danilla has worked on reconstructive and cosmetic surgery, performing randomised controlled trials in order to obtain reliable evidence for plastic surgery procedures, useful for patients and surgeons. His research work is now dedicated to providing reliable results in plastic surgery, developing patient and surgeon outcome reported instruments.

- International collaboration
  Wednesday 20 June

GUEST SPEAKERS

Mr A Fitzgerald

Aidan is currently Chair of the SAC in Plastic Surgery and took part in the Keogh review of cosmetic surgery regulation. He trained as an SpR in Scotland, undertaking microsurgery fellowships in Melbourne and Toronto prior to commencing a consultant post in Sheffield in 2003 with a sub-specialty interest in head and neck surgery.

He has a particular interest in medical education and has a number of roles related to training. He has been the Regional Training Programme Director in Yorkshire and the East Midlands for the last six years, an examiner for both the MRCS and FRCS, regional advisor for the RCSEd, and GMC associate.

- Reflections on the cosmetic surgery regulation review
  Thursday 20 June

Miss A Hazari

Anita has been elected to serve as the Council member for the South East Coast from 2013-2015 and is also a member of the BAPRAS Finance Committee. Anita has been a consultant plastic surgeon at the Queen Victoria Hospital NHS Foundation Trust, East Grinstead, since 2006 with a sub-specialty interest in breast reconstruction. As the oncoplastic breast lead (2009-2012), she has been a key member of the Kent Breast Cancer Network. Anita is an educational supervisor with the Kent, Surrey and Sussex Deanery and interviews for national ST3 plastic surgery training posts. She was awarded the Hunterian Professorship in 1999 by the Royal College of Surgeons for research in nerve regeneration.

- Financial management
  Thursday 20 June

Professor I Kuzanov

Iva Kuzanov was born into a physicians' family. His mother was a general practitioner and his father a famous surgeon in Georgia.

He graduated from Tbilisi State Medical University in 1972 and was trained at the Soviet Scientific Center of Surgery in Moscow. Under the guidance of Viktor Krilov, Iva Kuzanov, along with his colleagues, became pioneers of microsurgery in the Soviet Union. In 1980 he formed the first center of microsurgery in Georgia, which received the State Prize for the development of microsurgical services in the Soviet Union. From 1980 to present, the team has performed more than 800 replantations and over 250 flap transplantations.

Since 1989 Iva Kuzanov with his team made a contribution into the development of aesthetic surgery in Georgia. They performed the first liposuction, open rhinoplasty, and breast augmentation in Georgia. Following the founding of the first department of plastic and reconstructive surgery, at the Tbilisi State Postgraduate Medical Academy in 1994, in 2007 the Department of Plastic Surgery was established at the Tsibli State Medical University. On this base, a residency of plastic surgery programme was formed and most plastic surgeons in Georgia were trained by Iva Kuzanov. In 1999 Iva founded the Georgian Society of Plastic, Reconstructive and Aesthetic Surgeons (GeoPRAS) and was awarded the Order of Honor for developing of plastic surgery in Georgia.

Since 2004 Iva Kuzanov has been the Head of the Kuzanov Clinic private hospital and in 2006 he became a full professor of Tbilisi State Medical University and the Head of Department of Plastic Surgery.

- Problems with nasal tip modelling – our point of view
  Wednesday 19 June

Dr A Kuzanov

Alexander was born into a physician's family- His mother Alla Kuzanova a biologist and father Iva Kuzanov a plastic surgeon.

In 2004 he trained in the Russian Postgraduate Education Academy department of Plastic Reconstructive and X-ray surgery, with a speciality in microsurgery (particularly, microsurgical technique, replantology, plastic surgery, and microvascular surgery). In 2005, he became a candidate of medicals sciences ("Bone revascularization with vascular periosteal-cortical flaps" Moscow, Russia) and in 2006 undertook his PhD ("Bone revascularization with vascular periosteal-cortical flaps". Tbilisi, Georgia). In 2007 he was appointed honorary fellow in burns and plastic surgery at Nottingham City Hospital.
Since 2006, he and his team have made a contribution into the developing of new methods of modern rhinoplasty and in 2007 was appointed as assistant professor, Tbilisi State Medical University, Department of Plastic Surgery.

- Problems with nasal tip modelling – our point of view
  Wednesday 19 June

GUEST SPEAKERS

Miss B Jemec

Barbara is currently chair of the BAPRAS Overseas Committee. She previously sat on Council as the representative for the London Region.

- International collaboration
  Wednesday 19 June

Mr D Lam

David Lam is a non-regional member of BAPRAS Council, elected for the period 2012-14, and is responsible for the BAPRAS annual workforce planning survey. He has been a consultant at Sheffield Teaching Hospitals since 2006 with an interest in microsurgical reconstruction of the breast and head & neck regions. A firm believer in safety standards, he has chaired the clinical governance committee in Sheffield since appointment and is Undergraduate Lead in Plastic Surgery for the University of Sheffield. He is an Examiner for the Intercollegiate Specialty Board in Plastic Surgery 2012-2017.

- Training pathways and leadership
  Thursday 20 June

Professor M Leung

Michael graduated with an MBBS from University of Melbourne in 1978, gaining several honours during his course. He was accepted into the plastic surgery training program in 1984, and completed the FRACS in plastic surgery in 1987. Michael was awarded a plastic surgery fellowship in 1988 to Singapore General Hospital and also to the Kantonossipital Aarua, Switzerland. He returned to Melbourne in 1989 and was appointed plastic surgeon at Alfred Health and Southern Health. Michael is appointed Director of the Plastic, Hand and Facio-maxillary Surgery Unit, Alfred Health in 2002 until now, and has been Director of Plastic Surgery Unit at Southern Health as from 2009.

Michael's many professional achievements include appointment to the Court of Examiners-RACS- for plastic and reconstructive surgery since 2004 and as a senior examiner in plastic and reconstructive surgery from May 2009. Michael is also a member of the surgical committee of Interplast Australia and undertakes regular trips to perform and teach plastic surgery in developing countries. Michael has been an honorary senior lecturer in the Department of Surgery, Alfred Hospital since 2007 and appointed Clinical Associate Professor in 2009.

His principal surgical interests include skin cancer surgery, reconstructive microsurgery in head and neck surgery and limb trauma. He also specialises in osseointegration, especially in treatment of amputees.

- The use of loco-regional flaps in head and neck reconstruction
  Wednesday 19 June
- International collaboration (Wednesday 19th June); My department (Thursday 20th June), Major trauma
  Friday 21 June

Professor P McArthur

- My department
  Thursday 20 June

Mr C Moran

Chris is National Clinical Director for Trauma to NHS England and Professor of Orthopaedic Trauma Surgery at Nottingham University Hospital. He is a full-time trauma surgeon with a special interest in polytrauma, complex articular fractures and the treatment of nonunion. His research portfolio includes 140 published scientific papers and abstracts with over 3,000 citations, mainly in the field of trauma. He continues in active research in this field. He has authored 16 chapters in textbooks and is editor of the AO Principles of Fracture Surgery and co-authored the BOA/BAPRAS Standards for the Management of Open Fractures of the Lower Limb. He has chaired regional and national clinical advisory groups for the development of Major Trauma Networks throughout England.

- Major trauma networks in England: is it making a difference?
  Friday 21 June

Dr L Mu

Dr Mu received her medical degree from Sun Yat-Sen University of Medical Sciences in 1988, GuangZhou, China. She subsequently completed her surgical research fellowship and received a PhD in plastic surgery at the Hospital of Peking Union Medical College and Chinese Academy of Medical Sciences in 1997, Beijing, China.

Dr Mu worked as a research fellow for six months in the Department of Plastic and Reconstructive Surgery in Gent

GUEST SPEAKERS

University Hospital, Belgium. She was selected as a recipient of the International Scholar Program for 2000, and supported by Plastic Surgery Education Foundation (PSEF) of the USA and Tsinghua Education Foundation (North American).

Dr Mu returned to China in 2001, where she has worked as an attending plastic surgeon, Chief Assistant to the President of Plastic Surgery Hospital and Associate Director of Department of Clinical Operations and Education of Plastic Surgery Hospital, and Associate Director Aesthetic Plastic Surgery Center of the Breast.

Dr Mu has served on several national committees and is President of the Expert Group of Aesthetic Plastic Surgeons, China Medical Woman Association (CMWA) and Vice-president of Aesthetic Plastic Surgery of Breast, China Medical Doctor Association (CMDA)

- Breast reconstruction: my perspective
  Wednesday 19 June
- My department
  Thursday 20 June

Mr M Murray

Martin Murray is one of the partners at Sandison Easson & Co, Specialist Medical Chartered Accountants. They have been acting for the medical profession since the 1970s and have a wealth of knowledge and experience of all matters relating to doctors.

- Financial management
  Thursday 20th June

Dr M Novikov

Mikhail is Director of Brachial Plexus and Facial Paralysis programs at N Solovjov's Emergency Medicine Hospital and Yaroslavl State Children's Hospital. Following his medical degree at Yaroslavl State Medical Academy, Dr Novikov undertook postgraduate training in Russia and the USA. He is a member of the World Society for Reconstructive Microsurgery and the American Society for Peripheral Nerves.

- Paediatric facial reanimation
  Wednesday 19 June
- Major trauma
  Friday 21 June

Professor J Perks MBE

Jonathan is the Honorary Visiting Professor in Leadership at Cass Business School. His executive clients and top teams at Asda, Nestle, Christie's, HSBC, Barclays, KPMG, Sainsbury's, RBS, Eversheds, and Cambridge University describe him as one of their top board-level coaches. He is frequently asked to act as the CEO's Trusted Leadership Advisor. He loves his work and travels widely to Europe, USA, Arctic Circle and Southern Africa.

Jonathan is a popular international speaker and author of "Inspiring Leadership". He gives a lot of his time and all the profits from his book and audio to charities such as Help for Heroes, Kids Out and the HIV/AIDS initiative in Botswana. His book is deeply personal and draws lessons from his setbacks and inspiring role models over 32 years raw leadership experience in the British Army, PwC, IBM and as Penna PLC's MD of Board and Executive Coaching. HM the Queen awarded him the MBE for his services to leadership. He is passionate about learning and researching his leadership calling and consequently has an MA and MBA.

Jonathan focuses on high performance leaders, boards and teams in the corporate, financial and retail sectors. Jonathan's life purpose is "inspiring leadership by supporting and challenging you to make a positive impact in the world". He encourages clients to also lead by example, have courageous conversations and give inspirational feedback.

What is so rare with his background is that Jonathan combines applied, hard neuroscience and thought provoking challenge with softer skills of deep listening, intuition and relationship building. He brings you "brains and scar tissue"; having made more than his share of mistakes.

- Training pathways and leadership
  Thursday 20 June

Mr J Pollock

Jonathan Pollock is a specialist registrar in plastic surgery on the East Midlands rotation.

He has been a member of the PLASTA committee since 2011 and is the trainee representative on the UK and Republic of Ireland SAC. He has been an invited trainee observer at the last four rounds of ST3 National Selection, and a member of the Curriculum Development Group for both the Final and Intermediate Years curriculums.

GUEST SPEAKERS

Jonathan graduated from the University of Nottingham in 2004 and has trained in the Midlands and Yorkshire. His areas of clinical interest are skin oncology and head and neck reconstruction, but he also has a special interest in education and training, and has completed a Postgraduate Medical Education Certificate from the University of Dundee.

- Training pathways and leadership
  Thursday 20 June

Mr D Sammut

Donald Sammut trained in London, Strasbourg, Paris and Barcelona, and was appointed hand surgeon in Bristol in 1993, where he set up the hand unit and the congenital hand services. He now works in private practice. He divides his time between clinical practice and the teaching of anatomy and hand surgery. His main work bases are in Windsor and in Bath. His interests include the reanimation of paralysed hands, congenital hand surgery and reconstruction after trauma, particularly skin cover. He travels to, works and teaches in Nepal, where he has set up programmes of surgery in leprosy villages and in Italy, where he lectures and previously ran a congenital hand service. He has held posts on Council of BSSH and on various educational committees. He is also an illustrator and artist, both medical and non-medical, providing most artwork for the BSSH and BAPRAS conferences and also illustrating non-medical publications.

- International collaboration
  Wednesday 19 June

Ms V Sanders

Vanessa Sanders graduated in English and Theatre from Warwick University during the Thatcher years. She trained as a tax inspector and then as a chartered accountant. Vanessa has more than 25 years' experience of advising entrepreneurs in business gained by spending 10 years with two of the largest accounting firms in the heart of our capital city and latterly as a director of Stanbridge Associates specifically advising consultant doctors on their business affairs.

- Financial management
  Thursday 20 June

Professor M Tarar

Moazzam Tarar graduated from King Edward Medical College (now University), Lahore in 1985 and completed his general and plastic surgical training in the UK from 1988 to 1995. On his return to Pakistan he established the plastic surgery unit at Jinnah Hospital, Lahore.

Lower limb and hand reconstruction are his special interest areas. He started the limb replantation service at Jinnah Hospital, Lahore and since 2007 has run the reconstructive microsurgery course there in collaboration with the plastic surgery unit at Frenchay Hospital, Bristol. He organised relief efforts after the October 2005 earthquake from the Pakistan Association of Plastic Surgeons' platform as it's Secretary and also invited BAPRAS members to participate.

He has been made an Honorary Fellow of the College of Physicians and Surgeons of Pakistan in 2010. He is currently President of the Pakistan Association of Plastic Surgeons. He is founder and Executive Director of the Jinnah Burn and Reconstructive Surgery Centre and Head of Department of Plastic and Reconstructive Surgery at Allama Iqbal Medical College Jinaah Hospital, Lahore Pakistan

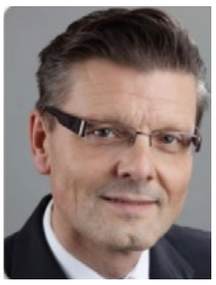
- My department
  Thursday 20 June
  Major Trauma
  Friday 21 June

Miss S Tucker

Sarah graduated from Bristol University in 1992. She trained in plastic surgery mainly in the South West, and has completed a hand fellowship at Oxford. In 2006 she took 2 years out from her training to work in Nepal, dividing her time between a mission hospital for reconstructive surgery and rehabilitation, and the local government hospital. She went with her family, Simon her husband, a general practitioner, and her 2 daughters then aged 6 and 9.

- International collaboration
  Wednesday 19 June

GUEST SPEAKERS



Professor P Vogt

Following medical school at the J W Goethe University, Frankfurt, Peter Vogt undertook post-doctoral training in Germany, and a research fellowship in the USA. Since 2001, Professor Vogt has been Professor and Head of Plastic Surgery at Hannover Medical School. In 2010, Professor Vogt became President of the German Society of Plastic, Reconstructive and Aesthetic Surgeons. He is Past President of the German Burn Society and Vice-President of the German Surgical Society and European Burn Society.

His major research interests are in burns, microsurgery, surgical oncology and wound healing.

- My department
  Thursday 20 June

Professor H Williams

Hywel Williams trained in dermatology in London (King's College and St John's) and then in clinical epidemiology at the London School of Hygiene and Tropical Medicine. In 1984, he came to the University of Nottingham to set up the Centre of Evidence-Based Dermatology which includes the Cochrane Skin Group (identifying research gaps) and the UK Dermatology Clinical Trials Network (addressing those gaps through randomised controlled trials). Hywel is a prolific writer and has raised over £9m in competitive non-commercial research funding over the last 8 years. He is chief investigator of three independent clinical trials. Hywel is a strong advocate of evidence-based dermatology and for working with patients and within multidisciplinary teams to conduct high quality applied research that informs clinical practice in the NHS. Hywel is Chair of the NIHR CCRN National Speciality Interest Group for Dermatology and is an NIHR Senior Investigator. Outside of dermatology, Hywel chairs the NIHR Health Technology Assessment Commissioning Board.

- How to cheat at clinical trials
  Friday 21 June

Mr S Withey

Simon Withey is a consultant plastic surgeon at the Royal Free Hospital, London. He has been a member of BAAPS Council from 2010-2013 and has sat on a number of review panels, including the BSI committee for safety of implantable devices, CEN (European Standards), BSI committee for standards in cosmetic surgery, the Keogh Expert Group for the investigation into PIP implants and the Keogh review of cosmetic surgery

- Reflections on the cosmetic surgery review
  Thursday 20 June

WEDNESDAY 19 JUNE 2013

09:00 – 10:10

09:00 **Registration and refreshments**

09:55 **Welcome by the President**

10:00 **Introduction to the Georgian Society of Plastic Surgeons**
Professor I Kuzanov

Modern plastic surgery in Georgia began in 1977, when the first microsurgical laboratory was set up for improving microsurgical techniques in an experiment on laboratorial rats. In the same year the first successful replantation of amputated finger was made. In 1978, replantation of the hand to a four-year boy was performed- the first in the Soviet Union.

The first microsurgical center of Georgia was founded in 1980. From 1977 to present, more than 1,000 replantations and over 450 flap transplantations have been made.

In 1996, the first transsexual operation (from woman to man) was performed. A new method of one-stage phalloplasty (using the third finger flap) was investigated and put into practice. In 1985 the microsurgical team began collaboration with oncological surgery teams, (head and neck, breast and soft tissue surgeons) as well as with the orthopaedic team.

In 1984, the State Prize for the developing of microsurgical services in the Soviet Union was awarded to the microsurgical team and ten years later, at Tbilisi State Postgraduate Medical Academy, the first department of plastic and reconstructive surgery was founded. After the merging of the Tbilisi State Postgraduate Medical Academy with Tbilisi State Medical University in 2007 the Department of Plastic Surgery was established.

The Georgian Society of Plastic, Reconstructive and Aesthetic Surgeons (GeoPRAS) was founded in 1999.

Free Papers: Vascular

Chair: Mr P McArthur

10:10 **Liposuction and post-operative compression in the management of upper and lower limb lymphoedema: the Dundee experience**
Miss P Gill, Mr A Munnoch (Dundee)

Aims: To present outcomes of liposuction for upper and lower limb lymphoedema at a tertiary centre.

Methods: The Ninewells lymphoedema clinic database was reviewed for all patients with arm or leg swelling.

Results: 41 patients underwent liposuction for lymphoedema, 19 upper limb and 24 lower limb. The mean pre-operative upper limb volume difference was 1350ml (620-2428ml), with 1584ml (600-2600ml) of fat removed.

NOTES

10:17 – 10:27

The upper limb percentage reductions were 79% at 2 weeks (*n*=19), 81% at 1 month (*n*=19), 87% at 3 months (*n*=17), 89% at 6 months (*n*=15), 101% at 1 year (*n*=12), 109% at 2 years (*n*=11), 118% at 3 years (*n*=11) and 126% at 5 years (*n*=8).

The mean pre-operative lower limb volume difference was 4796ml (2393-9465ml), with 4955ml (2700-9250ml) of fat removed.

The lower limb percentage reductions were 51% at 2 weeks (*n*=23), 61% at 1 month (*n*=23), 64% at 3 months (*n*=22), 76% at 6 months (*n*=16), 83% at 1 year (*n*=16), 89% at 2 years (*n*=9), 96% at 3 years (*n*=7) and 95% at 4 years (*n*=4).

Conclusion: Liposuction for both arm and leg lymphoedema is effective at reducing bulk and improving function. Careful post-operative monitoring and patient compliance with garments is required to maintain these results.

10:17 Questions

10:20 Lymphatico-venous anastomosis and near-infrared imaging: a new frontier in the management of lymphoedema?
Mr K Ramsey, Mr A Hayes, Professor P Mortimer (London)

Introduction: Management of lymphoedema has historically centred around techniques focussing on compression bandaging, decongestive therapy and symptom control. Surgical options have had variable results.

The combination of new dynamic imaging techniques as well as advancements in supermicrosurgery has led to significant developments. Imaging delineates the residual functioning lymphatic channels, which are used for lymphaticovenular bypass procedures. Results for this technique have shown optimistic initial results and we present the first British experience combining these techniques.

Methods: All patients had lymphaticovenous bypass procedures at our unit. All were assessed by the same surgeon and lymphoedema therapy team and limb volumes measured. Near-infrared spectroscopy was used to analyse the functioning lymphatics in the affected limb pre and post-operatively. The same post-operative therapy regime was used with all patients.

Results: Post-operative volumetric improvements of the affected limbs measured with a perometer are presented for each patient. Complications and outcomes are discussed. Technical tips and pitfalls including the surgical learning curve are also presented.

Conclusions: Lymphaticovenous anastomoses compare favourably to other options and can be a useful adjunct in the management of this most debilitating condition. Patient selection, using imaging techniques, is crucial and there is a clear need for further investigation and research.

10:27 Questions

NOTES

WEDNESDAY 19 JUNE 2013

10:30 – 10:40

10:30 **Treatment of vascular malformations of the tongue: the Middlesbrough experience**

Mr J Wokes, Dr G Kessell, Dr F Hampton, Dr R Jayaraj, Mr T Muir (Middlesbrough)

Introduction and Aims: Vascular malformations of the tongue represent a difficult management challenge. Surgical excision sacrifices tissue and is often followed by recurrence. We present our experience of non-surgical Bleomycin sclerotherapy treatment under Remifentanil sedation of tongue vascular malformations.

Material and Methods: Analysis of a prospectively collected database revealed 21 vascular malformations of the tongue treated by a single surgeon between 2004 and 2012. Previous treatment, total Bleomycin dose, number of treatments and the clinical outcomes were evaluated.

Results: We treated 11 male and 10 female patients aged 2-68 with a mean age of 31. The lesions treated were 11 venous and 10 lymphatic malformations. Total Bleomycin dose ranged from 0.7-81.6mg with a mean of 10.3mg per patient. The number of treatment sessions ranged from 2-9 with a mean of 4.9 sessions. All patients reported improvement in associated symptoms and over 60% reported significant reduction in size of the malformation.

Conclusions: Treatment of vascular malformations of the tongue remains a specific challenge. We have found Bleomycin sclerotherapy to be an excellent non-surgical choice. Treatments are performed in 15 minutes under Remifentanil sedation, most often as day cases but occasionally patients require an overnight stay if the malformation is extensive.

10:37 **Questions**

10:40 **Microvascular anastomoses using sutures and couplers: a computational study of blood flow characteristics**

Mr R Wain, Dr J Whitty, Professor M Holmes, Professor W Ahmed, Mr M Dalal (Preston)

Introduction and Aims: Sutured and coupled anastomotic flow was simulated using Computational Fluid Dynamics (CFD) to investigate the effect of each technique on intravascular blood flow. Characteristics potentiating thrombus formation, for example changes in velocity, wall shear stress (WSS) or recirculating flow (vorticity) were examined.

Materials and Methods: Idealised geometries of sutured and coupled anastomoses were created with dimensions identical to microvascular suture and the GEM coupler. Vessels were modelled as non-compliant 1mm diameter ducts, and blood was simulated as a Newtonian fluid, in keeping with previous studies. All analyses were steady-state and performed in arteries.

Key Results: The sutured simulation revealed a low boundary velocity, high WSS, high shear strain rate (SSR), and elevated vorticity at the suture sites.

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10:47 – 10:57

The coupled simulation produced a maximum WSS at the anastomotic region of less than half that of the sutured model.

Conclusions: In these idealised models, a more thrombogenic profile is demonstrated in sutured anastomoses compared to coupled vessels. Data from a coupled simulation reveals a flow profile that is nearly equivalent to that of a pristine vessel. Based purely on the less favourable flow properties in sutured anastomoses, it is concluded to be an inferior method compared to coupled anastomoses.

