CORRESPONDING MEMBER SOCIETY

EASAPS European Association of Societies of Aesthetic Plastic Surgery

ICOPLAST INTERNATIONAL CONFEDERATION OF PLASTIC SURGERY SOCIETIES MEMBER SOCIETY

ISAPS GLOBAL ALLIANCE PARTNER

BEIRUT – LEBANON – Sept. 14-15, 2018

ICOPLAST endorsed PROGRAM

LEBANESE PLASTIC & RECONSTRUCTIVE MICROSURGERY CONFERENCE

1ST CONGRESS OF THE PAN ARAB FEDERATION FOR RECONSTRUCTIVE MICROSURGERY

With the participation of

THE PAN ARAB FEDERATION FOR HAND SURGERY

Organized by

Lebanese Society of Reconstructive Microsurgery – LSRM

Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery – LSPRAS

With the collaboration of

Association of Plastic Surgeons of Lebanese Descent – APSLD

Euro-Mediterranean Council for Burns and Fire Disasters – MBC

Designated for CME Credit Hours by EACCME®

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A MESSAGE FROM THE CONFERENCE DIRECTORS

Dear Colleagues and Friends,

It is our privilege and enormous pleasure to welcome you to the Lebanese Plastic and Reconstructive Microsurgery Conference and the 1st Congress of the Pan Arab Federation for Reconstructive Microsurgery organized by the Lebanese Society of Reconstructive Microsurgery, corresponding member of the European Federation of Societies for Microsurgery (EFSM), in association with the Lebanese Society of Plastic, Reconstructive and Aesthetic Surgery, member of the European Association of Societies of Aesthetic Plastic Surgery (EASAPS), on September 14-15, 2018.

With renowned international and local speakers, we can guarantee that the Conference will be a rewarding scientific exchange in many aspects of Plastic and Reconstructive Surgery with a special focus on hand surgery and on reconstructive microsurgical techniques and training. The program is broad and varied in content and should include topics of interest to orthopedic, head and neck, and plastic and reconstructive surgeons.

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President, Euro-Mediterranean Council for Burns and Fire Disasters – MBC
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PROGRAM AT A GLANCE

THURSDAY Sept. 13		

FRIDAY Sept. 14		
7:00-8:00	REGISTRATION	
7:45	OPENING	
8:00-9:30	(S1) SESSION 1: Breast Surgery	(S1') SESSION 1': Hand & Upper Extremity Surgery
9:30-10:00	Coffee Break	
10:00-11:30	(S2) SESSION 2: Breast Surgery	(S2') SESSION 2' Reconstructive Surgery
11:30-13:00	(S3) SESSION 3: Breast Surgery	(S3') SESSION 3': Management of Complex Wounds & Stem Cells
13:00-13:30	LUNCH	
13:30-14:00		Industry Sponsored Symposium
14:00-14:30	(S4) SESSION 4: Hand & Upper Extremity Surgery	
14:30-15:30		(S4') SESSION 4': Aesthetic Surgery
15:30-16:00	(S5) SESSION 5: Lymphedema & Brachial Plexus Surgery	
16:00-17:30		(S5') SESSION 5': Aesthetic Surgery
17:30-18:15	General Assembly of the Pan Arab Federation of Societies for Reconstructive Microsurgery – PAFSRM	Industry Sponsored Symposium

SATURDAY Sept. 15		
7:00-8:00	REGISTRATION	
8:00-9:30	(S6) SESSION 6: Mini Course: Gluteal Augmentation & Body Contouring	(S6') SESSION 6': Reconstructive Surgery
9:30-10:00	Coffee Break	
10:00-1130	(S7) SESSION 7: Mini Course: Gluteal Augmentation & Body Contouring	(S7') SESSION 7': Reconstructive Surgery
11:30-12:00	Industry Sponsored Symposium	(S8') SESSION 8': Lower Limb Reconstruction
12:00-13:00		
13:00-14:00	LUNCH	
14:00-15:30	(S9) SESSION 9: Head & Neck & Craniofacial Surgery	(S9') SESSION 9': Hand & Upper Extremity Surgery
15:30-17:00	(S10) SESSION 10: Head & Neck & Craniofacial Surgery	(S10') SESSION 10': Reconstructive Surgery
17:00-18:30	(S11) SESSION 11: Facial Aesthetic Surgery	(S11') SESSION 11': Reconstructive Surgery

To claim CME credit hours, confirmation of attendance by signing the attendance sheet and nametag barcode scanning is mandatory

Certificate of Attendance will be issued upon submission of evaluation form

FRIDAY Sept. 14

7:00-8:00		REGISTRATION			
7:45		OPENING			
8:00-9:30 HALL A	SESSION 1: Breast Surgery Moderators: Moustapha Hamdi, David Ross, Bishara Atiyeh		8:20-9:30 HALL B	SESSION 1': Hand & Upper Extremity Surgery Moderators: Manu Sood, Swenn Maxence Krähenbühl, Ramzi Moucharafieh	
8:00-8:10	S1-1	How To Perform Efficiently SGAP Flap Based Breast Reconstruction *Giovanni Zoccali*, Paul Roblin, Jian Farhadi*	8:20-8:30	S1'-1	Medial Femoral Condyle Microvascular Periosteal Transfer As Treatment For Metacarpal Non Union In The Hand *Swenn Maxence Krähenbühl*, Camillo Müller, Thierry Christen, Sébastien Durand*
8:10-8:20	S1-2	Use Of The Spy Elite Imaging System To Evaluate Tissue Perfusion & Associated Complications Following Free Diep Breast Reconstruction *Natalie Redgrave*, N. Haram, D. Masud, W. Albadry, P. Mohanna*	8:30-8:40	S1'-2	3rd Digit Bone And Joint Reconstruction In A 7 Year Old By Combining Masquelet, Ilizarov And Microsurgical Transfer Techniques *Elias T. Sawaya*, B. Sommier*
8:20-8:30	S1-3	Evaluation Of Mastectomy Skin Flap Necrosis Following Breast Reconstruction In A UK Plastic Surgery Unit *Natalie Redgrave*, Katie Lancaster, Pari-Naz Mohanna, Marlene See, Victoria Rose, Helen Mcevoy, Joannis Constantinides, Mark Ho-Asjoe, Jian Farhadi, David Ross, Paul Roblin*	8:40-8:50	S1'-3	Lipofilling In The Digital Pulp: Indications, Technique And Results *Elias T. Sawaya*; B. Sommier*
8:30-8:40	S1-4	Wide Local Excision Defects Of The Breast – A Treatment Algorithm Based On Oncological Resection Patterns *Paul Roblin*, Nadine Hachach-Haram, A. Bashir, M. See, P. Mohanna*	8:50-9:20	KN1'	KEYNOTE LECTURE Osteoarthritis Of The CMC Joint Of The Thumb: Evidence, Techniques And An Algorithm For Management Based On The St Andrews Experience *Manu Sood*
8:40-8:50	S1-5	Strategy In Breast Reconstruction After Prophylactic And Nipple Preserving Mastectomy *Michel Moutran*	9:20-9:30		DISCUSSION
8:50-9:20	KN1	KEYNOTE LECTURE Autologous Breast Reconstruction In The 21st Century *Moustapha Hamdi*			
9:20-9:30		DISCUSSION			
9:30-10:00		COFFEE BREAK			

10:00-11:30 HALL A	**SESSION 2: Breast Surgery Moderators: Basel Sharaf, Grant Fraser-Kirk, Michel Moutran**		**10:00-11:30 HALL B**	**SESSION 2': Reconstructive Surgery Moderators: Mehdi Daghfous, Paul Roblin, Marwan Nasr**	
10:00-10:15	**S2-1**	**Breast Reconstruction - An overview** *Roman Skoraki*	**10:00-10:30**	**S2'-1**	**La Chirurgie Palliative Du Membre Supérieur Chez Le Tétraplégique** *Mehdi Daghfous*, Lamjed Tarhouni*
10:15-10:30	**S2-2**	**A Novel Approach In Breast Reconstruction: The Flip-Over Fasciocutaneous Thoracodorsal Flap Combined With Loops** *Marwan Abboud*, Nicolas Abboud, Hiba El Hajj*	**10:30-10:40**	**S2'-2**	**The ALT Flap: Is It The Ideal Soft Tissue Flap?** *Yehia Zakaria*, Qutaibah Al-Kandari*
			10:40-10:50	**S2'-3**	**Workhorse Flaps For Intrathoracic Catastrophes** *Karim Bakri*
10:30-10:45	**S2-3**	**Evolution Of The Surgical Technique For "Breast In A Day" Direct To Implant Breast Reconstruction: Transitioning From Dual Plane To Pre-Pectoral Implant Placement** *Anuja Antony*	**10:50-11:00**	**S2'-4**	**Treatment Of Challenging Nasal And Peri-Orbital Skin Cancer With Local Flaps** *Salim Saba*, Rita Ayoub*
			11:00-11:10	**S2'-5**	**Cutaneous Squamous Cell Carcinoma of the hand: About 10 cases** *Fatma Bouaziz*; Ghorbel.I ; Moalla.S ; Ben Othmen.G ; Bellaaj.H ; Loukil.K ; Ennouri.Kh*
10:45-11:00	**S2-4**	**An Algorithmic Approach to Prepectoral Direct to Implant Breast Reconstruction** *Anuja Antony*	**11:10-11:20**	**S'2-6**	**Biomimicry in hand surgery. Reconstructive artificial systems derived from Flexor Digitorum Superficialis** *Sébastien Durand*, Sandra Monnier, Wassim Raffoul*
11:00-11:10	**S2-5**	**Breast Implant Infections After First Stage Breast Reconstruction: What Have We Learned After 135 Infections In 10-Years At The Mayo Clinic?** *Basel Sharaf*	**11:20-11:30**		**DISCUSSION**
11:10-11:20	**S2-6**	**Dermal Barrier With Skin-Sparing/Reducing Mastectomy For Direct-To-Implant Single-Stage Immediate (DISSI) Breast Reconstruction** *Bishara Atiyeh*			
11:20-11:30		**DISCUSSION**			
11:30-13:00 HALL A	**SESSION 3: Breast Surgery Moderators: Roman Skoraki, Anuja Antony, Sami Saad**		**11:30-13:00 HALL B**	**SESSION 3': Management Of Complex Wounds & Stem Cells Moderators: George Ghanimé, Wassim Raffoul, Michel Costagliola**	
11:30-11:50	**S3-1**	**No Scar Breast Reduction: Is It Possible?** *Marwan Abboud*, Nicolas Abboud*	**11:30-11:50**	**KN3'**	**KEYNOTE LECTURE Supermicrosurgery For New Topics In Future: Prophylactic Bypass Surgery In Lymphatic, Vascular, And Nervous System** *Isao Koshima*
11:50-12:10	**S3-2**	**Breast Augmentation Using Lipofilling And Loops: How I Do It?** *Marwan Abboud*, Nicolas Abboud*	**11:50-12:00**	**S3'-1**	**Stem Cells And Their Clinical Applications In Aesthetic Surgery**

12:10-12:20	**S3-3**	**Lower Breast Pole Dermal Fixation In Mamopexy: The Hammock Technique** *William Watfa*, Pietro Di Summa*			
12:20-12:30	**S3-4**	**Mastopexy Augmentation** *Sami Saad*			
12:30-12:40	**S3-5**	**Transaxillary Breast Augmentation: Evolution Over 16 Years** *George Bitar*			
12:40-12:50	**S3-6**	**Mammareduction With Central Pedicle** *Afschin Ghorfani*			
12:50-13:00		**DISCUSSION**			
13:00-14:00		**LUNCH**			
			13:30-14:30 HALL B	– INDUSTRY SPONSORED SYMPOSIUM **Rationale Why To Move From Anatomical Textured Implants To Round Smooth/Nanotextured In Breast Augmentation And/Or Masto** *Fabio Satanelli*	
14:00-15:20 HALL A	**SESSION 4: Hand & Upper Extremity Surgery** **Moderators:** **Joseph Bakhach, Amr El Sayed, Elias Sawaya**		**14:30-16:00 HALL B**	**SESSION 4': Aesthetic Surgery** **Moderators:** **Lakhdar Belhaouari, Nicolas Chami, Paul Audi**	
14:00-14:10	**S4-1**	**Microsurgical Reconstruction Of Finger Nails By Total Or Custom Made Toe-To-Finger Transfers** *Joseph Bakhach, Reem Karami*	**14:30-14:55**	**KN4'**	**KEYNOTE LECTURE** **Facial Beauty Through Science: Mid Face And Lower Face Go Together** *Lakhdar Belhaouari*
14:10-14-20	**S4-2**	**Early Excision And Coverage Of Deep Hand Burns: About 6 Cases** *Ghada Ben Othmen*, Iyadh Ghorbel, Hiba*	**14:55-15:05**	**S4'-1**	**Lower Blepharoplasty With Muscle Suspension And Midface Lift** *Afschin Ghorfani*
			12:00-12:10	**S3'-2**	**Taming Regenerative Stem Cell Biology Into Office Based Applications - The State Of The Art Technologies** *Ali Ghanem, Xavier Chalhoub**
			12:10-12:20	**S3'-3**	**Burns Management In Major Trauma Centre (MTC) Getting It Right First Time** *Samer Saour*, R. Adlard, F. Ali*
			12:20-12:30	**S3'-4**	**Evaluation Of The Early Tangential Burn Wound Excisions With Methylene Blue Guidance** *Qutaiba Abdulla Yassin Aldori*, Jalal Ali Hassan, Ari Raheem Qader*
			12:30-12:40	**S3'-5**	**Acute Graft Versus Host Disease In Allo Grafted Burned Child** *Qutaiba Abdulla Yassin Aldori*
			12:40-12:50	**S3'-6**	**Complex Intraoral Reconstruction Using A Single Free Anterolateral Thigh Flap And Supermicrosurgery After Corrosive Ingestion In A 14-Month-Old Child** *Mohammed Hassan El Fahar*
			12:50-13:00	**S3'7**	**Egyptian Revolution 2011 Recall of World War I; Management of Complex Facial Defects** *Tarek El Banoby*

		Bellaaj, Slim moalla, Fatma bouaziz, Khalil Ennouri	**15:05-15:15**	**S4'-2**	**Upper Eyelid Aesthetics** *Shahram G. Sajjadi*, Afschin Ghofrani*
14:20-14:35	**S4-3**	**Microsurgical Reconstruction Of Single Digit Amputations With Immediate Toe Transfer** *Manu Sood*	**15:15-15:25**	**S4'-3**	**Suture Suspension Neck lift: A Versatile Technique for Long-Term Neck Rejuvenation** *George Bitar*
14:35-14:50	**S4-4**	**Reconstructing the persistent scaphoid nonunion: evidence, techniques (including microsurgical reconstruction) and an algorithm based on the St Andrews experience** *Manu Sood*	**15:25-15:35**	**S4'-4**	**A Staged Approach In The Rejuvenation Of Neck Ageing: The Role Of Deep Structures Modifications To Achieve Long Lasting Results** *Michel Moutran*
14:50-15:00	**S4-5**	**Reconstruction Of Extensor Pollicis Longus Tendon By A Combined Hunter And Dermal Regeneration Template Procedure** *Elias T. Sawaya*, B. Sommier, V. Casoli*	**15:35-15:45**	**S4'-5**	**Single Stage Lipofilling In Aesthetic And Reconstructive Surgery** *Nicolas Chami*
15:00-15:10	**S4-6**	**Comparison Of Trapeziectomy In Brachial Plexus Block Anesthesia And Local Anesthesia, Regarding Postoperative Pain Satisfaction And Post-Operative Consultation** *Camillo Müller*, P. Erba, Thierry Christen, Wassim Raffoul*	**15:45-15:55**	**S4'-6**	**Recurrent Gigantomasia After Inferior Pedicle Reduction Mammaplasty** *Ahmad Khashaba*
15:10-15:20		**DISCUSSION**	**15:55-16:00**		**DISCUSSION**
15:20-17:30 **HALL A**	**SESSION 5: Lymphedema & Brachial Plexus Surgery** **Moderators:** **Isao Koshima, Sayed Baccari, Amir Ibrahim**		**16:00-17:20** **HALL B**	**SESSION 5': Aesthetic Surgery** **Moderators:** **Zaher Jandali, Anuja Antony, Firas Hamdan**	
15:20-15:40	**KN5**	**KEYNOTE LECTURE** **Surgical Treatments For Lethal Lymphatic Diseases** *Isao Koshima*	**16:00-16:15**	**S5'-1**	**Medico Legal Aspects Of Plastic And Aesthetic Surgery** *Michel Costagliola*, Remi Costagliola*
15:40-16:55	**S5-1**	**Advances In Microsurgical Treatment Of Lymphedema** *Moustapha Hamdi*	**16:15-16:30**	**S5'-2**	**Post Bariatric Surgery Tips And Tricks** *Zaher Jandali*
16:55-16:05	**S5-2**	**Extreme Supermicrosurgical Treatment Of Lymphedema**	**16:30-16:40**	**S5'-3**	**Evaluating The Safety Of Lipo-Abdominoplasty In The Clinically Obese: A Meta-Analysis** *Salim Saba*, Rita Ayoub*
			16:40-16:50	**S5'-4**	**"Avelar" Extended Thigh-plasty**

		Edward Chang			*Firas Hamdan*
16:05-16:15	**S5-3**	**Surgical Management Of Lymphedema**	**16:50-17:00**	**S5'-5**	**Challenging Cases In Aesthetic Breast Surgery**
		Roman Skoraki			*Rim Hammami*
16:15-16:25	**S5-4**	**Lymphatic Leak Management, Prospective Study And Algorithm Of Management**	**17:00-17:10**	**S5'-6**	**Place Of Microthane Coated Implants In Secondary Breast Surgery**
		Pietro Di Summa, William Watfa, Wassim Raffoul*			*Michel Moutran*
16:25-16:35	**S5-5**	**Robot-assisted harvesting of mesenteric lymph nodes for lymphedema treatment**	**17:10-17:20**	**S5'-7**	**Biomimetics In Plastic Surgery: A Concept Already Applied ?**
		Karl Waked, Assaf Zeltzer, Randy De Baerdemaeker, Moustapha Hamdi*			*Wassim Raffoul*, Sebastien Durand*
16:35-16:45		**DISCUSSION**	**17:20-17:30**		**DISCUSSION**
16:45-17:05	**S5-6**	**Management Of Traumatic Brachial Plexus Injuries**			
		Sayed Baccari			
17:05-17:15	**S5-7**	**Reconstruction For Peripheral Nerve Disorders From Brachial Plexus To Diaphragm Paralysis**			
		Eric Chang			
17:15-17:25	**S5-8**	**Neuropathic Pain After Repair Of Brachial Plexus Injury: A 30-Year Follow-Up Of The Narakas' Series**			
		Swenn Maxence Krähenbühl, Chantal Bonnard, Laurent Wehrli*			
17:25-17:30		**DISCUSSION**			
17:30	**General Assembly of the Pan Arab Federation of Societies for Reconstructive Microsurgery - PAFSRM**		**17:30-18:15 HALL B**		– INDUSTRY SPONSORED SYMPOSIUM **Hidradenitis Suppurativa: Updates In The Holistic Management Of The Disease** *Adele Chedraoui*

SATURDAY Sept. 15

7:00-8:00 REGISTRATION

8:00-9:30 HALL A

SESSION 6: MINI COURSE: Gluteal Augmentation & Body Contouring

Moderators:

Marwan Abboud, Elie Abdelhak, Bishara Atiyeh

8:00-8:20	S6-1	**Buttock Implants: Surgical Technique** *Richard Abs*
8:20-8:40	S6-2	**Gluteal Implants – Training Methodology For Better Results** *Romeu Fadul*
8:40-9:00	S6-3	**The Art Of Gluteal Augmentation Using Liposuction And Lipofilling: My Experience Over 10 Years** *Marwan Abboud*, Nicolas Abboud, Hiba El Hajj*
9:00-9:20	S6-4	**Gluteal Flaps For Buttock Augmentation** *Moustapha Hamdi*
9:20-9:30		**DISCUSSION**

8:00-9:30 HALL B

SESSION 6': Reconstructive Surgery

Moderators:

Joannis Constantinides, Edward Chang, Fadi Sleilati

8:00-8:10	S6'-1	**Microsurgery Scope In Peripheral Nerve Injuries in the Republic of Iraq; Presentation of Variable Cases** *Atheer Al Ameri*
8:10-8:20	S6'-2	**Our Experience In Management Of War Nerve Lesions In Syria** *Ghassan Kaadan*
8:20-8:30	S6'-3	**The Use Of Cadaveric Nerve Allografts In The Treatment Of Nerve Gaps** *Samer Bassilios Habre, P. Konofaos*
8:30-8:40	S6'-4	**Vascularized Sural Nerve Flap For Complex Peripheral Nerve Injuries Using Perforator To Perforator Techniques** *Mohammed Hassan El Fahar*
8:40-8:50	S6'-5	**Inferior Gluteal Artery Perforator Based Flap Reconstruction After Abdominoperineal Excision For Low Rectal Carcinoma** *Kavan Johal*, N. Hachach-Haram, H. Creasy, M. Pramateftakis, P. Mohanna,P. Roblin, J. Constantinides, A. Schizas, M. George, D. Ross*
8:50-9:00	S6'-6	**Anatomical Variant Of Physeal Blood Supply To The Fibula: A Case Discussion** *Maleeha Mughal*, Natia Gabuniya, Paul Roblin*
9:00-9:10	S6'-7	**Randomised Control Trial Of Effect Of Home Based Training Modalities In Acquisition Of Basic Microsurgery Skills** *Eunsol Kim*, N. Hachach- Haram, D. Masud, M. Moustaki, M. Malik, P. Mohanna*
9:10-9:25	S6'-8	**Augmented Reality - The Future Of Surgery** *Nadine Haram*
9:25-9:30		**DISCUSSION**

9:30-10:00 COFFEE BREAK

10:00-11:30 HALL A	**SESSION 7: MINI COURSE: Gluteal Augmentation & Body Contouring** **Moderators:** **Richard Abs, Mark Ho-Asjoe, Sami Saad**		**10:00-11:30 HALL B**	**SESSION 7': Reconstructive Surgery** **Moderators:** **Alexandru Georgescu, Salim Saba, Joseph Bakhach**	
10:00-10:20	**S7-1**	**Male Body Contouring: Pectoralis Implants** *Richard Abs*	**10:00-10:25**	**KN7'**	**KEYNOTE LECTURE** **Why, When And How Propeller Perforator Flaps?** *Alexandru Georgescu*
10:20-10:40	**S7-2**	**Calf Augmentation** *Richard Abs*			
10:40-11:00	**S7-3**	**Volume Redistributing Mastopexy In Post Massive Weight Loss Patients** *Moustapha Hamdi*	**10:25-10:35**	**S7'-1**	**Perforator Flaps For Upper And Lower Extremity Reconstruction** *Zaher Jandali*
11:00-11:20	**S7-4**	**Refinements In Body Contouring And Muscular Liposculture** *Marwan Abboud*, Nicolas Abboud, Yamina Dupont*	**10:35-10:45**	**S7'-2**	**Perforator Flaps In Lower Limb Reconstruction: Our Experience** *Slim Moalla*, I.Ghorbel, A.Karra, G.Ben Othmane, Kh. Ennouri*
11:20-11:30		**DISCUSSION**	**10:45-10:55**	**S7'-3**	**Reconstructing Melanoma And Non-Melanoma Skin Cancers Below The Knee: The Role Of The Keystone And Perforator Flaps** *Salim Saba*, Rita Ayoub*
			10:55-11:05	**S7'-4**	**Abdominal Wall Reconstruction, Free Vs Pediculed Flaps** *Pietro Di Summa*, William Watfa, Wassim Raffoul*
			11:05-11:15	**S7'-5**	**New Concepts In Abdominal Wall Reconstruction** *David Ross*
			11:15-11:20		**DISCUSSION**
11:30-12:00 HALL A	– INDUSTRY SPONSORED SYMPOSIUM **Cellulite, A Long Lasting Solution** *Sami Saad*		**11:20-13:05 HALL B**	**SESSION 8': Lower Limb Reconstruction** **Moderators:** **Ramzi Moucharafieh, Eric Chang, Yehia Zakaria**	
			11:20-11:40	**KN'8**	**KEYNOTE LECTURE** **Muscle Flaps Versus Perforator Flaps In Lower Limb Reconstruction** *Alexandru Georgescu*
			11:40-11:50	**S8'-1**	**Reconstruction Of Composite Leg Defects Post Blast Injury During Isis-Related Conflicts** *Amir Ibrahim*, Reem Karami, Fadi Ghieh, Said Saghieh, Suhail Lakkis*
			11:50-12:00	**S8'-2**	**Retrospective Review Of Free Fibula Transfer In Paediatric Sarcoma: A Single Centre Study Of Epiphyseal Transfers** *Maleeha Mughal*, Natia Gabuniya,*