10:47 Questions

10:50 Technical refinements in the surgical management of neonatal limb ischaemia: the Canniesburn experience
Mr G Orfaniotis, Mr S Watson (Glasgow)

Introduction and Aims: Neonatal limb ischaemia (NLI) is a rare but potentially catastrophic condition. Although medical therapy remains as first-line treatment, surgery has an important role when limb-threatening events are present. Despite the large number of successful reports of outcomes after surgery, very little is presented concerning the operative approach in these challenging situations. We now present an update on what we believe are the key points in the surgical management of NLI, specifically regarding open thrombectomy and wound management.

Materials and Methods: Since 2000, five neonates have undergone surgical exploration for limb salvage by the senior author (3 upper and 2 lower limbs). In all cases, a "milking" technique was used to perform open thrombectomy, following extensive exposure of the affected arteries. In the most recent case, the upper limb fasciotomy wounds were resurfaced with a dermal regeneration template (Integra). Serial excision of the Integra silicone layer was carried out to avoid further surgery in a sick preterm neonate.

Results: All limbs were successfully re-vascularised. The described technique was effective even with lengthy thrombi. In 2 cases, prolonged ischaemia (more than 16 hours) resulted in partial loss of fingertips and toes. The wound covered with Integra has healed completely without the need for a skin graft.

Conclusion: Open thrombectomy with milking of the thrombus is an effective technique, if performed correctly. Application of Integra offers an attractive alternative in the management of these wounds, providing excellent results with minimal disruption of the NICU care. Skin grafts over the Integra can be avoided by staged excision of the silicone layer from the margins.

10:57 Questions

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WEDNESDAY 19 JUNE 2013

11:00 – 11:45

11:00 **Guest speaker- The use of locoregional flaps in head and neck reconstruction**
Professor M Leung

The history of head and neck reconstruction is briefly discussed.

The aesthetic and functional outcomes in head and neck reconstruction have certainly improved a lot over the years. With the advance and popularity in microsurgery, it is the author's opinion that microvascular tissue transfer is overused in head and neck reconstruction.

The advantages and disadvantages of the locoregional flap versus the free flap are discussed. Local flaps can be used to close large head and neck defects. Clinical examples are presented. The reconstructive surgeon must be familiar with the techniques of free tissue transfer and locoregional flap transfer in order to achieve optimal results for head and neck patients.

11:20 **Refreshments and exhibitions**

International collaboration

Chairs: Mr R Uppal and Mr B Richard

11:40 **BFIRST: an update**
Miss B Jemec

BFIRST, British Foundation for International Reconstructive Surgery and Training, is BAPRAS' charity for overseas development, training surgeons in their home countries to an independent level.

11:45 **Laying the foundation: evaluation of the effectiveness of Kanti-Alder Hey burns link in Nepal. Multidisciplinary training model 2010–2012**
Ms S Falder, Dr R Chaudhary, Dr R Rajkarnikar, Mr T Belfield, Ms N Holman, Dr H Wallace (Liverpool)

Introduction: The burn unit partnership between Alder Hey Children's Hospital, Liverpool and Kanti Children's Hospital, Kathmandu aims to improve burn care by increasing good practice, reducing time-to-grafting and contractures and teaching essential burn care (EBC).

Activities have included: Multidisciplinary UK team visits (October 2010, April 2011, November 2011, June 2012); surgical, nursing, therapy, psychosocial hands-on teaching; medical student electives; data analysis; regional networking; five burn care courses (159 participants); Kanti team visit to Alder Hey (September 2012).

Methods: Semi-structured interviews with stakeholders (Nepali=21; UK=6) assessed attitudes towards link activities and self-reported behaviour. Interviews were recorded, transcribed and analysed. Teaching was evaluated by course questionnaire (*n*=29) and longer-term by telephone survey (*n*=58).

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Results: Positives included formation of the Nepal Burns Forum; agreement of burn care protocols; prospective data (7 months, *n*=132: baseline time-to-grafting 29 days; contracture rate 8%). Nepali stakeholders unanimously stated the link was beneficial, particularly for improving quality and engendering positive attitudes. Negatives included lack of inclusiveness, communication and follow-up difficulties. 58 teaching participants were telephoned: 98.3% felt the course was useful and had passed on their knowledge.

Discussion: Change in practice has occurred. Guidelines and other interventions need reinforcement. Teaching is well received. Resources are appropriately targeted.

11:52 Questions

11:55 Experiences in reconstructive plastic surgery training in post-colonial West Africa
Mr M H C Webster, Mr A Burns, Mr A Paintsil, Mr O Ampomah, Mr O Shelley (Glasgow)

The experience gained by the charity "ReSurge Africa" in Ghana and Sierra Leone will be evaluated and pointers towards success identified. In particular the importance of communication with the local Ministry of Health, University Medical School, the Hospital Administration, the British High Commissioner and a local political backer will be discussed

The selection of a surgeon to undergo training is of particular importance and the selection process will be discussed. Facilities and buildings required may, or may not, be available. Techniques of acquiring the necessary facilities will be discussed.

Teaching is by far the most important role. Carrying out treatment without training is to waste a great opportunity.

The result of such an endeavour should be the formation of an up-to-date facility, not dependent upon foreign aid, and capable of training its own staff. This has been achieved in Ghana and "ReSurge Africa" is now carrying out a similar exercise in Sierra Leone.

12:02 Questions

12:05 Interplast Australia
Professor M Leung

Interplast Australia is a non-profit organisation. It was founded in 1983 by the Royal Australian College of Surgeons and Rotary International District 980. Interplast Organisation is now in many countries but each is autonomous.

The role of Interplast Australia is flexible depending on the visiting country and the programme carried out may be service delivery, teaching, development of

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12:25 – 13:13

training programmes, and occasionally treatment of patients in Australia. It may also include sponsoring higher training of local surgeons in Australia.

The author has been involved in Interplast programmes since the beginning of his career. In recent years, the author has mainly been involved in microsurgery training programmes in various countries including Papua New Guinea, Indonesia, Myanmar. The experience and challenges are presented.

12:25 **'Lead us not into temptation!' The economics of healthcare**
Dr A Banerji

12:45 **Setting up an overseas project**
Mr D Sammut

Donald Sammut has been travelling to India and Nepal since 1999, operating on leprosy paralysis of the hand.

He presents a personal view of such work and insights into funding, setting up and running a surgical programme in a resource-poor environment.

13:05 **Experiences in Nepal**
Miss S Tucker

Sarah served in Nepal for just under 2 years, providing a reconstructive surgery service to the Western District of Nepal. She will talk about some of the practicalities of taking on such a venture with a young family, and what she learned from the experience overall.

13:13 **Beyond the horizon: enriching tomorrow's plastic surgeons**
Miss J Tang

Overseas Plastic Surgery Appeal (OPSA) is a UK-based charity that has been sponsoring biannual plastic surgery camps in Pakistan for 15 years. UK-based plastic surgeons, trainees, nurses, anaesthetists, more recently plastic surgeons from USA as well as members of other related specialties like ENT have been attending these camps to provide a host of free reconstructive procedures, including cleft lip and palate repairs, to the underprivileged population of Pakistan.

Under Mr Riaz's guidance, a cleft unit has been opened in Gujrat, providing a state-of-the-art service based on UK guidelines. Plastic surgery trainees attending these camps gain excellent exposure to all aspects of congenital paediatric surgery. We performed over a hundred operations in our week there, working alongside international faculty and local staff through the late hours of the evening.

Time management skills to maximise theatre utilisation, lunchtime lectures, accommodating 'constraints' including the occasional intra-operative power breakdowns and conducting 'mass' ward rounds were highlights of

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13:20 – 14:35

our experience, enabling true understanding of resource utilisation in an environment with limited assets.

There is much to be learnt by UK trainees from surgical exposure in countries that do not have the privilege of the NHS and free healthcare. Our trainees should be encouraged to avail these opportunities.

13:20 Lunch and exhibitions

14:15 Guest speaker: Problems with nasal tip modelling: our point of view
Professor I Kuzanov, Dr A Kuzanov, Dr G Kuzanov, Dr G Ioseliani

Modern rhinoplasty suggests prevention of nasal tip drooping by reinforcing of nasal tip cartilages. Most useful techniques are columellar strut and tongue-in-groove. Most surgeons prefer to use columellar strut, and they avoid tongue-in-groove technique because of problems of high rigidity of the nasal tip which they meet after using this technique. In order to narrow the nasal tip most surgeons prefer to use suture or lateral crura slide techniques. Most frequently unsatisfactory results were an unnatural appearance of nasal tip.

Since 2006 we have performed more than 1200 primary and 150 secondary rhinoplasties.

In this presentation we explain how to use tongue-in-groove technique to avoid problems from nasal tip rigidity, high projection, retracted columella and in which case it is better to use a columellar strut. Also we will talk about narrowing of the nasal tip using a preparation technique of alar cartilages and suture technique.

Thus, the main principles of nasal tip reinforcement are: avoiding of nasal tip drooping and making it less rigid, and the main principle of nasal tip narrowing is achievement of a natural appearance of the nasal tip. We can say that tongue-in-groove technique for nasal tip reinforcement and preparation of alar cartilages for nasal tip narrowing meets these demands.

Free Papers: Body contouring, breast and aesthetic surgery
Chairs: Miss A Hazari and Mr G Ross

14:35 3D scanning for assessment of patients seeking breast reduction: eliminating the postcode lottery and preserving patient dignity
Mr P Lim, Mr S Rimouche, Mr M Henley (Nottingham)

Introduction: Breast reduction transforms lives but is a low priority procedure, subject to financial constraints and rationing. Assessment frequently involves physical examination compromising patient dignity and criteria are often crude or highly subjective in nature. We report the long term outcome of an Action on Plastic Surgery Project which has become an established part of practice. Patient acceptance of the process has been very high with few appeals.

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Methods: Patients seeking breast reduction were assessed using a 3D body scanner in addition to measurements of weight and height. BMI, breast volume and breast-to-torso volume ratio were compared with consensus criteria established by a pilot study of 50 patients which also confirmed the validity of the pathway.

Results: 980 patients (age range 17-76 years) were referred by 11 primary care trusts over a 6 year period. 300 patients (30.6%) fulfilled assessment criteria of BMI <30, mean breast volume >1000ml and ratio of combined breast volume to normalised partial torso volume >13%.

Conclusions: The 3D scanner provides objective and reliable assessment of patients seeking breast reduction with very high patient acceptance of both process and outcome. It permits effective and equitable rationing of the service with complete preservation of patient dignity

14:42 Questions

14:45 Risk of thromboembolism following body contouring surgery after massive weight loss

Miss M Griffin, Mr M Akhavani, Miss N Muirhead, Mr A Fleming, Mr M Soldin (London)

The bariatric patient poses a significant risk factor for post-operative surgical complications. We aimed to define the risk of venous thromboembolism (VTE) after body contouring surgery following massive weight loss.

We retrospectively analysed all patients who had undergone any type of body contouring procedures between January 2005 and August 2012. Data collected included patient demographics (including body mass index (BMI)), surgical procedure, pre-operative risks known to be causative for VTE, VTE prophylaxis pre and post-operatively and post-operative complications.

In total 135 operations were performed on 53 patients, including 43 females with average age 44.71 years (range 26-56 years). Most patients had staged procedures including 55 abdominoplasties, 23 brachioplasties, 31 thigh lifts, 14 buttock augmentations and 12 mastopexies. All patients received VTE prophylaxis post-operatively including low molecular weight heparin (dalteparin) within an average of 22.44 hours and application of graduated compression stockings. Patients received dalteparin for an average of 4 days (range 2-14 days). One patient (BMI 40) had a DVT 14 days post-operatively and then 2 days later developed a non-fatal pulmonary embolus, illustrating an overall risk factor for VTE as 1.96%.

We provide evidence of a successful algorithm to prevent VTE for patients undergoing body contouring procedure following massive weight loss.

14:52 Questions

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14:55 – 15:05

14:55 Funding for bariplastic (post bariatric body-contouring) surgery in England: the present reality

Mr S Mukherjee, Mr S Kamat, Mr S Adegbola, Mr S Agrawal (London)

Background: With the number of bariatric procedures increasing each year in the UK, there has been a substantial increase in the number of patients experiencing massive weight loss who are seeking bariplastic (post-bariatric body-contouring) surgery. However, there is a wide variation of availability of these procedures on the NHS. The aims of this study were to review the funding policies of PCTs for bariplastic surgery in England.

Methods: We sent out detailed questionnaires to 147 PCTs in England regarding their funding policies for bariplastic surgery and requested the number of procedures that were funded in 2008-09 and 2009-10.

Results: 121/147 (82%) PCTs replied to our questionnaires. 73 (60%) excluded all bariplastic procedures. 106/121 (87.6%) PCTs had referral guidelines for plastic surgery. The most commonly funded bariplastic procedure was abdominoplasty-apronectomy (A-A). 46/121 (38%) PCTs provided the total number of funded A-A in the two financial years. The total number of A-A applicants rose from 393 to 531, but the approval rate for funding fell from 24.2% to 19.6% consecutively in these two years. On future service provision, only 3 (2%) PCTs indicated that they would increase their spending on bariplastic procedures in the next 5 years.

Conclusion: This study shows that there exists a postcode lottery for bariplastic surgery in England.

15:02 Questions

15:05 Severe gynaecomastia: new technique using superior pedicle NAC flap through a circum-areolar approach

Dr S Ibrahiem (Alexandria, Egypt)

Gynaecomastia is defined as benign proliferation of glandular breast tissue in men. Gynaecomastia causes considerable emotional discomfort due to limitation of everyday activity especially in young men. Surgical treatment of gynaecomastia significantly contributes to an increase in social activity and an improvement of social acceptance and emotional comfort, and thus significantly improves satisfaction from personal life. Various surgical techniques were suggested to treat gynaecomastia, but most of them end with visible scars especially in severe degree gynaecomastia. The aim of many plastic surgeons is to advocate new techniques treating severe gynaecomastia (grade II B and III according to Simon et al) with less visible scars.

Objective: The author proposed a new technique combining both surgery and liposuction for treating grade II B and III gynaecomastia using only periareolar approach.

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Aim: Evaluation of the aesthetic results and the quality of life after surgery and assessment of the incidence of early and late post-operative complications.

Method: The patient was marked pre-operatively while standing. Under general anesthesia, liposuction of the peri-glandular area, deepithelialisation of excess skin was undertaken, plus creation of a superiorly based NAC flap based on the subdermal plexus. The excess glandular tissue was resected through the lower half of the circle of the deepithelialised area.

Results: This treatment protocol was applied to 14 patients, 18 to 53 years of age, between February 2008 and September 2012. Among these patients, 4 were classified as type IIB, and 8 as type III. Follow-up ranged from 3 months to 4 years. Complications were: one haematoma, one wound dehiscence, one loss of NAC, 2 cases of hypertrophied scars, and 3 minor aesthetic problems near areolae.

Conclusions: A new periareolar approach for correction of severe grade gynaecomastia permits broad resection of excess skin and sub-mammary tissue, while avoiding unattractive scars on the patient's chest.

15:12 Questions

15:15 The learning curve for using acellular dermal matrix (ADM)
Mr M Cheema, Dr S Nandi, Mr S Thomas (Birmingham)

Introduction: Use of ADM is a well-known technique for breast reconstruction. Many studies do not emphasise the fact that ADM has a different biological response and clinical course from an inert implant. Many new users who try using it for large reconstruction may be caught unaware. This may result in unnecessary antibiotics, clinic visits or even re-operation.

Aim: Our aim is to present our early experience of using ADM for breast reconstruction in a university hospital setting.

Methods: All patients undergoing breast reconstruction with ADM after mastectomy were included.

Results: Over a three-year period, 21 patients had 26 breast reconstruction procedures done with ADM. Pre-operatively, their mean BMI was 24.9. Nineteen mastectomies were due to known cancer (DCIS or invasive), 5 were risk reducing. One patient had bilateral reconstruction of pectus excavatum. Most common implants used in the reconstruction were between 335cc and 410cc. Post-operatively, 7 patients developed small volume seromas that were aspirated. Most patients had some redness of skin. Four patients were re-explored in theatre fearing an underlying infection.

Discussion: ADM does not yet have a wide-spread acceptance as a standard management option for breast reconstruction. As with any technique, patient selection and awareness of its limitations are important. ADM has a different

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biological behavior than implants; there is skin redness without any other sign of infection and any seromas tend to be smaller volume.

Conclusion: Surgeons planning to start using ADM need to be aware of the natural course of events post-operatively. Robust criteria should be used to diagnose an infection around the ADM.

15:22 Questions

15:25 The use of lipofilling as an adjuvant in breast, aesthetic and reconstructive surgery
Mr A Souéid (Birmingham)

Introduction and Aims: Fat transfer has become an established method in breast surgery and lipofilling as an adjuvant technique is helping improve final outcomes. We also describe the use of breast zones as a concept.

Method: A retrospective data collection on all patients over a 5 year period was undertaken.

Results: Over a 5 year period, 37 patients had lipofilling procedures. The age ranged from 18 to 65 and BMI from 20 to 36. The majority of patients had surgery for breast carcinoma (21 cases). Implants were used in 15 cases. Radiotherapy was previously used in 18 patients. The upper inner and outer quadrants were the most lipofilled areas (14 and 12 cases retrospectively). Lipofilling volume ranged from 6 to 465ml per episode and an average of 34ml per zone. The average surgical time was 75 minutes (for lipofilling only procedures).

Conclusions: Lipofilling is a safe and reliable adjuvant in breast surgery. Describing zones of deficit in the breast helps in the assessment and surgical planning and subsequent assessment of post-operative results.

15:32 Questions

15:35 Refreshments and exhibitions

Free Papers: Body contouring, breast and aesthetic surgery (continued)
Chairs: Miss A Hazari and Mr G Ross

16:00 Novel subfascial and traditional suprafascial harvest of the autologous latissimus dorsi myocutaneous flap in breast reconstruction: a retrospective comparative analysis of two techniques
Ms R Holt, Mr O Branford, Ms N Keleman, Mr C Hartman, Mr D Floyd (London)

Introduction and Aims: The autologous latissimus dorsi flap breast reconstruction provides a good alternative in selected patients. The technique is limited by complications such as seroma, wound breakdown, and painful adherent donor scars. The dissection plane may be above or below the superficial

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layer of thoracolumbar fascia. The aim of this study was to investigate whether retaining this fascia on the back skin flaps reduces morbidity.

Methods: Consecutive women treated with autologous latissimus dorsi breast reconstruction by a single surgeon were studied. A retrospective comparative analysis of the effect of varying the plane of dissection on outcome was assessed.

Results: 80 patients were reviewed: 47 treated with traditional suprafascial harvest (Group A); 33 had novel subfascial harvest (Group B), retaining the superficial layer of thoracolumbar fascia on the back skin flaps. Group B patients showed a significant reduction in the mean number of seroma drainages (p=0.027) and mean total aspirated seroma volume (p=0.006). Group B patients reported a reduction in donor site pain (p=0.041) and reduction in observed and reported donor site scar adherence (p=0.026).

Conclusions: This new technique of subfascial harvest significantly improves back donor site morbidity without compromising flap survival.

16:07 Questions

16:10 A comparative study of analgesic requirements in patients undergoing muscle-sparing latissimus dorsi (MSLD) and latissimus dorsi (LD) flap breast reconstruction

Mr R Nassab, Mr H Shaaban, Mr R Alvi, Mr A Iqbal (Liverpool)

Introduction: The muscle-sparing latissimus dorsi (MSLD) flap utilises only the lateral segment of the muscle containing the descending branch of the thoracodorsal artery with its thoracodorsal artery perforators to supply the skin paddle and fascial components of the flap. The aim of this study was to determine the post-operative analgesic requirements of patients undergoing a standard LD reconstruction compared to the MSLD.

Methods: Consecutive patients undergoing MSLD and LD breast reconstructions were identified. All patients received post-operative analgesia using morphine via a patient-controlled analgesia (PCA) infusion pump. The patient's weight was used to calculate total morphine dose adjusted for weight (in milligrams per kilogram) in order to allow comparison of requirements. The total operative time and hospital stay were also recorded.

Results: During the study period fifteen patients underwent unilateral MSLD and 20 patients unilateral LD reconstructions. Independent sample t-tests revealed a significant difference in post-operative analgesic requirements. The MSLD required significantly less total PCA in comparison to the LD group (MSLD mean 0.498 mg/kg versus LD 0.935 mg/kg, p<0.05). The MSLD also had a shorter hospital stay (MSLD 5.0 days versus LD 6.85 days, p<0.01). The operative time was similar in both groups. No differences were found for bilateral MSLD and LD reconstructions although the number performed was small.

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Conclusion: The MSLD results in a shorter hospital stay and less post-operative analgesic requirements compared to the LD flap without any additional operative time.

16:17 Questions

16:20 Immediate versus delayed contralateral breast symmetrisation with unilateral deep inferior epigastric artery perforator flap breast reconstruction

Mr A Figus, Dr R Wade, Miss E Sassoon, Mr R Haywood, Miss R Ali (Norwich)

Introduction: Breast symmetry is one of the goals and challenges of unilateral DIEP flap breast reconstruction. Contralateral balancing breast surgery can be performed either at the time of reconstruction (immediate symmetrisation) or a later stage (delayed symmetrisation) to improve breast symmetry. To date, the literature is lacking comparative outcome data on immediate versus delayed contralateral symmetrisation for women undergoing unilateral DIEP flap breast reconstruction.

Methods: Over a five year period, demographics, cancer treatments and operative outcomes of all consecutive unilateral DIEP flap breast reconstructions were prospectively recorded. Contralateral balancing surgery was categorised as immediate or delayed symmetrisation for comparative analysis using t-tests for continuous data and Chi Square or Fisher Exact tests for categorical data to generate odds ratios (OR). Significance was set at <0.05 and confidence intervals (CI) generated to the 95% level.

Results: Out of 251 unilateral DIEP flap breast reconstructions, 127 were associated with contralateral symmetrisation, 103 (81.1%) immediate balancing procedures and 24 (18.9%) delayed balancing procedures. Immediate symmetrisation did not increase total operative time (6.29 versus 6.55 hours, p=0.528). There was no difference in the risk of peri-operative complications between groups, although delayed symmetrisation was associated with a significantly increased rate of revision surgery (OR 4.00 [95% CI 1.55, 10.3], p=0.003).

Conclusion: Immediate contralateral breast symmetrisation appears to be a safe, beneficial and cost-effective adjunct to unilateral DIEP flap breast reconstruction, without increasing operative time or risk of adverse outcomes. Delayed contralateral breast symmetrisation seems to be associated with higher numbers of revision surgery.

16:27 Questions

16:30 Free flap surgery in the obese: the Newcastle experience

Mr T P Crowley, Mr D Sainsbury, Mr M Ragbir (Newcastle upon Tyne)

Introduction: With rising obesity levels, free flaps are increasingly performed in obese patients.

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Methods: Data on all free flaps performed in Newcastle upon Tyne were prospectively collected from January 2007 to December 2012. Demographics and surgical outcomes were analysed.

Result: 625 free flaps were performed; 119 in patients with a BMI over 30 (mean 32.97; range 30-45).

Indications for free flap in obese patients

Indication	Breast Oncology	Head/Neck Oncology	Sarcoma	Lower Limb Trauma	Other
n	75	23	7	6	8

Free flaps performed in obese patients

Flap	DIEP	TRAM	Radial Forearm	Fibula	ALT	Latissimus Dorsi	Gracilis	Groin	Other
n	43	30	11	10	7	5	5	2	6

Comparison of demographic, BMI and operative details

Group	Mean Age	Mean ASA Grade	Median Operation Time (mins)	Median Flap Ischaemia Time (mins)	Theatre Return Rate	Flap Loss Rate
BMI>30 (*n*=119)	52.4	1.9	469	84	13.4%	4.2%
BMI<30 (*n*=506)	52.0	1.8	430	83	7.7%	4.8%

Conclusion: Obese patients demonstrated no significant increase in free flap loss although they were more likely to need to return to theatre compared to the non-obese cohort (13.4% versus 7.7%; $p<0.05$). With appropriate patient selection and close post-operative monitoring obesity does not appear to be a contraindication to free flap surgery.

16:37 Questions

16:40 A ten-year surgical experience of angiosarcoma of the breast

Mr T P Crowley, Mr D Sainsbury, Mr C Lewis, Mr C Gerrand, Mr R Milner, Mr M Ragbir (Newcastle upon Tyne)

Introduction: Angiosarcoma is an aggressive tumour of vascular endothelium. It may arise secondary to radiation, as often observed in breast angiosarcoma. We review our management of breast angiosarcoma.

Methods: Data on all patients with breast angiosarcoma were prospectively recorded (2002-2012). Demographics, surgical details and outcomes were analysed.

Results: Sixteen female patients presented with breast angiosarcoma. The mean age at presentation was 68.6 years (range 52-83). Fourteen patients previously underwent adjuvant radiotherapy following surgery for breast carcinoma. The mean duration between radiotherapy and angiosarcoma development

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was 7.9 years (range 3-21). Resections were as follows: radical mastectomy (*n*=12), simple mastectomy (*n*=1), wide local excision (*n*=3). One patient had a planned positive margin. Reconstruction was undertaken accordingly: pedicled latissimus dorsi (LD) myocutaneous flap (*n*=5), pedicled LD muscle flaps and split-skin graft (*n*=6), free DIEP flap (*n*=1), VRAM and split-skin graft (*n*=1), pedicled LD muscle flap / VRAM and split-skin graft (*n*=1), direct closure (*n*=2). Two patients received adjuvant radiotherapy. Three patients developed local recurrence; mean duration from resection to recurrence was 12 months (range 9-19). Two patients developed metastasis. Six patients died; mean survival was 13 months (range 2-27). The remaining ten patients remained well with no disease recurrence; mean follow-up was at 31 months (range 5-111).

Conclusion: Breast angiosarcomas are rare and challenging to manage. Successful outcomes can be achieved by early, aggressive resection and appropriate reconstruction.

16:47 Questions

16:50 Evolution of otoplasty technique: a review of 126 consecutive patients
Mr K Y Wong, Miss A Segaran, Miss N Aikman, Mr T Ahmad (Cambridge)

Introduction: Over 200 techniques have been described for prominent ear correction. We describe our choice of procedure and evaluate the post-operative outcomes of otoplasties performed by the senior author over a 10 year period.

Methods: A retrospective study of all otoplasties performed by the senior author (2002-2012) at a single hospital was undertaken. Pre-operative assessment included severity grading of ear prominence and cartilage stiffness. All patients were sent questionnaires.

Results: A total of 126 patients (237 otoplasties) with a mean age of 10 years (range 3-23) were evaluated. Only absorbable sutures were used. A posterior scoring technique was used in 191 otoplasties (80.5%). Scoring was not used for the remaining procedures and this has been since 2010.

Complications occurred in 44 cases (18.6%) including asymmetry in 22 cases (9.3%) and recurrence in 13 cases (5.5%). Revisional surgery was performed in 11 cases (4.6%). There were no haematomas. All patients were satisfied with the improvement in appearance.

Using multivariate analysis with logistic regression, younger patients ($p<0.05$) and use of posterior scoring ($p<0.05$) were both found to independently significantly increase the post-operative rate of asymmetry and recurrence.

Conclusion: Our evolved technique without the use of scoring is a safe procedure with a high satisfaction rate.

16:57 Questions

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17:00 **Guest speaker: Measuring patient-reported outcomes in body-contouring patients and the BODY-Q**
Dr S Danila

Objective: To develop a new patient-reported outcome instrument (PRO) designed to measure patient satisfaction in body contouring procedures such as lipo-sculpture, abdominoplasty, body lift, thigh lift and arm lift.

Methods: Literature review, in-depth patient interviews and expert focus groups with body contouring patients and plastic surgeons were performed to develop a conceptual framework for the outcomes deemed important to body image and preliminary PRO instruments.

Results: Sixteen patients and 5 plastic surgeons were interviewed. Domains identified for the conceptual framework included clothing and body image, sexual and affective life, self-image and self-esteem, social relationships and physical symptoms.

Conclusions: Once psychometric evaluation is completed, the BODY-Q and subscales will provide a reliable tool for plastic surgeons, researchers and patients to measure the impact and effectiveness of body contouring procedures from patient perspective.

17.10 **Guest speaker: Breast reconstruction: my perspective**
Dr L Mu

Breast reconstruction in China has increased in popularity dramatically over the last twenty-five years. Breast cancer is now the number one cancer for women in big cities in China and many have begun to use the internet to search for information on reconstruction options following mastectomy.

Our method for breast reconstruction is according to the deformity post-mastectomy. To begin with, chest wall reconstruction, ulcer post radical mastectomy and radiation therapy were the main problems faced. Large flaps including bilateral pedicle TRAM or free bilateral muscle–sparing TRAM, and also enlarged (or expanded) lattisimus dosor myocutaneus flap were used to cover the surface of the chest. We first used the proximal and distal ends of internal internal mammary artery and vein to supply bilateral deep inferior epigastric vessels, in an effort to guarantee the complete survival of the whole free TRAM. In 2000, following teaching from Dr Phillip Blondeel in Gent, Belgium, I brought the peforator technique back to China and we have begun to popularise this technique.

Surgical treatment of breast cancer has progressed from radical, modified radical mastectomy to simple mastectomy or breast conservation therapy including lumpectomy and sentinel lymph nodes dissection. Lymphoedema post-auxillary dissection (or sentinel lymph nodes dissection) and radiation therapy are gaining attention and expander and breast implants are used more. Fat grafting is also gaining in popularity. Research on breast tissue engineering is underway.

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The tasks for breast reconstruction in China now are:

1. A robust public education program;
2. The co-operation between plastic surgeons and oncological surgeons
3. Public health care insurance.

17:40 **BAPRAS EGM**
Open to all members of BAPRAS

18:00 **Drinks reception and barbeque**

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THURSDAY 20 JUNE 2013

08:30 – 09:10

08:30 **Registration and refreshments**

Free papers: Face
Chairs: Mr D Lam and Mr O Ahmed

09:00 **The 'free floating' cartilage technique: a more physiological approach to prominent ear correction**
Mr P Brooks, Miss I Teo (Nottingham)

Introduction and Aims: We describe a novel 'free floating cartilage' technique for prominent ear correction. The philosophy is one of the tissues being responsible for maintaining the shape of the ear rather than suture material. The technique combines both anterior scoring and complete dislocation of the superior and central parts of the auricular cartilage.

Material and Methods: A retrospective review of all patients undergoing this technique from 2007 to 2011 by a single surgeon was undertaken. All patients were photographed and reviewed at 3 to 6 months post-operatively with an open appointment for late problems.

Key Results: 120 otoplasties performed on 67 patients are reported. 31 male and 36 female, with an average age of 11.8 years (range 5 – 20 years). The complication rate was 0.83% with one post-operative bleed. Objectively, all patients had their prominent ears corrected. No revision procedures were requested.

Conclusions: This is a technique that has not been described previously. It benefits from a lack of reliance on suture material to maintain the position of the correction. From our experience this is a safe and effective method for the correction of prominent ears and yields a natural looking and stable result.

09:07 **Questions**

09:10 **Periosteal flap: A novel approach for elevation of the pinna in microtia**
Dr S Ibrahiem, Dr R Magritz, Professor R Siegert (Recklinghausen, Germany)

Introduction: For optimal aesthetic construction of the auricle in patients with severe microtia it is not only important to construct an exquisite framework, but also to place it into the correct natural position. Besides its correct vertical and sagittal position, a normal elevation is of utmost importance because this determines what is recognised of the auricular width from the common anterior view in interpersonal communication. Many techniques have been described to stabilise the constructed auricle in the elevated position - some of them are prone to relapse like simple skin transplantation, others are intricate using cartilage, huge pedicled flaps and free skin grafts.

Aim: To describe a simple and reliable technique and present the authors' experience in 158 patients operated between February 2005 and November 2007.

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Technique: Its principles were elevation of the framework from posterior, stabilising with autogenous rib cartilage, covering this with a special periosteal flap and skin grafting.

Conclusion: The technique proved to be straightforward simple and reliable. All flaps had unrestricted microcirculation. In all patients a good and stable projection of the auricle was achieved and the technique presents the most updated trial in our experience of caring for microtia patients in our institution.

09:17 Questions

09:20 'Leicester Lasso' lateral canthoplasty
Mr R Y Kannan, Mr J Chuah, Ms J Burns, Mr R Sampath (Leicester)

Introduction: In canthoplasties, the lateral canthal ligament (LCT) may be fixed by periosteal hitching, Mitek® bone anchors and transosseous sutures but securing the LCT from the inside out can be difficult given the proximity of the globe.

Patients and Methods: In these situations, we employ a 'lasso' technique to ease the procedure. This technique has been used in seven cases requiring LCT anchoring at the Leicester oculoplastics unit for the past two years. Using a trans-blepharoplasty approach, the LCT has been secured to the lateral orbital rim from the inside out using a 'lasso' technique to ease the procedure and minimise the risk of globe perforation.

Discussion: Given the flexibility that this technique offers us, we would like to suggest the 'lasso' technique to the fraternity as a useful technique when LCT transosseous anchoring to the inner aspect of the lateral orbital rim is desired.

09:27 Questions

09:30 The impact of a single surgical intervention for patients with cleft lip and palate living in rural eastern Ethiopia
Mr M Fell, Mr T Hoyle, Dr M Eshete, Dr Y Medhin, Dr Y Kebede, Dr F Hiwot, Dr T Cifeta, Dr I Ali, Professor M McGurk (London)

Background: Humanitarian organisations commonly provide reconstructive treatment for patients with cleft lip and palate within developing countries, but follow-up is often non-existent, particularly for those living in rural areas. This study aimed to assess whether a single surgical intervention was sufficient to produce an observable change to the life of a patient with cleft lip or cleft lip and palate (CL/P) living in eastern Ethiopia.

Methods: 356 patients with a CL/P, who received a single surgical treatment at least 6 months previously, were interviewed and examined in 21 rural health centres in Ethiopia.

Results: CL/P patients and their families expressed unhappiness before treatment, mainly because the society reacted negatively towards the

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deformity, isolating the patient from community activities. Post-operatively, the percentage of school-aged children participating in education almost doubled (from 44% to 78%), some older patients were able to marry, but employment was unaffected. The type of cleft was the biggest factor in predicting surgical outcome, with bilateral cleft lip repairs having a higher wound dehiscence rate (8%) than unilateral cleft lip (0.3%).

Conclusions: This study provided an insight into the effectiveness of surgical treatment for cleft patients in rural Ethiopia and highlighted areas where further action could be directed.

09:37 **Questions**

09:40 **Residual fistula rate following primary palate repair with intravelarveloplasty: a pan-regional 3-year birth cohort audit**
Miss K Moar, Miss V Beale, Miss F Mehendale (South Thames/ Manchester/ Edinburgh)

Aim: To evaluate fistula rate (a primary outcome measure) following one stage palate repair in Norcleft (all cleft services in Scotland and Northern England). This is the largest review of fistula rate in patients undergoing primary intravelarvelopalsty (IVVP), compared to published data.[1-3]

Patients and Methods: A retrospective case note review of babies with cleft palate born in 2006-2008 who underwent one stage palate repair was undertaken

Outcome Measure: Presence of fistula posterior to incisive foramen at age 3. Review was based on intraoral examination or history of fistula repair.

Results:

- 743 patients had cleft palate
- 69 (9.3%) patients were excluded (no procedure by age 3, no age 3 review, unavailability of records).
- 626 patients underwent a Sommerlad IVVP type repair.
- 48 patients did not undergo IVVP and are not discussed further.
- 87 (13.9%) IVVP patients had a fistula posterior to the incisive foramen. Fistula/ non fistula groups were not statistically different in age of repair.
- Overall fistula rate was 13.9%, comparable with Sommerlad.
- There was a higher fistula rate in patients with LRI (21.09%) or BCLP (25.4%).

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	Included (IWP)	Fistula	Fistula patients with Lateral Releasing Incisions	Lateral Releases	% Lateral Release Patients with fistula	% no lateral release patients with fistula	Age (x) of patients without fistula	Age of patients with fistula
All Patients	626	87 (13.9%)	58 (66.7%)	275 (43.9%)	21.09%	29 (8.26%)	9.52	9.37
BCLP	63	16 (25.4%)	16 (100%)	48 (76.2%)	33.4%	0 (0%)	9.38	10.43
UCLP	160	19 (11.88%)	10 (52.6%)	93 (58.1%)	10.7%	8 (11.94%)	8.79	8.47
CP	400	51 (12.75%)	32 (62.7%)	134 (33.5%)	23.9%	19 (7.1%)	9.81	9.35
CP - HS	278	46 (16.55%)	29 (63.0%)	119 (42.1%)	24.37%	17 (10.69%)	9.71	8.80
CP - S	122	5 (4.1%)	3 (60.0%)	15 (12.3%)	20.00%	2 (1.87%)	9.85	9.41

Conclusion: There is significant correlation between LRI and fistula formation, except in the UCLP group. Further data is available. Norcleft is undertaking a prospective audit including cleft width measurements.

References:

1 Sommerlad BC. A Technique for Cleft Palate Repair. *PRS* 2003; **112:** 1542–8

2 L Yong, S Bing, H Qinggang, W Zhiyong. Incidence of palatal fistula after palatoplasty with levator veli palatini retropositioning according to Sommerlad. *BJOMS* 2010; **48:** 637–40.

3 William N, Williams, M, Seagle B, Ines Pegoraro-Krook M et al. Prospective Clinical Trial Comparing Outcome Measures Between Furlow and von Langenbeck Palatoplasties for UCLP. *Ann Plast Surg* 2011; **66:** 154–63.

09:47 Questions

09:50 Versatility of the scapula free-flap for osseous reconstruction of the maxilla, mandible and calvarium

Mr S Gore, Dr S Ch'ng, Mr Z Hasan, Dr B Ashford, Dr J Clark (Sydney, Australia)

Background: A number of osseous free flap techniques exist for reconstruction of head and neck cancer ablation defects. No autologous source of bone stock has ideal flap characteristics or donor site profile. A study was undertaken to assess the versatility of the scapula flap for this indication.

Methods: A series of 42 scapula osseous flaps was retrospectively identified between 2006 and 2012. Information regarding patient demographics, indication for surgery, reconstructive methods, complications and prosthodontic outcomes were reviewed.

Results: Of 42 osseous scapula flap reconstructions, 24 were for mandible, 13 for maxilla and 5 for calvarial reconstruction. Of the maxilla reconstructions five used the scapula tip in a horizontal fashion whilst eight were used in a vertical orientation. Median patient age was 70. Dental restoration was achieved in eight patients with maxillary reconstruction and two patients with mandibular reconstruction. There were 11 major complications including two total flap failures.

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Conclusions: The versatility of the scapula flap is unrivalled in terms of soft tissue components and bone configurations and has minimal long-term donor site morbidity. It is a valuable reconstructive option for patients with complex head and neck defects and in patients in whom comorbid disease contraindicates the harvest of a fibula free-flap.

09:57 **Questions**

10:00 **Microsurgical reconstruction of defects following radical parotidectomies**
Mr R Y Kannan, Ms K Tzafetta, Mr B S Mathur (Chelmsford)

Introduction: In the multidisciplinary world of head and neck surgery, soft tissue reconstruction following radical parotidectomies often requires microsurgical input for skin cover and immediate facial nerve coaptation.

Patients and Methods: In 114 cases of head and neck cancer reconstructions performed in our unit from 2009 to 2011, 12.3% of cases (*n*=14) required reconstruction of either facial nerve or skin defects following extended parotidectomies. Of these were eight cases requiring free tissue transfer procedures. Post-operatively, there was one case of haematoma, requiring washout. Otherwise, follow-up for this cohort was uneventful. Of the facial nerve defects, four patients had primary nerve grafting using sural nerve, greater auricular nerve or cervical plexus nerve grafts (*n*=4), whilst one patient had a primary mini XII-VII nerve transfer (*n*=1) and another had a combined direct browlift and tarsorraphy.

Discussion: Microsurgical reconstruction of complex post-parotidectomy defects in an MDT setting allows for immediate reconstruction of otherwise debilitating defects and should be incorporated as part of treatment protocols.

10:07 **Questions**

10:10 **John Potter Lecture**
(in association with the University of Newcastle upon Tyne)

Introduction
Professor T Lennard

Smile restoration in developmental facial paralysis
Dr M Novikov

Introduction: Developmental facial paralysis (DFP) is a rare condition that may cause multiple problems for the newborn, such as difficulty with nursing and incomplete eye closure. In addition to the facial nerve, other cranial nerves can be involved. In 1888 German neurologist Paul Julius Möbius first described condition of combined bilateral VI and VII cranial nerves palsy, later called after his name – Möbius Syndrome (MS). Some cases of MS are accompanied by hypoglossal (25%), trigeminal and spinal accessory (6%) nerves paralysis. The difference in CNS involvement leads to a variety of clinical features of developmental FP patients including incomplete or unilateral facial paralysis.

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10:40 – 11:40

It may affect the child's speech and mastication. The psychological disability mainly rises from a lack of emotional expression through facial movements. Restoration of even a small amount of facial animation can dramatically improve nonverbal communication. The search for a smile brings MS patients to a reconstructive microsurgeon. Free neurovascular muscle transfer has become a standard in facial reanimation for DFP.

Materials and methods: From 2006 to 2012, 31 patients diagnosed with DFP were evaluated at our centre. 16 of them had MS with bilateral FP. 15 patients suffered from unilateral FP. Free bilateral microsurgical transfer of neurovascular gracilis muscle flap was performed in 12 cases. In 10 cases a unilateral muscle transfer was carried out. 34 procedures were done in total. Thorough clinical evaluation and electrophysiological study were used in all cases before and after surgery. Post-operative assessment was carried out at 3, 6 and 12 months.

Results: All muscles regained contractility in 6 months after surgery, which usually stopped growing in 12 months. By the end of the 12th month all of the patients were able to reproduce the smile. A spontaneous smile was achieved in 40% of cases.

Conclusion: Free microsurgical muscle transfer is an effective method in treating of bilateral and unilateral DFP. Almost half of the patients are able to smile spontaneously.

10:40 Refreshments and exhibitions

Reflections on the cosmetic surgery regulation review

11:10 Medical negligence
Mr P Balen
The presentation will provide a summary of the legal rights of a cosmetic surgery patient when things go wrong and the possible reforms as a result of the review.

11:25 The Keogh Review of Cosmetic Practice: implications for surgeons
Mr S Withey
During the last two years Mr Withey has been involved in a number of the reviews of cosmetic surgery in the UK and Europe. His presentation will explain why we have suddenly found our practices under such scrutiny and what the recommendations of the Keogh review might mean.

11:40 Cosmetic surgery training
Mr A Fitzgerald
In recent years there has been increasing concern about the provision and delivery of aesthetic training in the UK. This talk hopes to clarify the role of all parties in that training as well as suggest what is expected of both trainees and trainers.

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Current and future proposed training programmes will be discussed and who the SAC regard as the most suitable providers of training.

The recent Keogh review into cosmetic surgery regulation touched on training. It made a number of recommendations that if legislated would have a significant impact on both current and future trainees as well as all current practitioners in the field. The implications of these recommendations will be discussed.

12:00 **Panel Discussion**

12:20 **Lunch and exhibitions**

12:30 **Introduction to the sKINship Project**
(Conference Suite 3)

My Department
Chair: Mr M Henley

13:20 **Professor M Tarar, Pakistan**
The Department of Plastic and Reconstructive Surgery at Jinnah Hospital/ Allama Iqbal Medical College, Lahore is one of the busiest units in Pakistan. It started as one consultant seconded to orthopaedics and later on a few allotted beds in the general surgery ward and gradually grew over a few years to its current status.

Our department has many firsts to its credit: it was the first unit to offer emergency services as primary responder, first unit to offer regular limb replantation services, first unit to have a regular microvascular surgery training course with international collaboration.

We are about to move to a purpose built centre, that will be the largest in Pakistan. The unit has six floors, with 164,000 square feet built up area, having a total bed strength of 85 including burns ICU, HDU, wards, day care unit and private rooms. There are six fully equipped operation theatres, out-patient department and dedicated diagnostic and rehabilitation services under one roof.

527 personnel including clinicians, nurses, paramedics, auxiliary and support services will be working for the centre when it became fully functional with 7 consultants and more than 30 trainees in plastic surgery. Additionally there will be a dedicated department of anaesthesia.

Establishing such an ambitious project was no easy task but we will be facing an even bigger challenge to deliver effectively as a state of the art centre and the way forward will be forging links both nationally and globally to make it work.

13:40 **Dr L Mu, China**
The Breast, Aesthetic, Plastic and Surgery Center, is one of the 19 centers of the Plastic Surgery Hospital, Chinese Academy of Medical Sciences, Peking Union Medical College. My hospital was founded by Professor Ruyao Song in

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1975. There are 320 beds for plastic surgery, 19 divisions and more than 100 plastic surgeons.

We have five members of staff: two professors, one assistant professor, one attending and one resident. There are a lot of master-degree and PhD degree candidates and national visiting scholars.

Clinical work:

1 Breast augmentation (both breast implant and fat grafting), breast reduction, second breast reconstruction (post mastectomy/trauma/burn), congenital breast deformity (Poland's syndrome), modification of breast ptosis, gynaecomastia
2 Immediate breast reconstruction (was invited to the oncological hospital)
3 Modification of failed operation outside our hospital
4 Aesthetic surgery: liposuction, double eyelid, blephoroplastic, rhytidectomy
5 General plastic surgery procedure: soft tissue expander flap
6 Non-surgical treatment: injection beauty

Research programmes on: Lymphatic flap; TUG /PAP; MDCTA; fat grafting; three-dimension scan.

14:00 Professor M Leung, Australia

The author is the Director of the Plastic Surgery Department of 2 Healthcare Networks in Victoria, Australia.

The Alfred Health includes 3 major hospitals and runs the major trauma centre in Victoria, with the capacity of about 1000 beds. The Southern Health includes 4 major hospitals, with a total capacity of about 2000 beds, and covers about ¼ of metropolitan Melbourne. The Unit set-up and work profile in each department is presented.

The major challenges in management are discussed, which include:

- Maintenance of clinical standards
- Financial restraint
- Unit Performance
- Management of Unit surgeons
- Management of trainees
- Research capacity and resources

14:20 Professor P Vogt, Germany

I have led the Department of Plastic, Hand and Reconstructive Surgery at Hannover Medical School since 2001. The unit was formerly located in the Hannover East City Hospital and had been successfully directed by Professor Heinz-Edzard Koehnlein (1974-1981) and Professor Alfred Berger (1981-2000). The department was relocated onto the main campus of the Medical School in 2006.

The clinical spectrum covers plastic and reconstructive, aesthetic, burns and hand surgery, with a specific focus on reconstructive microsurgery and replantation and surgery of the brachial plexus and peripheral nerves. The

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burn centre is the only one in the state of Lower Saxony. Teaching and clinical training in plastic, reconstructive and aesthetic surgery is provided for plastic surgical trainees and all medical students.