					Robert Pollock, Paul Roblin
			12:00-12:10	S8'-3	**Soft Tissue Reconstruction Of Open Lower Limb Injuries In A Single Centre: 5 Year Review** *Victoria Rose*, Nadine Hachach-Haram, Eunsol Kim, Natalie Redgrave, Irene Cosentini, Michelle Griffin*
			12:10-12:20	S8'-4	**Microvascular Reconstruction Of Complex Lower Extremity Defects; Orthoplastic Approach** *Yehia Zakaria*, Qutaibah Al-Kandari*
			12:20-12:30	S8'-5	**Reconstruction Of Post-Traumatic Lower Limb Defects By Vascularized Bone Flaps (20 Years Experience)** *Amr El Sayed*
			12:30-12:40	S8'-6	**Sole Defects: Reconstructive Peculiarity** *Fouad Ghareeb*
			12:40-12:50	S8'-7	**Salvage Of The Foot By Free Tissue Transfer** *Wael Ayad*
			12:50-13:00	S8'-8	**Lower Limb Reconstruction Between Reversed Sural Flap And Free Tissue Transfer. Short Term Follow-Up About 14 Cases** *Atheer Al Ameri*
			13:00-13:05		**DISCUSSION**
13:00-14:00		**LUNCH**			
14:00-15:30 HALL A	**SESSION 9: Head & Neck & Craniofacial Surgery Moderators:** **Mutaz Habal, Romeu Fadul, Khaldoun Haddadin**		**14:00-15:30 HALL B**	**SESSION 9': Hand & Upper Extremity Surgery Moderators:** **Mohamed Ellabban, Sebastien Durand, Shady Hayek**	
14:00-14:15	**KN9**	**KEYNOTE LECTURE** **The Orbit Is The Window Of Face To The Outside World; Aesthetic Considerations** *Mutaz Habal*	**14:00-14:10**	**S9'-1**	**Microsurgical Reconstruction Of Complex Upper Extremity Defects** *Karim Bakri*
14:15-14:25	**S9-1**	**Reconstruction Strategy For The Unilateral Paralyzed Face** *José Carlos Faria*	**14:10-14:20**	**S9'-2**	**Aesthetic And Functional Outcome Of Thinned Anterolateral Thigh Flap In Reconstruction Of Complex Wounds Of Upper Limb** *Mohamed Ellabban*
14:25-14:35	**S9-2**	**Outcome Of Facial Nerve Reconstruction In Oncological And Traumatic Conditions** *Khaldoun Haddadin*	**14:20-14:30**	**S9'-3**	**Management And Outcomes Of Volar Wrist Lacerations** *Farah Gritli*, Khairi Saibi, Zied Mabrouki, Imene Chamkhi, Hamdi Dimassi, Mouna Ounaies, Sayed Baccari, Lamjed Tarhouni*
14:35-14:45	**S9-3**	**The Split Hypoglossal Nerve To Supply The Free Functional Muscle Transfer In Facial Reanimation** *Tarek Amer*	**14:30-14:40**	**S9'-4**	**The Role Of Groin (Inguinal) Flap In Management Of Acute Hand Injuries**

14:45-14:55	S9-4	**Nerve Transfers in Facial Paralysis** *Tarek Amer*			*Amjad Abdelhay*
14:55-15:05	S9-5	**CAD/CAM Technology In Head And Neck Reconstruction** *Roman Skoraki*	14:40-14:50	S9'-5	**Fascia-Temporalis Free Flap The Ideal Coverage For Deep Defects Of The Dorsal Hand Aspect** *Ramzi Mahmoud*, Sebastien Durand, Wassim Raffoul*
15:05-15:15	S9-6	**Microsurgical Flap Reconstruction Of The Head And Neck Following Tumor Ablation** *Yehia Zakaria*, Qutaibah Al-Kandari*	14:50-15:00	S9'-6	**Dupuytren Contracture: A Case Report** *Walid Al Eadini*
15:15-15:25	S9-7	**Alternate Free Flaps For Complex Microvascular Head And Neck Reconstruction** *Edward Chang*	15:00-15:10	S9'-7	**Correction Of Congenital Radial Club Hand, A Modified Sayre Technique** *Abdelrahim Al Jayar*, Monim Shakeer, Mutaz Al jayar*
15:25-15:30		**DISCUSSION**	15:10-15:20	S9'-8	**Dorsal Finger Perforator Flap For Finger Reconstruction** *Magdy Abd-Almoktader*
			15:20-15:30		**DISCUSSION**
15:30-17:00 HALL A	**SESSION 10: Head & Neck & Craniofacial Surgery** **Moderators:** **Samir Mardini, José Carlos Faria, Edmond Massoud**		**15:30-17:00 HALL B**	**SESSION 10': Reconstructive Surgery** **Moderators:** **Karim Bakri, Waleed Al Eadini, Atheer Al Ameri**	
15:30-15:55	KN10	**KEYNOTE LECTURE** **Face Transplantation** *Samir Mardini*	15:30-15:50	S10'-1	**The Free-Style Microsurgery Concept – What Is True And What Is Fake** *Zaher Jandali*
15:55-16:05	S10-1	**Virtual 3D Planning For Mandible And Maxilla Reconstruction** *José Carlos Faria*	15:50-16:00	S10'-2	**Post Abdominoplasty Intra-Abdominal Desmoid Tumor; a rare presentation** *Saif Badran*, Mohammed Murshid, Habeeb al- Basti, Mohammed Elnoor*
16:05-16:15	S10-2	**Microvascular Surgery Of The Maxillofacial Region Free Flaps And Face Transplantation** *Jamil Mohammed Al-Jamali*	16:00-16:10	S10'-3	**The Use of Vascularized Fibular Grafts. Our Experience** *Zied Mabrouki*, Lamjed Terhouni*
16:15-16:25	S10-3	**Reconstruction Of The Craniofacial Skeleton: State Of Art And Challenges** *Jamil Mohammed Al-Jamali*	16:10-16:20	S10'-4	**New Peno-Urethro-Scrotal Reconstruction With Bilateral Superficial Circumflex Iliac Artery Perforator Osteocutaneous (SCIP-OC) Flap** *Isao Koshima*
16:25-16:35	S10-4	**Free Vascularized Fibula Flap For Reconstruction Of The Mandible** *Wael Ayad*	16:20-16:30	S10'-5	**Reconstruction Of Extensive Scalp And Skull Defects With Dural Exposure. Our 10 Years Experience** *Fadi Sleilati*, S. Abou Zeid, N. Hokayem, M. Nasr*
16:35-16:45	S10-5	**The Versatility Of Freestyle Facial Perforator Flaps For Reconstruction Of Facial Defects** *Mohamed Ellabban*	16:30-16:40	S10'-6	**Role Of The Plastic Microsurgeon In Live Related Donor Liver Transplantation: Technical Tips For The Hepatic Artery Anastomosis**
16:45-16:55		**The External Jugular Vein Used As**			

		Recipient Vessel In Head And Neck Free Flap Reconstruction: Outcomes Compared To The Internal Jugular Vein *Fadi Ghieh*, A. Ibrahim, D. Adelman, Ch. Parham, Z. Hong, M. Villa, F. Chahine*			*Khaldoun Haddadin*
16:55-17:00		**DISCUSSION**	**16:40-16:50**	**S10'-7**	**Evaluation Of 50 Cases Of TIP Hypospadias Repair Using Dorsal Prepucial Double Layer Flap By Button Hole Technique** *Atheer Al Ameri*
			16:50-17:00		**DISCUSSION**
17:00-18:30 HALL A	**SESSION 11: Facial Aesthetic Surgery** **Moderators:** **Georges Bitar, Afschin Ghofrani, Ahmad Khashaba**		**17:00-18:30 HALL B**	**SESSION 11': Reconstructive Surgery** **Moderators: Fouad Ghareeb, Ghassan Kaadan, Abdulrahim Al Jayar**	
17:00-17:20	**KN11**	**KEYNOTE LECTURE** **16 Years Of Experience With Ethnic Rhinoplasties** *George Bitar*	**17:00-17:20**	**S11'-1**	**Lower Extremity Reconstruction And Salvage Without Free Flaps** *Eric Chang*
17:20-17:30	**S11-1**	**Piezo Ultra Surgery In Rhinoplasty, 3 Years Experience** *Shahram G. Sajjadi*, Afschin Ghofrani*	**17:20-17:30**	**S11'-2**	**Sensate Free ALT Flap For Foot Reconstruction In Pediatric Population** *Mohammed Hassan El Fahar*
17:30-17:40	**S11-2**	**Essential Anatomy And Evaluation Of Functional Rhinoplasty** *Romeu Fadul*	**17:30-17:40**	**S11'-3**	**Microvascular Reconstruction Of Soft Tissue Defects Of Foot And Ankle: Minimizing Deformities And Avoiding Long-term Complications** *Ahmed Talaab*
17:40-17:50	**S11-3**	**Functional Rhinoplasty** *Richard Abs*	**17:40-17:50**	**S11'-4**	**Venous Compartment Syndrome And Chronic Leg Ulcers: Plastic Surgical Treatment** *Michel Costagliola*
17:50-18:00	**S11-4**	**Endoscopic Brow Lift Revisited: What Have We Learned Since Its Initial Description In 1992?** *Basel Sharaf*	**17-50-18:00**	**S11'-5**	**High Pressure Injection Injury: A Case Series** *Mohammed Muneer*, Habeeb al-Basti, Mohammed Murshid, Saif Badran*
18:00-18:10	**S11-5**	**Challenge In Lips Beautification: The Long Lip** *Lakhdar Belhaouari*	**18:00-18:10**	**S11'-6**	**Flap Failure, Causes, Diagnosis And Management** *Magdy Abd-Almoktader*
18:10-18:20	**S11-6**	**Lip Lift: A Simple Office Based Procedure that can both enhance and rejuvenates the perioral area** *Firas Hamdan*	**18:10-18:20**	**S11'-7**	**Surgical Approaches To The Skull Base: The Plastic Surgeon's Perspective** *Khaldoun Haddadin*
18:20-18:30	**S11-7**	**Otoplasty Art For Improved Results** *Khaled Nwair*	**18:20-18:30**	**S11'-8**	**DISCUSSION**

FACULTY AND SPEAKERS

S2-2; S3-1; S3-2; S6-3; S7-4	**Marwan Abboud, MD** Head of Division of Plastic and Reconstructive Surgery at the CHU Tivoli, La Louvière, Belgium
S9'-4	**Amjad Abdelhay, MD** DIS Plastic Surgery, DU Micro Surgery, Al Kindi University Hospital, Aleppo, Syria
S9'8; S11'-7	**Magdy Abd-Almoktader, MD** Professor Plastic and Reconstructive Surgery Al Azhar University, Egypt
S6-1; S7-1; S7-2; S11-3	**Richard Abs, MD** SOFCEP Past President, Marseille, France
S6'-1; S8'-8; S10'-7	**Atheer Al Ameri, MD** Senior specialist board certified plastic surgeon, MD, FIBMS (PRS), Ministry of health (Alwasity teaching hospital for plastic surgery, Member of Iraqi Society Of Plastic And Aesthetic Surgeons, Iraq/ Baghdad / Saydia district
S3'-4; S3'-5	**Qutaiba Abdullah Aldori** Burn and Reconstructive Surgeon, Azadi teaching hospital, Iraq/Kirkuk
S9'-6	**Waleed Al Eadini, MD** Consultant of Orthopedic & Hand Surgery, King Fahad Hospital, Jeddah, Saudi Arabia
S10-2; S10-3	**Jamil Mohammed Al-Jamali, MD** Consultant plastic, hand, and reconstructive surgeon, Freiburg University medical Center – Germany
S9'-7	**Abdelrahim Al Jayar, MD** Hand surgery unit, Aljala Teaching Trauma Hospital. Benghazi / Libya
S9-3; S9-4	**Tarek Amer, MD** Professor Plastic Surgery, Cairo University, Egypt
S2-3; S2-4	**Anuja Antony, MD** Associate Professor, Medical Director, Director of Breast Reconstruction, Plastic & Reconstructive Surgery, Rush University Medical Center, Past-President, Illinois Society of Plastic Surgeons, Chicago, IL, USA
S2-6	**Bishara Atiyeh, MD** President, MBC, President, APSLD, President, LSRMS, Executive Editor, Annals of Burns & Fire Disasters, Professor, Plastic & Reconstructive Surgery American University of Beirut Medical Center, Beirut, Lebanon
S8'-7; S10-4	**Wael Ayad, MD** Professor Plastic and Reconstructive Surgery, al Azhar University, Cairo, Egypt
S5-6	**Sayed Baccari, MD** Professeur à la faculté de médecine de Tunis, Chef de service à l'institut KASSAB d'orthopédie, Chirurgie plastique et réparatrice, Chirurgie de la main, Tunis, Tunisia
S10'-2	**Saif Badran, MD** Plastic Surgery Resident, Hamad Medical Center, Qatar
S4-1	**Joseph Bakhach, MD** President, Pan Arab Federation for Reconstructive Microsurgery Assistant Professor, Plastic & Reconstructive Surgery, American University of Beirut Medical Center, Beirut, Lebanon
S2'-3; S9'-1	**Karim Bakri, MD**

	Assistant Professor of Plastic Surgery and Orthopedic Surgery, Division of Plastic Surgery and Division of Hand Surgery, Associate Program Director, Plastic Surgery Residency, Mayo Clinic College Of Medicine, Rochester, MN USA
S6'-3	**Samer Bassilios Habre, MD** Department of Plastic Surgery, University of Tennessee Health Sciences Center, Memphis, TN, USA Assistant Professor of Plastic & Reconstructive Surgery University of Balamand , St George Hospital University Medical Center, Beirut
KN4'; S11-5	**Lakhdar Belhaouari, MD** Plastic and Aesthetic Surgeon, Centre de Chirurgie Esthétique, Toulouse, France
S4-7	**Ghada Ben Othmen, MD** Resident In Plastic Reconstructive And Aesthetic Surgery, Chirurgie plastique réparatrice et esthétique du CHU habib Bourguiba Sfax, Tunisia
S3-5; S4'-3; KN11	**George Bitar, MD** Clinical Assistant Professor – George Washington University School of Medicine and Health Sciences, Bitar Cosmetic Surgery Institute, Medical Director, Northern VA, USA
S2'-5	**Fatma Bouaziz, MD** Resident In Plastic Reconstructive And Aesthetic Surgery, Chirurgie plastique réparatrice et esthétique du CHU habib Bourguiba, Sfax, Tunisia
S3'-1; S4'-5	**Nicolas Chami, MD** FMH Chirurgie Plastique, Reconstructive et Esthétique, Membre SSCPRE, Membre ISAPS, Lausanne, Switzerland
S5-2; S9-7	**Edward Chang, MD** Assistant Professor, Department of Plastic Surgery, Division of Surgery The University of Texas MD Anderson Cancer Center, Houston, TX, USA
S5-7; S11'-1	**Eric Chang, MD** Institute for Advanced Reconstruction at the Plastic Surgery Center, Past Associate Professor in the Division of Plastic and Reconstructive Surgery at Fox Chase Cancer Center in Philadelphia, USA
Industry Symposium	**Adele Chedraoui, MD** Dermatologist, Private Practice, North Lebanon
S5'1; S11'-5	**Michel Costagliola** Pr Emérite-Chirurgie Réparatrice et Esthétique, Faculté de Médecine Toulouse-Rangueil, France
S2'-1	**Mehdi Daghfous, MD** Centre de la Main et du Membre Supérieur de Tunis, Membre fondateur de la société Tunisienne de chirurgie de la main (STCM), Tunis, Tunisia
S5-4; S7'-4	**Pieto Di Summa, MD** Senior Reconstructive Microsurgical Fellow, Canniesburn Plastic and Reconstructive Surgery Unit, Glasgow Royal Infirmary, University of Glasgow, Past Chief Resident Service de chirurgie plastique et de la main, Centre Hospitalier Universitaire Vaudois, CHUV, Lausanne, Switzerland
S2'-7	**Sébastien Durand, MD** Médecin Associé, Service de chirurgie plastique et de la main, Département de l'Appareil Locomoteur Coordinateur de la 15echerché en chirurgie de la main, Responsible de la chirurgie prothétique de la main et du

poignet, Centre Hospitalier Universitaire Vaudois, CHUV, Lausanne, Switzerland

S3'-7 **Tarek, El Banoby MD**
Plastic and Reconstructive Surgery, Al Azhar University, Egypt

S3'-6; S6'-4, S11'-2 **Mohammed H. El Fahar, MD**
Associate Professor of Plastic & Reconstructive Surgery, Burn, Plastic & Reconstructive Surgery Center, Mansoura University, Mansoura, Egypt

S9'-2; S10-5 **Mohamed Ellabban, MD**
Associate Professor, Division of Plastic and Reconstructive Surgery, Department of Surgery
Suez Canal University Hospital, Egypt

S8'-5 **Amr El Sayed, MD**
Professor, Department of Orthopedic Surgery and Traumatology Faculty of Medicine, Assiut University, Egypt

S6-2, S11-2 **Romeu Fadul, MD**
Consultant Plastic Surgeon, Coordinator of Hands-On Cadaver Lab. Courses of Research Institute Sirio Libanês Hospital, São Paulo, Brazil

S9-1; S10-1 **José Carlos Faria, MD**
Associate Professor, Plastic Surgery and Reconstructive Microsurgery, University of São Paulo
Hospital das Clínicas (FMUSP), Professor of Plastic Surgery – PUC Campinas – Brazil

KN7'; KN8' **Alexandru Valentin Georgescu, MD**
Professor in Plastic Surgery and Reconstructive Microsurgery
General Secretary, European Federation of Societies for Microsurgery (EFSM), President Romanian Society for Surgery of the Hand (RSSH), University of Medicine Iuliu Hațieganu , Spitalul Clinic de Recuperare, Cluj Napoca, Romania

S3'-2 **Ali Ghanem, MD**
Clinical Senior Lecturer in Plastic, Reconstructive and Aesthetic Surgery, Barts and the London School of Medicine & Dentistry, Queen Mary University of London, UK

S8'-6 **Fouad Ghareeb, MD**
Professor of Plastic Surgery ICOPLAST Egyptian National Delegate, Egypt

S3-6; S4'-1 **Afschin Ghofrani, MD**
Plastic and Aesthetic Surgeon, Hand Surgeon, Medical Director and General Manager, Aestheticon, Member of the Association of German Plastic Surgeons (DGPRAEC), Member of the German Association of Hand Surgery (DGH), Member of the Emirates Plastic Surgery Society, Dubai, UAE

S9'-3 **Farah Gritli, MD**
Plastic and Hand Surgeon, Institut KASSAB d'orthopédie, Tunis, Tunisia

KN9 **Mutaz Habal, MD**
Editor in Chief, Journal of Craniofacial Surgery, Director, Tampa Bay Craniofacial Center, Tampa, FL, USA

S9-2; S10'-6; S11'-8 **Khaldoun Haddadin, MD**
President Jordanian Society of Plastic and Reconstructive Surgeons, King Hussein Cancer Center, Amman, Jordan

S5'-4; S11-6 **Firas Hamdan**
Plastic Surgery, Highness beauty Clinics and Spa, Beirut- Dubai – Doha – Kuwait

KN1; S5-1, S6-4; S7-3 **Moustapha Hamdi, MD**
Head of Plastic Surgery Department and Director of Lymph Clinic, Brussels University Hospital – Brussels, Belgium,

President of the Royal Belgian Society of Plastic Surgery (RBSPS)

S5'-5 **Rim Hammami, MD**
Professor, Plastic and Reconstructive Surgery, University of Aleppo, DIS Plastic Surgery, DU Maxillofacial Surgery, Aleppo, Syria

S6'-8 **Nadine Haram, MD**
Co-Founder Proximie, NHS Clinical Entrepreneur Fellow, Plastic Surgery Registrar at NHS, UCL Honorary Clinical Lecturer, Exponential Medicine Faculty, TED Speaker, London, UK

S8'-1; S10-6 **Amir Ibrahim, MD**
Assistant Professor, Plastic & Reconstructive Surgery American University of Beirut Medical Center, Beirut, Lebanon

S5'-2; S7'-1; S10'-1 **Zaher Jandali, MD**
Head, Department of Plastic, Aesthetic, Reconstructive and Hand Surgery; Protestant Hospital Oldenburg, Medical Campus University, Oldenburg, Germany

S6'-5 **Kavan Johal, MD**
Trainee plastic surgeon at NHS, University of Manchester, Manchester, United Kingdom

S6'-2 **Ghassan Kaadan, MD**
Orthopedic Surgery, Hand Surgery, President Of Syrian Committee Of Hand Surgery 2000-2008, Member Of Scientific Council Of Orthopedic Surgery In The Syrian Health Ministry, Institution al Fayha Hosp Center Damascus, Syria

S4'-6 **Ahmad Khashaba, MD**
Professor of Plastic Surgery, Zagazig University, Head of the Department of Plastic Surgery, Nasser Institute, Cairo, Cairo

S6'-7 **Eunsol Kim, MD**
Guys & St Thomas Hospital, London, UK

KN3'; KN5; S10'-4 **Isao Koshima, MD**
President, World Society for Reconstructive Microsurgery, European supermicrosurgery course (founding and live surgery member), International Course of Perforator Flaps (founding and live surgery member), Professor and Chief Plastic, Reconstructive and Aesthetic Surgery, Tokyo University, Japan

S4-3; S5-8 **Swenn Maxence Krähenbühl, MD**
Service de chirurgie plastique et de la main, Département de l'Appareil Locomoteur , Centre Hospitalier Universitaire Vaudois, CHUV, Lausanne, Switzerland

S10'-3 **Zied Mabrouki, MD**
Plastic and Hand Surgeon, Institut KASSAB d'orthopédie , Tunis, Tunisia

S9'-5 **Ramzi Mahmoud, MD**
Service de chirurgie plastique et de la main, Département de l'Appareil Locomoteur , Centre Hospitalier Universitaire Vaudois, CHUV, Lausanne, Switzerland

KN10 **Samir Mardini, MD**
Professor of Surgery Mayo Clinic College of Medicine Chairman, Plastic Surgery Division, Mayo Clinic Rochester, MN, USA

S7'-2 **Slim Moalla, MD**
Resident In Plastic Reconstructive And Aesthetic Surgery, Chirurgie plastique réparatrice et esthétique du CHU habib Bourguiba, Sfax, Tunisia

S1-5; S4'-4; S5'-6 **Michel Moutran, MD**

	Consultant, Plastic & Reconstructive Surgery, Clemenceau Medical center, Bellevue Hospital, Lebanon
S6'-6; S8'-2	**Maleeha Mughal, MD** Plastic Surgery Registrar, Guys & St Thomas Hosp., London, UK
S4-6	**Camilio Müller, MD** Centre de la main, CHUV, Lausanne university hospital, Lausanne, Switzerland
S11'-6	**Mohammed Muneer, MD** Specialist Plastic Surgery, Hamad Medical Corporation, Instructor in Clinical Surgery (Plastic Surgery) at Weill Cornell Medicine - Qatar (WCM-Q), Teaching Assistant at Harvard T.H. Chan School of Public Health Principles and Practice of Clinical Research, Qatar
S11-7	**Khaled Nwair, MD** Senior Consultant and Trainer of Plastic Surgery, Head of Surgery Department, Al Mahalla Hospital. International Speaker. MOH, Egypt
S5'-7	**Wassim Raffoul, MD** Chef de Service de chirurgie plastique et de la main, Département de l'Appareil Locomoteur , Centre Hospitalier Universitaire Vaudois, CHUV, Lausanne, Switzerland
S1-2; S1-3	**Natalie Redgrave** Plastic Surgery SOH, Plastic Surgery SOH, Guys & St Thomas Hospital, London, UK
S1-4	**Paul Roblin, MD** Consultant Plastic and Reconstructive Surgeon, Guy's and St Thomas' NHS Trust, London, UK
S8'-3	**Victoria Rose, MD** Consultant Plastic and Reconstructive Surgeon, Guy's and St Thomas' NHS Trust, London, UK
S7'-4	**David Ross, MD** Consultant Plastic Surgeon and Head of Plastic Surgery at Guy's, St Thomas' Hospitals and Kings College Hospital, London, UK
S3-4, Industry Symposium	**Sami Saad, MD** Consultant Plastic Surgeon, Past LSPRAS Secretary, Past ISAPS Board Member – Trustee, Beirut, Lebanon
S2'-4; S5'-3; S7'-3	**Salim Saba, MD** Assistant Professor, Plastic and Reconstructive Surgery, Director Graham and Meredith Rooke Wound Care Center, American University of Beirut Medical Center
S4'-2; S11-1	**Shahram Ghotb Sajjadi, MD** Consultant Plastic Surgeon, Aestheticon®, Dubai, UAE
S3'-3	**Samer Saour, MD** Consultant Plastic and Reconstructive Surgeon, St. George's Hospital, London, UK
Industry Symposium	**Fabio Satanelli, MD** Chair of Plastic Surgery Department, University Sapienza, Rome; Head of Plastic Surgery Department at Sant'Andrea Hospital, Rome; Chief of the Fellowship Experimental Laboratory for vascular and nerves microsurgery at the Department of Biosciences, Tecnopolo, Rome, Italy
S2'-6; S4-4; S4-5	**Elias Sawaya, MD** L'Institut Aquitain de la Main**,** Chirurgie de la Main et du membre supérieur Microchirurgie**,** Chirurgie plastique reconstructrice et esthétique**,** Chirurgien attaché au CHU de Bordeaux et à l'institut Bergonié**,** Pessac – Bordeaux, France

S2-5; S11-4	**Basel Sharaf, MD** Consultant- Division of Plastic Surgery, Assistant Professor of Surgery, Mayo Clinic College of Medicine, Rochester, MN, USA
S2-1; S5-3; S9-5	**Roman Skoraki, MD** Professor Division Chief of Reconstructive Oncological Plastic Surgery Department of Plastic Surgery, Ohio State University, Columbus, OH, USA
S10'-5	**Fadi Sleilati, MD** Assistant Professor, Plastic and Reconstructive Surgery, Hôtel Dieu de France Hospital, Vice-President LSRM, Beirut, Lebanon
KN1'; S4-3; S4-4	**Manu Sood, MD** Consultant Plastic Surgeon, St. Andrew's Centre for Plastic and Reconstructive Surgery, Mid Essex Health Services – NHS Trust, London, UK
S11'-3	**Ahmed Talaab, MD** Plastic Surgery lecturer, Menoufia University, Egypt
S5-5	**Karl Waked, MD** Resident Plastic Surgery, UZ Brussels, Belgium
S3-3	**William Watfa, MD** Assistant Professor of Clinical Surgery, Faculty of Medicine, University of Balamand, Attending Plastic & Reconstructive Surgery/Aesthetic Surgery and Microsurgery, St. George Hospital University Medical Center (SGUMC), Assistant Professor of Clinical Surgery, Beirut, Lebanon
S2'-2; S8'-4; S9-6	**Yehia Zakaria, MD** Professor of Plastic Surgery, Consultant Reconstructive Microsurgery, Faculty of Medicine, Zagazig University, Egypt
S1-1	**Giovanni Zoccali, MD** Consultant Plastic Surgeon, Department of Plastic Surgery – Guy's and St. Thomas' Hospital, London, UK

GENERAL INFORMATION & ACCREDITATION

OVERVIEW OF THE PROGRAM

The Lebanese Society of Reconstructive Microsurgery – LSRM, a corresponding member of the European Federation of Societies for Microsurgery – EFSM, in association with The Lebanese Society of Plastic Reconstructive & Aesthetic Surgery – LSPRAS, member of the European Association of Societies of Aesthetic Plastic Surgery – EASAPS, has the pleasure to invite you to the Lebanese Plastic and Reconstructive Microsurgery Conference and the 1st Congress of the Pan Arab Federation for Reconstructive Microsurgery to be organized in Beirut. Prominent internationally known guest speakers have been invited and the Scientific Program will cover a wide range of topics including all aspects of Plastic and Reconstructive Surgery.

LSRM was established by an official decree from the Ministry of Interior No. 6812 date 25/05/1995, published in the Lebanese official Journal No. 31 on 3/08/1995. The founding members were B. Atiyeh, MD, R. Moucharafieh, MD, S. Roukos, MD, G. Khalil, MD, and M. Abi Fadel, MD. LSRM activities included the organization in collaboration with the Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery – LSPRAS of local Microsurgery Conferences and numerous Microsurgery Sessions to which several pioneers of Reconstructive Microsurgery have been invited such as H. Millesi, V. Meyer, J. Baudet, M Merle, E Biemer, J. Terzis, R. Khouri, P. Soucacos, P. Tos, M. Hamdi, Ph. Blondeel, P. Vogt, N. Hakim, and S. Moran, just to name few. For 4 consecutive years, it has supported several residents to train in microsurgical techniques. At present, it is at the down of a new revival and is organizing a major conference on Sept. 14-15, 2018 in Beirut in association with the Pan Arab Federation for Reconstructive Microsurgery and the Pan Arab Federation for Hand Surgery.

Acting under the guidance of the World Society of Reconstructive Microsurgery – WSRM, LSRM is dedicated to promote Reconstructive Microsurgery and to provide the highest standard of education and training in the field of Reconstructive Microsurgery in Lebanon as well as in the Middle East. In 2011 B. Atiyeh was appointed by WSRM as WSRM Country Liaison for Lebanon. All Plastic and Orthopedic Surgeons interested in Reconstructive Microsurgery are welcome to join the LSRM and the WSRM.

Though LSRM has already collaborated with other Lebanese Societies to organize several Microsurgery sessions since it was founded in 1995, this is the first major Regional Reconstructive Microsurgery meeting with international standards to be organized in Lebanon and will be the milestone for the organization of similar meetings regularly in the future.

The scientific program of this conference will include sessions about most aspects of plastic and reconstructive surgery and microsurgery including composite tissue allotransplantation, reconstructive surgery of the upper and lower extremity, hand surgery, peripheral nerves and brachial plexus surgery, lymphedema surgery, breast reconstruction, head and neck reconstruction, chest wall and abdominal wall reconstruction, surgical training in austere environment and war injuries reconstruction, as well as special sessions on aesthetic surgery.

OBJECTIVES

1- Review the basic principles of reconstructive surgery and microsurgery
2- Describe the recent developments and innovations in reconstructive surgery and microsurgery
3- Demonstrate microsurgical techniques of various body locations
4- Illustrate basic guidelines for hand surgery
5- Describe new trends and innovations in facial aesthetic surgery and body contouring

DISCLAIMER

The information in this educational activity is provided for general medical education purposes only and is not meant to substitute for the independent medical judgment of a physician relative to diagnostic and treatment options of a specific patient's medical condition. The viewpoints expressed in this CME activity are those of the authors/faculty. They do not represent an endorsement by the Lebanese Society of Reconstructive Microsurgery (LSRM), the Lebanese Society of Plastic, Reconstructive and Aesthetic Surgery (LSPRAS), the Pan Arab Federation of Societies for Reconstructive Microsurgery (PAFSRM), the Pan Arab Federation for Hand Surgery (PAFHS), the International Confederation of Plastic Surgery Societies (ICOPLAST), and the European Accreditation Council for Continuing Medical Education (EACCME®). In no event will the EACCME® be liable for any decision made or action taken in reliance upon the information provided through this CME activity.

ACCREDITATION

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All others have indicated they have no relationship which in the context of their presentation(s), could be perceived as a potential conflict of interest.

VENUE

The conference will be held at Hilton Metropolitan Palace Hotel Beirut, on September 14-15, 2018.

TARGET AUDIENCE

This activity is targeted towards plastic and reconstructive, head and neck, and orthopedic surgeons, interns, residents and medical students.

REGISTRATION AND ACCOMMODATION

For Registration, hotel accommodation and dinners reservations contact
Ms. Nadine Gemayel executive5@trustandtraders.com

REGISTRATION FEE	LSRM, LSPRAS & APSLD members	DELEGATES	DELEGATES ACCOMP. PERSONS	INTERNS & RESIDENTS
BEFORE Sept. 10	350 $	400 $	225 $	175 $
ON SITE	400 $	450 $	250 $	200 $

- Free registration for medical students, interns and residents of Lebanese and Arab Plastic Surgery training programs
- Gala Dinner invitation is extended to all speakers and registered delegates – advanced reservation is required
- Gala Dinner tickets for none registered accompanying persons may be purchased separately (125 $)
- Delegates are welcome to the Pre-Congress Faculty Dinner – advanced reservation is required (65 $)
- Advanced reservation required for Farewell Party (110 $)

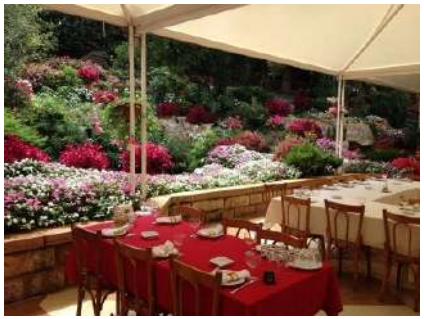
Upon confirmation of registration by e-mail, you will receive a registration confirmation form with the amount due. You may pay directly (modality of payment to be agreed with Ms. Nadine Gemayel) or you may choose to pay on-site.

You are required to provide a copy of this form when paying on-site otherwise on-site registration fee will apply.

Hilton Metropolitan Palace Hotel***** (including 11% VAT)	Single room 190$	Double room 212$

Rooms at hotel venue site are limited; first come first served. All reservations are to be made with the congress organizer to guarantee negotiated preferential rates. Alternative hotels are available upon request. Hotel reservation guaranteed only if made before August 15th 2018 pending availability accompanied by full payment of hotel and registration fee.

SOCIAL PROGRAM



Restaurant Mounir – Broumana

Set in Broumana, amidst a forest of pine and oak trees, a private vineyard, vast gardens, waterfalls, with a panoramic view of the Mediterranean sea, Mounir's Restaurant stands for excellence in Lebanese food. The Restaurant has been welcoming customers for over 35 years, some of which include esteemed clients like politicians, society's elite crowd as well as tourists who come to enjoy the beautiful setting, service and the quality Mounir has well been renowned for. An added plus, Mounir is open all year round, serving a menu of over 50 specialties.

TRANSFER BY BUS DEPARTING FROM HOTEL VENUE AT 8:00 PM

Le Péché Aquamarina – Tabarja

Located right on the seafront of Aquamarina 2's yacht Marina, Le Péché is a destination for all those who appreciate the taste of high quality seafood and recognize superior services.

TRANSFER BY BUS DEPARTING FROM HOTEL VENUE AT 7:30 PM

Music Hall Beirut Waterfront

Described by international media as "the place where the heart of world fusion music beats", the MusicHall is not just a theatre venue and much more than a club. In 2003, Elefteriades Productions launched the first MusicHall in Beirut, a live music stage representing a new and unique concept: very short live musical acts unveiling talents from around the world in a series of staged eclectic performances using the best technologies in sound and light equipment.

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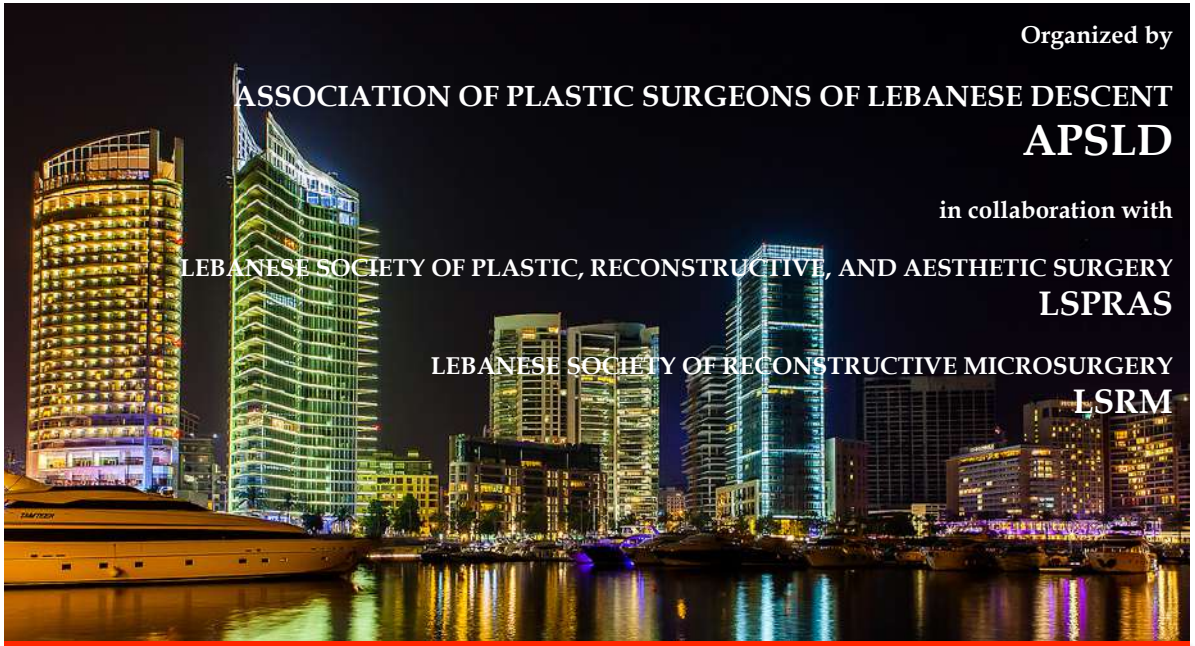
Vth WORLD CONGRESS OF PLASTIC SURGEONS OF LEBANESE DESCENT

September 19-21, 2019 – Beirut – LEBANON



It is our privilege and enormous pleasure to welcome you on September 19-21, 2019, to the Vth World Congress of Plastic Surgeons of Lebanese Descent (APSLD) organized by the Association of Plastic Surgeons of Lebanese Descent in collaboration with the Lebanese Society of Plastic, Reconstructive and Aesthetic Surgery (LSPRAS), member of the European Association of Societies of Aesthetic Plastic Surgery (EASAPS) and the Lebanese Society of Reconstructive Microsurgery (LSRM), corresponding member of the European Federation of Societies for Microsurgery (EFSM).

After 4 successful meetings in Beirut (2010), Cancun (2012), Beirut (2014), and São Paulo (2017), we meet again in Beirut for yet another memorable scientific, cultural, and emotional gathering further strengthening ties of common heritage and friendship.

With renowned international and local speakers, we can guarantee that the Congress will be a rewarding scientific exchange in many aspects of Plastic and Reconstructive Surgery. The program is broad and varied in content and should include topics of interest to all Plastic and Reconstructive Surgeons.

EASAPS
European Association of Societies of Aesthetic Plastic Surgery

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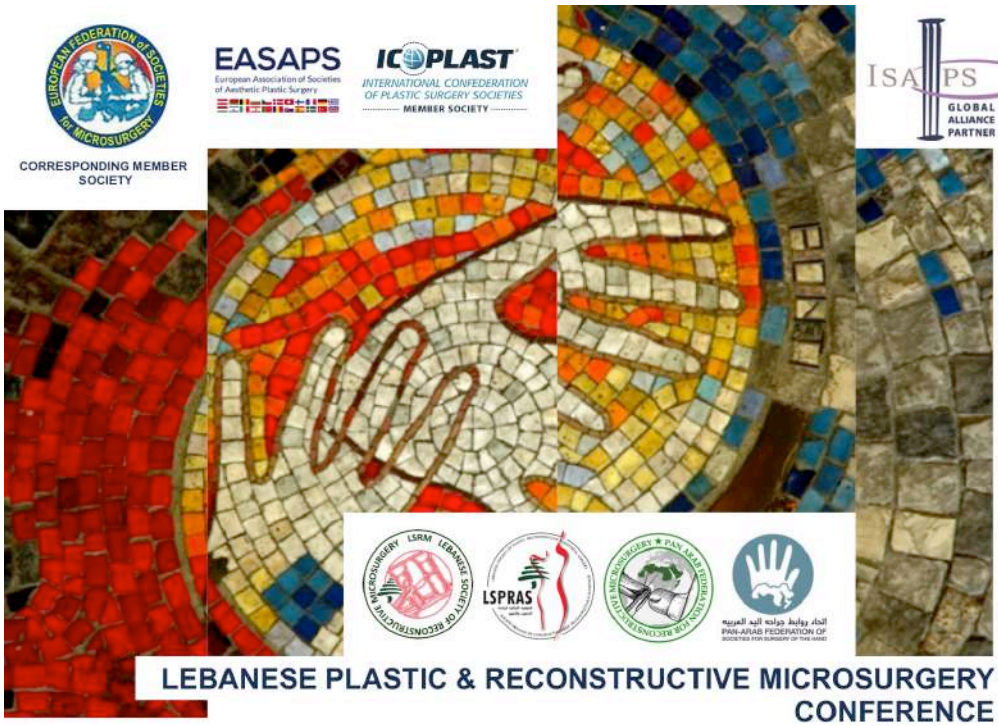

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1ST CONGRESS OF THE PAN ARAB FEDERATION FOR RECONSTRUCTIVE MICROSURGERY

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S2-2 A Novel Approach In Breast Reconstruction: The Flip-Over Fasciocutaneous Thoracodorsal Flap Combined With Loops
Marwan Abboud*, Nicolas Abboud, Hiba El Hajj

Introduction: The use of thoracodorsal musculocutaneous flap has been limited to donor site complications. The Thoracodorsal fasciocutaneous flap spares the muscle and limits these morbidities. Our objective is to describe a new technique of breast reconstruction using a fasciocutaneous flip- over thoracodorsal flap associated with surgical loops to achieve better breast remodeling.
Methods: Between 2013 and 2017, a total of 64 patients underwent breast reconstruction using a fasciocutaneous flip-over flap combined with surgical loops. The flap is designed in an elliptical transverse pattern and extends three centimeters lateral to the back midline up to the mid infra-mammary fold. It is centered on perforators from the descending branch of thoracodorsal artery identified pre-operatively with Doppler. Infiltration and tunnelisation of the breast recipient site and abdominal breast surroundings are done followed by de-epithelialization of the skin paddle. Dissection of the breast pocket and scoring of the scar tissue are performed. Flap dissection is done from distal to proximal. Once the perforators are identified, dissection is discontinued and the flap is turned over to fill the upper breast pole. The flap is inserted in the pocket and fixated to the medial part of the thoracic wall. With patient in dorsal decubitus, breast remodeling is realized with loops passed transcutaneously, spanning the superficial subcutaneous tissues at the lower inner and outer quadrants and upper outer quadrant of the breast. At the upper inner quadrant, the loop is taken in the deep plane to act as an anchor for suspension. The loop is pulled to enhance breast projection and recruit skin from breast surroundings.
Results: 73,4% of reconstructions were delayed and 92.2% were unilateral. A fourth of the patients were smokers, and 39.1% received radiotherapy. No complications were reported except for the shoulder function which was affected at 6 weeks after the procedure with a DASH score rising from 6.53 in preoperative to 11.32 at 6 weeks. The average operative time was 57 minutes, and drains were removed at day one after surgery.
Conclusion: Thoracodorsal Fasciocutaneous flap should be considered as a simple,safe, and reliable alternative for breast reconstruction.

S3-1 No Scar Breast Reduction: Is It Possible?
Marwan Abboud*, Nicolas Abboud

Introduction: In the context of continuous interest to develop and refine minimally invasive breast reduction surgery, the authors adopted a power-assisted lipomodeling technique combined with surgical loops to achieve breast reduction and elevation of the nipple areola complex (NAC).
Methods: Between 2014 and 2017, a total of 80 patients underwent breast reduction by combined lipomodeling and the use of breast loops. Patient population included patients with breast ptosis and fat hypertrophy that required NAC elevation shorter than 8 cm. Patients with mainly glandular hypertrophy were excluded. Following infiltration of the breasts, reduction of breast volume was achieved with the Lipomatic machine using 3 or 4 mm mutli-hole cannulas. Specifically, liposuction of the outer quadrants and lower pole reduces the breast footprint as well as the lateral and inferior heaviness of the breast. This facilitates elevation and remodeling of the breast to the desired volume and shape. Using number 0 PDS sutures, three loops are taken around the breast to suspend and elevate the breast skin envelope and parenchyma. The loop spans the superficial subcutaneous tissues except for the upper inner quadrant, where it is taken in the deep plane to allow rigid fixation during repositioning. A fourth loop is passed circumferentially around the N.A.C, and then cephalad along the breast axis in the superficial subcutaneous plane. It is then pulled until the desired N.A.C elevation is reached.

Results: Follow up ranged from 6 to 36 months, whereas the mean operative time ranged between 45 and 60 min. The total complication rate was 2.2%, and included mild cellulitis in one breast that resolved on oral antibiotic therapy.
Conclusion: The proposed technique is a simple, time efficient and reproducible novel option to achieve safe breast reduction without scar.

S3-2 Breast Augmentation Using Lipofilling And Loops: How I do it

Marwan Abboud*, Nicolas Abboud

With the growing popularity of autologous fat grafting in breast cosmetic and reconstructive procedures, the authors adopted a power assisted autologous fat transfer to the breast combined with surgical loops in order to achieve breast augmentation in primary cases and after exchange of implants.
Methods: Between 2013 and 2017, a total of 80 patients underwent aesthetic breast augmentation by combined lipofilling and the use breast loops. Patient population included patients who desire primary autologous breast augmentation, patients who had previously undergone implantation with unsatisfactory outcomes, who desire to undergo explantation while keeping the same breast volume. Patients who were active or former heavy smokers, had a family history of breast cancer were excluded from the study.
In cases of exchange of implant with fat, explantation is achieved through a 4 cm inframammary crease incision. Capsulotomy or capsulectomy are performed depending on the grade of capsular contracture and the integrity of the implant. Infiltration of the donor site and fat harvesting are achieved using a 3mm multi-hole cannula attached to the handpiece under a low suction pressure and collected in a closed system. Using a number 0 PDS suture, 3 loops around the breasts are taken. Each loop spans the superficial subcutaneous tissue at the lower inner and outer quadrants, the deep plane at the upper inner and outer quadrants of the breast beyond the footprint markings. The loop is guided using a straight hollow cannula passed through skin stab incisions. The loop is pulled to achieve desired breast projection and the knot is tied. Lipofilling is achieved using the lipomatic machine by simultaneous tunnelisation, vibration and fat injection in a multiplanar multiaxial pattern. Thus, the final breast volume results from the native breast volume, its surroundings and the volume of fat injected. The inframammary fold is reinforced by taking deep dermal bites along the axis of the inframammary fold. External vibration is performed using the lipomatic handpiece to enhance fat diffusion.
Results: Total fat injected per breast ranged from 300 to 400 ml. The mean operative time was one hour. The complication rate was 2.5% and included two cases of mild infection that spontaneously resolved with oral antibiotics.
Conclusion: Lipofilling combined with loops is a novel, simple, safe and alternative technique for aesthetic breast augmentation.

S6-3 The Art Of Gluteal Augmentation Using Liposuction And Lipofilling: My Experience Over 10 Years

Marwan Abboud*, Nicolas Abboud, Hiba El Hajj

Autologous fat grafting to the buttocks has become popular during the past decade. My experience about gluteal augmentation using lipofilling and liposuction extends over more than 10 years. My technique combines buttocks augmentation with autologous fat and liposculpting using power assisted liposuction lipofilling (PALL).
Gluteal augmentation involves a synergistic approach of removing fat from areas of excess surrounding the buttocks and transferring it to volume-deficient areas to achieve an aesthetically pleasing result. The final frame of the buttocks is dependent primarily on sculpting the posterior zones, the lateral flanks, the waste line, and around the buttock. This meticulous sculpting of these surrounding zones offers long-term aesthetic changes to the gluteal shape and limits the volume needed to be injected. Hence, the megavolume of fat injection is no longer needed and the volume I actually inject passed from an average of 650 cc to 300 cc per buttock.
In order to achieve more aesthetic contour and definition of the buttocks, i use barbed suture placed around the buttock and guided through 3 mm, 3-holes cannula passed through skin stab incisions.
Thus, optimal gluteal augmentation by autologous fat transfer depends primarily on excessive liposuction and sculpting of buttocks surroundings and secondarily on lipofilling.

The barbed suture is used as a temporary dressing to achieve better buttocks definition.