The department serves 1700 inpatients (170 burns per annum) and 7000 outpatients yearly. A 32 bed ward, a 6 bed burn unit, 3 operating theatres for inpatients and one for outpatients are available. The burn centre is one of the newest in the Germany and provides state of the art burn care. Currently an in-house skin bank is being established.

The clinical staff consists of one chief/full professor (Professor Peter M Vogt), 6 consultants and 13 trainees. A fully equipped research laboratory under the direction of an associate professor and biologist (Professor Kerstin Reimers PhD) has a strong research focus on regenerative therapies, tissue engineering and oncology in plastic surgery. Numerous patents for innovative biomaterials have been filed. Experimental and clinical research papers are covering topics in reconstructive, hand, burn surgery and regenerative plastic surgery. Hannover Medical School is one of Gemany's locations of excellence in medical research.

Teaching and training in the department are based on the clinical service and is supported by a surgical skills laboratory, a microsurgical training unit and numerous teaching modules. On a daily basis interactive case presentations are provided and a weekly CME course covers the whole theory of plastic surgery during a 24-month curriculum. For students practical teaching as junior members of the team, skills labs, seminars, lectures (grand rounds) and an open source e-learning platform is provided.

In 2011 a one volume textbook (The Practice of Plastic Surgery, Springer) was published, written by the members of the department, based on the core training curriculum of plastic surgery in Germany.

Since 2002, nine consultants left the department, being elected into positions as chiefs of plastic surgery departments in Germany and the USA.

Currently the department is under revision for an optimisation of outpatient care. A new emergency and outpatient facility is being planned and expected to be functioning in 2016/2017.

14:40 Professor P McArthur, UK

14:50 Questions and panel discussion

15:10 Refreshments and exhibitions

Training pathways and leadership

Chairs: Mr J H E Laing and Mr J Srinivasan

15:30 Update on the BAPRAS workforce planning survey
Mr D Lam

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15:40 Practical, inspiring leadership tips for you (the neuroscience behind soft leadership skills)
Professor J Perks

You will see that the news is full of medical drama: Mid Staffordshire NHS Foundation Trust's unusually high mortality rates, Sir David Nicholson, Sir Bruce Keogh and Sir Roger Boyle's political drama over Leeds General Hospital children's heart unit. Do you think that the NHS's increasing micro-management is creating rules-based regulation which erodes values-based inspiring leadership?

Then you may well have experienced otherwise bright doctors being horrible to new trainees. The Royal College of Surgeons has investigated a number of doctors whose behaviour leads them to conclude that they have: limited insight, a tendency to upset colleagues and patients, a refusal to accept responsibility and a tendency blame others for their own dysfunctional behaviour.

Jonathan Perks will be drawing on his 33 years of experience as a leader developing leaders as highlighted in his recent book *Inspiring leadership*. His highly interactive session will focus on helping you become an even more inspiring leader who others willingly follow. With practical tips from neuroscience to help you be more successful leader and better handle the occasional "snakes in suits" - psychopaths working in the NHS.

16:00 ST3 National selection
Mr J Pollock

National Selection for plastic surgery has been running since 2008 and is held twice a year, coordinated by the London Deanery. The process remains extremely competitive with high applicant to job ratios. This presentation provides an outline of how the interviews work for any prospective applicants, discusses the facts and figures of successful candidates and provides an insight into the overall selection process from both the trainee observer and consultant perspectives.

16:10 Questions and panel discussion

Financial Management

16:25 Finance in the NHS
Miss A Hazari

As plastic surgeons, we are at our most comfortable when we are engaged in patient care. However, with the Government drive to achieve cost efficiency savings within the NHS, we have seen several of the operations we have performed in the past relegated as 'low priority procedures', effectively reducing the repertoire we can offer patients. It is time to step outside of our comfort zones and be actively involved in the financial management of the service you provide within your trust.

This talk will outline the structure of the NHS in England and covers:

- how the NHS is funded,

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- how the money is spent,
- how the NHS knows and looks after its spending and
- the impact of current and future developments in NHS finance

With NHS Commissioning bodies in place this year and controlling the funding, the talk will also provide a basic understanding of the commissioning process and will look at:

- What commissioning is and how it fits into the NHS
- Who is responsible for what
- What commissioning involves in practice

16:35 Setting up in private practice
Ms V Sanders, Stanbridge Associates

Accountancy solutions for medical professionals.

16:50 Changes in income and projections for the future
Mr M Murray, Sandison Easson

This presentation will look at the historical sources of income and structures by which consultants have practiced in the past and still practice now, together with a review of the new sources and structures that have been adopted and their benefits for tax saving in the future.

Drawing on his and his fellow partner's wide experience in dealing with consultants both new and established, the speaker will look at what is available at present and which can be used as a springboard for increasing private practice income for the future.

The talk will include methods to increase market exposure and, as such, income.

17:05 Questions and panel discussion

17:30 Close

19:15 Association Dinner

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FRIDAY 21 JUNE 2013

08:30 – 09:10

08:30 Registration and refreshments

Free papers: Skin
Chairs: Mr P T H Brackley and Mr M Moncrieff

09:00 The East Yorkshire experience on the management of melanomas in the perineum
Ms J Y M Tang, Ms J Caddick, Dr A Roy, Dr B Matthews, Mr P Stanley (Hull)

Introduction: Mucosal melanoma accounts for 1.3-1.4% of all melanomas and confer a poorer prognosis than its cutaneous counterpart. Here, we report our unit's experience in the management perineal melanoma and a review of current literature.

Methods: Retrospective case note analysis of all patients with perineal melanoma referred in the past 12 years was undertaken. Further data was obtained from the Trust's histopathological database.

Results: Eighteen patients were identified (median age 68.5), all of whom were female. None had significant comorbidities nor family histories of melanoma. The median Breslow thickness was 5.8mm. In all but one case, initial excision or incision biopsies were done by the referring specialty and referred to the skin cancer MDT on diagnosis. Seven patients went on to have wider excision, 2 had a vulvectomy and 1 had a pelvic exenteration. Nine patients had sentinel lymph node biopsies, of which one was positive and went on to have lymphadenectomy. Eight patients required reconstructive procedures. Three patients had distant metastases on staging. We report 67% survival at 1 year and 16.7% at 5 years.

Conclusion: Overall prognosis for perineal melanoma is poor and the potential morbidity associated with the need for more extensive surgery was high. There is potential in exploring the efficacy of tyrosine kinase inhibitors such as imatinib in the treatment of perineal melanoma that are C-Kit positive in addition to surgery to improve survival in this cohort of patients.

09:07 Questions

09:10 Melanoma: The Jamaican experience
Mr G D L Arscott (Kingston, Jamaica)

We examine the presentation pattern of melanoma in the Jamaican population and the surgical management.

Cases of malignant melanoma presenting to the surgical services of the University Hospital of the West Indies and the Kingston Public Hospital were studied over a twelve-year period between January 1995 and January 2007. The epidemiological factors examined were age, sex, anatomical sites, clinical classification and histological classification.

This resulted in one hundred and thirty cases being identified of which 63 were female and 67 were male. The age of presentation ranged from the second

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to the ninth decade. The anatomical sites of the presenting lesions were as follows: extremities *n*=96; head and neck *n*=16; torso *n*=10; genitalia *n*=3 and other *n*=5. 55% of cases presented as ulcerating lesions.

Histological classifications revealed that the majority (65%) of cases presented with acral lentiginous Clarke's level IV and V disease. The mainstay of management was surgical excision.

Although a wide spectrum of melanoma was seen in our series, the majority presented with acral lentiginous lesions at a late stage when poor prognosis is inevitable. Public education is needed for both health professionals and the general public to heighten awareness of this disease. This should help decrease the numbers who present with incurable disease.

09:17 **Questions**

09:20 **Malignant melanoma of the external ear: an 8-year second-cycle national audit of surgical management and outcomes in Scotland**

Miss J Mennie, Dr A Dearden, Mr Z Sheikh, Mr K Stewart (Edinburgh)

Introduction and Aim: Recurrence rates of external ear melanoma have been reported as higher than any other site; 21-58% 5 year recurrence versus 2-10%. The complex embryological development of the ear, variable lymphatic drainage, and propensity to compromise recommended excision margins, have all been speculated as contributory factors. Debate exists as to whether radical excision reduces recurrence or merely compromises the optimal cosmesis.

Our aim was to re-audit surgical management and recurrence rates of ear melanoma in Scotland, and analyse prognostic factors.

Methods: A retrospective analysis of all patients in Scotland diagnosed with melanoma of the ear was undertaken from 2004-2011. Patients were tracked through the Scottish Cancer Network and case notes reviewed. Results were compared to our first cycle audit dating 1995-2003.

Results: A 2-fold increase in incidence was found, with 102 patients diagnosed in Scotland from 2004-2011 versus 47 from 1995-2003. Mean Breslow and follow-up remained static between groups (2.03mm and 4.32 years respectively). The proportion of >2cm excision margins had increased from 8% to 25%, p=0.011. Recurrence rates were reduced from 33% to 6%, p<0.01.

Breslow >2mm, p=0.046, nodular histopathology, p=0.009, and excision margin <2cm, p=0.03, significantly affected recurrence free survival.

Conclusion: Excision margins should not be compromised for cosmesis in ear melanoma. Adequate excision can reduce recurrence rates. In those cases of thick, nodular melanoma we advocate an excision margin of >2cm, with secondary referral for ear reconstruction as necessary.

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09:27 **Questions**

09:30 **Electrochemotherapy for cutaneous metastases of skin and breast malignancies: a case series**
Mr J Barnes, Mr A Mishra, Mr S Liew (Liverpool)

Background: Electrochemotherapy (ECT) is a novel, local, therapeutic approach to control and treat cutaneous and subcutaneous tumours of skin and non-skin origin. It uses a low dose, poorly permeable chemotherapeutic agent with high intrinsic cytotoxicity in combination with local electroporation of the cellular membrane to target malignant cutaneous deposits. It has been shown to reduce pain, odour, bleeding and further growth of various tumours.

Method: A review was undertaken of our current practice including patient selection, pre-operative assessment and aftercare as well as outcomes for a case series of 30 patients treated with ECT with bleomycin for cutaneous metastases of malignant melanoma, SCC, Merkel cell carcinoma and breast carcinoma.

Results: We present thirty consecutive ECT cases (57 treatment sessions), with outcomes including reduced tumour bulk, prolonged disease free periods and improvement in ulceration and pain. Early treatment was found to give significant improvement in tumour control. The main side effect was pain.

Conclusions and Clinical Applications: ECT is a novel and, as yet, little used modality with a beneficial role to play in palliation of cutaneous metastatic deposits of several malignancies, where other palliative treatment modalities have failed. It is cost effective and well tolerated. We will also present an easy to use pain control pathway.

09:37 **Questions**

09:40 **Atypical fibroxanthoma: do we need guidelines?**
Dr D Hunt, Mr A Sadri, Miss L Touil, Mr A El Gawad, Mr S Rhobaye, Mr A Juma (Chester)

Introduction: Atypical fibroxanthoma (AFX) is a malignant dermal tumour. A lack of appreciation for this tumour can lead to loss of follow-up and lack of treatment. No guidelines exist for the management of AFX. We present our 10-year experience with these malignant tumours of the skin.

Methods: A retrospective review of all cases of AFX was performed between 2002 to 2012. The following outcomes were recorded: location of lesion, method of biopsy, excision margin, total follow-up period, metastases, recurrence and time to recurrence and finally deaths.

Results: Thirty-three cases of AFX were treated between 2002 and 2012. The scalp (67%) was the commonest site and predominated in elderly male individuals (90.9%). Biopsy was performed in 30% of cases. Three percent of biopsy proven AFX did not go on to have formal excision. Four lesions (12%)

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were incompletely excised. The recurrence in incompletely excised cases was 50% and 6.1% overall. 18% of patients were discussed at an MDT. No deaths were recorded.

Conclusion: This is the largest UK series of AFX. It shows similar management issues that other series have described such as lack of follow-up, incomplete excision without re-excision and lack of MDT discussion.

09:47 Questions

09:50 Glomus tumours are just as common in non-subungual locations: a 20-year retrospective study
Dr C Sethu, Miss R Khundkar, Dr I Cook, Miss C McGuiness (Salisbury)

Introduction: Glomus tumours are rare tumours which are commonly, although erroneously, thought of as tumours in the subungual region only. These tumours are often misdiagnosed, leading to delay in treatment, even in the hand. Our 20-year study, the largest series reported to date, demonstrates and confirms the variable location of this tumour.

Method: A retrospective study was undertaken identifying tumours diagnosed between 1992 and 2012 at Salisbury District Hospital. Data were collected and analysed from notes in conjunction with the histopathology and plastic surgery teams.

Results: 76 (39 male, 37 female) patients were identified with 99 separate tumours. 8% of tumours were subungual, 22% in the hand (non-subungual), 30% in the upper limb (excluding hand), 27.3% in the lower limb, 7% on the head/neck region and 5% on the trunk. 7% of tumours recurred. 90% of patients had single tumours, 10% had multiple lesions.

Conclusion: This study demonstrates the importance of understanding that glomus tumours can also be found in non-subungual sites. In order to provide an early and accurate diagnosis, these tumours need to be considered in the differential diagnosis when faced with a painful lesion in any location, especially if the patient has been seen by multiple specialties and remains without a diagnosis.

09:57 Questions

10:00 The effects of intradermal interleukin:10 on scarring in humans of African continental ancestral origin
Dr I Kieran, Dr J Bush, Mr M Rance, Mr A Boanas, Dr A Metcalfe, Ms R Hobson, Professor D McGrouther, Professor M Ferguson (Manchester)

Background: Scars in African Continental Ancestral (ACA) skin-type heal with an exaggerated inflammatory response and wider scar. Interleukin-10 (IL-10) is an anti-inflammatory/anti-fibrotic cytokine. An RCT in Caucasian incisions showed exogenous IL-10 resulted in improved macroscopic scar appearance and reduced scar redness.

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Aim: To explore the effect of exogenous IL-10 on scarring in humans of ACA.

Methods: An exploratory, single-centre, randomised, within-subject, placebo-controlled double-blind trial was undertaken. Fifty-six subjects received two of four potential pre-randomised concentrations of IL-10 (5ng, 25ng, 100ng, 250ng/100µL) into two full-thickness incisions on the upper inner arms. Anatomically-matching incisions on the contralateral arm received placebo. Scars were excised at one month for histological analysis and excision scars were assessed for 12 months for scar width and appearance.

Results: Histology showed that incisions treated with 100ng/100µL had significantly reduced scar widths; however, subsequent excisions treated with 100ng/100µL were significantly wider than the placebo between 8 and 12 months of maturation. There were no histological differences for the other concentrations. Scar appearance of placebo-treated excisions was preferred (not significantly) over 250ng/100µL treatment. 5ng/100µL treated excisions were preferred (not significantly) at some time-points.

Conclusion: IL-10 has a detrimental effect on scarring in ACA skin at higher concentrations. There may be a scar-reducing response at lower concentrations.

10:07 **Questions**

10:10 **Laser therapy for pigmented lesions of the skin**
Miss H John, Mr P Mahaffey (Bedford)

Introduction: Over the past 20 years, laser therapy has increasingly been thought of as an alternative to surgical excision for a range of pigmented lesions of the skin, both congenital and developmental.

Aim: This paper attempts to define the limitations of laser therapy for pigmented cutaneous lesions.

Materials and Methods: We reviewed 325 consecutive cases of pigmented lesions referred to our unit from 1997 to 2012, and examined the case-mix, treatment methodologies and outcomes.

Results: Significant drawbacks included frequent re-pigmentation after apparently effective removal, and also the difficulties of fine-tuning ablation to provide a homogeneous colour match with surrounding normal skin tones.

Conclusion: During the 15 year study period of the cases in this presentation, initial optimism that laser therapy might offer a better solution has been tempered with a belief that in a significant number of cases, surgery still offers the better solution. Experience was also accumulated to allow more expert opinion in the triage of referrals at the outset so that laser therapy could become optimally employed, thus conserving resources of referring clinicians and the National Health Service.

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10:17 – 10:30

10:17 Questions

10:20 Do local flaps for reconstruction of defects following excision of basal cell carcinomas result in more patient morbidity compared to the use of skin grafts?
Ms D Saeed, Ms J Tang, Dr V Miu, Mr P Matteucci (Hull)

Introduction: Surgeons commonly use local flaps or skin grafts to reconstruct defects following excision of basal cell carcinomas (BCCs). However, local flaps distort the margins of the original defect, potentially resulting in more patient morbidity when lesions are incompletely excised. Here, we present our excision rates and compare our use of local flaps and skin grafts.

Methods: A retrospective case note review of patients who had BCCs excised over a one-year period was undertaken. Data was collated on Excel and analysed.

Results: We identified 512 patients who underwent 745 procedures.

In lesions <1cm diameter, we report a 91.4% complete excision rate in high-risk subtypes compared to 95.1% in low-risk subtypes (3mm excision margin). This does not improve with larger excision margins in high-risk subtypes. We reconstructed 60 cases with local flaps and 32 cases with skin grafts. Three patients (5%) who had local flaps had incomplete excisions. Two of these patients underwent further excision successfully with no recurrence or complications. Five patients (15.6%) with skin grafts had incomplete excisions. One had two further procedures to achieve tumour clearance.

For lesions between 1 and 2cm, we achieved complete excision rates of 86.7% (local flaps) and 87.1% (skin grafts) respectively. Four patients (local flaps) and three patients (skin grafts) had incomplete excisions respectively, with 1 further procedure to achieve clearance. None had any complications nor any recurrences.

Conclusion: Use of local flaps in practice does not result in more patient morbidity when BCCs are incompletely excised, in terms of future clearance, complications or recurrences, compared to use of skin grafts.

10:27 Questions

10:30 Guest speaker: How to cheat in clinical trials
Professor H Williams

Randomised controlled trials are the cornerstone of evidence-based medicine, yet like any other methodology, they can be designed, conducted and reported badly. Worse still, inconclusive or "negative" results can be hidden or written up creatively in order to "save face" or just to sell a product that is not especially effective.

NOTES

11:00 – 11:40

I am not seriously proposing to teach you how to cheat in clinical trials in this talk, but to help you develop a good nose for sniffing out some of the creative ways that give clinical trials a bad name.

Learning how to critically appraise a clinical trial is a key clinical competency for any practising plastic surgeon and is just as important as learning to do a skin biopsy. I shall use game theory to explain how problems in clinical trials can occur at design, analysis, writing up and at publication stages, and conclude with some solutions such as prospective trial registration and reporting according to the CONSORT statement.

11:00 Refreshments and exhibitions

Free papers: Flaps and Burns

Chairs: Mr K Khan and Mr P Brooks

11:30 Burns and the injury severity score

Dr J T Cassidy, Mr M Phillips, Professor D Fatovich, Professor J Duke, Dr D Edgar, Professor F Wood (Perth, Australia)

Introduction and Aims: Quantification of burn severity is complex yet facilitates research and treatment center comparisons. Burns often present to trauma centers where the injury severity score (ISS) is the most established scoring system. This study examined the concordance of the ISS with burn mortality and assessed if combining age and total body surface area (TBSA) with ISS improved burn mortality prediction.

Method: Data from the Royal Perth Hospital Trauma Registry and the Royal Perth Hospital Burns Minimum Dataset were analysed for the period 2004-2011. Area under the receiver operating characteristic (ROC) curve (AUC) estimated concordance with mortality. The burn-specific injury severity score (BISS) was developed using logistic regression models with death as the dependent variable.

Key Results: There were 34,572 trauma patients with 673 deaths (1.9%) of which 1,344 (3.9%) were burns of median TBSA 5% (IQR 2-10) with 25 deaths (1.9%). Concordance of ISS for the sample was 85% (95% CI 83-87%). For burn patients, AUCs adjusted for age, gender and cause, for ISS and BISS were 84% (95% CI 82–85%) and 94% (95% CI 92–95%) respectively.

Conclusions: Combining ISS, age and TBSA into BISS performed significantly better than ISS alone in post-burn mortality prediction.

11:37 Questions

11:40 Six year burns mortality statistics: outcomes from a UK burns unit

Dr R Silk, Miss S Hassan, Miss P Muthayy, Mr C O'Boyle (Nottingham)

Mortality is the commonest outcome measure used by burn care providers worldwide. UK burns units admit and manage adult patients with burns up to

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11:47 – 11:50

50% TBSA and children up to 30% TBSA. The authors compare burns mortality data for a UK burns unit with those of a UK burns centre, and draw inference regarding suitable measures of outcome for UK burn care providers.

A six-year, retrospective analysis of all patients admitted with burn injuries was conducted. The calculated LA50 data was compared to published data from UK burns centres.

3165 patients were treated for burn injuries, of which 1038 were admitted, with 25 mortalities. The mortality outcome data from this burns unit compared favourably with previously published data, however, LA50 statistics could not be reliably derived, due to the limitation on admission by burn size.

The authors present the first comprehensive six-year burns mortality rates from a UK burns unit. The data show that, for burn-injured patients of comparable age and TBSA, mortality outcomes from burns unit-level care are no worse than those from burns centre care. Derivation of a LA50 statistic appears invalid with restricted admission criteria and risks misleading healthcare commissioning bodies, in planning for future burn care provision.

11:47 Questions

11:50 The use of an enzymatic alginate gel in the treatment of cement burns: a case series

Dr L Ng, Mr K Rahman, Mrs S Pape, Mr S Varma (Newcastle upon Tyne)

Background: Cement burns account for relatively few admissions to burns units but can be challenging to manage due to the insidious onset of injury and late presentation. For optimum wound healing a suitable micro-environment with exudate control and antimicrobial activity is essential.

There is limited evidence on the comparative efficacy of wound management products in cement burns. Here we describe our positive experiences following the use of an enzymatic alginate gel (Flamanil) in the North-East Regional Burns Unit.

Method: A retrospective review of admissions from 2006 to 2012 yielded 34 cases of patients with lower and upper limb cement burns. This accounted for approximately 2% of all admissions to the unit. Clinical photographs taken of burns during their varying stages of healing were reviewed.

Results: Photographs taken demonstrate excellent wound healing with the use of Flamanil in superficial to mid-dermal burns. Wounds appeared to re-epithelialise well and a satisfactory level of debridement was achieved. Average length of stay was 7 days.

Conclusion: Flamanil is an effective option that minimises wound exudate, reduces bioburden and provides an ideal environment for healing. As demonstrated by our case series it is clear that this is a safe and effective option worth considering in the management of cement burns.

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11:57 – 12:10

11:57 Questions

12:00 Antiseptic efficacy of skin preparation solutions used on common pathogens in burns surgery

Mr E Smock, Dr E Demertzi, Mr A Abdolrasouli, Mr M Akhavani, Dr B Azadian, Miss I Jones, Mr G Williams (London)

Introduction and Aims: Comparative investigation of the microbicidal efficacy of antiseptics in the concentrations and temperatures used in burns surgery.

Materials and Methods: A panel of 10 strains was assembled comprising 8 common strains of S aureus (including MRSA), S pyogenes , E faecalis, E coli, P aeruginosa, C albicans, B cereus and multi-drug resistant Klebsiella and Acinetobacter. The following formulations were tested:

1. PVP-iodine 10% stored at room temperature
2. PVP-iodine stored at 40-42°C
3. Chlorhexidine digluconate stored at room temperature diluted with warmed saline to concentrations of 4%, 2%, 1%, 0.8% and 0.5%.

Results: All concentrations of formulations tested at both temperatures fulfilled DIN EN requirements for antiseptics (a reduction of 5 log steps was achieved). Both antiseptics showed the same high bactericidal and fungicidal efficacy (P=<0.5). For chlorhexidine all MICs (24 hours and 48 hours) were very low (<0.5mg/L) but for PVP-iodine the MICs were much higher and ranged from 64 to 512 mg/L (P=<0.01).

Conclusion: Warming PVP-iodine does not affect its antimicrobial activity. Both antiseptics demonstrate effective skin antispesis, however when a prolonged contact time for antiseptic treatment is required for skin antispepsis, chlorhexidine was found more effective than PVP-iodine, regarding their effective microbistatic and microbicidal concentration.

12:07 Questions

12:10 Paradoxical effects of HO-1 induction on myocutaneous flaps

Miss M Edmunds, Professor S Wigmore, Dr D Kluth (Edinburgh)

Introduction and Aims: Ischaemia reperfusion injury (IRI) contributes to partial free flap failure. Heme-oxygenase-1 (HO-1) is a cytoprotective enzyme in mammals. Upregulation of HO-1 can improve outcome in solid organ IRI models. The aim was to assess whether preconditioning with haem arginate (HA), an HO-1 inducer, could improve outcome as measured by percentage area full-flap necrosis in a rat, myocutaneous IRI model.

Materials and Methods: Forty male, Lewis rats were randomised to receive intravenous: 1) Control- NaCl; 2) HA; 3) HA and Tin Mesoporphyrin (SnMP) or 4) SnMP alone. 24 hours later an in situ transverse rectus abdominis myocutaneous (TRAM) flap with 0.5 hour ischaemic time was performed.

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12:17 – 12:30

Results: One-way ANOVA between treatment groups on percentage area flap necrosis at 48 hours showed significant differences between the preconditioning groups [F (3, 36) = 10.16, p< 0.0001]. Post hoc comparisons by Tukey's test showed; control versus HA (MD = -31.91, CI -60.2 to -3.7, p=< 0.05); Control versus HA + SnMP (MD = -47.2, CI -75.4 to -18.9, p<0.001) and HA + SnMP versus SnMP (MD = 47.07, CI 18.8 to 75.3, p< 0.001).

Conclusions: In contrast to solid organ data HA preconditioning lead to significantly worse outcome in myocutaneous IRI.

12:17 Questions

12:20 The profunda femoral artery perforator (PFAP) propeller flap for ischial pressure sores: a new concept
Dr K Peters, Dr C Healy, Dr F Stillaert, Dr N Roche, Professor K Van Landuyt, Professor S Monstrey, Professor P Blondeel (Gent, Belgium)

Introduction and Aims: The most commonly used flaps for treatment of ischial pressure sores are gluteal musculocutaneous rotation flap, V-Y hamstring musculocutaneous advancement flap, posterior thigh flap and IGAP flap. In our department however, we experienced poor results using these flaps. Here we describe a prospective study of the novel use of the profunda femoral artery perforator (PFAP) flap, recently described by Allen and co-workers, for ischial pressure sore reconstruction.

Material and Methods: Since November 2012 we have performed the PFAP flap as the primary reconstructive procedure for all ischial pressure sores that were candidates for surgery. The flap was raised on a single perforator with a longitudinal skin paddle and "propelled" into the defect. Data was prospectively recorded to include patient parameters, wound characteristics and post-operative wound healing.

Key Results: Four patients with ischial pressure sores were treated with a PFAP propeller flap and study recruitment is on-going. All flaps survived uneventfully.

Conclusion: The PFAP propeller flap is a new option for treatment of ischial pressure sores. This muscle sparing technique mobilises healthy tissue from the posteromedial thigh based on a reliable perforator to cover the defect. In addition it avoids use of gluteal tissue that may be needed for the sacral region.

12:27 Questions

12:30 Detection of perforators with thermal imaging
Mr Y Sheena, Mr T Jennison, Mr J Hardwicke, Mr O Titley (Birmingham)

Introduction and Aims: Perforator flaps require accurate vascular anatomy navigation. Hand-held doppler (HHD), colour-doppler ultrasound, computed tomography and magnetic resonance angiography imaging can help. A growing

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12:37 – 12:40

literature supports thermal imaging (TI) and his study assesses its efficacy and the perforator anatomy in four body regions.

Methods: Twenty volunteers had abdominal, sacral and bilateral anterolateral thighs assessed for cutaneous perforators using TI. We established a surface land-marking method by drawing black crosshairs centred on the umbilicus, superior natal cleft and traditional anterolateral thigh (ALT) flap landmarks. All TI-identified perforators were marked by red crosses and circled blue if unconfirmed by HHD.

Results: TI identified 875 'hot spots' and 849 (97.0%) were confirmed by HHD. In 40 ALTs we identified a mean of 1.3 perforators within 2.5cm, and 4.6 perforators within 5cm of the traditional landmark. In 20 abdomens we found a mean of 0.7 and 3.7 perforators within 2.5cm and 5cm of the umbilicus respectively. In the 20 sacral regions there was a mean of 0.3 and 2.3 perforators within 2.5cm and 5cm of the superior natal cleft respectively.

Conclusions: TI quickly, easily and accurately assesses cutaneous perforators and should be considered a useful adjunct and its best clinical role further investigated.

12:37 Questions

12:40 Perineal reconstruction within a 'hub and spoke' model in a district general hospital setting

Mr K Bisarya, Mr J Randall, Mr I Basu, Mr S Baxter, Mr F D'Souza, Mr R Farouk, Mr R Uppal (Wexham)

Introduction: Perineal reconstruction post-APER (abdomino-perineal excision of rectum) and ELAPE (extra-levator abdominoperineal excision) extended resection, which decreases margin involvement but leaves bigger defects for rectal carcinoma, is increasing. This study investigated outcomes by plastic surgeons working across two district general hospitals (Wexham Park and Reading).

Methods: A retrospective review of notes was undertaken to obtain background characteristics, treatments, flap types, and complications.

Results: Over ~ 3 years 19 patients underwent APER including 10 ELAPE. Characteristics included age 38-89, 8 females, 10% diabetics and 75% peri-operative chemo or radiotherapy.

The number of immediate perineal flap reconstructions is below. Before 2011 RAM (rectus abdominis myocutaneous) flaps were the major reconstruction and post all were gluteal (9).

Flap	APER Group	ELAPE Group
Gluteal	3	8
RAM	6	2

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12:47 – 13:00

There were no flap failures or perineal hernias. 3 patients (16%) had major perineal complications (requiring re-operation). 8 (42%) experienced minor complications.

Flap	Major Complications	Minor Complications
Gluteal (11)	2 dehiscence	2 dehiscence 4 infection
RAM (8)	1 dehiscence	1 dehiscence 1 infection

Conclusions: APER is common in DGH settings with flap reconstructions becoming increasingly required especially with more ELAPE procedures. These flaps can be safely carried out including within a Hub and Spoke model.

12:47 Questions

12:50 One-stage dynamic pelvic floor and perineal reconstruction following LEAPR for previoiusly irradiated low rectal cancers using bilateral gracilis muscle flaps and gluteal transposition flap

Mr A Siddiqui, Mr L Suleman-Verjee, Mr S Mukherjee, Mr S Bannerjee, Dr S Elnaas, Mr J Huang, Mr M Sood (Chelmsford)

Introduction and Aims: We present five patients with primary reconstruction of the pelvic floor and perineum following laparoscopic extended abdomino-perineal excision of the rectum (LEAPR) for low rectal cancers with irradiated skin. The principle of separation of the pelvic floor reconstruction from skin cover and logistics of the procedure are discussed.

Materials and Methods: In a series of 10 cases of LEAPR, the first five cases were managed by direct closure of wounds with/without biological mesh by the colorectal team. In remaining five patients we adopted a combined approach and performed a dynamic pelvic floor reconstruction using pedicled bilateral gracilis muscle flaps. Skin cover and volume restoration was achieved by a gluteal perforator based transposition flap. Patients were assessed with post-operative dynamic MRI scans and dynamic ultrasonography to demonstrate absence of herniation on performing the valsalva manoeuvre and active elevation of the pelvic floor up to 1.4 cm on thigh adduction.

Results: Four patients with this combined approach healed completely in two weeks. One patient healed uneventfully after evacuation of an infected haematoma. There were no wound breakdowns, pelvic herniation or intraperitoneal adhesions.

Conclusion: Following ELAPR, reconstruction of the pelvic floor with pedicled gracilis muscle and cover with a gluteal local transposition flap is a reliable technique.

12:57 Questions

13:00 Lunch and exhibitions

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FRIDAY 21 JUNE 2013

14:00 – 14:32

Major trauma

Chairs: Mr U Khan and Mr S Hettiaratchy

14:00 **Introduction to the BAPRAS Trauma Special Interest Group**
Mr U Khan, Mr S Hettiaratchy

14:05 **Guest speaker: Major trauma networks in England: is it making a difference?**
Mr C Moran

The 22 major trauma networks in England went live in April 2012. These have centralised care of the severely injured patient for the entire population of England. Professor Moran will outline the structure of the new networks and discuss early results and performance. The early results are very encouraging and suggest that the odds of survival following severe injury (ISS 9+) in England increased by over 20% ($p<0.05$) during the first 9 months that the major trauma networks were operational.

Free papers: Limbs

14:25 **Learning to fix hand fractures with unicortical fixation on a human cadaveric model**
Mr J Paget, Mr J Dickson, Mr S Gujral, Mr W Bhat, Mr S Lee (Bristol)

Unicorticate fracture fixation has been reported as an alternative technique to bicortical plate fixation in treating hand fractures. The aim of this study was to assess the robustness of acquiring the technique for new operators.

Methods: Two operators fixed 96 transverse fractures in human cadaveric bones. Half were fixed with a familiar bicortical plating technique; half with unicortical plating. Time taken for each was recorded. Plated bones' breaking force was measured using a four point breaking system.

Results: There was no overall significant difference in fracture fixation strength between the two operators (370N versus 336N $p=0.46$) or the two fixation types (393N versus 313N $p=0.07$). One operator was faster than the other (6.7 minutes versus 11.0 minutes $p>0.0001$) but both showed "learning curve improvement" in the unicortical fixation.

Discussion: Our results show that unicortical fixation is simple to learn, has reproducible results and is similar in strength to bicortical fixation. This study also demonstrates the acquisition of skills with a training model that is relevant, cost-effective and assessable. This may help junior surgeons acquire skills in a safe environment when clinical exposure is limited by the EWTD reform.

14:32 **Questions**

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14:35 – 14:45

14:35 Distraction management of post-traumatic proximal interphalangeal joint contracture

Miss S Jing, Dr M Tehrani, Mr S Houshian (Chelmsford)

Purpose: Management of chronic post-traumatic flexion contracture of the proximal interphalangeal (PIP) joint remains challenging. We present the long-term outcome of joint distraction using mono-lateral external fixation in the treatment of such injury.

Methods: Between September 2001 and October 2011, 94 consecutive patients (98 PIP joints) with a mean age of 43 years (range: 17-69 years) were treated with external fixation following chronic flexion deformity of the PIP joint from trauma. The average time from injury to surgery was 48 months (range: 6-84 months) and duration of joint distraction was ten days (range: 7-22 days). Patients were followed-up for a mean period of 54 months (range: 12-72 months).

Results: The mean range of motion gained post-operatively was 67° (range: 30°-90°). There was no loss of gain during follow-up. Patients aged less than 40 years fared slightly better than compared with those aged more than 40 years, but the difference was not statistically significant. Two patients had swelling, pain and redness during treatment, which were resolved by temporarily stopping distraction. We had 12 superficial pin site infections and related discharge managed successfully by oral antibiotics, but no serious complications. The outcome was not affected in all cases.

Discussion: External fixation is a simple and effective treatment modality for chronic PIP joint contractures with good predictable long-term results. Careful patient selection and monitoring are important.

14:42 Questions

14:45 Tissue engineering peripheral nerve repair with human adipose-derived stem cells

Mr M Kolar, Dr L Novikov, Dr L Novikova, Professor M Wiberg, Dr P Kingham (Umeå, Sweden)

Peripheral nerve gap injuries pose a challenge clinically. Adipose-derived stem cells (ASC) are an easily accessible source of stem cells that could be used to create a tissue engineered alternative to autografts.

In this study, human ASC were isolated from the abdominal fat from five patients. RT-PCR showed that the cells expressed a range of neurotrophic and angiogenic molecules. In-vitro stimulation of the cells with a mixture of growth factors resulted in increased secretion of BDNF, GDNF, VEGF-A and angiopoietin-1. Conditioned medium from stimulated cells increased neurite outgrowth of dorsal root ganglia neurons. Similarly, stimulated cells showed an enhanced ability to induce capillary-like tube formation in an in-vitro angiogenesis assay. The cells were seeded into a fibrin conduit which was used to bridge a 1cm gap in the injured rat sciatic nerve. After 2 weeks,

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14:52 – 15:05

L4-L6 DRG and spinal cord segments were harvested and the effect of ASC transplantation on regeneration and apoptosis-related gene expression determined. Immunohistochemistry using human cell specific antibodies showed the ASC survived transplantation and were found in close proximity to proliferating Schwann cells and regenerating axons.

Thus, ASC express neurotrophic and angiogenic factors, creating a more desirable microenvironment for regeneration in nerve conduits.

14:52 Questions

14:55 Oxygen reduces tourniquet associated pain (ReTAP): a double-blind randomised controlled trial for application in hand surgery
Dr N White, Dr T Dobbs, Mr G Murphy, Mr K Khan, Miss L Cogswell (Oxford)

Introduction and Aims: Why do limb tourniquets cause pain? If ischaemia is the mechanism, can supplemental oxygen reduce pain? Could this simple treatment extend tourniquet tolerance time (TTT) to facilitate hand surgery under local or regional anaesthesia? The ReTAP study investigated this important question.

Materials and Methods: ReTAP was a double-blind, randomised controlled trial of healthy volunteers. Participants received either 50% inhaled oxygen or air placebo for three minutes before and up to 30 minutes after upper arm tourniquet inflation to 250mmHg. Pain scores were recorded at 2 minute intervals using the 100mm visual analogue scale (VAS) and overall TTT measured.

Key Results: Forty-six participants were analysed. Oxygen supplementation was associated with a 28.5% mean reduction on VAS compared to placebo over the entire period of inhalation (p=0.024; T-test). Oxygen also extended the time to VAS ≥40mm by a mean of >6½ minutes compared to placebo (p=0.0043; T-test).

Conclusion: Oxygen is a readily available, low-risk, low-cost treatment that significantly reduced tourniquet associated pain and significantly increased TTT. Its use can facilitate complex hand surgery procedures under local anaesthesia. We recommend it for hand surgery requiring a tourniquet under local anaesthesia; and when a regional block fails to control tourniquet pain.

15:02 Questions

15:05 Functional reconstruction of hand and upper limb defects using composite anterolateral thigh free flap
Mr J Wiper, Dr H Beem, Dr C Fox, Dr M Wagels, Dr D Rowe (Brisbane, Australia)

Complex defects of the hand and upper limb involving vessels, nerves and muscles require multiple tissue types for functional reconstruction. Local options are often limited, especially in the setting of trauma.

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15:12 – 15:22

The free functional unit anterolateral thigh (ALT) flap meets the reconstructive demands for many of these defects with the availability to provide multiple tissues with a range of functional benefits. Here we review twenty-one cases in a series where the ALT was employed to reconstruct complex upper limb defects presenting to the Princess Alexandra Hospital, Brisbane, Queensland, Australia between 2006 and 2012. The aetiology of most complex upper limb defects were high-energy trauma, although neoplastic and infectious causes were also encountered.

The cases illustrate the versatility of the composite ALT free flap by demonstration of a vascular flow through flap, a neurotised flap, a gliding surface for underlying structures and an extensor tendon reconstruction including the fascial component.

15:12 Questions

15:15 Reconstruction of traumatic soft tissue defects in the lower half of the leg with medial hemisoleus flaps

Mr P Lim, Mr S Cairns, Mr C O'Boyle, Mr S Al-Benna (Nottingham)

Introduction: Traumatic soft tissue defects of the lower half of the leg remain problematic with limited solutions in terms of local flap coverage.

The medial hemisoleus flap can be reliably used to treat small-to-medium-sized defects in this area. The aim of this study was to determine the indication and clinical outcome of medial hemisoleus flaps used for the reconstruction of defects in the lower half of the leg.

Methods: Consecutive patients with lower leg defects who received treatment between 2011 and 2012 were analysed retrospectively. Patient data analysed included epidemiological, clinical and management details, including complications.

Results: Mean age of the patients was 58.0 ±25.2 years (mean ±sd). 90.9% were male and 9.1% were female. Mean defect size was 34.4 ±3.1 cm^2 (mean ±sd).

All soft tissue defects were secondary to trauma. Flap survival was complete in 10/11 patients and partial in 1/11 patients. There were no flap losses. After a follow-up of 6 ±2 months, there were no further reports of recurrent defects.

Discussion: Medial hemisoleus flaps should be included in the armamentarium for reconstruction to provide durable closure of small to middle-sized traumatic lower leg defects. These flaps are limited in length and width and cannot always cover large defects, particularly after major trauma.

15:22 Questions

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15:25 – 16:15

15:25 Combined ortho-plastic approach to open tibial fractures: a prospective multicentric study
Mr F Boriani, Mr M Fell, Mr U Khan (Bristol)

Introduction: Combining the skills of plastic and orthopaedic surgeons can optimise limb salvage in complex lower limb injury. We compared centres with different protocols for management of these challenging cases.

Method: Patients were prospectively recruited from three trauma centres during a six-month period: Maggiore Hospital (Bologna, Italy) had no dedicated orthoplastic service whereas Frenchay (Bristol, UK) and Jinnah Hospital (Lahore, Pakistan) had adopted an orthoplastic approach. Mechanism of trauma, injury severity and techniques of bone and soft-tissue reconstruction were documented. The primary outcome was duration of hospitalisation.

Results: The number of patients included was 42. Mechanism, injury severity and bony fixation was similar across the three centres. Soft-tissue management differed with VAC therapy commonly utilised by the Italian centre, compared with vascularised tissue transfer in Britain and Pakistan. The mean duration of hospitalisation in the Italian centre was 72 days compared with 25 days in Britain and 24 days in Pakistan. Patients treated in a centre with an orthoplastic team, therefore, spent an average of 46 fewer days in hospital (P<0.005, 95% CI -69 to -24days).

Conclusion: Evaluation of open tibial fracture management shows an advantage deriving from a combined orthoplastic approach, even when applied into a comparatively hostile cohort.

15:33 Questions

15:35 Refreshments and exhibitions

Major trauma (continued)

Chairs: Mr U Khan and Professor A Hart

15:55 Brachial plexus injury: my approach
Dr M Novikov

16:15 Spare part surgery
Professor M Leung

In major limb trauma, it is important that the reconstructive surgeon is referred the cases on admission and participate in the discussion of the management plan. Early referral is mandatory in achieving a good surgical outcome for patients with severe trauma. Clinical scenarios are presented.

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16:35 – 17:30

16:35 **Trauma management in Pakistan: who cares?**
Professor M Tarar

Health care delivery systems in developing countries are usually under-resourced in the face proportionately heavy disease burden. That leads to lower standards of care and exclusion of services considered expensive or less essential by the policy makers and managers. Scarcity of trained personnel in a particular area provides a legitimate excuse and justifies that exclusion. This fact can be amply illustrated with the current state of involvement of plastic surgery services in trauma reconstruction in Pakistan. We took the initiative by volunteering on call.

16:55 **What would you do?**
Case discussion from panel

17:30 **Close**

NOTES

POSTERS

1 – 2

1. **The operative trauma workload in a plastic surgery tertiary referral centre in Scotland**

Dr M Abdelhalim, Mr J Chatterjee (Glasgow)

Introduction: The trauma workload in plastic surgery is not well documented in the literature. The authors aimed to demonstrate the demographics, mechanisms of injury, sites of injury and operative procedures performed for trauma in a large tertiary referral centre.

Methods: This study used a prospectively tabulated comprehensive database in which details of every trauma operation performed at the Canniesburn Plastic Surgery Unit were logged. The data from an 8 year study period (2003–2010) was collected for patient demographics, site of injury and operative procedures performed.

Results: Analysis of 21,929 operative procedures on 8,880 patients was undertaken. More than 75% of trauma affected the limbs. The mechanism of injury was predominantly accidents (31%) followed by violent crime (17%), of which 27% involved a knife. Notably, alcohol was a contributing factor in 3.4% of all trauma cases.

Conclusions: Plastic surgery trauma involves injury to all sites of the body with variable mechanisms. However, certain mechanisms are arguably preventable through public health initiatives and legislative change. There is a significant operative caseload with a requirement for varying complexities of reconstruction and many specialist procedures. This illustrates the importance of plastic surgeons in trauma care and consequently, their vital role in trauma centres.

2. **Serratus anterior artery perforator flap in the treatment of axillary hidradenitis suppurativa: case report**

Mr A Al-Mousawi, Mr D Dewing, Mr S Mashhadi (London)

Introduction and Aims: Hidradenitis Suppurativa (HS) is a chronic debilitating inflammatory disease presenting as painful subcutaneous nodules, sinus tracts and abscesses. Previously considered of apocrine origin, it is now believed to be caused by follicular occlusion. Patients present for operative management after failure of medical treatment to control moderate or severe disease. Various surgical options including local and regional perforator flaps have been described for axillary reconstruction.

Material and Methods: We report a case of axillary HS managed with the use of a Serratus Anterior Artery Perforator (SAAP) flap following wide local excision. The patient presented with a six year history of severe bilateral axillary HS after failing previous treatment with multiple antibiotic courses and previous incision and drainage. Optimal planning, doppler use, flap design and technique are described in detail.

Results: Following detailed discussion, the decision was made to proceed with wide local excision and reconstruction, achieved with SAAP flap reconstruction,

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in an effort to alleviate regional disease. Review several months post-operatively demonstrated excellent outcome and preserved range of movement.

Conclusion: Although to our knowledge not previously published, use of an SAAP flap offers a valuable option in reconstruction of axillary defects following wide excision of axillary HS.

3. Are systemic antibiotics indicated in aesthetic breast surgery? A systemic review of the literature

Mr J Bechar, Ms J Skillman, Mr J Hardwicke (Birmingham)

Background: The use of systemic prophylactic antibiotics to reduce surgical site infection (SSI) in aesthetic breast surgery remains controversial. The aim of this review is to weigh the available evidence with respect to reducing SSI.

Methods: Two literature searches were performed to analyse the available data for studies involving reduction or augmentation mammoplasty and the results of different antibiotics regimens. Outcome measures included SSI and capsular contracture.

Results: 2,971 patients (5,891 breasts) were included. A meta-analysis of SSI incidence after aesthetic breast surgery revealed a significant reduction in infections overall with antibiotic prophylaxis, compared to the control ($p = 0.02$). This was most significant with a single pre-operative antibiotic dose ($p = 0.02$). In cases of reduction mammaplasty, when antibiotics are used as a single pre-operative dose, the risk of developing SSI is halved. With augmentation mammaplasty there was no effect on infection rates with any antibiotic regimen. Data concerning incidence of capsular contracture did not allow for meta-analysis.

Conclusions: For cases of reduction mammaplasty, we would recommend a single intravenous peri-operative dose of antibiotic with action against Staphylococcus spp. For augmentation mammaplasty, there is no evidence to refute current guidelines, based upon recommendations obtained from other forms of implant surgery.