S7-4 Refinements In Body Contouring And Muscular Liposculture
Marwan Abboud*, Nicolas Abboud, Yamina Dupont

Aesthetic abdomen contouring remains a difficult aspect in plastic surgery. There have been many attempts made to better define aesthetic abdominal lines. However, creating a long lasting definition with external bandages following liposuction has been proved to be inefficient. Hence, the author has created a new technique using internal threading after liposculture. The threads that are used absorb after 6 weeks leaving fibrosis and thus long lasting definition of the abdominal aesthetic lines.
The gender based difference in fat distribution and unique goals and perspectives need to be taken into account when performing liposuction to ensure meeting the patients' needs and expectations.
While female perspective of beauty is characterized by a well-defined waist, relatively toned abdomen and enhanced curves, ideal male abdomen is based on well-toned and defined muscles. Using liposuction and threadings, the author achieves the athletic six pack definition in men and the well-defined waist and curves in women.
Preoperative counseling is very important in the aesthetic patient desiring toning of the abdominal wall. Each patient needs an individual anatomical analysis and plan for enhancement. Abdominal muscular liposculpture with additional threading is a new, safe and fast technique to achieve a naturally toned look in selected patients.

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S9'-4 The Role Of Groin (Inguinal) Flap In Management Of Acute Hand Injuries

Soft tissue deficiency in the hand is a common presentation following trauma, burns infection and tumor removal, in conditions that may lead to important functional impairment, especially when tendons, nerves or vessels are exposed or involved in the initial lesion. Soft tissue coverage is a challenging problem for reconstructive surgeons to manage. The ultimate choice of soft tissue coverage will depend on the size and site of the wound, complexity of the injury, status of surrounding tissue, exposure of the vital structures and health status of the patient. There are several local cutaneous flaps that provide adequate soft tissue coverage for defects of the hand. Microsurgery has taken on an important role in the reconstructive arsenal from many perspectives. Two situations can be encountered. First, in many centers around the world, especially in low- and middle-income countries, microsurgery is not common practice due to the surgical team's lack of experience and training, and the unavailability of microsurgical equipment. Secondly, in equipped settings and centers where microsurgery is common practice, the patient's condition can sometimes be a contraindication for microsurgery. In both situations, a pedicled flap as groin inguinal flap may be the only option for the hand surgical team. It has been shown to be reliable and it has minimal peri-operative complications, which make it the procedure of choice in many centers around the world.

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S9'-8 Dorsal Finger Perforator Flap For Finger Reconstruction

Reconstruction of soft tissue defects in the fingers with exposed tendons, joints, nerves and bone represents a challenge to the plastic surgeons, and such defects necessitate flap coverage to preserve finger functions and to protect its vital structures. There are very limited options for flaps to cover such defects. The field of reconstructive surgery has taken a significant leap forward with the introduction of perforator flaps. The primary advantage of these flaps, one stage, local with same character of the tissue and minimization of donor site morbidity. We present multiple varieties of dorsal perforator flap from the dorsum of the finger to cover finger defects and finger tip.

A11'-7 Flap Failure, Causes, Diagnosis And Management

The enemy of the plastic surgeon is the flap failure. Flap failure are due to many cause either pre, intra and / or postoperative causes. Early diagnosis and management avoid the risk of another surgery. In these study I try to collect causes, diagnosis, how to prevent and how to deal with the ischemic flap.

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S6-1 Buttock Implants: Surgical Technique

The number of buttock implant surgeries has significantly increased. Through the study of 328 patients with the benefit of nine years of hindsight, the author presents the results of a reliable technique of buttock augmentation with intramuscular gluteal implants.
Then after detailing the different surgical techniques currently used as well as the different morphotypes of patients, the author proposes his own surgical strategy adapted to each case.
Buttock augmentation surgery using gluteal implants has now become a reliable and secure procedure. The ever increasing demand for gluteal implants requires a carefully planned surgical solution minimizing the risk of complications.
It is to be obviously compared to breast enlargement surgery.
The use of gluteal implants associated with Hyaluronic Acid, liposuction – and/or fat grafting-Butt lift, is a procedure that should not be neglected in the treatment and rejuvenation of the figure.
The author describes the various complications, in the short term or in the long term, and how to manage them.

S7-1 Male Body Contouring: Pectoralis Implants

Introduction: Body-contouring implants are becoming increasingly popular and more accepted and requested for aesthetic purposes. These implants must be placed in a safe and reproducible plane of anatomic dissection for a successful long-term outcome.
Materials and Methods: Fisrt indication was reconstructive with Poland Syndrome: customized implants were required. Predominantly aesthetic clinical cases are exposed. The incision is trans-axillary and the integration plan is backward the pectoralis major

muscle. The postoperative recommendations and complications are discussed.
Results: The author presents his experience with the pectoral muscle implant for aesthetic purposes.
Discussion: There are common points with breast implants; nevertheless, different points must be respected: always use smooth implants, never dissect below the areola, place the implant vertically, and put the right implant in the left pocket and the left on the right side, in order to draw the male cleavage and not having a lateral bulging when the patient raises his arms.
Other solutions are hyaluronic acid and autologous fat grafting; this last may lead to an appearance of gynecomastia.
Conclusion: The significant enhancement of the chest contour achieved and the satisfying results obtained with no major complications makes this procedure an interesting advancement in male body contour surgery.

S7-2 Calf Augmentation

Introduction: The calf augmentation by implant is first described by J. Glicenstein in France in the 60s for polio sequelae. Currently, reconstructive demand remains; the aesthetic is when the calf is particularly graceful.
Materials and Methods: Predominantly aesthetic clinical cases are exposed. The incision is below the popliteal fossa and the integration plan is backward the fascia. A three-minute film outlines the technical points. The postoperative course and complications are discussed.
Results: In our series, the indications are aesthetic. The preoperative assessment is similar to breast implants.
Discussion: Inserting calf implants for aesthetic indications is easy (tissues are soft and flexible). However, in reconstructive indications, the dissection plane is fibrous and spaces are tight (the danger would be to create an ischemia distally).
Prostheses are pre-filled with silicone gel. The choice is possible between fusiform symmetrical prostheses (Glicenstein) and anatomical (Montellano).
The implant is made also to be inserted elsewhere in the calf, in other member segments (example: biceps, ..) and several implants can be inserted in the same area (intramuscular) .. (a clinical case of reconstructive surgery illustrates this use).
Complications are: insufficient volume, high position of the prosthesis, ..
Conclusion: After the reconstructive indications of origin, calf implants find use in aesthetic, calf and elsewhere ...

S11-3 Functional Rhinoplasty

Management of the nasal dorsum remains a challenge in rhinoplasty surgery.
Currently, the Joseph or open roof technique results in destruction of the keystone area, which requires reconstruction with either spreader grafts or spreader flaps.
The author presents operative technique (short video) for dorsal preservation in reduction rhinoplasty performed through the original closed approach using a electric powered micro-saws.
The key question before any primary rhinoplasty procedure should be “Can I keep the nasal dorsum intact?” small or moderate hump, slight convexity, cartilaginous nose, tension nose … are a good indications; conversely, kyphotic bony nose, deviated or asymmetrical nose will rather be candidates for the classical technique.
In conclusion, the limits of the push-down are the residual bumps and the learning curve; its benefits are a result of a nonsurgical nose, which breathes well with a low revision rate and short surgical time. Moreover, rhinoplasty surgeons should consider incorporating dorsal preservation techniques in their surgical armamentarium.

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S6'-1 Microsurgery Scope In Peripheral Nerve Injuries in the Republic of Iraq; Presentation of Variable Cases

In conflict areas trauma representing a major concern to health service and nerve injuries is not an exclusion adding other causes like RTA and work injuries , in al Wasity teaching hospital (the main tertiary referring centre for plastic and reconstructive microsurgery in IRAQ) brachial plexus, sciatic nerve, all other peripheral nerves involving upper and lower limbs ,reconstruction of sensory soft tissue defects ,tendon transfer and orthopaedic intervention in lately presenting cases are dealt with in our centre.
As for microneurosurgery different techniques starting from direct repair , nerve graft to nerve transfer done for hundreds of cases and transfer of sensate free flaps to cover soft tissue defects in sensory important areas using sensate RFF and sensate ALT flap , brachial plexus is dealt with whether supra or infra clavicular level , early or late presentation with different techniques. Sciatic nerve reconstruction done to treat foot drop in early presentation with very good results and protective sensory restoration of planter aspect of the foot done at any stage in tibial division injuries ,nerve transfer used to reduce the recovery period especially in proximal nerve injuries at different site when it is indicated (examples of our surgeries with results evaluation media will be presented in the conference), in our physiotherapy division follow up with neurophysiologist started and continue for years . Our results are consistent with other centres elsewhere with comparable results taking in consideration the geopolitical (ISIS terrorism confrontation), socioeconomic circumstances of our country.

S8'-8 Lower Limb Reconstruction Between Reversed Sural Flap And Free Tissue Transfer. Short Term Follow-Up About 14 Cases

Reconstruction of medium to large defect involving lower third of leg, ankle and foot presenting a challenge due to shortage of options and high incidence of complications related to lower limb reconstruction in general. Aim of this study is to evaluate 14 male patients with trauma associated with soft tissue loss ,bone loss, exposure and infection , average age is 20 years, follow up period average is 6 months ,7 patients managed with reversed sural flap in 2 of them delay technique with two stage surgery due to heavy smoking history to cover planter defect ,ankle joint and tendo achillis(3 patients) ,lower third leg with bone exposure (2 patients) only one case (large planter defect) developed about 20 % loss due to distal part necrosis which has been managed conservatively and healing is accomplished ..others cases healed uneventfully (i.e 14.2% complication), 7 patients managed with free flaps(4 L.D flap) 1 for stump reconstruction of chopart's amputation, 1 for exposed ankle joint,2 for lower tibia exposure , 1 developed thrombosis 48 hour re explored but later on non reflow phenomenon (24 hours later) and failure was imminent ,3 cases managed with ALT flap for tibia exposure with uneventful healing course (total success rate 85.7% of all free flaps done)…both techniques are effective but size of defect ,local and general condition ,cost and availability of microsurgery facilities are detecting factors in selecting which technique is implemented.

S10'-7 Evaluation Of 50 Cases Of TIP Hypospadias Repair Using Dorsal Prepucial Double Layer Flap By Button Hole Technique

Since the introduction of TIP in 1994 many studies done with original or modifications in this regard, the aim of this study is to evaluate the importance of de-epithelialized dorsal preputial dartos facial flap which is transferred by buttonhole technique in reduction of the complications (especially the fistula rete , penile shaft rotation), 50 cases with mean age 18 months, 40 patients with distal penile shaft hypospadias and 10 patients with mid shaft

penile hypospadias not associated with chordee, operated between march 2014 and april 2017 in Baghdad at al wasity hospital for plastic surgery by slandered TIP technique with modification of facial covering by using the DE epithelialized dorsal prepucial facia transferring it ventrally by buttonhole technique ,flipping it dorsally over neourethra and under glanular wings fixing it by quilting sutures to para neo urethral and sub glanular tissue and then adding further layer by flipping lateral excess flap over itself with closure of the penile skin by re-draping it, 2 cases of fistula developed in the early P.O period, the 1st due to obstruction of Foley catheter (the only one ruber Foley catheter used since 49 sialastic stomach tube used as urethral stent) for more than 24 hour in the 7th post-operative day; the 2nd one developed in the 2nd week and healed completely within 5 weeks and we couldn't follow up the 1st case because the family gave up the subsequent visits , 2 cases(early cases) suffered from meatal stenosis managed by dilatation with good results pushing us to adoption oval shaped neomeatus routinely with no further meatal stenosis observed ,all other 46 patient healed uneventfully with mean follow up(8 months) revealing good urine stream , good cosmetic appearance and the total fistula rate 1% . So this technique is effective in reducing fistula and preventing penile shaft rotation with acceptable appearance.

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S3'-4 Evaluation Of The Early Tangential Burn Wound Excisions With Methylene Blue Guidance

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Prospective study for evaluation of the use of methylene blue staining in heterogeneous depth of acute e deep partial and full thickness burn wounds, enabling burn surgeons intraoperatively for easily excising burn wound reaching the vital plane in least time; least blood loss; with more conservative vital tissue excisions. The assumption is that the dye will only stain dead tissues which can be removed leaving the healthy unstained tissue behind, where m ethylene blue in vital tissues is converted into leucomethylene by the enzyme reductase ; the m mean intra operative blood loss amount is one third of that with conventional method with topical hemostat. The mean value of graft take rates in this study was found to be 85.52 % in the patients treated by early skin grafting following tangential excision of all blue colored wound tissue with pre-operative methylene blue application. Although this result including the complicated cases which if excluded the mean value of graft take rates result may reach more than 92.7% success.

S3'-5 Acute Graft Versus Host Disease In Allo Grafted Burned Child

Female child 2.5 years old presented with scald burns by a hot milk the patient fall in a large cooking pot ,the BSAB was about 21% FTB burnt involving the buttock area and back right shoulder and right upper limb, the burns were fourth degree early fascial excision and allo grafting from her father thigh skin harvested at the same time of here excision ,the wound of patient show good progress of healing and patient general condition, the patient improved and her family insist for discharge after 26 days since allo graft operation the patient developed eruption in most of her skin parts (maculo –papular **+/-** scaling erythematous rash) with abdominal pain and diarrhoea ,we excise the taken allo graft and took a biopsy from skin maccule 3 cm distant from wound 1X1 cm sq. and start systemic steroid therapy , patient respond to steroid over two days very well ,we stop steroid , after one week we cover her wound with auto skin graft , biopsy result confirm diagnosis of AGVHD .

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S9'-6 Dupuytren's Disease

Dupuytren's disease is a debilitating condition of the hand characterized by development of new tissue in the form of cords and nodules. It leads to progressive flexion contracture with subsequent loss of function. It constitutes a technical challenge to the surgeon and needs careful dissection.

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S10-2 Microvascular Surgery Of The Maxillofacial Region Free Flaps And Face Transplantation

Defects in the maxillofacial skeleton vary in their size and nature and represented a challenging task for both plastic and maxillofacial surgeons.
The choice of the optimal method of reconstruction requires a good understanding of the three dimensional anatomy of the defect and an optimal cooperation of different specialities. Every method of reconstruction needs an excellent surgical skills combined with an optimal preoperative and postoperative care.
Microvascualr free flaps represent a very good option for management of different types of defects and require a good microvascualar training and sufficient experience of the anatomy of the head and neck region.
Sever and big defects require an ultimate solutions which cannot obtained by the conventional flaps. In such cases face transplantation is the optimal solution.
The aim of this presentation is to show different clinical cases where microvascular flaps were used with a good planning and to show step by step a case of face transplantation to have a close view of such complex procedure.

S10-3 Reconstruction Of The Craniofacial Skeleton: State Of Art And Challenges

Defects in the craniofacial region can result from congenital anomalies, trauma, tumors and other causes. Reconstruction of Such defects represents a very difficult goals since they are near all impotant structutres such as the brain, eyes , nose , ear and major blood vessels and results in affection of the function of one or more of such essential areas.
The latest developments in the field of microsurgery, imaging studies, minimal invasive procedures and prosthetic device producion resulted in minimizing the complications during such complex procedures. The aim of such presentation is to go through a couple of different clinical cases managed with such procedures which certainly reduced the time of healing and the associated morbidities.

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S9'-7 Correction Of Congenital Radial Club Hand, A Modified Sayre Technique
Abdulrahim ALJAYAR, Monim SHAKEER, Mutaz ALJAYAR

Congenital radial club hand is a spectrum of complex pre-axial upper limb defect, characterized by radial deviation and flexion of the hand, hypoplasia, or aplasia of the radius and thumb, shortened forearm and generalized underdevelopment of the involved extremity.
Since first described by Petit in 1733, however a huge diversity of techniques ranging from conservative stretching, to the complex microsurgical interventions, have been suggested for treatment, the centralization remains the core idea, despite the recognized relapse rates. Such diversity would reflect the great challenge of management.
Here is a prospective assessment of our local exposure, and satisfying results of correction in 11 hands with congenital radial club hand deficiency, with 9 of them who benefited from the modified (Sayre*) technique.
We have achieved a mean total correction of hand-forearm angulation of 85.4 degrees, with only 11.8 degrees mean residual angulation after an average period of 3.8 years follow up.

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S9-3 The Split Hypoglossal Nerve To Supply The Free Functional Muscle Transfer In Facial Reanimation

The introduction of the concept of free muscle transfer ushered a new era in the management of facial paralysis. Several nerves were used to supply the newly introduced muscle. The current work studies the use of the split hypoglossal nerve in supplying the functional muscle transfer. Patients with long standing facial nerve paralysis were treated by the author using free muscle transfers and the split hypoglossal nerve. Use of the split hypoglossal nerve in special situations of facial paralysis as in scarred face and bilateral facial paralysis is also studied. The distance and the angle of commissure excursion were measured pre and post operatively for both the treated and healthy sides and results were statistically analyzed. The first contraction observed after muscle transfer occurred 3 to 6 months post-operatively (mean 4.6 months). Post operatively both the amount of excursion and the angle of smile on the treated side improved significantly. There were no statistically significant difference in the amount of excursion between the healthy and treated sides post operatively. In conclusion, the split hypoglossal nerve is a possible alternative nerve to supply the free functional muscle transfer. The choice of donor nerve should be tailored according to the patient situation and need.

S9-4 Nerve Transfers In Facial Paralysis

Nerve transfers have been widely used in facial nerve paralysis. It is indicated when repair or grafting of the facial nerve is not possible but the distal nerve branches and mimetic muscles remain viable. Several nerve options are mentioned in the literature for this transfer. The current study focuses on different nerve options and different techniques available for the transfer. The pros and cons of each nerve will be

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S2-3 Evolution Of The Surgical Technique For "Breast In A Day" Direct To Implant Breast Reconstruction: Transitioning From Dual Plane To Pre-Pectoral Implant Placement

Introduction: Direct to implant (DTI) breast reconstructions offer the intuitive advantages of shortening the reconstructive process and reducing costs. In our practice, DTI has evolved from dual-plane (DP) to pre-pectoral (PP) implant placement. We sought to understand post-operative complications, aesthetic outcomes, postoperative pain and LOS in DTI reconstructions and identify differences in sub-cohorts.
Methods: A retrospective review of a prospectively maintained database was conducted from November 2014 to March 2018 to identify DTI reconstruction patients. Post-operative complication data, re-operation, LOS and 24-hour pain scores were reviewed. Aesthetic outcomes were evaluated by a blinded panel of practitioners using standardized photos.
Results: 134 DTI reconstructions were performed in 81 women; 42% DP and 57% PP. Data collection and statistical analysis was limited to patients with follow-up > 1 year. Total complications were low overall (8%) though incidence of PP complications (1, 2%) were lower than DP (7, 12%) ($p = 0.07$). The two cohorts were similar in the incidence of reoperation for aesthetic revision. Mean pain scores were low (DP 3.6, PP3.5) and mean LOS were similar (DP 1.81d, PP 1.81d). Panel evaluation for aesthetic outcomes favored PP reconstructions.
Conclusion: We present the largest comparative DTI series using ADM to date. Overall, DTI reconstruction demonstrated low incidence of post-operative complications. Transition to PP technique has not resulted in increased complications, degradation of aesthetic results, or increase in revisional procedures. Pre-pectoral reconstruction in properly selected patients is a viable reconstructive option with elimination of animation deformity and potential for enhanced aesthetic results.

S2-4 An Algorithmic Approach to Prepectoral Direct to Implant Breast Reconstruction

Introduction: Prepectoral direct to implant (DTI) breast reconstruction has historically been fraught with complications including flap necrosis, implant extrusion, and capsular contracture as well as high rates of operative revisions. This may result from a number of factors, including the lack of an algorithmic approach, failure to predict postoperative migration of the implant, use of improper implants, and unsuitable patient selection. Over the last 5 years, we have gained significant experience in
prepectoral direct-to-implant breast reconstruction.
Video: Using video, technical aspects to achieving superior results will be demonstrated, including suture technique, application of acellular dermal matrix (ADM) and creation of the implant pocket, implant selection and placement, and postoperative dressings. Video will be used to highlight technical aspects to yield consistent, predictable results using the anterior tenting technique.
Literature Review: A systematic review was conducted to amalgamate our experience and others with regards to technique, material and outcomes.
Conclusions: Prepectoral DTI reconstruction represents a significant paradigm shift in post-mastectomy breast reconstruction and warrants reconsideration. PP DTI provides the potential benefits of a single stage operation, elimination of dynamic deformity, enhanced aesthetic outcomes and increased patient satisfaction.

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S2-6 Dermal Barrier With Skin-Sparing/Reducing Mastectomy For Direct-To-Implant Single-Stage Immediate (DISSI) Breast Reconstruction

Background: One-stage implant-based breast reconstruction with minimal scarring is a highly appealing option to most patients. In fact, expander/implant reconstruction accounts for nearly 70 % of all breast reconstructions. We present our experience with a simplified skin-preserving/reducing excision pattern in association with immediate breast reconstruction using permanent expander or prosthesis.
Methods: Thirty-two patients with 45 reconstructed breasts (unilateral or bilateral) between February 2010 and March 2014 are included in this study. All implants, except for two reconstructed breasts, were placed in a dual plane. Implants used were either a permanent expander or permanent silicone prosthesis.
Results: Two patients developed postoperative infections requiring removal of the implants. Minor wound dehiscence without implant extrusion occurred in one breast. One breast had a late deflation of the permanent expander secondary to trauma. Another patient required postoperative revision with fat grafting to improve breast contour.
Conclusions: One-stage prosthetic-based immediate breast reconstruction is a safe option with gratifying outcomes provided adequate patients' selection and enough surgeons' expertise to perform it.

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S8'-7 Salvage Of The Foot By Free Tissue Transfer

The foot is vulnerable to repetitive trauma which may end with a defect.
Part of these defects can be managed by simple reconstructive techniques but the others require more sophisticated procedures.
The free tissue transfer helps a lot in foot salvage after difficult injuries by one stage of reconstruction.
A lot of free flaps can be used for foot reconstruction as, Fasciocutaneous flaps, Muscle flaps and Vascularised bone flaps.
Also, by the tool of free tissue transfer we can select the proper flap for each defect to get the best functional & aesthetic results and reduce the incidence of amputation after these severe injuries.

S10-4 Free Vascularized Fibula Flap For Reconstruction Of The Mandible

Segmental mandibular defect reconstruction is one of the most difficult tasks in reconstructive surgery.
These mandibular defects caused by resection of tumours, traumatic injuries, inflammatory diseases and congenital anomalies. Due to particularities of each patient and despite a large variety of surgical techniques available for such cases, the choice of the most suitable method remains an important issue.
The free transfer of the osteofasciocutaneous flaps is one of the most frequently used

methods for mandible reconstruction.
The free fibula flap was developed by Taylor1 in 1975,
Nowadays it became a standared flap for reconstruction of the mandible.
The advantages of the use of free fibula are: 1-Long length of bone. 2-Adequate diameter of its vascular pedicle.3- The ability to restore contour with multiple osteotomies .4 The ability to restore osteointegrated implants.
So, the fibula free flap became the workhorse of mandible reconstruction.

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S5-5 Management Of Traumatic Brachial Plexus Injuries

In Tunisia, Brachial Plexus surgery has started at Kassab Institute at the end of the 70's by Hichem Bahri.
The first Plexus was operated on July 1979 by Y. Allieli and H. Bahri .
Most of the cases in Tunisia have been treated by H. Bahri's team at Kassab Institute.
So far, over 200 Plexus injuries have been operated and through some of these cases, we are going to present our attitude and evolution during 40 years of experience.

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S10'-2 Post Abdominoplasty Intra-Abdominal Desmoid Tumor; a rare presentation
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Background: Desmoid (tendon like) tumors are benign myofibroblastic neoplasms originating from the muscle aponeurosis and are classified as deep fibromatoses. They constitute 3% of all soft tissue tumors. 50% of the cases occur at the anterior abdominal wall and mostly affects young women. Desmond tutors are aggressive locally, have a high risk of local recurrence but lack the ability to metastasize.
Case: Two years post abdominoplasty, a 63-year-old menopause lady, Para eight, presented with a feeling of abdominal wall mass. The mass was excised with histopathology report of a Desmoid tumor with negative margins, one year later the tumor recurred with an intraabdominal extension that was adherent to the bowel and protruding through the abdominal wall, recurrence lesion was excised again with negative margins and the defect was repaired with a mesh.
Conclusion: Desmoid tumor is a rare and locally aggressive neoplasm with high risk of recurrence. During abdominal wall repair in abdominoplasty, desmoid tumor filaments might seed deep intra-abdominally. Therefore, it is necessary to take enough safe margin before abdominal wall repair and to have high index of suspicious for tumor recurrence post abdominoplasty.

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S4-1 Microsurgical Reconstruction Of Finger Nails By Total Or Custom Made Toe-To-Finger Transfers
Joseph Bakhach, Reem Karami

Objectives: Amputation and defect of the fingernail system is a relatively frequent pathology often associated to the amputation of the finger pulp. Its reconstruction is often neglected to the benefit of the reconstruction of the skin finger pulp. Finger nail defects showed clinical situations of different kind and types. They can be total involving the whole nail bed and matrix. Often they are secondary to avulsion injuries but also its whole surgical resection can be dictated by a malignant process. Patients with partial fingertip amputation leading to a hook nail deformity were eliminated from our series.
Methods: Twelve patients were enrolled in this study and benefited from the free microsurgical transfer of the total nail system either from their big, second or third toes. Nine patients presented with total nail system loss and/or deformity were from traumatic origin while the three remaining patients were diagnosed with melanonychia and required total nail system excision for oncological reason. All these patients were concerned particularly by the absence of their fingernail. The three patients with melanonychia were reconstructed by the transfer in bloc of the nail system with pulp and distal phalanx (two from the second toe and one from the third toe). The four patients with zone IV fingertip amputation were reconstructed by the second tip transfer for two of them and by the lateral half of the big toe for the remaining two. Finally, the four patients with nail loss and/or nail dystrophy were reconstructed by only nail system transfer from the big toe in three cases and from the second toe in one case.
Results: No free flap total or partial failure were recorded. Based on the nail shape obtained, the harmony of the eponychial & paronychial processes, the growth of the transferred nail, the orientation of the nail apparatus and the adhesion of the nail plate to the nail bed, four patients recorded “Excellent”, seven recorded “Good” and one recorded “Fair” results.
Conclusion: The free microsurgical transfer of the nail system is the only available way which allows us to restore a lost fingernail system and re-establish the finger aesthetic and function identities knowing that the newly transferred nail requires month to years to recover a normal shape and normal growth speed.

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S2’-3 Workhorse Flaps For Intrathoracic Catastrophes

Complications of cardiac and thoracic surgery can present life-threatening situations that are challenging to resolve. These situations include intrathoracic bronchial or esophageal fistulas, exposed aortic prostheses/mechanical devices, persistent mediastinal infection, and large chest wall defects. The reconstructive surgeon may be called on to help resolve some of these situations and minimize the chances of recurrence. The workhorse flaps for intrathoracic reconstruction of will be reviewed including the omentum, serratus anterior and pectoralis flaps. Recent data from a large series of these reconstructions will be presented, and challenging case will be discussed.

S9'-1 Microsurgical Reconstruction Of Complex Upper Extremity Defects

Free tissue transfer is infrequently necessary for upper extremity reconstruction given the numerous pedicled or regional flaps available. However, certain situations including massive wounds or compromised anatomy may benefit from microsurgical reconstruction. A case-based review of free tissue transfer for large upper extremity defect will be presented.

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S6'-3 The Use Of Cadaveric Nerve Allografts In The Treatment Of Nerve Gaps
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Purpose: Although autologous nerve grafting is the gold standard treatment for nerve injuries with ≥ 1 cm gap, it can be limited due to the supply of donor nerve, to insufficient caliber of graft and to donor site morbidity. These limitations can be overcome by the use of cadaveric nerve allografts (CNA). The purpose of the current study is to report a single center's experience with CNA for functional restoration following traumatic nerve injuries.
Methods: Sixteen patients were included in the current study. The main indication for the use of CNA was nerve gaps ≥ 1 cm in which both the proximal and distal stumps of the injured nerve were available. The patients were given the option of selecting between autologous nerve grafts and CNA following a detailed consult regarding pros and cons of each treatment option. Only allografts from cadavers were used, and none of the patients underwent immunosuppressive treatment.
Preoperative workup included a detailed neurologic examination. Postoperative electromyography studies (EMG) were performed in patients with mixed nerve injuries at 3 months interval following reconstruction and then at 6 months after the first EMG
those graded ≥ 4 for both sensory and motor function, using the MRC scale.
Results: There were 6 male and 10 female patients. Fourteen patients were adult and 2 were pediatric. The majority of the lesions was located in the upper extremity (n=13). The majority of the nerves involved were sensory (n=11), followed by mixed nerves in 5 patients. Sensory recovery was graded as good and excellent in 12 out of 15 patients (80%), while motor recovery was graded good and excellent in 3 out of 5 patients (60%). Factors related with functional outcome was the level of the injury ($p < 0.05$) and the patient's age ($p < 0.05$).
Conclusions: Although our study has limitations (small sample size, lack of a control group, heterogeneous group of subjects, variation in the length of nerve grafts), the results of the current study suggest that peripheral nerve injuries can successfully be treated by the use of CNA. Avoiding donor site morbidity, minimizing operative time and availability are the most important advantages of using CNA instead of autologous nerve grafts. The cost and the risk of graft-versus-host disease are the main disadvantages of the use of CNA.

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KN4' **Facial Beauty Through Science: Mid Face And Lower Face Go Together**

Classically, face is divided in upper, mid and lower face. Here we present a different approach using not horizontal division but vertical: Proface, Mesoface and Metaface (from medial to lateral). This original method of segmentation takes in consideration the dynamic of the face and changes with ageing.
The mesoface is dynamic, mobile and sags with ageing, both in its upper part (Midface) and in its lower part (contour).
Mid Face and Lower face go together. Sagging at this level is usually the first sign of facial ageing. Improvement and rejuvenation of the facial contour is a growing request, which may be performed by a surgical lifting and also by filler injections.
This presentation describes the anatomical background of the facial contour, the description of ensuing sagging mechanisms in this area, with the proposal of an original scale to describe the sagging severity, and technical guidance for surgical lifting and rejuvenation by filler injection.
Key Words: Face contour, Rejuvenation, Beautification, Surgical lifting, Medical lifting, Fillers, Hyaluronic acid

S11-5 **Challenge In Lips Beautification: The Long Lip**

Lips age with loss of volume and loss of tonicity: atrophy, shape changes (J to I), become vertical, elongate, retrusion, especially the upper lip. Bone support and teeth age also with atrophy.
Take care with very long white lip because upperlip can drop beyond the level of teeth, loses its posterior bone and teeth support.
In this case any volumisation will be below the dental support: no projection possible. At the opposite, you increase the weight of the lip: lip is going to hang more.
Better to propose first a Surgical Lip Lifting. You can fill after if needed.

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S4-7 **Early Excision And Coverage Of Deep Hand Burns : About 6 Cases**
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Introduction: The hand is extremely susceptible to burn injuries, the acute management of hand burns needs to be approached carefully with a tailored treatment .Optimal time for excision and reconstruction is not a consensus. Surgical management for hand burns is often required, however it depends on the extent and location of the burn injury, as well as its depth. We aim to expose the indications and advantages of an early excision and coverage.
Materials and methods: This recent study was conducted in the Plastic surgery departement of Habib Bourguiba's hospital from September 2015 to April 2018, 6 patients with deep second and third degree hand burns and average burn size less than 30% total body surface area (TBSA) underwent early excision and coverage within five days using skin grafts and flaps .

Age of patients ranged from 7 days to 58 years .All hands were subjected to pre and pos operative program of physiotherapy. Measurement of total active motion (TAM) of each digit and grip strength was recorded pre and post operative; the aesthetic outcomes were also evaluated.

Results: Measurement of TAM of the digits of the hands post-grafting revealed an improvement in the overall range of motion with a better grip strength enabling the affected patient to return to a normal routine life. Our early urgery shortened the healing time and the hospital stay , minimizing reconstructive surgery with a reasonable aesthetic appearance .

Conclusion: We believe that early excision and coverage of burned hand with prompt physiotherapy leads to significant and faster regain of hand function and cosmetic long-term outcomes.

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S3-5 Transaxillary Breast Augmentation (TBA): Evolution Over 16 Years

Background: Breast augmentation is one of the most popular cosmetic procedures that plastic surgeons perform. According to the American Society of Plastic Surgery (ASPS), it was the number one cosmetic surgery procedure performed in the USA with 300,378 performed (up from 2016 by 3%). Transaxillary Breast Augmentation (TBA) is an elegant, easy, and dependable technique for breast augmentations with a low rate of complications and very high patient satisfaction. A 16-year experience and the evolution of the TBA technique and different breast implants is presented.

Advantages of the TBA Approach: The TBA approach has several advantages over the peri-areolar or infra-mammary approach. The TBA approach leaves an imperceptible scar not on the breast but rather in the axilla; that scar is not under tension and heals very well. There is no dissection of breast tissue per se and the muscle is not split to introduce the implant. Dissection from the axillary approach is performed through the delto-pectoral fascia and posterior to the pectoralis major muscle. Another advantage is that the dissection is away from the milk ducts and the blunt dissection of the sub-pectoral pocket makes the injury of the fourth intercostal nerve that innervates the NAC incredibly rare. Furthermore, by nature of the efficient dissection and lack of need to tighten the muscles anterior to the implant from the other two popular approaches, the operative time is significantly reduced with average surgical time being 25 minutes skin to skin in more recent years.

Evolution of TBA in My Practice: I have performed all my breast augmentations with tumescent fluid (250 cc of saline, 50 cc of lidocaine plain and 1 ampule of epinephrine 1:10,000). It decreases the rate of hematoma to almost zero, creates a nice plane of hydro-dissection, and provides for immediate post-operative local anesthetic relief. Initially, TBA was performed endoscopically assisted. The advantage of the endoscope assistance is to delineate anatomy, allow the surgeon to visualize the structures, and to achieve hemostasis under direct visualization. The disadvantage is that is ads a step of reliance on the endoscopic equipment being sterilized and functional as well as adds time to the procedure. The endoscope does not offer a substantial advantage after the learning curve is reached and with the use of the tumescent technique to minimize bleeding.

The next phase was performing TBA with saline implants through a 2 cm incision without endoscopic assistance (Non-endoscopic TBA). That was also performed in conjunction with mastopexy. That was performed while keeping the sizer in place, performing the appropriate mastopexy technique, and then removing the sizers and replacing them with saline implants via the axillary incision.

The most recent phase was to perform TBA with silicone implants with a Keller Funnel and a No Touch technique. A 5 cm incision is sufficient for implants up to about 600 cc, above which, the incision may need to be extended to fit the larger implant. The technique of combining a mastopexy with a transaxillary silicone implant is performed in a similar

approach to that with saline implants

Results and Avoidance of Pitfalls: Our series over 16 years combining the saline and silicone implant results of patients who underwent breast augmentations and augmentations/mastopexy with the TBA technique has been very favorable. Post-operative pain in general has been limited to the first few days and controlled with analgesic medications. Return to daily activity has occurred within a week to 10 days. Exercise is usually encouraged after the third week. The complications have been limited to minor wound infections (3%), capsular contracture (1.5%), deep vein thrombosis (less than 1), loss of nipple sensation (less than 1%) hematomas (less than 1%), and saline implant deflation (less than 1%). Less than 1% of patients were dissatisfied for reasons of asymmetry. It is important to note that there were no implant infections, high-riding implants, double-bubble signs, pneumothorax, loss of ability to breastfeed, or death.

Over the years, technical improvements -Excellent pre-oping
-Ancef 30 minutes before surgery
-Inject tumescence and wait 7 minutes
-Proper finger dissection (make sure two fingers fit in transaxillary incision for silicone implants)
-Be aggressive with Van Buren Sound –especially at bottom pole –to avoid “high riding” implant
- Excise or liposuction excess breast tissue in axilla/lateral breast
- Asymmetry: choose size range in office not on the table!
-Place sizers and sit patient up to assess result
-Kennel Funnel needs to be cut to proper size
-Squeeze breast into pocket gently
-Tape breasts for 1 week

Conclusion: The Non-endoscopic TBA technique is safe and effective way to perform a breast augmentation. This presentation has demonstrated the simplicity and elegance of this approach, with a low rate of complications and high level of outcome predictability and patient satisfaction.

S4’-3 Suture Suspension Neck lift: A Versatile Technique for Long-Term Neck Rejuvenation

Background: The suture suspension neck lift is a very versatile, reproducible and dependable technique to give both short and long term improvement and rejuvenation to the neck contour that I have used for 17 years with excellent outcomes for various neck types. Achieving a youthful neck and jawline is a very critical step in facial rejuvenation. The suture suspension technique has demonstrated to play an important factor in the desired treatment for a more defined jawline in all classifications of neck types with the appropriate facial surgery being performed. Whether a neck lift is performed solely or with other facial rejuvenating procedures such as a facelift, a secondary facelift, blepharoplasties, facial fat grafting, or a chin implant, a suture suspension neck lift is a valuable technique.

Suture Suspension Technique: It is of paramount importance to set realistic patient expectations. A patient has to initially understand the difference between a facelift and a neck lift and the limitations of a neck lift if performed alone. The technical aspects of a neck lift is as follows and can be performed under local anesthesia with tumescent solution, sedation, or general anesthesia with intubation according to the surgeon and the patient’s preference:

1. The patient is anesthetized, prepped and draped
2. The neck is injected with tumescent solution
3. The neck is liposuctioned if necessary with a spatulated cannula
4. Midline curvilinear submental incision is made and the excess skin posterior to the ears is excised in an elliptical fashion.
5. Skin overlying the platysma is elevated
6. The two platysmal bands are imbricated at the midline with prolene sutures
7. At the level of the hyoid bone, at the midline, a prolene suture is placed in a mattress suture at the medial edge of the platysma, interlocked with another prolene suture at the midline, placed in a similar fashion but as a vertical suture. Bothe sutures are free floating laterally
8. The ends of both sutures are tied to the left and right mastoid facsia respectively, creating an artificial ligament that suspends the platysma and creates a well-

defined neck line.

9. The skin is re-draped over drains and sutured.

Advantages of the suture suspension neck lift technique: This technique has many advantages:

1. This technique can be adjusted to fit different types of necks ranging from a neck with little excess fat and no excess skin to a very heavy neck
2. It can be performed alone or in combination with other facial procedures such as facelifts or chin implants.
3. The lateral scars are behind the ears and don't have the stigma of a visible facelift scar.
4. It can be performed in about 90 minutes.
5. It can be the technique performed to just improve the neck and jaw-line in someone who previously had a facelift and is unhappy about their neck.
6. It can be used as the way to rejuvenate the neck in virtually every facelift.
7. It has long term durability of results

Avoidance of Pitfalls:

1. It is best to make sure before the surgery that a patient is aware of the limitations versus a facelift
2. The amount of skin resected from the post-auricular area should be conservative-better to err on the side of less than more
3. The prolene sutures should be tied to the mastoid fascia without tightening them significantly otherwise the patient with complain of discomfort and the sutures will have to be redone.
4. In massive weight loss patients, a neck lift may result is some skin laxity and that should be explained to the patient
5. Liposuction should not be performed or should be performed very minimally in a neck with little or no fat to avoid uneven skin redraping
6. When performed with a chin implant, its best to place the chin implant and cover with platysma muscle before tying the prolene sutures to create the suture suspension neck lift

Complications: As with every technique, there is a learning curve, and the results improve with time and experience. Most of the complications occurred in the early years because of lack of experience and the performance of neck lifts on people who should have had a face lift instead or who should have been turned away because of a myriad of reasons such as that they were smokers or non-compliant patients. Minor complications such as small wound dehiscence, suture abscess, small seroma/hematoma, minor smile asymmetry that was self-limiting have been 3.5%. Major complications including hematomas that required reoperation, permanent nerve damage, skin necrosis requiring scar revision, excess skin that required a secondary neck lift were 1.2%

Conclusions: A suture suspension neck lift has proven to be a very useful technique for me in the past 17 years and I hope to have shared that it is safe, effective, and useful technique for improved neck contour results for the short and long term.

KN11 Ethnic Rhinoplasties- a 16 Year Experience

Introduction: The nose is the centerpiece of the face and its esthetics are essential to well-balanced facial features. "I want my own nose only prettier" is something commonly heard from a rhinoplasty patient. Rhinoplasty patients are typically ones who have done a lot of research before coming to their consultation and know what they want. It is very important to listen to them carefully and assess the following: Are they reasonable and realistic? Can they articulate what they want? Do you agree with them? Can you as a plastic surgeon give them the nose they want? In ethnic rhinoplasty surgery, a further layer of complexity is added: Does the patient truly want an ethnically-balanced rhinoplasty, or do they want their nose to look more Caucasian, or another race?

Various Elements to be Considered: Performing ethnic rhinoplasties successfully requires many skills. Technical expertise is must. A plastic surgeon should have the skill-set to perform a rhinoplasty and accept to perform such surgeries commensurate with his or her level of expertise, resulting in naturally looking results. Secondly, Artistic eye is important. Appreciation of facial harmony, beauty considerations and how those metrics differ from one culture to another is essential to give the patient a result that is ethnically compatible. Ethnic and cultural sensitivity should also be taken into consideration. A rhinoplasty is an emotionally charged operation and is handled differently in different

cultures: In the Arabic culture, the older brother, husband or mother articulates the desired results, which may not be what the patient wants, so listening carefully and allowing the patient to express her opinion is very important. The operation is also age sensitive. Teenagers and millennials have a sense of entitlement where anything less than perfection is hardly tolerated. It is important for the plastic surgeon to articulate not only the goals, but the limitations of the surgery. On the other end of the spectrum, older patients requesting an ethnic rhinoplasty tend to be more conservative and will not appreciate a huge change to a nose they have lived with for a long time. Knowledge of pop culture affects the plastic surgeon's ability to relate to his/her patients. In the age of the "Selfie", more people are seeing the base of their nose and not liking it, prompting a rhinoplasty! Also, in the age of YouTube, Instagram Stories, and Face-time, cyber-bullying has made young people very self-conscious and has taken "getting a nose job" from a want to a need. Celebrities influence the patients' requests, so knowledge of celebrities enables a plastic surgeon to understand what a patient wants and whether their demand is realistic.

Consultation and Anatomical Considerations: A rhinoplasty consultation needs to be detailed, thorough, and informative to both the patient and surgeon. A thorough history and exam is performed. The patient and the surgeon should see eye to eye on the objectives, the risks, and the post-operative management and plan to handle any untoward events or complications. The ethnicity and facial beauty balance of the patient will influence the surgical plan, and the details need to be share with the patient. Each patient is unique, and so should each rhinoplasty be. Customizing a nose to the individual patient based on photographs, digital imagery, other family members noses, other patients' before and after photos in the office is all beneficial to decide whether to proceed with the surgery. Revision, or secondary rhinoplasties, are more difficult, and emotionally charged, thus require more time, patience, and explanation, since the patient has already been disappointed once.

Various Ethnic Rhinoplasties and Goals of Surgery:

1. **Caucasian nose (European white):**
   The characteristics of a Caucasian nose are thin skin, high radix, long, narrow bones, thin dorsum, moderate dorsal hump, large cartilages, asymmetrical lower lateral cartilages (LLC).
   The surgical goal is to balance radix to dorsal height, shape dorsal hump, improve tip symmetry and projection, and narrow the dorsum if necessary while being mindful of the thin skin.
   Rhinophyma is a specific condition with development of large bulbous nose predominantly in Caucasian noses with overgrowth and hypertrophy of sebaceous glands and untreated rosacea
2. **Hispanic nose (Subsets of Hispanic noses include Caribbean noses that have some characteristics of African noses, whereas other south American countries where there was Northern European migration, such as Argentina, noses are with Caucasian influence).**
   The characteristics of a Hispanic nose are thickened sebaceous skin, wide dorsum, small osteocartilagenous vault, prominent dorsal hump, droopy wide bulbous tip with fibro-fatty tissue, minimal tip support, short columella, broad alar base with moderately round nostrils, weak LLC cartilage
   The surgical goal is to generally decrease the size of the nose, improve radix to dorsal relationship, dorsal augmentation or hump reduction, depending on the nasal anatomy, tip refinement with LLC cephalad resection, suturing, grafts for improved projection and support, and lengthening the columella, and alar base reduction by alar sill excisions
   Usually, Hispanic rhinoplasty patients are happier than Africans who wished their nose could have been smaller, or Asians who wished their tip could be more defined.
3. **Middle Eastern nose (Arabic, Turkish, North African, and Persian Descent)**
   The characteristics of a Middle Eastern nose are moderately thickened skin, over-projecting radix, wide bridge, prominent dorsal hump, long nose, nasal deviation, bulbous or ill-defined droopy tip with significant fibrofatty tissue, moderately flared, asymmetrical nostrils, hyperactive depressor septi nasi muscle.
   As a subset, Non-Gulf patients (Syria, Lebanon, Turkey, Egypt and Morocco) desire more tip projection and less dorsal height than patients from Gulf countries

(Saudi Arabia, UAE, Kuwait, Iran and Oman).
Harmony is achieved by reducing height of radix, reducing dorsal hump moderately, straightening the septum if necessary, defatting tip, and creating a more defined and thinner tip, resecting or transposing the depressor septi nasi muscle to elevate the tip, alar base reduction, and reducing dorsal width.

4. **Asian Nose (Chinese, Japanese, Filipino, Korean, and Indonesian)**
The characteristics are moderately thickened skin, low narrow bridge, short nose, flattened tip, flared nostrils with weak lower lateral cartilages, paucity of septal cartilages.
In general Asians desire dorsal augmentation and increased tip projection, which can frequently be achieved with fillers to both improve the contour and allow patient to see temporarily how a dorsal and tip augmentation affects their nose before they commit to surgery.
For surgical correction, the decision should be made whether to go with implants or cartilage augmentation. Caudal extension cartilage graft is sometimes needed to lengthen the nose and provide tip support.

5. **African nose**
African noses are characterized by thickened skin, low narrow radix, relatively small osteo-cartilagenous vault, low flat dorsum, short nose, rounded tip with significant fibrofatty tissue, minimal tip projection and definition, flared, ovoid nares, small septal cartilage, and short columella with an acute columellar labial angle.
In general, a rhinoplasty for an African nose should achieve nasal facial harmony and balance, narrower straight dorsum, enhanced tip projection and definition, and reduction of nasal alar flaring with defatting of tip

Non-Surgical Algorithm

Nonsurgical or filler rhinoplasty is becoming more popular due to safe and readily available fillers. Injectables are commonly done on all nose types with Calcium-based fillers for primary noses or when more volume needs to be achieved, and hyaluronic acid fillers for primary noses that need mild contour changes or secondary noses with concern for blood supply

Surgical algorithm

A nose should be thought of as a pyramid and should look good from all angles after a rhinoplasty is completed. My algorithm for a rhinoplasty is as follows:

i. Open approach
ii. Address dorsum (shave hump if necessary)
iii. Address septum (septoplasty if need to do so for functional concerns or for cartilage harvest)
iv. Address inferior turbinates (either formal reduction or out-fracturing if necessary)
v. Spreader grafts or spreader flaps if necessary
vi. Address tip (debulk fibrofatty tissue if necessary, LLC cephalad resection, suturing of LLC to define tip better, tip cartilages for support and reshaping tip, and alar cartilage grafts)
vii. Address tip skin thickness
viii. On-lay dorsal graft (with septal cartilage dorsal on-lay graft (<2 mm), AlloDerm (2-5 mm), and diced cartilage in temporalis fascia/ AlloDerm or rib graft (> 5 mm) depending on the surgeon's preference)
ix. Close
x. Bilateral osteotomies (if necessary)
xi. Alar base reduction (Weir excision- but not above the alar groove otherwise will jeopardize the lateral nasal arteries + possibly a nasal sill excision if necessary)
xii. Crushed cartilage to improve asymmetries, create a softer look, and camouflage tip grafts
xiii. Splints

Conclusion: Ethnic rhinoplasty is a precise and demanding operation due to many factors discussed in this talk. The upside is that if all the considerations are addressed, then our patients will be very happy and have noses that match their identity and sense of beauty.

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S2'-5 Cutaneous Squamous Cell Carcinoma of the hand: About 10 cases

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Introduction: Cutaneous squamous cell carcinoma (CSCC) is the most common malignant tumor of the hand. It occurs mainly on precancerous lesions and carries a risk of metastatic spread, initially ganglionic.
Through this study we will analyze the epidemiological, clinical and therapeutic characteristics of a series of patients of our service having a CSCC of the hand.
Patients and methods: This is a retrospective descriptive study of patients with CSCC of the hand. After consultation of the medical files, sociodemographic, clinical, paraclinical and therapeutic variables were collected.
Results: The series consists of ten patients, whose average age was 66.7 years (48-84years), with sex ratio = 7Males / 3Women. All patients experienced chronic sun exposure. Two of them have a genetic dermatological disease (albinism and epidermolysis bullosa). The CSCC developed on a precancerous lesion in three patients. The dorsal side of the hand was the most affected. The average size at the discovery was 3.17cm. The diagnosis has been proven in all cases with histopathological examination. The preoperative extension assessment showed the presence of homolateral axillary lymph node metastases in only one case.
All patients received exclusively surgical treatment with a safety margin of 1 cm. The residual skin loss was covered by a total skin graft in most cases. The definitive pathological examination showed healthy exeresis limits in nine patients. In one case, the exeresis limits were not healthy and we opted for a surgical revision
The late onset was marked by the appearance of locoregional lymph node metastases in two patients within an average delay of 3 months requiring an additional act of lymph node dissection.
Conclusion: CSCC is potentially aggressive and is frequently associated with significant sun exposure or genetic predisposition. Given its potential for lymph node metastasis, sentinel node indication is justified by many teams. Surgery remains the therapeutic method of choice.