4. Outcomes following Abbe flap reconstruction of the lip: a five-year retrospective study

Dr H Beem, Dr C Fox, Dr J Wiper, Dr D Theile (Brisbane, Australia)

Background: The Abbe lip-switch flap was first described by Sabbatini in 1837, though cross-lip flap reconstruction of composite tissue defects had been already been in use for some 100 years. It remains in wide use today, as a technique for reconstructing significant defects of the upper or lower lip. Despite its ubiquitous use, there is a paucity of evidence in the literature regarding outcomes following Abbe flap reconstruction.

Methods: All lip-switch flaps performed in a five-year period at a metropolitan Queensland hospital from 2006 to 2011 were included for review. Outcome

measures included early complications, patient satisfaction, functional status, oncologic outcome, and requirement for revision operation.

Results: 57 Abbe flap reconstructions were undertaken over a five-year period. It is a safe procedure that is easy to learn, reproducible and reliable. It has good oncologic, aesthetic, and functional outcomes.

Conclusions: The lip-switch flap remains a valid technique in the reconstructive surgeons' toolbox for defects of the lip. It has a low complication rate and satisfactory aesthetic outcomes. This is the first study that quantifies outcomes following lip-switch flap reconstruction of the lip and should be considered in cases where defects of the lip are not amenable to direct closure.

5. **Static and dynamic facial reanimation post-facial nerve resection using the free functional unit alt flap**
Dr H Beem, Mr J Wiper, Dr M Wagels, Dr A Kane (Brisbane, Australia)

Extirpation of tumours extensively involving the parotid gland often requires en-bloc resection of the facial nerve with subsequent facial paralysis. These resections are often combined with significant cutaneous defects requiring reconstruction. Radiotherapy is frequently indicated in these patients, warranting a robust reconstruction to ensure tissue survival and neural regeneration. We present two cases where the ALT flap has been employed not just for dead space control and cutaneous replacement but providing dynamic facial reanimation through the use of different components of the ALT flap.

Case 1 utilised the lateral femoral cutaneous nerve as a vascularised nerve graft for a segmental excision of the facial nerve trunk along with the fasciocutaneous component as static facial slings and dermal replacement.

Case 2 utilised a segment of vastus lateralis with its motor nerve to act as a free functioning muscle transfer for dynamic facial reanimation. The fasciocutaneous component was also used as static facial slings and dermal replacement.

Both patients underwent post-operative radio therapy and acquired demonstrable dynamic facial reanimation.

6. **A decline of facial trauma exposure for plastic surgical trainees? A survey of referrals of facial trauma in the UK**
Mr W Bhat, Mr D Saleh, Miss M Mughal, Dr J Stallard, Mr M I Smith (Leeds)

Background: Facial trauma forms part of the plastic surgical curriculum. A&E referrals for facial trauma have traditionally been a training ground where trainees learnt and practiced fundamental techniques. Anecdotal evidence suggests trainees no longer have this opportunity as referrals of facial trauma are to allied specialities such as ENT and maxillofacial surgery (MFS). This study presents the referral pattern of facial trauma from A&E to determine as link with decline in facial trauma exposure for plastic surgical trainees.

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Methods and Materials: We carried out a survey of all "level 1" referring A&E departments. The questionnaire was standard for all and constructed to ascertain which specialities facial trauma cases were referred.

Results: 70% of trusts surveyed responded (*n*= 70). 100% referred all bony injuries excluding the nose to MF. Pathways existed to refer isolated nasal fractures to ENT. 93 % of units referred all soft tissue injuries to MFS; 6 % to all specialities dependent on anatomical region. Only 1% referred all to plastic surgery.

Additional reviews from the public and general practitioners were carried out to see where they ideally thought facial trauma should be sent and whom they referred such cases to.

Conclusion: A change in referrals patterns has led to the decline in facial trauma case exposure. A&E referrals no longer provide the training opportunities for significant number of plastic surgical trainees.

7. Case report: burning risks of superglue

Miss S Butcher, Mrs S Pape (Newcastle upon Tyne)

Cyanoacrylate glue is the generic name for cyanoacrylate-based fast acting adhesives such as methyl 2 cyanacrylate and ethyl-2-cyanoacrylate, which are commonly sold under trade names like 'Superglue' or 'Krazy Glue'. Cyanoacrylate glues are widely available and commonly used by the general public in domestic and industrial environments.

We describe two cases of full thickness burns in children following accidental spillage of cyanoacrylate glue onto cotton clothing. Both children required skin grafting.

Although there has been a case report of a full thickness flame burn caused by ignition of cyanoacrylate glue on cotton clothing and another of a burn resulting from direct contact of cyanoacrylate with the skin in a child, we have not been able to find any published cases similar to ours. However, we have discovered that when large volumes of cyanoacrylate glue are exposed to cellulose (eg cotton clothing) the hydroxyl groups initiate a polymerisation reaction, resulting in exothermic reactions sufficient to cause full thickness burns.

8. Litigation in breast surgery

Miss F Choukairi, Mr J Ring, Mr W Kisku, Mr S Rayatt (Stoke on Trent)

Introduction and Aims: Reconstructive and aesthetic breast surgery is technically challenging, making it an area with high potential for dissatisfaction and litigation. We present the most common areas of patient dissatisfaction leading to litigation in breast surgery from 2010-2011.

Methods: We requested data from the National Health Service Litigation Authority (NHSLA) under a freedom of information request.

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Key Results: There were a total of 350 plastic surgery claims in the 2010-2011 period. Breast surgery accounted for 30.6% (107/350). These were subdivided into reconstruction 31.8%, reduction 29.9%, augmentation 18.7% and unspecified/miscellaneous 19.6%.

The results of this work show that the commonest causes for complaints were alleged 'incompetent-surgery', 23.4% and 'problems with consent and/or explanation', 18.7%. Causes of complaint were spread evenly between different procedure types. A group comprised 2% and these were never events, which included retained foreign materials.

Conclusion: In the breast surgery field, there is subjective as well as objective interpretation of the outcome of surgery and many factors play a role in patient satisfaction. This data can be used to highlight issues likely to cause dissatisfaction and be used as part of training to avoid the major causes of complaint.

9. Point of technique: the Edinburgh position – fingers and thumbs technique
Mr J Edet, Mr F Urso-Baiarda, Mr S Alexanda, Miss S Jivan (Wakefield)

This is a poster presentation highlighting the importance of safe immobilisation of the hand after injury and demonstrates an easily reproducible method to achieve this position accurately. The Edinburgh position (position of safe immobilisation) is considered to be the position for splinting hand injuries that reduces the likelihood of stiffness whilst maintaining adequate support and protection, facilitating healing.

Despite good documentation of this there is sometimes a discrepancy between this and what position hands are actually splinted in. This prompted the study and a detailed look at the angles that hands were splinted in. Fifty splints were randomly collected over a 2-month period and the angles were measured and casts examined to see if they held the hand in extension at the wrist, flexion at the metacarpal phalangeal joints (70-90°) and full extension of the interphalangeal joints. The findings showed that approximately 30% of the splints seen were accurate for all three parameters. A simple method was then used to teach staff how to apply splints accurately in accordance with the three parameters above and the process was repeated, collecting splints and measuring the angles again.

Over 95% were accurate after the teaching.

10. Using virtual simulation to aid facial reconstruction
Mr B Green, Mr D Nikkhah, Mr R Farhadieh, Mr N Bulstrode, Mr P Ayliffe, Mr D Dunaway (London)

Introduction: Complex craniofacial surgery requires thorough planning as the face is a challenging structure. There are few studies that describe tools for planning facial reconstruction. Currently, 3D-computed tomography and cephalometric studies are used. From this, stereolithographic models can be produced. However, reliance on the surgeon's skill is needed to fashion the final

template needed for facial reconstruction. We use the example of a Hemifacial Microsomia patient with a Pruzansky type III mandibular deformity.

Methods: Virtual simulation can be used to create stereolithographic models. By using Robin© 3D software, a mirror image of the patient's mandible with targeted landmarks was used to create the absent mandible. Virtual simulation allows merging into one mandible and so correcting the underlying asymmetry. Editing can be done to produce an effective stereolithographic model ready for surgery.

Results: A stereolithographic template of the corrected mandible and the original mandible were designed using 3D rapid prototyping. The templates were used as a guide in the harvesting and sculpting of a bicortical deep circumflex iliac artery flap.

Discussion: Stereolithographic models designed using virtual simulation decrease surgical time and provide more predictable and accurate results. Furthermore, the technique can help solve complex asymmetry and improve the final aesthetic outcome in congenital craniofacial disorders.

11. Amniotic constriction band: a Liverpool case series

Miss L Homer, Mr A Mishra, Professor P McArthur (Liverpool)

Introduction: Amniotic constriction band is one of 30 names for the condition. It occurs in approximately 1 in every 15,000 live births. It is postulated to form from torn amnion membrane from its rupture into the chorion in which the developing fetus becomes entangled. It is graded using the Patterson classification system.

Methods: A case series of all patients with amniotic constriction band that presented to Alder Hey Children's Hospital was compiled between the years 1993 and 2012. From this, data was described. Incidence in the North West was also calculated.

Results: 32 patients were identified. Of these 17 had bands confined to the upper limb and 3 of the lower limb only. Eleven had both upper and lower limb deformity while 1 child had a band of unlisted location. Twenty two children underwent surgical intervention whilst 10 were managed conservatively. Of the group 21 were male and 11 female.

Conclusion: From the results constriction band of the upper limb was the most common deformity with no gender dominance. It is also clear that there is no agreement on the nomenclature of this condition making amalgamation of the literature problematic. A more specific classification of upper limb bands has also been proposed.

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POSTERS

12 – 17:30

12. A precise excision technique for schwannomas (Innovation)

Mr M A Hussain, Dr A Pandya, Dr H Jhattu, Wg Cdr A Pandya (Portsmouth)

Introduction: Schwannomas are benign peripheral nerve tumours originating from cells of the Schwann sheath. Clinical presentation is dependent on the anatomical site and includes pain radiating along the course of a peripheral nerve, paraesthesia, weakness or compression neuropathy. The current technique, primary extra-capsular excision, puts nerve fibres at great risk of damage, making patients prone to post-operative neurological deficits. We describe a novel, intra-capsular excision and release not previously documented.

Methods: A retrospective case study review was undertaken regarding a 40-year-old, right hand dominant, presenting with 12-month history of a painless lump. There was a 12-month post-operative follow up period.

Results: Three patients have undergone this novel technique with excellent results. No neurological deficits were documented in a 12-month follow-up. All resumed normal work duties.

Conclusion: Primary resection warrants careful dissection as accidental injury to adjacent nerve fibres causes chronic pain and long-term neurological sequelae. The extracapsular approach of the tumour puts nerve fibres that traverse the surface of the capsule at great risk of damage. This alternative reduces this risk by incising the capsule far lateral to the path of the nerve and dissecting the tumour circumferentially from its capsule. The epineural capsule is then left behind as a protective covering of the nerve.

13. A transmanubrioclavicular approach to the brachial plexus and subclavian vessels

Mr V Itte, Mr S Hassan, Mr R Winterton, Professor S Kay (Leeds)

Surgical exploration of the retroclavicular space is a specialised procedure and a detailed knowledge of the regional anatomy is essential. Several approaches to the brachial plexus have been described, including use of the transclavicular osteotomy. However, this does not provide adequate exposure for some regions particularly involving medial or caudal lesions

We present the transclavicular transmanubrial approach in such cases. This involves a collar incision, a claviculotomy followed by splitting of the manubrium and elevating the bone flap on the sternocleidomastoid muscle. This provides excellent exposure of the confluence of vessels for arm and head and neck and of the C8/T1 roots. This technique can thus reduce the risks of iatrogenous injuries to adjacent structures.

We report and discuss cases using the above approach. This method to date has been used to treat lesions involving the vascular thoracic outlet as well for resection of para-vertebral tumours abutting the roots of the plexus. No complications to date have been noted.

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14. A ten year epidemiology of 1,797 self-harm referrals to mental health liaison service in South Wales at a regional burns and plastic surgery centre

Mr M Javed, Mr R Evans, Miss S Hemington Gorse, Mr N Wilson Jones (Swansea)

Introduction: Management of self-harm injuries can have a significant financial impact on an institution managing these cases. We review all the self-harm injury referrals made to our plastic surgery mental health liaison service in the last decade and aim to examine trends and explore the contributing factors leading to self-harm in the Welsh population.

Methods: The data was collected prospectively from 2001 to 2010 at the Welsh Centre for Burns and Plastic Surgery.

Results: We received a total of 1797 referrals (average 180/ year). 59% were male and 41% were female with the majority in their third decade of life. 52% (male 49.6%, female 50.3%) had mood/anxiety disorders, 36% (male 72%, female 27.9%) were alcohol/drug related incidents, 8% (male 72.5%,female 27.4%) had psychosis and 4% (male 42.8%,female 57.1%) had organic disorders. The majority of the patients were discharged with community mental health and drug/alcohol team appointments followed by the group of patients referred to the psychiatric team.

Conclusion: Men with mood/anxiety disorders involved in drug/alcohol incidents were the predominant group presenting with self-harm injuries. We noticed no decline in self harm injury referrals in the last decade at our centre, compared to declining rates in England. A more robust strategy is needed to improve prevention and education of patients with self-harm injuries to reduce the financial burden on NHS.

15. The UK plastic surgery specialist register: past and present

Miss Z M Jessop, Mr M Gardiner (London)

A Freedom of Information request to the General Medical Council enabled analysis of the specialist register for plastic surgery, introduced in 1997. This provides both an historical perspective to the current challenges faced by plastic surgery workforce planning in the UK and information on the current composition of UK registered plastic surgeons.

A snapshot taken at the start of 2012 shows 805 surgeons on the specialist register, of which 671 (84%) were male and 134 (16%) were female. The majority were UK-qualified but a further 54 countries were represented in the primary medical qualifications. These were split between countries inside the European Economic Area (234 entries) and those outside (145 entries). Entries have increased five-fold since 1997 (163 to 805); EEA entries have expanded the most (10 to 234). The percentage share of female entries has increased but in real terms represents a fall given the rise in female graduates.

These results are discussed with reference to changes in UK working patterns and workforce planning, as well as European legislation promoting medical

mobility. These factors present a challenge to maintaining the entry standards for the register whilst meeting the legislative requirements and balancing the supply of trained plastic surgeons.

16. Case report: surgical treatment of a Morel-Lavallée lesion of the distal thigh with the use of lymphatic mapping and fibrin sealant

Miss R Jones, Professor A Hart (Glasgow)

Introduction: A Morel-Lavallée lesion can occur after a closed degloving injury. It is a persistent seroma that may be resistant to conservative methods of treatment such as percutaneous drainage and compression therapy. We present a novel, successful method of surgical treatment.

Case report: A 70-year-old lady developed a 30x15cm rapidly enlarging right medial thigh/knee swelling after being hit by a car. Conservative treatments failed, sarcoma was excluded, and the diagnosis confirmed, by MR imaging and cytology prior to referral. The lesion was excised, and blue dye lymphatic mapping used to identify and ligate feeding lymphatic vessels. The cavity was then closed using fibrin sealant spray and resorbable quilting sutures. A pressure garment was fitted.

Result: The wound healed without complication, with no recurrence at six months. The patient returned to normal activities without pressure garments.

Conclusion: This method provides a novel, successful approach to the surgical treatment of a chronic Morel-Lavallée lesion.

17. How to set up an affordable microsurgery workshop: the Mid-Yorkshire Plastic Surgery Microsurgical Workshop experience

Miss N Kelemen, Mr D Wilks, Miss S Jivan, Mr S Southern, Mr S Majumder (Bradford)

The majority of the microsurgery courses available for the plastic surgery trainees are expensive or organised abroad. These courses are also aimed at participants already committed to pursuing a career in plastic surgery.

Our unit has noted the lack of microsurgery workshops targeted at core surgical trainees or foundation doctors who would like to experience microsurgery and also the absence of affordable microsurgery skills refresher courses.

We have set up and successfully run a microsurgery workshop using simulation models, animal tissue, microsurgical instruments and training microscopes. A sponsor provided the instruments and microscopes. The faculty members were recruited from the Yorkshire and Humber Deanery and are all are practicing microsurgeons and clinicians. The stations were based on step-by-step simulations to gain the basic microsurgery skills. The two-day course provided the participants with the opportunity to achieve or regain basic microsurgical skills including microsurgical dissection, end-to end, end-to side vessel anastomosis, and nerve repair. The faculty-to-participant ratio was 1:1, with high participant satisfaction, personal feedback and clinically relevant advice.

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We discuss the advantages of an affordable, targeted microsurgery course which can be attended prior to the main microsurgical course or as a refresher for microsurgery skills for plastic surgery trainees.

18. Reducing the donor defect of the gastrocnemius flap

Miss R Khundkar, Dr C Sethu, Miss C McGuiness (Salisbury)

The pedicled gastrocnemius muscle flap is useful for reconstruction of defects around the knee joint and upper tibia. Usually either the whole medial or lateral muscle belly is used. This can leave a considerable contour deformity at the donor site as well as significant bulkiness at the recipient site, especially if the defect is small. Transfer of the entire muscle can also contribute towards loss of plantar flexion, affecting jumping and running. We describe our technique to minimise these effects.

The gastrocnemius vascular anatomy allows the muscle belly to be split, allowing a split or segmental transfer. For smaller defects, the senior author uses only a small portion of the muscle, leaving the rest of the muscle in-situ. The vessel is isolated and followed distally to the segment of muscle required. This segment is then transferred to the required position, islanded on its vasculature. Preserving the rest of the donor muscle allows sparing of some function.

We have found this to be a very useful technique minimising morbidity at the donor site, with improved donor site post-operative aesthetics and function.

19. Designing an effective paediatric trauma pro forma for the safeguarding of children

Mr I King, Mrs S Pape (Newcastle upon Tyne)

Introduction: Children presenting to hospital with injuries should be thoroughly assessed by medical professionals. Recognition of non-accidental injuries is vital for prompt and sensitive safeguarding. Clear, comprehensive and contemporaneous documentation is essential. We developed a paediatric trauma pro forma to screen for safeguarding concerns in children aged 5 or less presenting with traumatic injuries.

Methods: Consultation with paediatric burns units across the UK was undertaken and assessment pathways freely shared. Incorporating elements from other units' charts with input from safeguarding nurses, paediatricians, coding and burns surgeons, a new pro forma was designed, implemented and audited to encompass all aspects of child trauma.

Results: An 8-page document was produced. This included fields for identifying nursing staff and responsible adults present, thorough paediatric history, detailed ready-made graphics for accurately recording location and extent of injuries and an approved safeguarding pathway for all to follow. Audit demonstrated much improvement on a previous burns pro forma. No safeguarding concerns were raised for any patients.

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Conclusion: Non-accidental injuries in children shouldn't be missed. Further, in an increasingly litigious society, documentary evidence of thorough assessment is important. Through linking with other burns units, a newly-designed trauma pro forma can be a valuable tool in the safeguarding of children.

20. Analysis of pinnaplasty outcomes: a comparison of suture types and skin incisions

Miss C Lipede, Mr I King, Miss S Tadiparthi, Mrs S Sriram, Mr S Varma (Newcastle upon Tyne)

Introduction: Suture materials and skin incisions in cartilage-sparing pinnaplasty vary among surgeons. However, there is a paucity of literature on outcomes with different sutures and incisions. This study compares:

1 Recurrence and suture-related problems with prolene and ethibond sutures
2 Scarring following a simple linear incision without de-epithelialisation and skin ellipse excision with de-epithelialisation

Methods: A retrospective review of 137 consecutive pinnaplasties performed in 74 patients between 2008 and 2010 was conducted. In all cases, a cartilage-sparing technique with Mustarde and Furnass sutures and an adipofascial flap was undertaken.

Two groups were identified: 4-0 Ethibond and linear skin incision was used in group A and 4-0 prolene and a de-epithelialised skin ellipse was used in group B. A single experienced surgeon performed the pinnaplasties in each group.

Results: Group A comprised of 54 pinnaplasties in 29 patients and group B consisted of 83 pinnaplasties in 45 patients. The groups were comparable, with a median age of 11 years (range 4-17 years).

Complications	Overall compli-cations	Stitch extrusion	Recurrence	Hypertrophic /Keloid scars	Infection	Asymmetry
Group A (*n*=54)	7.4% (*n*=4)	1.9% (*n*=1)	5.5% (*n*=3)	0% (*n*=0)	0% (*n*=0)	0% (*n*=0)
Group B (*n*=83)	9.6% (*n*=8)	4.8% (*n*=4)	0% (*n*=0)	1.2% (*n*=1)	1.2% (*n*=1)	2.4% (*n*=2)

Conclusions: No significant difference was noted in hypertrophic or keloid scarring with skin incision or skin excision. Although stitch extrusion rates were higher with prolene than ethibond and recurrence was more frequent with ethibond sutures, this was not statistically significant.

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POSTERS

21 – 22

21. A regional audit of PET CT in the management of melanoma: in the prognostic gap

Miss C McGoldrick, Mr C Leonard, Dr B Murphy, Mr C Hill (Belfast)

Regional guidelines indicate PET CT for primary cutaneous melanoma in patients with AJCC >pT2b disease. It is proposed that this threshold be increased to pT3b, with greater emphasis on clinical monitoring only in the absence of a sentinel lymph node biopsy (SLNB) service.

Aims and Objectives: To audit adherence to current regional guidelines of PET CT use in the management of cutaneous melanoma, providing evidence regarding the impact of proposed changes in guidelines.

Method: PET CT findings were correlated with pathology and clinical outcomes in melanoma patients over a 3-year period from January 2009.

Results: Three hundred and eighty-six patients underwent PET CT, with 141 scans performed for primary cutaneous disease. 21% (27/141) of these scans were for patients with <pT2b AJCC stage disease, contravening current guidelines. Five patients underwent further investigations for false positive findings as a result of these inappropriate scans. However, increasing the threshold to >pT3b would have resulted in missed distant disease in 4 patients.

Conclusion: Without SLNB, the proposed change in guidance is unlikely to reduce demand for PET CT. Despite known limitations, clinicians are using this modality for patients with <pT2b disease. This is reflected in a 15% increase in scans during the study period, compared to a 6% increase in melanoma incidence.

22. Erysipelas-like inflammation following breast reduction surgery: Case series and literature review

Dr J McManus, Dr C Fox, Dr P Belt (Brisbane, Australia)

Background: Superomedial pedicle reduction is a frequently used technique in breast surgery with complication rates reported at around 10%. Wound infection is relatively uncommon and usually occurs early in the post-operative period. Late complications are similarly uncommon and are usually a result of perceived or real aesthetic problems. Rarely reported in the elective breast surgery literature are late complications relating to disruption of local breast lymphatics, an inevitable consequence of any breast surgery.

Methods: We reviewed one surgeon's five-year experience with superomedial pedicle breast reduction. We conducted a literature review to establish similar cases previously reported.

Results: We report a series of patients who developed erysipelas-like inflammation up to four months following Wise-pattern superomedial breast reduction. No organisms were isolated in any case and patients responded slowly to parenteral antibiotic therapy.

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Conclusions: We propose that this phenomenon is secondary to the specific pattern of lymphatic disruption that occurs in superomedial pedicle breast reduction. Lymphatic stasis results in an erysipelas-like inflammation that is poorly responsive to antimicrobial therapy. We suggest alternate pathophysiologic mechanisms for this clinical presentation. Further research is required to definitively determine the pathologic basis of this phenomenon.

23. The importance of appearance and function in patient satisfaction after silicone metacarpophalangeal joint arthroplasty in rheumatoid arthritis

Dr T Mehta, Mr P Russell (Nottingham)

Current evidence suggests that loss of hand function is the main motivator for a patient to undergo surgical intervention of the rheumatoid hand, whist the main determiner of patient satisfaction post-operatively is an improvement in hand appearance. The aim of this study is to help understand the true nature of this source of satisfaction, through elucidating the relationship between two factors causing increased satisfaction after surgery - improved perceived function and improved perceived appearance.

We hypothesise that an improvement in perceived appearance is not associated with perceived function, lending to the theory that an improved appearance alone causes improvement in multiple hand outcomes.

Data from an ongoing prospective cohort study was collected at the Pulvertaft Hand Centre, Derby. Fifty-four patients were recruited. Perceived hand appearance was measured using the Michigan Hand Questionnaire. Perceived hand function was measured using the Arthritis Impact Measurement Scales. Data at recruitment baseline and at 1 year were analysed using Spearman's Rank correlations and effect sizes, using non-surgical patients (n=26) as a control group.

The correlation between perceived appearance and perceived function was not significant at twelve months (rs= 0.02). Surgical patients experienced a 7.8% improvement in perceived function and a 29% improvement in perceived appearance one year post-operatively. Effect sizes demonstrated a small decline in perceived function post-surgery, compared to the control (effect size -0.20). Perceived appearance was moderately improved after surgery (effect size 0.29).

This research supports existing evidence that loss of function is a bigger motivator prior to surgery, whilst appearance is more important to satisfaction post-operatively. We conclude that the satisfaction gained from improved aesthetics of the rheumatoid hand is not associated with a subjective improvement in function. More importance should be placed upon appearance when informing rheumatoid arthritis patients of what to expect from silicone metacarpophalangeal joint arthroplasty.

(This project was completed as part of The Healing Foundation's student elective award - the author is now a junior doctor based in Nottingham)

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24. Structural change within a plastic surgery unit: a review of outcome
Mr A Mohan, Mrs A Thirumalai, Mr D Chester (Birmingham)

Background: Following complaints from junior trainees and nursing staff, the Queen Elizabeth Hospital Birmingham plastic surgery department underwent a structural overhaul with the aim of increasing training opportunities for SHOs and improving healthcare delivery to patients.

The Change: The unit was divided into teams each with dedicated SHOs allowing more trainees to undertake shorter ward rounds. This allowed trainees increased time in theatre and clinic.

Methods: Weekly rotas for 12 weeks prior to change were compared with those 12 weeks after. The number of clinic, theatre, ward cover and on-call sessions that SHOs were allocated to was calculated. Satisfaction was assessed using questionnaires for nurses, SHOs and consultants. Trainee logbooks were analysed to assess whether trainees gained more operative experience.

Results: Following the change, trainees were assigned to 58.5% more theatre sessions and 127% more clinic sessions. Those responsible for ward cover were able to attend theatre/clinic sessions, as workload was shared. Logbook analysis demonstrated that trainees performed 33.6% more, and assisted with 44.7% more operations. Satisfaction amongst trainees and consultants increased. Nursing satisfaction increased since patients were seen and managed earlier in the day.

Conclusion: Constructive feedback can be used to improve working conditions and training opportunities for trainee surgeons while improving healthcare for patients.

25. Trapeziumectomy with capsular suspension: a new technique with results
Dr A Mohindra, Miss R Khundkar, Miss C McGuiness (Salisbury)

Introduction: Trapeziumectomy is an effective treatment for relieving pain and improving function in first carpo-metacarpal joint osteoarthritis. However due to the long post-operative rehabilitation period and thumb weakness associated with trapezieumectomy alone, variations of the technique have been described. The senior author employs a technique utilising the dorsal capsule to suspend the first metacarpal after the trapizieumectomy. We describe our technique and discuss results.

Method: A retrospective study, reviewing surgical and physiotherapy notes, was performed of all trapeziumectomies (multiple surgeons) undertaken with this method (August 2011-August 2012) at Salisbury District Hospital. Outcomes assessed included pain, range of movement and time to discharge.

Results: 18 patients underwent trapeziumectomy with capsular suspension. All of these patients had significant reduction in pain, with five describing no pain at 6 weeks. Eleven patients had full range of movement at this point. Full scores were achieved for pinch grip in 6 of the 7 patients who underwent

formal assessment at 6 to 8 weeks. Patients were discharged between 8 and 12 weeks.

Conclusion: We found that capsular suspension allowed a shorter rehabilitation period compared to other techniques. To assess this formally, we have set up a prospective case-control study (January 2013–December 2013) comparing trapeziumectomy with or without capsular suspension.

26. Tetanus prophylaxis for soft tissue wounds: are we delivering best practice?
Mr D Nikkhah, Mr J Rodrigues, Ms L Roberts (Sussex)

Introduction: Tetanus is a rare but potentially fatal infection caused by clostridum tetani. Patients presenting with soft tissue injuries are at risk, especially if wounds are contaminated.

We audited tetanus risk assessment and management for soft tissue injuries presenting to a typical district general hospital in the UK.

Methods: A retrospective audit was undertaken of notes coded for 'soft tissue trauma, burns, or lower and upper limb injuries' following a treatment episode in Tunbridge Wells A&E between February and March 2012. Thirty patients met the inclusion criteria. Gold standards for tetanus prophylaxis were taken from evidence-based guidance published recently in JPRAS, and from the Department of Health.

Results: Only 50% of patients were managed appropriately according to Department of Health guidelines. 16.67 % were managed inappropriately. In the remaining 33.3%, adequacy of treatment was not determinable due to inadequate documentation. Overuse of vaccination (e.g. Revaxis©) and the underuse of HTIG was noted.

Conclusions: Our audit highlights inconsistencies in the management of tetanus prophylaxis in a typical DGH. We propose the incorporation of tetanus risk assessment and a treatment flowchart into the existing A&E care plan. We advocate increased vigilance for tetanus risk amongst plastic surgery departments receiving referrals from A&E departments.

27. Composite grafts for alar reconstruction in the burnt face: some useful tips to optimise outcomes
Mr D Nikkhah, Mr P Gilbert (Sussex)

Introduction: Surgeons have used a number of techniques over the years to correct alar subunit loss. With the use of illustrations we describe a challenging case whereby we employed steps to optimise composite graft take in a patient who had suffered from partial thickness facial burns.

Operative Technique: The patient had lost both alar rims with the right alar region having a larger defect than the left. Both her ear donor sites had also suffered from burns. As the defect over the right alar rim was greater than 2cm^2 the most important intra-operative step was to provide a large recipient bed for

the graft to take. This is achieved using a large turn down flap. Harvest of the graft involves taking a wedge of helix that incorporates skin, subcutaneous tissue and cartilage. The defect can be closed primarily without leaving any donor site morbidity.

Discussion: This case highlights that composite grafts can be a very robust method of reconstruction even in the subset of patients with extensively scarred recipient and donor sites. Composite grafting avoids two-step procedures such as the forehead flap and can be considered as a first line procedure in alar subunit loss.

28. From guidelines to standards of care: increasing workload, but diminishing patient burden in open tibial fractures

Mr S Rahman, Mr R Trickett, Professor I Pallister (Morriston)

Background: Coordinated ortho-plastic surgery is the standard of care for open tibial fractures, aiming to minimise complications and unplanned revision surgery.

Aim: To establish whether the BAPRAS/BOA standards of care have altered referral pattern, workload and patients' surgical burden.

Method: Two cohorts were reviewed: Guidelines (pre-2009) and Standards (2009-2011). Comparison was made between patients directly admitted (DAP) and transferred (TP) for the first 30 days post injury.

Results:

- The admission rate increased from 2.7 per month (Guidelines) to 4.0 per month (Standards).
- The percentage of TP rose from 30% to 77%.
- In both time periods, TP required significantly more operative procedures than DAP.
- With early coordinated care, the DAP group have undergone less mean operations (2.9 to 1.7).
- Those referred outside the terms of guidelines or standards, limb salvage (LS) have the highest amputation rate.

Conclusions: Implementation of the standards has significantly increased the workload and the efficiency of care for open tibial fractures in our ortho-plastic unit. Long-term follow up is needed to determine if efficiency equals efficacy. A small group of mainly elderly patients (LS) highlight the importance of early referral, as even seemingly 'simple' cases can prove to be catastrophic.

29. Use of split palmar and plantar skin grafts in hand surgery: a single surgeon's experience

Mr K Gulraiz Rauf (Leicester)

Background: The skin over the palmar and plantar surfaces of hands and feet is unique, being thick and glaborous. The principle of replacing "like with like" is often ignored when reconstructing defects of the palms, resulting in sub-

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optimal functional and aesthetic outcomes. The author has been using split palmar and plantar skin grafts for reconstruction of palmar defects since 1995. The paper is presented to encourage their use instead of the commonly used full thickness skin graft from non-glaborous skin.

Methods: Patients operated upon at Leicester Royal Infirmary who underwent split skin grafting of palmar defects following burns, non-thermal trauma and resection of skin malignancy years will be presented, detailing the method and outcome.

Results: Satisfactory graft take was observed in all cases. However some patients required further grafting and z-plasties of graft edges.

Conclusion: Palmar and plantar split skin grafts display superior results as compared to the non-glaborous skin. There are, however, differences in the method and post-operative management of glaborous skin as compared to the non-glaborous skin which will be highlighted in the paper.

30. The use of a full thickness skin graft in the treatment of otophyma

Miss K Sharma, Mr J Pollock, Mr S Hasham, Mr T Brotherston (Sheffield)

Introduction: Bilateral otophyma is a rare condition that can present as the end stage of any chronic inflammatory disease affecting the ear such as rosacea, eczema or otitis externa. We present a case of bilateral otophyma related to chronic otitis externa that had failed medical management, and was successfully treated by excision of the affected area and full thickness grafting.

Case Report: A 41-year-old lady presented with a 23-year history of progressive bilateral ear swelling, discharge and progressive reduction in hearing. She had been treated conservatively by the dermatologists with topical and oral antibiotics, steroid creams and regular ear toileting however her progressive conductive deafness and social embarrassment warranted further intervention. Examination revealed bilateral diffuse enlargement of both conchal fossae associated with patulous follicular ostia (peau d' orange). The external auditory meatus was occluded. Intra-operatively, the plane between the skin and the cartilage was disrupted due to the coarse fibrous tissue resulting from the chronic lymphoedema. A full thickness skin graft from the supraclavicular fossa was used to resurface the resulting defect.

Result: The graft took successfully and the ear was fully healed within 3 weeks. The patient noticed significant benefit to her hearing with the improvement in external auditory canal opening.

31. Lymph node metastasis from soft tissue sarcomas: a rare and heterogenous group

Dr R Silk, Mr K Rao, Miss A Raurell, Mr R Ashford (Nottingham)

Background: Soft tissue sarcomas rarely give rise to lymph node metastasis. As a result there is little data on prognostic implications of lymph node metastasis.

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Methods: A case series of thirteen patients were identified with lymph node metastasis from soft tissue sarcoma. Data was collected retrospectively, including details of demographics, site of primary and metastasis, histopathology, time interval to metastasis and outcome.

Results: With the exception of one patient who had synchronous metastasis, the mean time to development of the metastases was 35.9 months. Groin was the site of metastasis in 9 patients, axilla in 3 and neck in 1 patient. Ten out of 13 metastases occurred from a primary within the lymph node basin while 2 were distant metastases, and 1 from an unknown primary. Six of the patients died, of which 3 deaths were from unrelated causes. Mean follow up period in the surviving patients was 59 months.

Conclusions: Although rare, lymph node metastases from soft tissue sarcoma represent a heterogenous group of patients. More than 50% of the patients in our group had a mean survival of 59 months, however, a small sub-group had a median survival of only 5 months from diagnosis of lymph node metastasis.

32. Complication rates following sentinel lymph node biopsy for melanoma

Mr J Smith, Mr A Wilson (Exeter)

Introduction and Aims: Sentinel lymph node biopsy (SLNB) is indicated for those patients with a clinically negative nodal basin and a primary melanoma with a Breslow thickness of >1mm. Complication rates in the literature are between 4-12%. The aim of this study was to ascertain the risk of complications in a regional unit.

Method: A prospective study of all patients undergoing SLNB following biopsy proven melanoma was performed during a six-month period. Complications were recorded from their outpatient follow up.

Results: One hundred and five patients were operated on during the study period. Twenty-one patients were positive for melanoma (20%), and 2 positive for haematomological malignancy (1.9%). Six patients had complications (5.7%) including 2 seromas, 1 haematoma, 1 neuropraxia, and 1 scar contracture. One patient returned to theatre for evacuation of haematoma. All patients positive for melanoma underwent completion lymph node dissection.

Conclusions: Complication rates are low for sentinel lymph node biopsy in keeping with the literature. Incidental haematomological malignancy was found in two patients. Results can be used to inform the consent process.

33. The use of long pulsed Nd:YAG laser in the treatment of paediatric venous malformation

Mr S Sofos, Mr S Liew (Prescot)

Introduction: We aim to investigate the use of the long pulsed Nd:YAG laser in treating symptomatic venous malformations in mucosa versus upper and lower limb lesions.

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Materials and Methods: A prospective clinical trial was carried out on 59 consecutive patients. Treatment criteria include large facial deformity, painful or bleeding lesions. 1-3 treatments were given at 6-8 weekly intervals. Results were evaluated both subjectively and objectively.

Results: A total of 59 patients were treated. Subjective and objective assessment of efficacy correlated well, and all patients achieved good to excellent results in pain and bleeding control, and in reducing size of lesions in lip and oral mucosa. It is, however, not effective in reducing the size of large, relatively high flow lesions in the limbs. Complications were also documented.

Conclusions: Complex venous malformation cannot be cured, but can be symptomatically controlled with the long pulsed Nd:YAG laser. The treatment satisfaction is high, and there is a small but definite risk of scarring from treatment.

34. Seroma formation after axillary or inguinal lymphadenectomy is not determined by volume of drainage in the preceding 24 hours: analysis of data from a randomised controlled trial

Mr D Thomson, Mr M Swan, Mr D Furniss, Mr H Giele (Oxford)

Introduction: Despite numerous RCTs there are no evidence-based guidelines to inform timing of drain removal following axillary or inguinal lymphadenectomy. This study aims to show that commonly used fixed-volume rules are inadequate to guide the timing of drain removal.

Methods: Data were analysed from 72 patients who underwent axillary or inguinal lymphadenectomy as part of a randomised controlled trial that showed no effect of Tisseel™ fibrin sealant. We compared drainage duration between patients who developed seroma and those who did not.

Results: There is no significant difference in drainage duration between patients who developed seroma and those who did not following axillary dissection (7 days versus 9.38 days, p=0.20) or inguinal dissection (9.67 versus 9.76 days, p=0.97) (student's t-test). There is no correlation between drainage duration and the number of seroma aspirations (R= -0.10, p=0.60, n=29) or volume aspirated (R=0, p=0.97, n=25). A strong positive correlation exists between duration of drainage and total fluid volume drained (R=0.55, p<0.01, n=74) (Pearson's product moment correlation).

Conclusion: Seroma formation is largely independent of the amount of fluid drained in the previous 24 hours and thus a fixed-volume rule of <30ml drained in 24 hours should not be used to guide drain removal.

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35. Wound drainage after axillary dissection: a meta-analysis (Cochrane review) of randomised controlled trials

Mr D Thomson, Mr H Sadideen, Mr D Furniss (Oxford)

Background: The role of drain insertion post-axillary dissection for breast carcinoma remains disputed despite three decades of reported RCTs. We conducted a Cochrane review to address this question.

Methods: An electronic search of Medline, Embase, Cochrane Library of Systematic Reviews and the WHO ITCRP Index was performed. Of 185 papers comparing undrained versus drained patients, seven RCTs including 960 patients were independently identified, having met Cochrane inclusion criteria, and data extracted by two independent researchers.

Results: Dichotomous variables were fitted to an age-adjusted generalised linear regression model. The odds ratio (OR) of seroma formation in undrained versus drained patients was 1.71 (p=0.0004). The OR of seroma formation per year older was 1.40 (p=0.02). There were no significant differences for infection rates or lymphoedema. Continuous variables were fitted to an age-adjusted linear model. Length of hospital stay increased by 1.6 days (p=0.0008) in drained patients. Total volume aspirated was not significantly different.

Conclusion: Patients without axillary drains are more likely to develop seroma but have shorter hospital stays. Advancing age independently increases seroma risk. This information may have important clinical implications for melanoma patients undergoing axillary dissection, for whom specific drain versus no drain RCTs do not exist.

36. Assessing the corrective effects of facial bipartition distraction in Apert syndrome using morphometrics

Miss M Verdoorn, Miss G Crombag, Mr D Nikkhah, Mr A Ponniah, Mr C Ruff, Mr D Dunaway (Rotterdam/London)

Background: Apert syndrome is a congenital disorder characterised by craniosynostosis and mid-face hypoplasia. This study looks to identify to what extent bipartition distraction corrects the morphological abnormalities of this condition.

Methods: Pre and post-operative three dimensional computed tomography (3DCT) scans of 10 patients with Apert Syndrome, (aged 12-21 years) were identified from the Great Ormond Street Hospital database. 98 landmarks were used to analyse pre and post-operative scans and 13 normal skulls.

Results: Principal component analysis (PCA) was used to analyse patterns in the datasets. Within each group, eigenvectors were identified that demonstrated the aspects of the skull where the most variation was found. Post-operative and normal scans both showed the same first three principal components. Warping from pre- to post-operative illustrates midface advancement and inward rotation of the orbits. Post-operative to normal warps demonstrate some remaining differences.

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Conclusion: This study allows us to understand the way bipartition distraction corrects the abnormalities of the Apert skull. Analysing the surgical outcome of facial bipartition with geometric morphometrics shows that some major Apert characteristics are corrected.

Further studies are necessary to determine how surgical procedures should be adapted in order to achieve a post-operative result closer to the normal population.

37. Lower limb sparing surgery for soft tissue sarcomas requiring vascular reconstruction

Mr J Wiper, Professor J Scott, Mr I Smith (Leeds)

Background: Extensive lower limb sarcomas invading one or multiple compartments can often involve the major vessels. Adequate resection of these large tumours frequently requires sacrifice of a segment of the femoral vessels which is encased by the tumour. In carefully selected cases limb sparing surgical resection is our preference with autologous vascular reconstruction and adjuvant radiotherapy.

Methods: These cases are managed in a multidisciplinary team setting within the Leeds Sarcoma Unit often in conjunction with vascular surgery. Imaging is performed pre-operatively and the segmental vascular defect is defined. Resection with appropriate margins and autologous vascular reconstruction of the femoral vessels is undertaken.

Results and Conclusion: We present a series of cases to illustrate the potential management of these challenging patients who have undergone en-bloc resection and subsequent lower limb vascular reconstruction using autologous vascular grafts. We believe that limb sparing surgery with vascular reconstruction provides an adequate functional lower limb and is less of a psychological burden to the patient when compared to a proximal lower limb amputation.

38. Reconstruction following acrectomy for sacral chordoma: the Princess Alexandra Experience

Mr J Wiper, Dr D Ratcliffe, Dr M Wagels, Dr S Sommerville, Dr D Theile (Brisbane, Australia)

Background: We present a series of 14 sacral reconstructions following surgical resection of sacral chordomas within the unit. Sacral chordomas are malignant tumours of the spine for which local recurrence and long term survival is linked with negative resection margins. Reconstruction of the sacral defect is challenging with common complications, especially wound dehiscence in the early stage and peri-sacral rectal herniation in the long term.

Method: The sacral chordoma is removed en-bloc combining a multi-specialty approach. Once the defect has been defined the reconstruction is the final part of this complex multidisciplinary procedure. Our technique is to raise bilateral (muscle only) gluteus maximus flaps. Employing advancement and rotation techniques, the gluteus maximus muscles are sutured in the midline

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tension free. If possible a column of paraspinal muscle fascia is sutured over the repair. Multiple large bore suction drains are placed. This reconstruction is completely autologous with no alloplastic meshes or dermal matrix used. Post-operative care is based around the principles of prolonged drainage and maintaining a strict no pressure regime on the repair site.

Results and Conclusion: Within our series (*n*=14) we have had no reported cases of rectal herniation. We continue to follow up these patients on a regular basis. This technique provides successful soft tissue reconstruction without using non-autologous material or sacrificing a rectus abdominus muscle in which other studies have described. We compare out results to the published literature.

39. Investigation of the cartilage-like characteristics of keloid scars

Miss E Woods, Mr M Soldin, Dr T Shaw (London)

Introduction: The fibrotic response to skin wounding can proceed out of control in a subset of the population, resulting in disfiguring and painful keloid scars. Based on the histological features of keloids, as well as gene expression studies, we hypothesised that inappropriate differentiation of dermal fibroblasts towards a chondrocytic phenotype underlies keloidogenesis.

Aims and Methods: The study aims were: 1) to histologically analyse keloid scars (versus normal skin) for characteristics associated with cartilage (elevated collagen density and glycosaminoglycan content) and 2) use quantitative RT-PCR to compare transcript abundance for c-Myc and Klf4 (reprogramming and proliferation factors), as well as Sox9 (cartilage-associated transcription factor).

Results: Semi-quantitative scoring of the histology results revealed greater collagen density in the keloid samples. Moreover, 3 of 11 keloid scars showed significant glycosaminoglycan content. Quantitative RT-PCR showed striking elevation of Sox9 expression in the three keloids histologically most similar to cartilage. Conversely, there was significantly less c-Myc expression in the keloids relative to normal skin, and Klf4 was unaltered.

Conclusions: The findings suggest that in mature keloid scars, such as those used in this study, markers of differentiation including Sox9 may be elevated, whereas reprogramming factors (eg c-Myc and Klf4) have normal or repressed levels.

40. 'Square Centimetre grid' and table: simple tips to facilitate transfer of CTA DIEP flap perforator mapping on to patient pre-operatively

Mr O Koshy, Mr A Mishra, Dr S Desmond, Mr K Graham (Liverpool)

Studying DIEP with CTA is useful in the surgical planning of breast reconstruction. In collaboration with our radiology department we have developed a graphic and systematic form of mapping the DIEP flap perforators from CTA or MRA imaging and then transferring this data on to our patient pre-operatively.

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We describe methods by which the information obtained could be transferred on to the patient pre-operatively for performing flap harvest more efficiently. We have used this technique to for over 200 patients.

Most of the patients have CT Angiogram imaging prior to surgery and location of the perforators as they emerge through the anterior rectus fascia. This is marked onto a square centimetre graph paper which is centred on the umbilicus. Our radiologist also determines the size of the perforators as well as the intramuscular course to enable us to choose the best perforator. These are incorporated with the CTA images on the GE PACS system and available on the hospital intranet for viewing or printing. The square centimetre grid is printed and the site of perforators is punched with a pencil or ball-pen. With the paper centred on the umbilicus, a permanent marker is used to transfer the location of perforators to patient's lower abdomen. This technique has significantly decreased our operative time.