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S3'-1 Stem Cells And Their Clinical Applications In Aesthetic Surgery

There is a lot of controversy in the indications for the use of stem cells worldwide.
Though many clinical trials are conducted internationally, the consensus is still not achieved.
The federal regulations in Switzerland are strict as to the clinical applications.
However, in collaboration with the Swiss Stem Cell Foundation, we are allowed to inject stem cells in the subcutaneous tissue for aesthetic indications.
Stem cells are also sometimes added to lipofilling in order to increase the viability of the fat grafts.
An overview is also presented about the future applications.

S4'-5 Single Stage Lipofilling In Aesthetic And Reconstructive Surgery

According to many studies, lipofilling is associated with 30-40% of fat resorption in the first 3 months after injection thus the procedure has to be repeated in order to achieve an optimal result.
Every surgeon has his own recipe in collecting the fat grafts and injecting it.
I would like to discuss my approach of fat grafting for correction of soft tissue defects in the breast or other areas that have been affected by trauma or radiotherapy.
Some cases are presented with a long-term follow up based on a single stage lipofilling.

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S5-2 Extreme Supermicrosurgical Treatment Of Lymphedema

Lymphedema is a chronic debilitating condition that most commonly results from surgical treatment for malignancy coupled with adjuvant therapies like radiation and chemotherapy in the modern world. With the increasing popularity and promising outcomes reported with lymphedema surgery, the potential for expanding current super microsurgical techniques seems limitless. Studies have demonstrated remarkable outcomes with the lymphaticovenular anastomosis (LVA) or the lymphovenous bypass (LVB) operation as well as the vascularized lymph node transfer (VLNT) operation. Previously, patients were considered candidates for one or the other; however, recently, we have been combining both approaches and have demonstrated promising results. However, the boundaries for super microsurgery for lymphedema are not limited to combining both approaches for a single extremity. Often patients present with lymphedema of multiple extremities and are seeking surgical treatment. In the most extreme cases, patients present with lymphedema of all four extremities which can now be treated safely with current techniques. Here we introduce the concept of combining both modalities for multiple extremities to maximize the outcomes for patients suffering from lymphedema.

S9-7 Alternate Free Flaps In Complex Microvascular Head And Neck Reconstruction

The use of free flaps has become the standard of care for reconstruction of complex head and neck defects following oncologic resection. For most reconstructive surgeons, there are a handful of workhorse flaps that can reconstruct the overwhelming majority of defects. The anterolateral thigh (ALT) flap, the radial forearm flap, and the latissimus dorsi muscle flap are generally regarded as the most reliable soft tissue flaps, and the free fibula osteocutaneous flap has become the most popular flap when bone is needed. However, there are circumstances when these flaps are not available, and reconstructive surgeons need to have other reliable flaps in their armamentarium. Here we present the use of a variety of secondary flap options that can be incorporated into the reconstructive algorithm when the workhorse flap options cannot be used. The profunda artery perforator (PAP) flap, the ulnar artery perforator (UAP) flap, the lateral arm perforator flap, and the medial sural artery perforator (MSAP) flap are all potential soft tissue options, while the iliac crest based off the deep circumflex iliac artery (DCIA) can be a useful alternative when bone is needed.

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S5-6 Reconstruction For Peripheral Nerve Disorders From Brachial Plexus To Diaphragm Paralysis

The principle goal in the field of plastic and reconstructive surgery is to restore form and function. Unfortunately this goal is often not completely realized leaving patients with significant disabilities even after reconstruction. Although reconstruction of form has been achieved, adequate function may still be lacking. In this setting, rehabilitative surgery is necessary to treat these deficiencies thereby enabling patients to regain this lost function. Peripheral nerve disorders due to trauma, previous surgical interventions, or treatment of malignancy are extremely devastating. Here, we present an overview of various debilitating disorders ranging from the brachial plexus and the upper extremity to the phrenic nerve and the diaphragm to the peripheral nerves of the lower extremity as well as the available options to treat these conditions. These treatment modalities often require a multidisciplinary approach and encompass all rungs of the reconstructive ladder spanning nerve decompressions, tendon transfers, and microsurgical techniques in order to adequately correct these disabilities.

S11'-1 Lower Extremity Reconstruction And Salvage Without Free Flaps

Reconstruction of the lower extremity can be challenging due to the nature of the defect as well as the paucity of soft tissue available to provide coverage of exposed bone, cartilage, and neurovascular structures. In these instances, a successful reconstruction is critical for limb salvage to preserve an ambulatory status for the patient. The lower extremity is often divided into thirds to facilitate a standardized approach to reconstruction. For instance, the gastrocnemius muscle flap is usually utilized for coverage of the proximal third while the soleus muscle flap is the primary option for the middle third. In the setting of defects and wounds along the distal third, the options for reconstruction become less reliable and free tissue transfer is often necessary. Here, we present the various alternatives for reconstruction of lower extremity defects prior to resorting to free flaps which may be beneficial especially when microsurgical procedures may not be available. Certainly, free tissue transfer always remains a viable option if local pedicled flaps are not possible.

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ABBVIE SYMPOSIUM

Hidradenitis Suppurativa: Updates In The Holistic Management Of The Disease

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S5'-1 Medico Legal Aspects Of Plastic And Aesthetic Surgery
Michel Costagliola, Remi Costagliola*

The assessments linked to medical liabilities are increasing constantly not only in France, but also in Europe. Claims for negligence against surgeons have risen in both plastic and aesthetic surgeries. Reconstructive and aesthetic surgeries are often opposed, but they both represent the two inseparable sides of plastic surgery; and the borderline between

both is often blurred.
The duty to inform and the methods of providing information are essential: in the preoperative phase and from the first consultation, loyal, reinforced, intelligible, appropriate information must be given. All known risks, even if they are exceptional, must be exposed, as well as the way the technical plan for performing the operation. A document explaining the type of operation performed will be given. Finally, the surgeon must respect the proportionality rule: the surgeon must observe a particularly careful attitude concerning the risk of the operation in relation to the degree of the trouble. They must not expose the patient to unacceptably high risk solely for aesthetic improvements. In case of a lawsuit, the level of detail provided in the medical and nursing files is fundamental in the assessing the liability of the surgeon, helping to establish if there is a link between a mistake or an unknown therapeutic factor and a physical injury. The important points in aesthetic and plastic surgery are: Good information, Good indication, Good and valid technique. And if a complication occurs, become this patient's best friend.

S11'-5 Venous Compartment Syndrome And Chronic Leg Ulcers: Plastic Surgical Treatment

Prolonged venous hypertension caused by incompetent valves in the leg and chronic venous insufficiency leads to the fibrotic tissue, scarred and hyperpigmented skin known as lipodermatosclerosis (LDS), with a stenosing aspect of the inferior part of the leg (cock calf like leg) Preulcers and non healing leg ulcers are usual. A venous compartment syndrome in the anatomical space of the leg (venous tourniquet effect) explain clinical and functionnal disorders.
A large fascio-aponevrotomy (releasing incisions) and a subfascial perforating vein ligation without removal of the ulcer and the surrounding pathologic skin, is performed and restore a good venous hemodynamic condition. A split skin graft of the complete trench is used ten days later.
48 patients (22 male mean ages 58 and 26 female mean age 63) underwent this procedure in eight years. Follow up ranged from 2 to 8 years.
In our serie, 41 patients healed with a continuous contention of the lower leg in post operative. 7 cases recurrent ulcers were identified (arterial participation).
Decompressive technic with subfascial perforating vein ligation followed by split thickness skin graft is both an efficacious and effective procedure in LDS. It's easy, no dangerous and reliable: it changes local situation and the quality of life of those patients.

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S2'-1 La Chirurgie Palliative Du Membre Supérieur Chez Le Tétraplégique
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La prise en charge chirurgicale du membre supérieur chez le tétraplégique, nécessite une bonne connaissance des grands principes de cette chirurgie. Elle ne peut être envisagée que lorsque le patient est stabilisé sur le plan des séquelles neurologiques.
Cette chirurgie repose essentiellement sur les transferts tendineux et les techniques de Ténodèse. Son objectif est de redonner une fonction satisfaisante à des membres peu ou pas fonctionnels, dans le but de pouvoir les réinsérer au sein de la société.
Il faut savoir que chaque patient est un cas particulier et sa prise en charge doit être pluridisciplinaire, impliquant médecins physiques, neurologues, kinésithérapeutes et chirurgiens.
Pour démarrer cette chirurgie, nous nous sommes plutôt référés à l'école française (Y. Allieu , M. Revol…), dont les écris ont preuve de logique et d'expérience.
Nous rapportons notre expérience en matière de prise en charge des patients tétraplégiques, qui quoi qu'elle est relativement récente, elle a permis d'améliorer la fonction des membres atteints de nos patients.

Nous exposons également certains principes et les indications chirurgicales en fonction des niveaux lésionnels et des groupes des patients.

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S5-4 Lymphatic Leak Management, Prospective Study And Algorithm Of Management
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Introduction: Surgical procedures interfering with the draining nodes at the inguinal region carry the intrinsic risk of lymphatic complications. Lesions of the inguinal lymphatic network can lead to lymphocele or lymphocutaneous fistulas (LF) and can eventually be associated to limb lymphedema with highly associated morbidity. To date, no surgical algorithm addresses lymphatic complications and leakages with adequate systematic solutions according to the wound properties. In this work we critically analysed prospectively maintained series of patients with lymphatic lower limb complications, where treatment was chosen according to the specific wound properties and ranged from vessel ligations to flaps and lymphovenous shunts.
Patients and Methods: The study retrospectively investigated 11 consecutive lymphatic complications (lympocele and lymphocutaneous fistulas (LF)) of the lower limb in 11 patients at the Lausanne University plastic surgery department after failed attempts to heal the complications by conservative or surgical treatment by other surgical specialities Operative time, complications, time to complete healing, duration of hospital stay, rate of recurrence and stability in the long term were assessed.
Results: All surgical repairs of lymphatic leaks and soft tissues coverage were successful. Among flaps reconstruction, we performed an abdominal fascicutaneous advancement flap in 2 patients (18 percent), while in 3 patients (27 percent), muscular flaps were necessary for wound coverage in addition to lymphatic ligation and LF treatment (pedicled gracillis muscle flap, pedicled VRAM flap and a free latissimus dorsi free flap). One patient had a distal flap necrosis that required flap revision for advancement. Mean follow up for all 11 patients was 11.8 months +/- 2.9 (average +/- SEM; range, 6-36 months) with no clinical sign of infection, lymphatic complications recurrence or wound breakdown.
Conclusions: This study reports our experience and long-term outcomes in surgical treatment of lymphatic complications following groin and thigh area surgery. A stepwise approach, combining lymphatic surgery principles and plastic surgery techniques, leads to an effective treatment algorithm where surgical options are wound-tailored to guarantee the best functional outcomes.

S7'-4 Abdominal Wall Reconstruction, Free Vs Pediculed Flaps
Pietro Di Summa, William Watfa, Wassim Raffoul*

Introduction: Reconstruction of three-dimensional abdominal wall defects by transposition of vascularised autologous tissue is the most effective to repair large composite abdominal defects. Among different techniques of autologous reconstruction, the use of free versus pedicled composite anterolateral thigh (ALT) flap was analyzed. The purpose of this study is to analyze long term outcomes and complications following abdominal wall reconstruction, establishing a systematic surgical algorithm according to tissue properties and defect localisation.
Patients and Methods: The study retrospectively investigated 12 patients who underwent abdominal wall reconstruction between May 2003 and June 2017, all presenting three-dimensional abdominal wall defects, not suitable for component release or inlay/outlay mesh reconstruction only, limiting reconstructive possibilities to autologous flap

reconstruction. Reconstructions were performed after either tumour resection or surgical debridement involving the rectus abdomini muscle layers. ALT were associated with vastus lateralis (VL) muscle and fascia lata (FL). Volumetric flap analysis on serial post-operative CT scans was used to assess flap atrophy over time. Operative time, complications, time to complete healing, duration of hospital stay, abdominal wall stability and flap stability in the long term were assessed.
Results: All flaps successfully covered the defects. No late complications such as fistulas or hernias occurred. Mean operating time of the reconstruction was 368 min. Following volumetric flap analysis on serial post-operative CT scans, flap atrophy over time was estimated. Donor-site recovery was uneventful with no functional deficits.
Conclusions: The ALT flap, when harvested together with the vastus lateralis muscle and the fascia lata, can mimic abdominal wall structures, allowing a functional reconstruction of the abdominal wall. Pedicled composite flap efficiently covered abdominal wall defects up to the umbilicus level. While free flaps were better indicated for total or supraumbilical defects.

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S2'-7 Biomimicry in hand surgery. Reconstructive artificial systems derived from Flexor Digitorum Superficialis
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Introduction: Biomimicry is the imitation of the nature for solving complex human problems. The hand surgeon, usually, tries to copy and recreate the structure-to-function and function-to-control relationship of the native tissues after damage. From its original structure and biomechanics, the Flexor Digitorum Superficialis (FDS) has been an important source of inspiration for reconstructive artificial systems (RAS). The aims of this study is to list the different RAS derived from FDS and evaluate their degree of biomimicry from native system.
Material and method: We conducted a literature review using PubMed, Ovid MEDLINE, and EMBASE databases. We selected English and French language articles that described RAS derived from FDS. RAS derived from FDS were classified into 5 categories according to the total or partial used of the system (whole system, tendon, muscle, nerve and synovial tissue). The degree of biomimicry was established on 4 dimensions (structure, form, function and control). Comparaison of the degree of biomimicry of RAS from native system was evaluated.
Results: 959 articles met our inclusion criteria and 105 articles studies were selected. 21 RAS derived from FDS were listed. Degree of biomimicry of RAS derived from FDS varied according to the type of RAS and dimension of biomimicry. RAS derived from FDS present the best biomimicry dimensions in less than 30% when compared to the other classic RAS not derived from FDS.
Discussion: In hand surgery and for many reasons (statistic, patient, pathology, environment…), clinical trial can be very difficult and maybe impossible to determine the best surgical solution for patient. Degree of biomimicry of RAS from native system could be an interesting solution and should be kept in mind by surgeon. This bio-inspired approach of the structure, function and control of the hand's musculo-squelettal system continues nowadays to improve with the development of new technologies.

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S3'-7 Egyptian Revolution 2011 Recall of World War I; Management of Complex Facial Defects

Background: World war I (1914-1918), often referred to as the great war, appears to have been the curial starting point for the development of what is now considered modern plastic surgery. In Egyptian revolution (2011), we faced unfortunately facial injuries typical to those in world war I.
We present a lot of cases with complex facial trauma reconstructed by a different modalities of flaps.
Patients and methods: Forty two patients presented by complex facial trauma varied from bone exposure to complex defect involves soft tissues and bones defects.
Variable reconstructive options ranged from direct closure, regional flaps to free flaps were applied with recall of some surgical procedures applied in world war I.
Conclusion: Recall of history is a difficult human evidence, in our work we will present a glance of typical human conflict history repetition with use of all reconstructive modalities including some applied in world war I

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S3'-6 Complex Intraoral Reconstruction Using A Single Free Anterolateral Thigh Flap And Supermicrosurgery After Corrosive Ingestion In A 14-Month-Old Child

Oral chemical burn injuries induce more damage to the underlying tissues with extensive scarring. It is very well known that alkali causes severe liquefaction necrosis and injury to the deeper tissues. Pediatric facial burns must be managed thoroughly and always require complex reconstruction, which is a challenging process. So, any reconstructive surgeon must be aware of all the deformities that may have significant functional and aesthetic impact on the burn survivors especially children. Few medical studies addressed pediatric microsurgical reconstruction for oral burn injuries induced by chemical materials. Anterolateral thigh (ALT) free flap is a common flap with a multitude of indications. The purpose of this article is to present the youngest case in the medical literature of caustic intraoral scarring managed with a very thin free anterolateral thigh flap in a 14-month-old child who underwent reconstruction of his inner cheek, the angle of the mouth and tongue using supermicrosurgery techniques. Further development of the surgical techniques is required to establish early and safe intraoral pediatric microsurgery with a long-term follow-up.

S6'-4 Vascularized Sural Nerve Flap For Complex Peripheral Nerve Injuries Using Perforator To Perforator Techniques

The superiority of the vascularized nerve graft over the traditionally used nerve graft, especially in a scarred recipient bed is very well documented. Longer defects are best repaired primarily with vascularized tissues. The vascularized sural nerve is one option of the vascularized nerves that could be used. In our series we tried to investigate the

harvesting the vascularized Sural nerve flap (VSNF) based on gastrocnemius perforator only for reconstruction of different nerve defects.
Patients and methods: Nine patients with evident nerve injuries diagnosed clinically and evidenced by nerve conduction and EMG studies were included in this study. The vascularized sural nerve flap was divided and folded to bridge the desired girth.
Results In our study, the average nerve gap was 9.1±1.1 cm. The VSNF was used to reconstruct patients with peripheral nerve injuries in the extremities. There were 5 cases of median nerve injury, 2 for posterior tibial nerve injury and two cases of peroneal nerve injury. The main cause of injury was machinery accidents and it represented 67%. The average Vascularized Sural Nerve flap (VSNF) that
was harvested was 25.2 ±4.2 SD cm. The shortest was 20 cm and the longest was 31cm. The follow-up period was 26.4± 2.6 months.
Conclusions: Vascularized sural nerve flap is a very promising solution for treatment of long gapping neuroma in peripheral nerve. Sural nerve flap is one of the best donor sites with constant anatomy. Supermicrosurgy allows us to anastomose very short pedicle without deep muscular dissection.

S11'-2 Sensate Free ALT Flap For Foot Reconstruction In Pediatric Population

The myriad of anterolateral thigh (ALT) in adult reconstructive microsurgery is well established, especially in the lower extremity. In the opposite side, the publication in pediatric lower extremity reconstruction is still limited. The aim of this study is to focus on the possibility of using the sensate free ALT flap for reconstruction of
soft tissue defects in the foot. Retrospective analysis of all patients who underwent sensate free ALT for lower foot reconstruction in the last 4 years with the least follows up 2 years postoperatively.
Methods: The study included 23 patient aged 3.2 -14.6 years with a mean of 9.4 years. All patients had crush injuries after run over motor vehicle accidents. All flaps were raised in sub facial plane and included one or two branches of the lateral cutaneous nerve of the thigh.
Results: Nerve anastomosis was done over sensory nerve around the ankle while vascular anastomosis on the anterior tibial vessels. No thinning was performed prior to flap inset. Mean Flap surface area was 123.2 cm2. 60 % of the donor site required a skin graft. Primary flap survival rate was 100%. Post-operative hospital stay averaged 7.2 days. Sensory recovery in nearly 0.95 of the cases as tested by the pinprick test and two-point discrimination of the new flap.
Conclusion: We suggest that sensate free ALT flap could be as safe, reliable, and aesthetically appealing option for foot/ankle resurfacing in children after traumatic soft tissue loss

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S9'-2 Aesthetic And Functional Outcome Of Thinned Anterolateral Thigh Flap In Reconstruction Of Complex Wounds Of Upper Limb

Objective: The aim of our study was functional and aesthetic evaluation of the use of free thinned anterolateral thigh (ALT) flap for reconstruction of complex upper extremity wounds.
Methods: A prospective analysis of 18 patients with complex upper extremity soft tissue defect from June 2014 till June 2016, was performed. All patients had free thinned ALT perforator flap for reconstruction of skin defects following repair and/or reconstruction of associated injuries as bones, nerves, tendons and vascular injuries. Perioperative data were collected. Aesthetic and functional outcome were recorded after six months. Aesthetic evaluation was done by four plastic surgeons (panel assessment). It included five items: color match, contour, texture, hair distribution and overall satisfaction. Each

item was evaluated as five-point Likert Scale. Functional assessment was performed using patient's self-assessment DASH scale.
Results: The study included 14(77.8%) males and 4(22.2%) females. The mean age of the studied population was 17.5 years (range, 5–45 years). 14(77.8%) patients presented with acute injuries while 4(22.3%) had chronic injuries. Forearm injury was the common site either isolated in 5 (27.8%) or combined with dorsum of the hand in another 5 (27.8%) patients. Associated injuries were tendons in 8(44.4%), fractures in 11(61.1%), joints in 5(27.8%), lacerated muscles in 6(33.3%), nerves in 3(16.7%), amputated fingers in 3(16.7%), arterial injuries in 5(27.8%), and compartment syndrome in 1 (5.6%). The mean flap length was 18.2 cm (range, 10-31cm) and the mean width was 9.47 cm (range, 5-14 cm). 11(61.1%) flaps had single perforator and 7 (38.9%) had two perforators. The mean thickness of the flaps after thinning was 5.3 mm (range, 4-9 mm) and the mean ratio of thinning was 24.8% (range, 16– 50%). Early complications showed flap ischemia in one patient with successful salvage, minor infection in 2 (11.1 %) and small wound dehiscence in 2 (11.1%) patients. Late complications showed further debulking of one (5.6%) flap and tendon transfer to restore wrist extension in 2 (11.1%) patients. The mean total aesthetic score was 20.6 and the mean score items was: color match was 4.3, contour was 3.6, Hair distribution was 4.1, texture was 4.5 and overall satisfaction was 4.1. The mean DASH score was 22.5 and and the mean score of four cases with low energy trauma was 9.5.
Conclusions: Thinned ALT Flap offers a good and reliable solution in reconstruction of complex upper limb wounds with high success rate with good aesthetic and functional results.

S10-5 The Versatility Of Freestyle Facial Perforator Flaps For Reconstruction Of Facial Defects

Reconstruction of facial defects always represents a surgical challenge as functional and cosmetic outcome must be taken into account more than any region of the body. The excellent vascularity of facial skin ensures a reliable blood supply to pedicled or islanded local flaps. Nevertheless, local flaps have not a complete range of freedom in their movement to reach the defect. The concept of free-style perforator flaps has been developed to allow a wide arc of rotation and single-stage operation for reconstruction of small to medium size facial defects.
We present our experience in Suez Canal University Hospital through using local free-style facial perforator flaps for reconstruction of small to medium size defects consequent to skin lesions excision, tumor or trauma in different regions of the face.

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S8'-5 Reconstruction Of Post-Traumatic Lower Limb Defects By Vascularized Bone Flaps (20 Years Experience)

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S6-2 Gluteal Implants – Training Methodology for Better Results

Gluteal implants is a procedure that is growing in number in all over the world, because of the famous latin model of this part of the body.
We will present a cadaver lab method for training young or more experienced surgeons for this surgery, focused in better results and avoiding complications.
It is a reproductive method that could be introduzed in all plastic surgery services.

S11-2 Essential Anatomy and Evaluation of Functional Rhinoplasty

The primary responsibilities of the nose include heating, humidifying, and filtering inspired air before reaching the larynx, trachea, and lungs. This is accomplished via a balance of laminar and turbulent airflow.
The surgeon must have a comprehensive understanding of the surface aesthetics, underlying structural anatomy, and functional components of the nose and how they are all linked.
The purpose of this study is to highlight the key anatomic structures involved in nasal obstruction and functional rhinoplasty, as well as discuss the diagnostic techniques at the surgeon's disposal to ensure the proper diagnosis is made.

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S9-1 Reconstruction Strategy For The Unilateral Paralyzed Face

Complete unilateral facial paralysis produces severe functional and aesthetic impairment. There are large numbers of treatment techniques that try to fit the particularities of each case, since the patient's age, cause and duration of paralysis vary enormously. The author organizes these procedures according to these variables and presents the concept of vertical and horizontal topographic compartmentalization of procedures in long-term paralyzes

S10-1 Virtual 3D Planning For Mandible And Maxilla Reconstruction

3D virtual planning is becoming popular as an important tool in bone reconstruction of the face. In the last 3 years, the technique was used by the author in 15 cases of reconstruction after tumor resection, being 10 cases of mandible and 5 cases of maxilla. The 3D planning in the reconstruction of the mandible provides aesthetic and functional precision of the obtained results. However, for reconstruction of the maxilla, there are still technical limitations that allow to obtain the same full potential of benefits as observed in reconstruction of the mandible

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KN7' Why, when and how propeller perforator flaps?