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MEETING INFORMATION

VENUE INFORMATION

The East Midlands Conference Centre is located on the Nottingham University Park Campus. Nottingham, NG7 2RD
+44 (0) 115 951 5151

REGISTRATION FEES

Those registering at the meeting will be charged the following rates:

	One Day	Three Days	Friday PM Only
BAPRAS Members (Full, Overseas, Interspecialty)	220	560	110
BAPRAS Members (Trainee, Junior, Associate, Affiliate)	60	155	30
Trainees (Non BAPRAS members)	220	560	110
Consultants (Non BAPRAS members)	315	810	157.50
BAPRAS Members (Honorary and Senior)	35	105	
Researchers or scientists (No access to study leave)	35	105	

EGM

The Extraordinary General Meeting will take place at 17:30 on Wednesday 19th June. The meeting is open to BAPRAS members in all categories

LUNCHTIME MEETINGS

Thursday 20 June – Conference Suite 3

sKINship™ is a research program and professional network founded by Rhian Solomon that promotes cross disciplinary collaborations between visual arts and science based practitioners. The forum provides a space in which to exchange ideas – exploring the processes of 'Making' as a universal visual language, to communicate and share subject specific knowledge.

sKINship's current research program looks to promote experimental collaborations between the specialisms of plastic surgery and pattern cutting for fashion. By exploring points of commonality and contrast between these subjects a unique dialogue is being developed. Key members of the sKINship team are Mrs Sarah Pape – Project Consultant, Juliana Sissons – Project Consultant, The British Association of Plastic, Reconstructive and Aesthetic Surgeons – Project Funders and Henry Poole, Tailors of Savile Row – Project Collaborators. sKINship aims to:

- Inform the planning of plastic surgery procedures through adapting and applying pattern cutting techniques.
- Inform the design of dress patterns and garments through the application of surgical technique.
- Engage wider audiences with the disciplines of plastic surgery and pattern cutting for fashion.

You are invited to join Rhian Solomon, Juliana Sissons and Sarah Pape at a lunchtime meeting to find out more.

Rhian Solomon, sKINship founder

Rhian Solomon is a practicing artist and founder of the sKINship research project, which nurtures experimental collaborations between medical and textile professionals. Currently her research interests focus on knowledge transfer between the professions of pattern cutting for fashion and plastic surgery and her visual arts practice is concerned with drawing parallels between skin and cloth, the body and dress. Rhian runs lectures on her practice for a number of professional and educational organisations including The Institute of Materials, The University of Brighton and The Royal College of Art.

Juliana Sissons, sKINship project consultant

Juliana tutors in pattern cutting and 'design through 3D form' at the University of Brighton, and as a visiting lecturer, she delivers a series of master classes to a number of colleges and universities, internationally. Her own fashion/

knitwear label focuses on the development of sculptural approaches to shape and pattern making and as a 'Designer in Residence' at the Victoria and Albert Museum, her recent collection was shown in the galleries earlier this year for the 'London Design Festival'. In addition to her practice, Juliana is a consultant to the sKINship project.

Sarah Pape, sKINship project consultant

Sarah Pape is a consultant plastic surgeon, working in Newcastle upon Tyne. Following general surgery training in Leeds, she began her plastic surgery career in Bradford. This was followed by posts in Stoke on Trent, University College Hospital London, Liverpool and Newcastle upon Tyne. Sarah was awarded the specialist fellowship at The Royal College of Surgeons of Edinburgh in 1994. Her specialist interests are burns and laser surgery. In addition to her clinical work, Sarah is a maker working with the processes of knit, stitch, spinning and crochet, amongst other creative interests. She is also consultant to the sKINship project.

ART EXHIBITION

Art and Plastic Surgery

Conscious of the connection between art and plastic surgery, we have invited plastic surgery colleagues to show off their non-surgical art work at the Summer Meeting. Throughout the conference, the exhibition will be available to view in Conference Suite 2.

SOCIAL PROGRAMME

Wednesday 19 June: Drinks reception and BBQ

Join us at the close of the first day of the conference for a BBQ and drinks reception in the grounds of the East Midlands Conference Centre (weather permitting!). One ticket for the BBQ is included in your registration fee and additional tickets are available at £30 per head.

Thursday 20 June: Golf

The BAPRAS annual golf tournament will this year be taking place at Norwood Park Golf Centre. Tee off times have been organised from 13:00.

The course is 45 minutes outside the centre of Nottingham. A mini bus will be organised to take golfers to the course, departing at 12:00 and will return players to the conference centre after their game.

Golf should have been booked through the online booking system and it will not be possible to book this at the conference.

Thursday 20 June: Association Dinner

The Association Dinner is being held in the Senate Chamber, part of the University of Nottingham's Trent Building. Join us for pre-dinner drinks from 19.15, and dinner at 20:00.

- Tickets: £60. Tickets should have been booked through the online registration system, however, a limited number may still be available. Visit the registration desk for more information
- Dress code: Lounge suit

MEETINGS IN 2013 AND 2014

- Winter 2013: The Convention Centre, Dublin, Ireland, 27–29 November. In partnership with the Irish Association of Plastic Surgeons
- ESPRAS 2014: The Association will be hosting the 2014 ESPRAS meeting in place of our usual summer scientific meeting. Edinburgh International Conference Centre, Edinburgh, Scotland, 6–11 July 2014

CME

Day 1: 6 points; Day 2: 6 points; Day 3: 6.5 points
Total: 18.5

EXHIBITORS

CareFusion UK **Stand 4**

The Crescent, Jays Close, Basingstoke, RG22 4BS
Contact: Emma Dalton, email: uk-customer-service@carefusion.com, phone: 0800 917 8776
www.carefusion.co.uk

CareFusion is a global corporation serving the healthcare industry with products and services that help hospitals measurably improve patient care. Focused on reducing medication errors and hospital-acquired infections, CareFusion's family of products includes ChloraPrep® patient preoperative skin preparation.

ChloraPrep reduces microorganisms on patients' skin prior to medical and surgical procedures. This one-step antiseptic system lowers the risk of dangerous bloodstream and surgical site infections. The efficacy and safety of ChloraPrep are supported by more than 35 clinical studies and recommendations by 17 internationally recognized organisations or guidelines, including 10 that specifically recommend 2% chlorhexidine gluconate – a key ingredient in ChloraPrep.

Cynosure UK Ltd **Stand 20**

The Old Barn Offices, Lower Mount Farm, Long Lane, Cookham, Berkshire, SL6 9EE
Contact: Ben Savigar-Jones, email: bsjones@cynosure.com, phone: 07795 412 281
www.cynosureuk.com

Cynosure UK Ltd was established in 1999 as a direct UK subsidiary of Cynosure Inc, Westford, MA, USA. Our lasers are market leading products which offer our customers the pioneering technology for applications such as hair removal in all skin types, tattoo removal, treatment of epidermal and dermal pigmented lesions and vascular malformations. The Cynosure product range also includes the more invasive treatments such as laser lipolysis, hyperhidrosis, surgical and non-surgical cellulite clearance and fractional rejuvenation.

As well as offering a product range that is second to none, we also realize the importance of offering our customers excellent after-sales service and support. We are proud to back our outstanding reputation for this, which has been proven throughout our large installed base.
For more information please visit www.cynosureuk.com or call 01628 522252.

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e-LPRAS **Stand 11**

e-Learning for Plastic, Reconstructive and Aesthetic Surgery
Contact: elpras.project@googlemail.com

The British Association of Plastic, Reconstructive and Aesthetic Surgeons is working in partnership with e-Learning for Healthcare to develop an e-learning resource to support good clinical practice.
e-LPRAS will support the training programme for plastic, reconstructive and aesthetic surgery and is aimed at plastic surgery trainees from specialty training year 3 (ST3) onwards.

The e-learning will also appeal to consultants and non-consultant career grades who want to increase and update their knowledge base.

Euromedical Systems Ltd **Stand 9**

Connaught House, Moorbridge Road, Bingham, Notts, NG13 8GG
Contact: Phillip Richardson, email: phil@euromedicalsystems.co.uk, phone: 01949 838 111
www.euromedicalsystems.co.uk

Euromedical Systems Ltd is one of the largest distributors of medical devices for cosmetic surgery, plastic surgery and medical aesthetics in the UK.

EXHIBITORS

We are proud to distribute the Eurosilicone range of breast implants and tissue expanders. Eurosilicone's new Integrated Valve Tissue Expander is ideal for breast reconstruction procedures following mastectomy as it allows for variable projections. It provides high elasticity and integrity and has similar dimensions and heights (low, moderate and full) as The Matrix range of anatomical implants.

The Lipoelastic® range of compression garments are designed for post-operative treatment following plastic or cosmetic procedures and the design and quality of Lipoelastic® products is first class.

Eurosurgical Ltd **Stand 16**

Merrow Business Park, Guildford, Surrey, GU4 7WA
Contact: Peter Cranstone, email: peterprs@eurosurgical.co.uk, phone: 01483 456 007
www.eurosurgical.co.uk

Eurosurgical Ltd are looking forward to welcoming all plastic surgeons to our stand. We shall be featuring our wide range of products and services that encompass all areas of plastic, burns and reconstructive surgery. The Silimed range of breast implants include the Pure –Polyurethane BioDesign range. With the lowest reported complication rates for any breast implant and particularly low incidents of Capsular Contracture. Available in 5 styles, including the Conical shape, (ideal for sliding breast shape) they are a must for all surgeons. Insorb, a subcuticular, absorbable staple, that fires the small 3/0 staples horizontally into the dermis, not through the skin, for fast and effective wound closure, and no spitting!! Aquavage and Lipivage for fat harvest, wash and transfer that eliminates the need for centrifuge, are closed and sterile systems, are disposable and cost effective. Snowden Pencer instruments, Design Veronique post-operative support garments.

Human Med UK Ltd **Stand 18**

19 Birchwood Road, Wilmington, Kent, DA2 7HF
Contact: Colin Pyne, email: colin@humanmeduk.com, phone: 01332 611 729

As well as the Bodyjet, Human Med UK Ltd are introducing the Bodyjet Evo. Along with the normal features of the Bodyjet, the Evo allows for further precision in regulating the pressure of the water assisted liposuction. This is particularly useful in cases of gynecomastia where sclerotic tissue is an issue. Quality of fat collected for transfer is also enhanced with the Evo thus eliminating the need for centrifuge.

Our technical team will be on hand to answer any questions you may have.

Ideal Medical Systems **Stand 7**

SBC House, Westmor Way, Wallington, Surrey, SM7 2DZ
Contact: Andrew Wakeling, email: andrew.wakeling@ideal-ms.com, phone: 0208 773 7844
www.ideal-ms.com

IHT **Stand 15**

1 The Mill, Copley Hull Business Park, Cambridge Road, CB22 3GN
Contact: Troels Jordansen, email: troels@iht-ltd.com, phone: 07917 130 019
www.iht-ltd.com

Photo Dynamic Eye (PDE) is by now a 10+ year old medical device that when used with ICG (indocyanine green) can visualise the lymph nodes and ducts. The technology has been pioneered in Japan and Spain for lymphoedema patents and is already in use in UK hospitals. Please visit www.IHT-Ltd.com/pde-photodynamic-eye for videos

EXHIBITORS

Integra NeuroSciences **Stand 1**

Newbury Road, Andover, SP10 4DR
Contact: Leanne Gray, email: leanne.gray@integralife.com, phone: 01264 345 739
www.integralife.eu

Integra LifeSciences, a world leader in medical devices, is dedicated to limiting uncertainty for surgeons, so they can concentrate on providing the best patient care. Integra offers innovative solutions in orthopedics, neurosurgery, spine, reconstructive and general surgery.

Intrapharm Labs **Stand 12**

The Granary, The Courtyard Barns, Choke Lane, Cookham Dean, Maidenhead, Berkshire, DA2 7HF
Contact: Sunil Shaunak, email: sunils@intrapharmlabs.com, phone: 01628 481 075

Intrapharm Laboratories are pleased to announce the availability of Terra-Cortril Ointment.
Terra-Cortril is a combination of two active components - oxytetracycline hydrochloride and hydrocortisone and is being reintroduced to the UK market due to popular request from healthcare professionals. Please do visit our stand.

Malosa Medical **Stand 10**

Ashday Works Business Park, Elland Road, Elland, HX5 9UB
Contact: Emma Cade, email: emma@malosa.com, phone: 0870 3000 555
www.malosa.com

Malosa Medical, specialist manufacturer of high quality Single-Use surgical instruments and procedure packs. State of the art manufacturing facilities and automated systems provide capability to produce low volume solutions with "Just in Time" deliveries. Malosa specialises in producing new/revised instruments to your own design and will assemble them into procedure packs with consumable items, to provide complete bespoke solutions

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The Medical Defence Union **Stand 5**

230 Blackfriars Road, London, SE1 8PJ
Contact: Nina Vaseer, email: nina.vaseer@themdu.com, phone: 07740 833 159
www.themdu.com

The MDU is a not-for-profit organisation wholly dedicated to our members' interests, providing expert guidance, personal support and robust defence in addressing medico-legal issues, complaints and claims. We provide high quality, specialised medico-legal advice, 24 hours a day, 7 days a week.

Our team is led and staffed by doctors with real-life experience of the pressures and challenges faced in practice. We would be delighted to meet you at our stand and answer any questions you may have about MDU membership.

Medira Ltd **Stand 13**

1 Monoux Place, Sandy, SG19 1JN
Contact: Roseanne Aitken, email: raitken@medira.co.uk, phone: 07810 358 815
www.medira.co.uk

Medira Ltd is pleased to announce that after rigorous assessment, their Type I Piscean collagen products were placed in the NHS Innovation catalogue. Aligned with the NHS Innovation and Wealth programme, the catalogue is an encouragement to explore the potential of these innovations to improve cost efficiencies and patient outcome. Visit our stand to receive a copy of the catalogue. For scar revision, we will also hand you further evidence for the unique PriMatrix fetal bovine dermis. Medira specialises in collagen biomaterials that are novel, highly effective and contribute to improved patient outcomes and reduced costs.

EXHIBITORS

Mentor **Stand 21**

Pinewood Campus, Nine Mile Ride, Wokingham, Berkshire, RG40 3EW
Contact: Elin Gillard, email: egillard@its.knk.com, phone: 07867 525 869
www.mentormedical.co.uk

At Mentor it is our aim to be the trusted leader in aesthetics among consumers & professionals to maintain, enhance and restore self-esteem & quality of life. Mentor is a member of the Johnson & Johnson family of medical companies

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Mercian Surgical Supply Co Ltd **Stand 3**

10 Topaz Business Park, Topaz Way, Bromsgrove, B61 0GD
Contact: John Duffy, email: johnduffy@merciansurgical.com, phone: 0844 879 1133
www.merciansurgical.com

Mercian has been established for over 45 years with a reputation for high quality plastic surgery instrumentation with a particular interest in the microsurgery field. The S&T microsurgery instruments which are supplied by Mercian are know the world over as leaders in the field of microsurgery instruments and micro-sutures. We will be showing at the forthcoming BAPRAS meeting;

- The original Acland Micro Vessel Clamps
- Our new Super-Fine microsurgery instrument set
- Hand Surgery Instruments
- Micro-sutures
- A complete range of S&T microsurgery instrumentation

Nagor Ltd **Stand 6**

129 Deerdykes View, Westfield Industrial Estate, Cumbernauld, Glasgow, G68 9HN
Contact: Douglas Black, email: douglas.black@nagor.com, phone: 0778 662 8317
www.nagor.com

NorthStar Orthopaedics Ltd **Stand 17**

26 Kingfisher Court, Hambridge Road, Newbury, Berkshire, RG14 5SJ
Contact: Sacha Bartlett, email: sacha@northstar-ortho.co.uk, phone: 01635 275 380
www.northstar-ortho.co.uk

NorthStar Orthopaedics Ltd is one of the country's leading distributors of orthopaedic medical devices and theatre ancillaries. We also have strong business in plastic surgery as the UK distributors for the Synovis Anastomotic coupler rings and now the Flow Coupler with integrated Doppler.

We source innovative, quality products and have built a unique, well-balanced portfolio in upper limb, knee, foot and ankle, trauma and plastic surgery. Established in 1986 as part of the Forth Medical group, we have over 27 years of experience selling medical devices to the NHS and Private sectors. In January 2012 we were acquired By Fannin Healthcare and now form part of Fannin (UK). Our strength lies in successfully combining our enviable product range with Industry-leading levels of service

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Optident Ltd **Stand 8**

IDC, Valley Drive, Ilkley, West Yorkshire, LS29 8AL
Contact: Sue Senczyszyn, email: sue.senczyszyn@optident.co.uk, phone: 01943 604 400
www.optident.co.uk

Optident Vision Boutique will be displaying their latest range of Surgical Loupes and Headlights, including a new design of loupe with an integrated prism to help improve comfort and reduce neck tilt whilst working. In addition and new to the range, they will launch their fully portable Surgical Headlight and Portable LED Endoscope light.

EXHIBITORS

Phoenix Surgical Instruments Ltd **Stand 14**

14b Pindar Road, Hoddesdon, Hertfordshire, EN11 0BZ
Contact: Rik Lester or John Twigger, email: info@phoenixsurgical.co.uk, phone: 07540 335 359 or 07867 802 174
www.phoenixsurgical.co.uk

Phoenix Surgical Instruments Limited is an independently owned British Surgical Instrument Manufacturer, Repairer and Supplier. We are able to manufacture a huge range of high quality Surgical Instruments for all specialities in both European and well trusted traditional British patterns. We are also proud to be distributors for Heinz Waldrich a well known and highly respected German Manufacturer of Microsurgical Instruments widely used by Plastic Surgeons throughout the UK and Europe.

As well as a wide range of Surgical Instruments as "standard" out of the catalogue we are able to custom make and modify to your exact and specific requirements. We have a highly experienced team of Surgical Instrument Makers and Technicians here in the UK who have served many years in the industry training at some of the most respected Surgical Instrument companies in the world.

We are also well known for our fully comprehensive Surgical Instrument Repair Service. With a network of Area Representatives we offer free collections and deliveries and a fast and very well priced service for the repair and refurbishment of all makes and types of Surgical Instruments, Endoscopes, and Air Tools as well as Instrument Set Refurbishment where we take complete sets of instruments and inspect and refurbish every item on a set ensuring all sets are fit for purpose every time!

If you would like to discuss any current or future requirements, or you just want a free pen, then please come and see us at Stand 14.

PRASIS **Stand 2**

The Garden House, Blackhall Lane, Sevenoaks, Kent, TN15 0HP
Contact: Gerard Panting or Sherry Williams, email: info@prasis.co.uk, phone: 0845 519 4393
www.prasis.co.uk

PRASIS is now a leading provider of comprehensive professional indemnity providing all the security you need for your NHS and independent sector practice. Exclusively for plastic surgeons practising in the UK, PRASIS is a not for profit company, owned and run by its members

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Surgical Acuity **Stand 19**

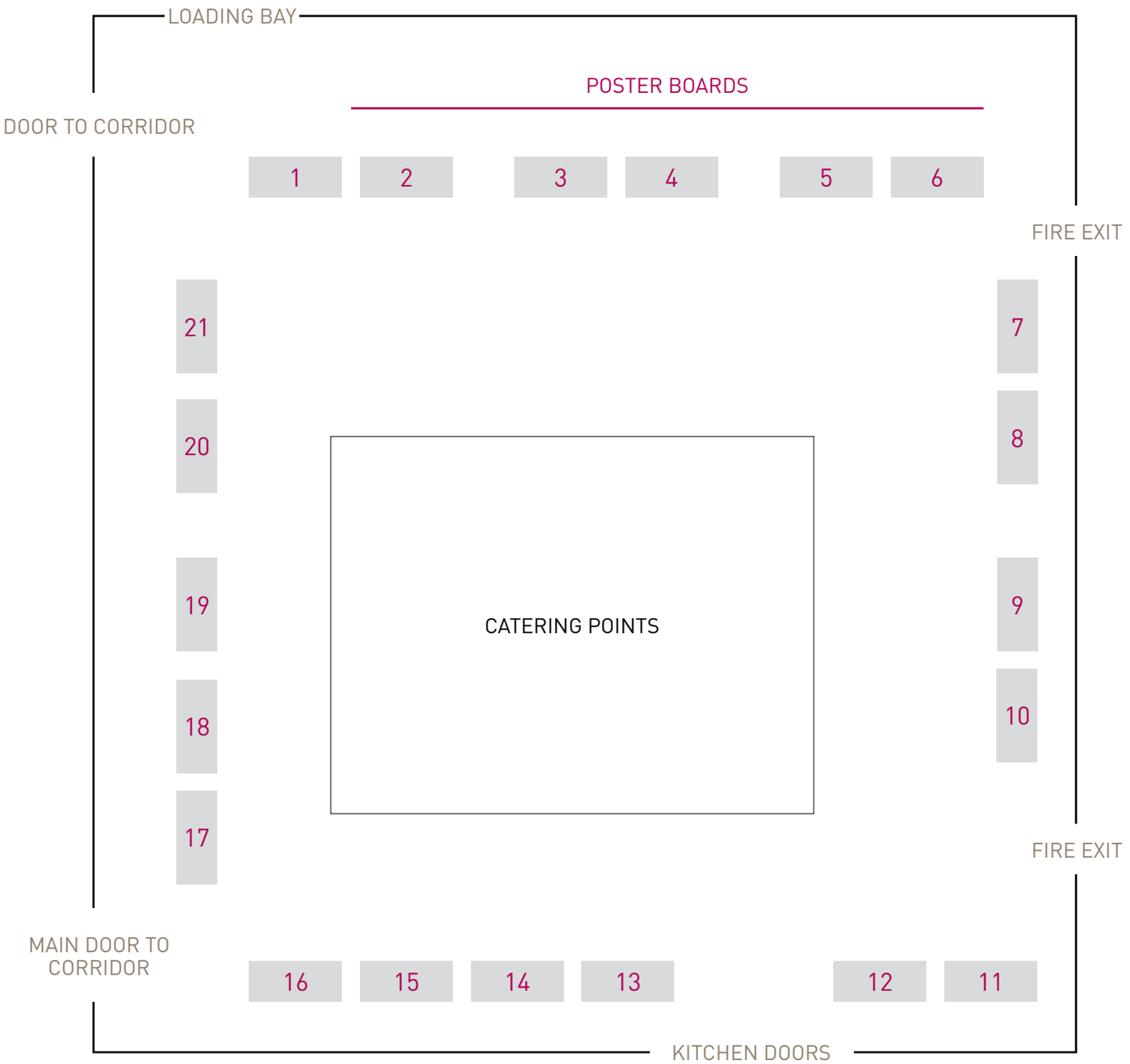
4 Flag Business Exchage, Vicarage Farm Road, Peterborough, PE1 5TX
Contact: Carol Curtis, email: carol.curtis@sybron.com, phone: 01733 352 865

Surgical Acuity Loupes are renowned for having the highest resolution across the widest field. Surgical Acuity's award-winning HiRes Plus line of expanded field prismatic telescopes deliver higher magnification power with generous field width and depth. An innovative adjustable focus feature allows you to fine tune your working distance at the operating site. We are so sure you will love what you see with Surgical Acuity that you can try us risk free for 45 days!

Purchase loupes at the BAPRAS and receive 10 per cent off the purchase price and IFC.

EXHIBITION FLOOR PLAN

BANQUETING SUITE



1 Integra
2 PRASIS
3 Mercian Surgical Supply Co
4 CareFusion
5 MDU
6 Nagor
7 Ideal Medical Solutions
8 Optident
9 Euromedical Systems
10 Malosa Medical
11 e-LPRAS
12 Intrapharm Labs
13 Medira
14 Phoenix Surgical
15 IHT
16 Eurosurgical
17 Northstar Orthopaedic
18 Human Med UK Ltd
19 Surgical Acuity
20 Cynosure UK
21 Mentor

BAPRAS and IAPS Winter Meeting

27–29 November 2013
The Convention Centre
Dublin, Ireland

BAPRAS
British Association of Plastic Reconstructive and Aesthetic Surgeons

IAPS

BAPRAS The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields, London WC2A 3PE
Tel: 020 7831 5161 Fax: 020 7831 4041
Email: secretariat@bapras.org.uk www.bapras.org.uk