Background: After the great success in using free perforator flaps during the last 30 years, in the attempt to improve the recipient site appearance and to shorten the time of surgery, in the last 20 years we assisted to the development of local perforator flaps. The aim of this paper was to evaluate the outcomes of propeller perforator flaps used all over the body, and to appreciate their advantages and/or disadvantages over the free perforator flaps.
Method: This paper does not intend to present a statistical analysis of the more than 300 propeller perforator flaps performed in our department during the last 18 years (1999-2017), but will try to present their harvesting method, main indications and advantages in well selected defects all over the body. Most of the flaps were performed for upper and lower extremity trauma cases. For post-excisional face and trunk defects after cancer or decubitus ulcers were performed approximately 25% of flaps. A preoperative Doppler examination was performed for all the flaps in the trunk and thigh, but not regularly in the face, lower leg, foot, forearm and hand.
Results: The present study allowed us to point on the most important technical aspects of harvesting the flaps, the main indications and advantages of using propeller perforator flaps, their disadvantages and possible complications. We had very good results in approximately 70% of cases. In the remaining cases, excepting 3 cases in which the flaps were completely lost, we registered only minor complications due to venous congestion, which were solved spontaneously or by skin grafting.
Conclusion: The main advantages of propeller perforator flaps, i.e. no need of microvascular anastomoses, replacing like-with-like, faster functional rehabilitation, can reduce in well selected cases the indication for free flaps. The rate of complications is not higher than by using other methods. The single real disadvantage of propeller perforator flaps is the location of the perforator close to the defect, what can be an impediment in trauma cases.

KN8' Muscle Flaps Versus Perforator Flaps In Lower Limb Reconstruction

In the new era of perforator flaps, the indication for muscle flaps has drastically diminished. And that, first of all, because is proved that a fasciocutaneous perforator flap brings the same good blood supply, but with a minimal donor site morbidity. However, in very complex defects of the lower leg and foot, and especially in those which need a gap to be filled, a muscle flap still remains a good indication.
We try to underline the remaining main indications in using muscle flaps, i.e. open fractures with large bone and soft tissue defects, but also to demonstrate that most of the defects can benefit nowadays of reconstruction by using both local and free perforator flaps. **Conclusion:** In conclusion, even nowadays the advantages of using perforator flaps are inestimable, the muscle flaps still representing workhorse flaps in some well-selected cases.

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S3'-2 **Taming Regenerative Stem Cell Biology Into Office Based Applications - The State Of The Art Technologies**
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S8'-6 **Sole Defects: Reconstructive Peculiarity**

Reconstruction of the sole is peculiar as regard surgical options, timing and selection of flaps. Because the sole is a modified structure anatomically adapted as weight carrier and balance stabilizer.
Reconstruction of defects of the sole should respect these functions in addition to its role as a resurfacing procedure. In this presentation the anatomical bases of the sole and the mechanisms of weight distribution to it well be addressed and utilized in choosing the proper reconstructive techniques weather microsurgical or conventional local and regional flaps.

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S3-6 **Mammareduction With Central Pedicle**

Introduction. There is possibly no other surgical technique in plastic surgery that has been modified more often then the mammaplasty. Numerous publications have focussed on this issue. Regarding the visible scars there are mainly three approaches 1. periareolar scar, 2. I-scar, and 3. T-scar. Another variable is the pedicle. Since 1996 we use a central pedicle combined with a T-scar with short sub mammary part for most of the cases.
Methods: The "inferior pedicle technique" was modified by Dr. Serdar Eren in 1992[1]. This modified approach is described by a detaching of the inferior part of the pedicle leaving only the central pectoral fascia attached. The blood supply is guaranteed by the intercostal perforators. The main sensory branch to the areola is routinely preserved thus maintaining a sensitive nipple in most cases. Because no dissection from the Nipple-Areola-Complex (NAC) from the gland is necessary, breast feeding after surgery is usually preserved. This pedicle gives a maximum degree of freedom regarding resection and positioning of the gland. Especially the hypertrophic lateral gland parts can be resected extensively down to the pectoral fascia.
Results/ Discussion: We overlook more than 2200 mammoplasties performed with this pedicle-technique in the recent 22 years. This technique is not recommended for an inexperienced surgeon due to potential pitfalls in the preparation of the gland. Provided sufficient familiarisation with the procedure, however, this technique can be regarded as a

safe method for almost all type of breast with excellent results in terms of shape and projection. Generally, breast feeding property and sensation of the NAC are preserved.

S4'-1 Lower Blepharoplasty With Muscle Suspension And Midface Lift

Introduction. The lower blepharoplasty aims to rejuvenate the periorbital and mid face area. In order to achieve superior results one needs to understand and address the misbalance between muscle, fat and skin. We have modified the known operation methods to significantly improve the postoperative outcome.
Methods: The lower blepharoplasty can lead to some complications like scleral show or even worse ectropion, which are very difficult to correct. A solution must be provided to tighten the skin and underlying tissue sufficiently and at the same time shift the downward traction force away from the lid. We utilize a very stable and reliable muscle suspension technique, which not only rejuvenates and lifts the lower lid area, but also the mid face and at the same time enables to remove a remarkable portion of excess skin. Parts of the orbicularis muscle are detached from the skin flap from medially to laterally and reattached to the periosteum of the lateral orbit, cranially to the lateral epicanthus. Once a secured tightening of the lower eyelid tissue is accomplished, the remaining skin excess can be removed safely and efficiently.
Results/ Discussion: We overlook more than 1400 lower blepharoplasties with this modified technique. It has proven its efficacy and safety. With this approach a remarkable amount of excess skin can be safely removed**.** The percentage of scleral show has been less than 2% and of ectropion less than 0.1%. The muscle suspension enables to correct existing scleral shows or ectropion as well.

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S9'-3 Management And Outcomes Of Volar Wrist Lacerations

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Introduction: Extensive volar wrist lacerations is an association of at least one flexor tendon, one nerve and or vascular section, they are frequently seen in emergency department. The management of these lacerations needs to be atraumatic with adapted physiotherapy protocol. The aim of this study is to evaluate the functional outcomes of patients with volar wrist lacerations.
Methodology: this retrospective study evaluated the outcomes of volar wrist lacerations in 104 patients who consulted the emergencies of plastic surgery department of Kassab institute of Tunis between January 2012 and September 2017. Nerve repair was evaluated by BMRC scale and tendon repair with buck Gramcko score.
Results: all the patients were relatively young with a mean age= 29, 7 year. 87 patient were male and 17 were female (sex ratio = 5, 1). More than 47% of accidents occurred in a stress context (hand through the glass). Median nerve was affected 68 times and ulnar nerve 60 times. 50% of our patients had more than 4 finger flexor tendon transected. Vascular lesion was associated in 63, 5% of cases. 65% of our patients were managed within the 24 first hours. Early physiotherapy was prescribed to all our patients but 85% of them underwent regular follow up.
At the last examination the tendon repair outcomes were excellent in 86% of cases and the nerve repair outcomes were good and excellent in 58% of cases.
Conclusions: Specialized management and early physiotherapy are required for a good functional outcomes in patients with volar wrist lacerations.

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KN9 The Orbit Is The Window Of Face To The Outside World; Aesthetic Considerations

The art of aesthetic plastic surgery is within the wide scope of plastic surgery, cosmetologists do cosmetic work with cosmetics. These were the uttered words of the principles that our mentors and predecessors passed to us, if we stay within our principles of advancement and innovation we will succeed if we want to chase the flow of the greens we will fail for sure. Staying within the excellence in our work will make us a special group that we have always been over the years. Having said all that the orbit is another area which we have a lot of respect for an interest in as plastic surgery have evolved in the past century. Surgeons weather they are involved in reconstructive surgery or any other action should always have an aesthetic values and perception to consider. Surgery in and around the orbit require a major attention. It is a word and technical procedures that dominated the global arena that is now changing slowly in an evolutionary form. Blepheroplasty was a buzz word considered to be the main theme that is dominated the aesthetic arena around the orbit; courses are set to educate those who are and who are not educated in the field to learn a technical aspect of a procedure. As such, Without knowing the indications, contra indications, consequences and outcome of what is done by a simple excision is meaningless. The arenas are filled with ectropium, sunken eyes and hollow appearing orbits. The focus was on the skin and the orbital fat that later was resected in a radical form as if it was a disease. With the today evolutionary changes the orbit is now considerate as two parts the fat, and the bone. The latter is not a dead organ. Bone is a living organ that changes with aging, as well as fat shifts in position with year progression. Adjustments in those two structures will allow the surgeon to produce the desired outcome. The skin drapes the orbits and the muscle is the power that controls the draping phenomenon. These aesthetic considerations in fat and bone adjustments are looked at in four categories, congenital, post traumatic and in rejuvenation of the aged skeleton. Feminization of the face is another aspect of the process. What is next is now for the future to tell and for the new innovations that are coming to us from where the wind blows.

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S9-2 Outcome Of Facial Nerve Reconstruction In Oncological And Traumatic Conditions

Facial nerve reconstruction in the setting of oncologic surgery or traumatic conditions is complex and requires expertise. Preservation of the Facial nerve is the current standard of care in Tumor surgery unless the nerve is adherent to, or imbedded in malignant tumor in which case immediate grafting in cases of sacrifice should always be attempted. This is possible in the majority of cases with acceptable outcome even in situations where the gland is grossly infiltrated, in view of the availability of post-operative RTX.
In traumatic conditions primary reconstruction of the nerve should be attempted if the general condition of the patient permits as results are superior to delayed reconstruction.
We present our experience with management of the facial nerve in surgery for complex lesions of the parotid gland and traumatic injuries of the parotid region.

S10'-6 Role Of The Plastic Microsurgeon In Live Related Donor Liver Transplantation: Technical Tips For The Hepatic Artery Anastomosis

Khaldoun Haddadin*, Nasser Q. Ahamad

Live related donor liver transplantation for both adults and children is multi-tasked surgery carried out by several teams of physicians. The aim of this talk is to describe the technical aspects of Hepatic Artery Reconstruction. At King Hussein Medical Center, Jordan for the last 15 years this part of the operation has been performed by Plastic Reconstructive Microsurgeons. Performing microsurgery in this setting is a departure from our entourage of routine plastic microsurgery cases and requires adaptation of the classical techniques in terms of instrumentation, sutures and overall technical skills.

All patients underwent CT angiography with a sixteen row CT scanner. Two and three-dimensional images were obtained from 1.25mm slice thickness axial images with multiplaner reformat and Maximum Intensity Projection (MIP) protocols. Images were evaluated for the arterial hepatic variations in potential live related liver donors. Anatomy variants are noted preoperatively to avoid surprises during surgery and compared with intraoperative clinical assessment and tips in choosing the best recipient artery for anastomosis.

The actual hepatic artery anastomosis in all patients was reconstructed using a classical end-to-end anastomosis using an 8/0 or 9/0 nylon suture under Microscope magnification by the same team of microsurgeons. We present our experience and show some of the more interesting cases and how difficulties were handled. Anastomotic adequacy is checked intra and postoperatively by color doppler.

There is a learning curve during the progress of our program and results have significantly improved with better selection of potential donors and recipient vessels, technical refinements, and improvements in perioperative care.

S11'-8 Surgical Approaches To The Skull Base: The Plastic Surgeon's Perspective

The Craniofacial Unit at King Hussein Medical Center was established in 1984 and is located at The Royal Jordanian Rehabilitation Center. The Multidisciplinary Team is dedicated to the treatment of all craniofacial conditions and is the only comprehensive unit in Jordan.

Techniques used in craniofacial surgery have found extensive application in the management of skull base tumours and tumor-like conditions. The improved exposure gained via osteotomies for facial disassembly has facilitated the en-bloc resection of tumours with clear surgical margins, and the advent of vascularised seals has significantly reduced the risk of meningeal contamination. We present our experience with the extirpation and reconstruction of benign and malignant conditions of the skull base at both King Hussein Medical Center and King Hussein Cancer Center over a 20 year period. Survival and functional outcome data are presented, with an emphasis on the wide range of pathologies and primary treatment strategies at presentation. Criteria used in surgical exposure, flap selection and the role of prosthetics are discussed. Observations are offered on salvage surgery, demonstrating that excellent palliation can be achieved, even in cases with massive recurrent disease.

A variety of craniofacial techniques (transfrontal, transorbital, transmaxillary, transpalatal, temporal, transcervical and direct) were used depending on extent and location of tumor and will be discussed. Skull base surgery is difficult and requires a multidisciplinary approach. It has a high complication rate which is understandable when you consider the nature of the surgery, but the results are very gratifying particularly for benign conditions and for slow growing malignant conditions.

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S5'-4 "Avelar" Extended Thigh-plasty

As Aesthetic Plastic surgeons, we have experience caring for the most demanding patients, but the surgical techniques continue to evolve and the aesthetic outcomes continue to improve, so we have to adapt accordingly with the newest techniques and technologies available
Thighplasty or Thigh lifts has always been a challenging procedure due to a multitude of factors including but not limited to the position and the length of the scar, the gravity pull factor, and paying attention to the sensory and motor nerves as well as the vasculature and lymphatic channels.
Applying the "Avelar" technique to thighplasty gives the surgeon the advantages of:
1- performing aggressive liposuction in the area to be excised
2- not performing "en-bloc" dermo-lipectomy
3- Preserve nerves, lymphatics, vasculature
4- Minimize the need for cautery use and blood loss
5- Stepwise elevation of skin and closure after re-approximation (staples or towel clips)
6- Can feather with liposuction or addition of fat if needed

S11-6 Lip Lift: A Simple Office Based Procedure that can both enhance and rejuvenates the perioral area

Lip Lift is an office based procedure that can both enhance and rejuvenates the perioral area. This simple procedure can be used for both young and older patients. Young patients who are unable to achieve lip beautification by adding filler material to their upper lip due to various reasons. Whereas older patients especially seeking full facial rejuvenation, face the fact that the aging face often develops changes in the perioral region, and a facelift will not affect the perioral region to any appreciable degree. So the lip lift can be used in conjunction with a facelift to better enhance the results.

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KN1 Autologous Breast Reconstruction In The 21st Century

The abdominal perforator flaps still my first choice for autologous breast reconstruction even in difficult indications. Gracilis flap (TMG) has become the second choice. The Lumbar and gluteal superior perforator flaps, so called "Exotic flaps", are indicated only when indicated. Fat grafting is the unavoidable ancillary tool to free flap.
The author will present his ongoing clinical experience for the last 25 years.
The course will emphasize the advances in:

- Flap selection, planning and marking.
- Aesthetic refinement in both recipient and donor sites.
- To illustrate surgical techniques of volume augmented flap options, such as implants, stacked flaps etc...

S5-1 Advances In Microsurgical Treatment Of Lymphedema

In the last decades survival of breast cancer patients has improved remarkably due to earlier diagnosis and a better therapy. This has shifted some of the treatment from the 'acute' problems of having a cancer diagnosed to the 'more chronic' problems accompanying its treatment. Lymphoedma due to radiotherapy and/or surgery is an important problem in this patient group.

The treatment of lymphoedema consists in the medical or the surgical treatment. Medical treatment is the basis of every good treatment and prevention and consists of manuel therapy, compressive therapy, diet and hygienic measures in order to prevent its complications.
Surgical therapy is subdivided in two major groups: the destructive and the reconstructive procedures. Destructive procedures can give a temporary improvement but cause a worsening of the situation on the long term (liposuction, dermolipectomy). Reconstructive procedures can be performed in selected cases and consists in lympho-venous anastomosis and in free node transfers.
Results that can be obtained with the reconstructive procedures range from no improvement to clinically impressive results.
More research is necessary in order to better define the patient selection and give a more accurate prognosis of the results to be expected.
To achieve these goals, we created ***LymphClinic*** which is a multidisciplinary approach to such difficult pathology. Our approach resulted in multiple advances in patient care in term of:

- Precise diagnosis and staging
- Providing personalised treatment
- Safer and more efficient surgical procedures
- Ability tom perform complex and long surgical procedures in efficient sit-up.
- QoL study and performance

Ref: www. europeanlymphaticsurgery.com
www. plasticsurguzbrussels.com

S6-4 Gluteal Flaps For Buttock Augmentation

Circumferential trunk plasty combined with lipoplasty and lifting procedures creates the possibility of obtaining a harmonious body-contour with trunk-perimeter reduction. Contour enhancement of the buttocks is one of the major assets of belt lipectomy. The type and degree of improvement is dependent on the deformity at presentation. Although the vertical height is diminished and the infragluteal crease is reshaped, our idea is that the fullness and projection of the buttock is difficult to recreate in post-weight loss patients with important buttock ptosis. The projection is dependent on the amount and firmness of the subcuaneous fatty tissue. Therefore we think the buttocks need to be augmented. The option is either prosthesis or autologous augmentation. We used a superiorly pedicled desepithelialised fat-dermis flap. Instead of resecting the excess of tissue, this is inferiorly advanced and redraped over the gluteus maximus muscle in order to obtain buttock projection.

S7-3 Volume Redistributing Mastopexy In Post Massive Weight Loss Patients

Introduction: An increasing number of women are presenting for breast surgery as a part of body contour surgery after massive weight loss (MWL). Classical breast reduction techniques are still indicated in large volume breasts. However, most of these patients present major breast ptosis with excess of fat-skin on the sides of the thorax. The described technique focuses on ways to improve shape, projection, and long-term results using autologous tissue without breast implants.
Surgical technique: Key concepts include
- increasing volume of the breast by utilizing excess axillary tissue (lateral thoracic/spiral/intercostal artery perforator flap)
- Central glandular pedicle
- Increasing breast parenchymal support with suture fixation and dermal suspension.
- Skin redraping and closure with inverted –T scar

Results: 35 patients underwent dermal suspension mastopexy procedures. All surgeries were done by the senior author MH during the last 8 years. Mean operative time was 150 minutes (range 120-180 minutes).
Patients left hospital after 1-2 days after surgery. No nipple necrosis was encountered. However, hematoma occurred in one patient. Wound dehiscence occurred in 8 cases (22%) which was treated by daily dressing until healing. Minor secondary scar revision was done in 10 patients (28%). All patients reported high satisfaction rate.
Conclusion: Breast reshaping and dermal suspension technique is a safe and efficient technique of mastopexy and autologous breast augmentation in patients after massive weight loss.

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S5'-5 Challenging Cases in Aesthetic Breast Surgery

The request for aesthetic breast surgery has remarkably increased in the last 10 years all around the world as well as in our practice in Aleppo due to a modern lifestyle (media, husband and work.)
But the more we operate the more challenging cases we confront that need vast experience and critical analysis of each case in order to choose the appropriate technique to avoid complications and dissatisfaction of the patient.
I present some of these cases alongside results obtained by surgery.

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S6'-8 Augmented Reality - The Future Of Surgery

https://www.ted.com/talks/nadine_hachach_haram_how_augmented_reality_could_change_the_future_of_surgery/up-next

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S8'-1 Reconstruction of Composite Leg Defects Post Blast Injury During ISIS-related Conflicts
Amir Ibrahim*, Reem Karami, Fadi Ghieh, Said Saghieh, Suhail Lakkis

Objective: In a high conflict region, blast injuries to the distal lower extremity are a major source of large composite defects involving bone and soft tissues. These defects are at the edge between using a single free flap [osteo-(+/-myo) cutaneous] vs double free flap reconstruction (bone and soft tissue). In this paper, we present our experience and outcomes in treating patients with distal leg blast injury reconstructed using a single free

fibula flap.
Methods: Fifteen patients (average age 33 years old) with distal leg composite defects secondary to blast injuries were treated between January 2015 and March 2016. 8 patients were treated in the subacute phase (between 2 and 6 weeks from injury), 5 patients in the chronic phase (≥ 6 weeks from injury) and 2 patients in the acute phase (≤ 2 weeks from injury). All patients were reconstructed using single barrel free fibula osteo-(+/-myo)cutaneous flap where single or double skin paddles were used according to the soft tissue defect requiring coverage.
Results: Mean Follow up time: 418.8 days. There were no cases of total or partial flap loss. Complications were limited to 3 cases including traumatic fibula fracture 4 months after allowing full weight bearing (1), venous congestion with negative findings (1), and residual soft tissue defect requiring coverage (1). There were no cases of wound dehiscence, infection, or hardware exposure. Mean bone healing time was 9 months after which patients were allowed full weight bearing.
Conclusions: A single barrel free fibula osteo-(+/-myo)cutaneous flap is a valid and reliable tool for reconstruction composite lower extremity defects post blast injury. Adequate planning of fibula flap soft tissue components (skin, muscle) rearrangement is essential for success in such challenging reconstructions.

S10-6 The External Jugular Vein Used As Recipient Vessel In Head And Neck Free Flap Reconstruction: Outcomes Compared To The Internal Jugular Vein

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Background: Contradictory data exists on the success rates of employing the external jugular (EJ) vein as a recipient vessel for venous outflow in free flap head and neck reconstruction compared to the internal jugular (EJ) vein. We hereby present a retrospective study of prospectively collected data over a 14-year period.
Methods: 578 patients underwent 639 free flap head and neck over 14 years. 278 free flaps employed the EJ vein as the recipient vessel while 326 free flaps employed the IJ vein. Rates of acute and late complications were compared.
Results: There were no differences in rates of complications: flap loss, venous thrombosis, arterial thrombosis, bleeding, hematoma, or infection between the EJ and IJ vein groups.
Conclusion: The external jugular vein as a recipient vessel for venous outflow in head and neck free flap reconstruction of post-oncologic resection defects is a valid option for both primary reconstructions and secondary surgeries.

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S5'-2 Post Bariatric Surgery Tips And Tricks

The number of patients requiring body contouring after massive weight loss increases daily. Thus, postbariatric body contouring procedures are getting more and more popular. Nevertheless performing body contouring procedures is demanding and different factors such as skin excess, previous scarring and combination of procedures must be taken into account for each individual patient to achieve optimal results. We present our experience over the past 15 years focusing on circumferential body lifts, autologous breast lifting augmentation and thigh liftings. Videos and 3D graphics will augment the understanding of our treatment concepts.

S7'-1 Perforator Flaps For Upper And Lower Extremity Reconstruction

Pedicled (PPP) or free perforator flaps are nowadays workhorses for soft tissue reconstruction all over the body. Here we present our concept on the use of these flaps focusing on the PPP, SCIP (supaerficial circumflex iliac artery perforator flap), MSAP (medial sural artery perforator flap) and ALT flap (anterolateral thigh flap). The presentation is focused on indications, harvesting technique as well as potential complications and pitfalls related to these flaps.

S10'-1 The Free-Style Microsurgery Concept – What Is True And What Is Fake

Pedicled or free perforator flaps have become nowadays a standard procedure in toolbox of the modern reconstructive surgeon. The *free-style microsurgery* concept has rapidly evolved after groundbreaking findings in the vascular anatomy of the skin and enables raising of either as local of free flaps from each region of the body. The lecture "Freestyle Microsurgery Concept – what is fake and what is true" aims to reduce the term to its essential meaning by delineating what is freestyle microsurgery, how is it performed, its pros and cons and where it might potentially serve to improve tissue reconstruction therapeutical concepts. Recent examples of procedures adopting these concept are presented, including propeller perforator, ALT, SCIP, and MSAP flaps.

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S6'-5 Inferior Gluteal Artery Perforator Based Flap Reconstruction After Abdominoperineal Excision For Low Rectal Carcinoma
Kavan Johal, N. Hachach-Haram, H. Creasy, M. Pramateftakis, P. Mohanna, P. Roblin, J. Constantinides, A. Schizas, M. George, D. Ross*

Aim: The use of fasciocutaneous flaps has been shown to reduce morbidity associated with perineal resection, to include wound healing and long-term functional outcomes. We present our 10 year experience of inferior gluteal artery perforator (IGAP) flaps for immediate perineal reconstruction. To our knowledge this represents the largest study of its kind to date.
Method: A retrospective study was carried out between April 2008 and April 2018 to evaluate patients who underwent IGAP flap reconstruction of the perineal region following resection for rectal carcinoma. Data was collected on demographics, surgical procedure, duration of surgery, length of hospital stay and post operative outcomes. The median follow-up was 16months.
Result: A total of 210 patients underwent immediate IGAP reconstruction for rectal carcinoma, 145 following abdominal perineal excision (APE), with the remainder undergoing multi-visceral excision (MVR). A high number of patients (94%) underwent neoadjuvant radiotherapy; likely related to this minor wound complications (cellulitis and mild superficial dehiscence) were seen in a quarter of patients. Return to theatre for wound complications was only seen in 4%, with 5.5% requiring late return to theatre for delayed wound healing. Any perineal complications occurred early in the study (13.8% reporting perineal pain on sitting) and improved with further follow-up, with the 3% that experienced hernias limited specifically to those patients undergoing simultaneous vaginal reconstruction.
Conclusion: Plastic Surgery is a core component of the patient's journey with rectal cancer. Our experience has shown that IGAP flaps are a safe, robust and reliable option for reconstruction of the perineum following major excisions. Morbidity is low and favourable compared to previously routine use of other reconstructive options such as the VRAM flap. In our unit and indeed many others, the IGAP now represents the mainstay of

treatment in the management of this patient cohort.

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S6'-2 Our Experience In Management Of War Nerve Lesions In Syria

Thousands of cases of nerve war lesion may we have seen but unfortunately it is very difficult pursuit
All cases, in such a difficult circumstances, we have tried to get more knowledge and better skill
For the treatment and management of this complex and difficult pathology
Methodology and material: A few hundreds of cases can be pursuit and studied, and because of the complexity of the initial lesion:
Bone, vascular, soft tissue, and nerve lesion, the classification is very difficult. Meticulous examination of
The patient was personally fulfilled and EMG in the third week and third months was made by an expert Neurologist, surgical exploration was done after the third month of the initial lesion
Result: Good result have been obtained when surgery fulfilled in a good condition: well torpidity of soft tissue
Microsurgery: nerve graft, neurotisation and neurolysis
Physiotherapy before and after surgery is essential for reasonable result
Conclusion: War nerve lesion must have a special management and treatment, surgical exploration must postponed until a good condition of soft tissue and circumstances (expert surgeon, microsurgery and
Well trained physiotherapist)

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S4'-6 Recurrent Gigantomasia After Inferior Pedicle Reduction Mammaplasty

Recurrent Gigantomasia after Reduction Mammaplasty is not a common encounter. The author's experience with this relatively rare condition shall be presented

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S6'-7 Randomised Control Trial Of Effect Of Home Based Training Modalities In Acquisition Of Basic Microsurgery Skills
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Introduction: It is essential that the acquisition of technical skills is undertaken without compromising patient care, which can be very challenging in microsurgery as it exhibits a

steep competency learning curve.
Aim: In view of the modern NHS directive for to change delivery of education to overcome these challenges, our aim was to develop a low fidelity, low cost simulation course that could be undertaken at home.
Method: 40 participants were given an introductory lecture to basic microsurgery and asessed at baseline and 4 weeks after training, using a chicken vessel anastamosis task, with 2 blinded assessors assessing their video recordings.
Participants were randomised into 4 groups: i) control group, C (no training), ii) gold standard, GS,(laboratory based training), iii) home tablet (HT) training group (using an Apple iPad at home), iv) home microscope (HM) group (using an inexpensive jewellers microscope for home training). The two home training groups followed a modified simulation training curriculum at home.
Result: Time to complete task: Statistically significant difference noted between control vs; GS p=0.006, HM p<0.001,HT <0.001.Number of sutures placed: A statistically significant difference noted between control vs; GS p=0.038, HM p=0.019, HT p=0.028.A statistically significant difference was noted between control vs; GS p=0.004, HM p<0.001, HT p<0.001.
Conclusion: Funding is not always available for simulators and scheduling time into the trainees already demanding schedule to access on site simulators can be challenging. Our study shows that home training modalities are comparable to gold standard training models, thus providing a low cost, accessible solution to training.

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KN3' Supermicrosurgery For New Topics In Future: Prophylactic Bypass Surgery In Lymphatic, Vascular, And Nervous System

With the development of supermicrosurgery, small vessels and nerve fibers can be dissected directly and anastomosed to the small (less than 0.5 mm) recipient vessels and nerves. Aesthetic microsurgery, vascularized nerve flaps, and a single funicular suture are now in new clinical applications. Supermicrosurgical reconstructions are: crushed fingertip replantations with venule grafts, toetip transfer for fingertip loss, partial ear transfers for trachea and eyelid defects, appendix transfer, and lymphaticovenular anastomoses and vascularized lymph channel transfer under local anesthesia. Free perforator-to-perforator flaps are now become popular in aesthetic reconstructions: short pedicle or true SCIP, ALT, DIEP, GAP, TAP, TFL perforator, and medial plantar perforator flaps etc. Adiposal, fascial, nerve, lymphatic, and periosteal flaps could be also transferred with tiny perforator. Combined flap transfers (Orochi flaps) are also new topic for 3D complex aesth. reconstructions. Head-up supermicro. without microscope and Nano-micro using 30micron needle with supermicroanatomy will be the next topics.

KN5 Surgical Treatments For Lethal Lymphatic Diseases

For the past 26 years we have undergone surgical treatment for about 2,500 patients with lymphedema. As a result, it has been clarified that functional preservation or reconstruction of lymphatic smooth muscle cell using supermicrosurgical technique leads to the prevention and reduction of edema. This concept is now popularized in the world. Recent topics are how to prevent lymphatic diseases and prevent deterioration.
In recent years various diseases related to lymphedema have been clarified. In severe lymphedema, it was found frequent infection often develop severe and progressive to septicemia (lethal edema), and it is known that at 10 years edema, some develop to angiosarcoma (Stewart-Treves Syndrome). Meanwhile, MonoMAC syndrome due to GATA 2 gene abnormality, which is a primary immunodeficiency syndrome, has also been

noted as a lethal disease associated with leg lymphedema. It was also found that LVA could rescue cases with such lethal lymphedema.
Regarding surgical treatment of lymphedema, there are methods for restoring physiological lymph circulation (lymphvenular anastomosis (LVA), functional vascularized lymphduct transfer etc.) and reduction of irreversibly accumulated soft tissue (reduction surgery). LVA is effective for early lymphedema. Prophylactic LVA simultaneously with ymphadnectomy could prevent occurrence of edema. For severe cases, combined surgical treatment with LVA and lymphduct transfer is indicated with added tissue reduction. The purpose of surgical treatments is improvement of quality of life, free from physio-compression therapy, complete recovery from edema. prevention of septicemia secondary to low immunity, complete recovery from sarcoma, and Salvage of Life. We report findings on surgical treatment and future prospects based on the past 26 years including immune-stimulation against cancer with LVA.

S10'-4 New Peno-Urethro-Scrotal Reconstruction With Bilateral Superficial Circumflex Iliac Artery Perforator Osteocutaneous (SCIP-OC) Flap

Background: Free radial forearm flap is very common for penile reconstruction. But the major problems are donor site morbidity, large depressive scar after skin grafting, and urethral fistula due to insufficient suture line for urethra, and need for microvascular anastomosis. To overcome those complications, new method using combined island SCIP osteocutaneous flap for urethra and penile shaft was installed for eight cases.
Patient summary: Eight GID patients were treated with bilateral SCIP with or without osteocutaneou flap and gracilis muscle flap. The age of patients were 24-56 (average 35±9) year old. The SCIP flaps ranged from 22 to 38 (average 29.8) cm in length and 5 to 14 (average 9.9)cm in width. Vascularized iliac crest was included in seven cases and bilateral or hemilateral gracilis muscle (or musculocutaneous) flaps were used for three cases. As for postoperative complications in the postoperative follow-up of seven months to 32 months (average 2.7 years), there was a small marginal necrosis of grance, but no serious complications such as wide flap necrosis, urethral fistula and stenosis, or iliac bone infection and resulting absorption. Postoperatively, there was no total flap loss and urethral fistula.
Conclusions: The advantages of this method are: minimal morbidity in concealed donor site, No urethral fistula due to large urethral reconstruction, no need for microvascular anastomoses, possible movement with gracilis muscle flap, possible vascularized penile stent and sensory repair, and possible one stage reconstruction for longer urethra of 30 cm in length without insufficiency even for GID female to male patients. The disadvantages are needs several-stage operation, and sometimes bulky penis. SCIP-OC flap has great advantages and less invasive for penile reconstruction.

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S1-1 Medial Femoral Condyle Microvascular Periosteal Transfert As Treatment For Metacarpal Non Union In The Hand
Swenn Maxence Krähenbühl, Camillo Müller, Thierry Christen, Sébastien Durand*

Metacarpal nonunion after closed fracture is uncommon and happens mostly in transverse diaphyseal fractures, usually after bone loss or expansive removal of the periosteum. Patients with this condition often present with persisting pain, loss of motion and loss of strength. Clinical and surgical handling is challenging. Recommended treatment is resection the pseudarthrosis, bone grafting and stable internal fixation. Periosteal medial femoral condyle has already been shown to be efficient as treatment for nonunion in distal radius and clavicle as it enhances vascular supply to bony union. Outcomes and technique following reconstruction by a free periosteal flap of the medial femoral condyle have never

been reported for metacarpal nonunion.
We describe the surgical technique. Pseudarthrosis was resected, cancellous bone grafting with re- osteosynthesis was realized. Then Periosteal bone flap is delineated on the medial condyle of the femur. Portion of periosteum vascularized by the descending genicular artery and its vein is then transferred to the hand. The periosteal flap is sutured to itself and a termino-lateral anastomosis with the radial artery was performed.
We report a short series of two cases using this technique to treat metacarpal nonunion and the functional outcomes. In both cases, satisfactory bone union was obtained with absence of pain. This microsurgical technique, previously described for the treatment of radius or clavicle nonunion may be applied in a similar fashion for the metacarpal with promising clinical results.

S5-7 Neuropathic Pain After Repair Of Brachial Plexus Injury: A 30-Year Follow-Up Of The Narakas' Series

Swenn Maxence Krähenbühl, Chantal Bonnard, Laurent Wehrli*

Traumatic brachial plexopathies can be devastating injuries. In addition to motor and sensory deficits leading to functional limitations, neuropathic pain can be debilitating and have a major impact on the quality of life. Nowadays, still very few evidence and knowledge is known on this subject. We therefore assessed long-term neuropathic pain evolution, the quality of life and satisfaction level after such injuries.
523 were identified as patients victim of traumatic brachial plexus injuries who underwent surgical repair by A. Narakas from 1969 to 1992. 215 patients coming from abroad were excluded from the study. 230 patients could not be reached, 13 medical files had been lost and 14 patients had died. 51 patients could be reached by telephone and 46 of them accepted to answer the following questionnaires: Short Form Health Survey (SF12), Neuropathic Pain Symptom inventory (NPSI), ABILHAND and Disability of Arm, Shoulder and Hand (DASH), and satisfaction with the surgery. Data were recorded and statistically analyzed using statistical software (SPSS version 23.0; SPSS, Inc., Chicago, IL). We than reviewed their clinical, operative and follow-up data. 45 patients accepted to come back for a physical examination.
Forty-five patients with a mean age of 21.9 years at the time of injury participated in the study. There was a vast majority of men (41M, 91%). The mean time to surgery was 3.8 months, and the mean follow- up period was 31 years. NPSI score was significantly (p=.05) higher for complete (C5 to D1) compared to partial injuries (36 vs 22.5). NPSI score of injuries involving C8 and D1 was significantly (p=.05) higher (37 vs 17) than for other roots. There were no significant differences in long-term neuropathic pain between avulsion and rupture, as well as supra- or infraclavicular injuries. Complete lesion have a significantly higher NPSI score of background (7, p=.5) and breakthrough (7.5, p=.2) pain compared to partial injuries. SF12 was directly correlated with NPSI according a linear regression analysis (p=.01). More surprisingly, quality of life was not different between complete and partial lesions. Regarding satisfaction, 36 patients (74%) answered “definitely yes” or “probably yes” whether they would undergo surgery again. Three patients answered “probably not,” one answered “definitely not,” and six were “uncertain.”
Our data suggest that complete brachial plexus injuries generate more pain than partial injuries. This can be explained by the fact that these complete lesions contain C8-D1 roots. Apparently, the lower the lesion is, the greater is the pain. It seems that the long-term evolution of pain is the same between all groups. The quality of life is directly correlated with pain and not function of the limb. Obviously, it is easier for the patients to cope with a non or dysfunctional limb than with omnipresent pain.
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S10’-3 **The Use of Vascularized Fibular Grafts. Our Experience**
Zied Mabrouki, Lamjed Terhouni*

Bony defects caused by trauma, tumors, infection or congenital anomalies present a significant surgical challenge. Free or pedicled vascularized fibular grafts provides an attractive reconstructive option, it can be transferred with skin, fascia or muscle as a composite flap.
This presentation assessed the clinical features of more than 50 cases of reconstructions underwent by free fibula flap and presents our experience results.
Union of the graft was achieved in 90% of patients, the mean time to union was very various depending of recipient site.
We discuss the variability of the vascularized fibular graft and it’s application to a variety of pathologies and recipient site. It also covers the applied anatomy, operative techniques, advantages, complications and donors-site morbidity.
The reconstruction of bone and soft tissue defect is a very challenging mission to surgeons in different specialties. Vascularized fibular graft have proven to be extremely effective and features a high healing rate with good functionality and a low complication rate

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S9'-5 **Fascia-Temporalis Free Flap The Ideal Coverage For Deep Defects Of The Dorsal Hand Aspect**
Ramzi Mahmoud, Sebastien Durand, Wassim Raffoul*

Full thickness skin loss of the dorsum of the hand has many etiologies: skin tumor excision, trauma, burn. The coverage of this area is hard because we are at the extremity of the limb, where there is no local pedicled flaps. Some of those lesions are complex with skin tendon, nerve, muscle and bone loss. Many techniques were used to correct this defect with variable functional and esthetic results. The most frequently described techniques are: the inguinal pediculed flap, the pediculed Chinese flap and the gracilis free flap.
We suggest a new technique based on the free flap of the fascia temporalis branched on the dorsal branch of the radial artery. The flap is to be covered by a dermal substitute and a thin skin graft.
Our choice was based on the thinness of this flap, adequate to the dorsum of the hand, the easiness of hiding the donor site scar with a face-lift incision and the constant pedicle of this flap.
Five cases will be presented, with 5 different etiologies and different associated lesions. No complications were faced in the whole series, and excellent cosmetic and functional results were obtained.

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KN10 **Face Transplantation**

Facial transplantation is a new frontier in reconstructive transplantation which allows patients with severe facial deformities to have parts of their face restored rather than reconstructed. This procedure offers patients with severe functional and aesthetic shortcoming the opportunity to lead a nearly normal lives. Since late 2005, over 40 face transplants have been performed worldwide. With so few cases performed, the indications, ethical, immunologic and psychosocial issues continue to be studied and discussed. This presentation details Mayo Clinic's first face transplant on a 31 year old male who underwent transplantation of most of the bones and soft tissues of his face.

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S7'-2 **Perforator Flaps In Lower Limb Reconstruction: Our Experience**
S.Moalla, I.Ghorbel, A.Karra, G.Ben Othmane, Kh. Ennouri*

INTRODUCTION: The discovery of perforator flaps was a real advancement in reconstructive surgery. It permitted to have new options in soft tissue coverage of the

lower limb. The aim of this work is to study our experience with lower limb reconstruction using perforator flaps.
PATIENTS & METHODS: We studied, retrospectively, patients with lower limb defects treated in our department of plastic and reconstructive surgery using a perforator flap during a period of 3 years between 2014 and 2016.
RESULTS: Our study included 17 patients, mean age 37 years, sex ratio 13:4, we used 2 anterolateral thigh flaps, 3 peroneal artery perforator flaps, 4 posterior tibial perforator flaps and 8 lateral supramalleoalar flaps. The cause of the defect was a chronic ulcer in 9 cases, traumatic in 4 cases, tumor resection in 2 cases and recent burns in 2. Preoperative echography wasn't systematic, when done it showed a perforator of good caliber. In 13 cases, flap viability was good. We noted 3 cases of partial superficial epidermolysis and one case of flap failure.
CONCLUSION: Perforator flaps for the coverage of lower limb defects is an interesting like by like option. It can help surgeon managing defects with decreased donor site morbidity limited to a single body area. Nowadays, knowledge and practice of perforator flaps in lower limb is mandatory for every plastic surgeon.

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S1-5 Strategy In Breast Reconstruction After Prophylactic And Nipple Preserving Mastectomy

Breast cancer is the first woman cancer. It has an incidence of 1 in 8 over a life span. 50 % of the patients are less than 50 yrs old. Family history is the strongest risk factor. In case of a breast cancer, the question of the controlateral breast modification for symmetry purposes is often discussed. Many women choose to have a prophylactic controlateral mastectomy. In the presence of genetic predisposition or with a heavy family history patients also inquire and undergo prophylactic bilateral mastectomy. We expose our systematic and staged reconstructive approach to these cases of prophylactic mastectomy in order to achieve the highest level of safety while obtaining a satisfactory aesthetic outcome.

S4'-4 A Staged Approach In The Rejuvenation Of Neck Ageing: The Role Of Deep Structures Modifications To Achieve Long Lasting Results

Neck rejuvenation is a key component of every cervico-facial lifting. Subcutaneous fat excess, skin laxity, muscle laxity and platysmal bands are the different superficial elements that should be adressed when seeking an efficient rejuvenation. Liposuction, lateral platysmal suspension and flaps are commonly used to treat these issues. These techniques are often sometimes not sufficient to achieve longevity of the outcome resulting in an early lack of definition in the neck contours, recurrence of the platysmal bands, lack of precision in the anterior neck/submental area. Mandibular gland protrusion, anterior digastric belly ptosis and retroplatysmal fat can be responsible of the above. A progressive graded approach will be exposed to discuss how to improve the outcomes and their stability while working with the deep structures of the neck.

S5'-6 Place Of Microthane Coated Implants In Secondary Breast Surgery

Mastopexy associated with implant augmentation is a 3 dimensional challenging procedure where 2 vectors are in opposition: the implant expands the breast and the mastopexy counteract the expansion. The initial satisfactory outcome is difficult to achieve but the real challenge remains in the stability of the outcome with time. The nipple position gets to change the dynamics of the implants vary with the implant type, position towards the muscle and quality of skin. And finally the breast tissue migrates caudally on its own

dynamics depending on the mastopexy technique, the quality of the tissues and the implant weight. We share our experience with the use of microthane coated silicone implants in secondary mastopexy breast augmentation. The use of this type of implant changes the implant dynamics to more stable and predictable. And when the mastopexy technique is adapted to this implant the outcome can be improved and the long term becomes also more predictable.

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S6'-6 Anatomical Variant Of Physeal Blood Supply To The Fibula: A Case Discussion
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Aim: We present a case of a six-year-old undergoing free vascularized fibular flap with epiphyseal transfer for skeletal reconstruction following osteosarcoma resection from the proximal humerus. This case report highlights a previously undescribed variation in blood supply to the epiphyseal plate of the fibula.
Case Report: Our patient is a 6-year-old girl who was diagnosed with a high-grade osteosarcoma of the right proximal humerus after sustaining a pathological fracture. She underwent neoadjuvant chemotherapy. The oncological resection involved the proximal 11cm of humerus and a fibular flap based on the anterior tibial vessels with epiphyseal transfer was planned.
The fibula was approached in a standard manner through a lateral incision; dissection was extended anteriorly in a plane between the Tibialis Anterior(TA) and Extensor digitorum Longus (EDL) to identify the anterior tibial (AT) vessels. At this point of dissection, the peroneal nerve with its network of muscular-periosteal branches was preserved to supply the fibular diaphysis. Dissection at this stage is challenging and can lead to the division of motor branches of the peroneal nerve to aid release of the vascular pedicle. We had to divide two motor branches; a neuro synthesis was carried out immediately. We found the calibre of the anterior tibial vessels small throughout its course lying directly on the bone. Whilst identifying and dissecting the recurrent epiphyseal branch, a large branch from the peroneal artery was identified which directly entered the head of the fibula. No dominant supply from the anterior tibial vessels to the head of the fibula was seen. This abnormal anatomical variant has not been previously described. This led to the need for a bipedicled flap with diaphyseal supply from the AT vessels and the epiphyseal transfer based on the peroneal artery. A vein graft was used to augment the pedicle length. The flap was anastomosed to branches from the brachial artery and had good flow in all anastomoses.
An internal Doppler was used for flap monitoring, and the patient made an uneventful recovery from the procedure.
Discussion: Multiple anatomical variants in the blood supply to the fibular flap have led to the formation of classification systems to aid description of the vascular patterns. However, the blood supply to the physeal plate has been constant in its origin from the anterior tibial vessels. Our case highlights the presence of aberrant blood supply to the fibular head not previously described in the current literature.

S8'-2 Retrospective Review Of Free Fibula Transfer In Paediatric Sarcoma: A Single Centre Study Of Epiphyseal Transfers
Natia Gabuniya, Maleeha Mughal, Robert Pollock, Paul Roblin*

Introduction and Aim: Primary Osseous tumours are relatively rare in the paediatric and adolescent age groups comprising of only 6% of malignancies in the paediatric population. Surgical resection remains the first choice of management to obtain local control.The concept of skeletal reconstruction in these cases encompasses not just replacement of tissue defects but also has to factor in the potential for osseous growth. The free vascularised Fibular graft provides rapid autograft integration and the potential for physeal transfer in paediatric patients. We present our experience in management of paediatric

skeletal reconstruction with the Fibular flap.
Methods: A retrospective review of all paediatric extremity sarcoma cases undertaken at our unit from 2014 to 2018 by the senior authors was carried out. Data collection parameters included patient demographics, diagnosis, tumour location, size of resection, size of skeletal reconstruction, flap ischaemia time, vessels used for anastomosis, postoperative complications, time to union, time to ambulation/mobilisation and measurement of limb growth.
Results: A total of 6 cases were reviewed with a mean age of 9 years. 4 male and 2 female patients were identified. All patients underwent epiphyseal transfer with a functionally salvaged limb reconstruction. None of our patients undergoing epiphyseal transfer had residual peroneal nerve palsy and had adequate limb growth on follow up.Primary union in most patients was achieved at six months. We had no mortalities in our case series.
Conclusion: Significant progress has been made over the last ten years in management of paediatric sarcoma. Enhanced microsurgical and oncological advances have resulted in a much-improved prognosis and survival rates. Also, limb salvage surgery has been associated with a more prolonged survival than the historically accepted primary amputation. In the younger patient reconstruction post sarcoma resections should meet demands of high function and cosmesis. The free vascularised fibular graft provides structural support and allows longitudinal growth of the limb from the proximal physeal plate. Anatomical studies confirm the independence of the diaphysis and epiphyseal blood supplies till growth is completed therefore it is imperative that the reconstructive surgeon isolate the physeal vessels and anastomose at the recipient site in addition to the fibular vessels. We emphasise the need for a separate anastomosis of the physeal blood supply as this would prevent future limb length discrepancy and ensure the axial growth of transferred fibula.
Keywords: free fibula flap, paediatric microsurgery, sarcoma, oncology

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S4-6 Comparison of Trapeziectomy in brachial plexus block anesthesia and local anesthesia, regarding postoperative pain satisfaction and post-operative consultation
Camillo Müller, P. Erba, T. Christen, W. Raffoul*

In spite of lack of scientific evidence, brachial plexus block anaesthesia (BPBA) is the preferred anesthesiologic technique for trapeziectomy. Superior postoperative analgesia associated with a decreased number of postoperative complications (eg. CRPS) and improved function are assumed by the promoters of this technique. A retrospective pilot study was performed to compare patients undergoing trapeziectomy either under brachial plexus block or local anesthesia (LA) in regard of post-operative pain and complications as well as in regard of the satisfaction with the.performed surgery. Patients in the local anesthesia group had slightly lower pain scores (4.1 vs 3.6) as well as fewer postoperative consultations (3.6 vs 2.8) compared to patients of the BPBA group. No difference could be identified regarding long-term satisfaction and willingness to repeat the operation which was high in both groups. In conclusion comparable clinical outcomes of LA and BPBA obtained in our study provide the first insights for a safe use of LA in trapeziectomy surgery.

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S11'-6 **High Pressure Injection Injury: A Case Series**

*Mohammed Muneer *, Habeeb al-Basti, Mohammed Murshid, Saif Badran*

BACKGROUND: High-pressure injection (HPI) injury to the hand is a work-related injury, it is estimated to be 1 in each 600 hand injuries, with a significant increase in incidence due to the widespread use of high-pressure paint sprays and hydraulic systems. It is commonly underestimated by the patient and the physicians due to their presentation as a puncture wound, while the hidden effect can lead to devastating outcomes.
METHODS: This study was conducted in 2011 in a retrospective method till 2008, and in a prospective method till 2015. A total of 32 cases of HPI injuries in Hamad Medical Corporation was collected.
RESULTS: 63% of the cases happened at the dominant hand, most common location is the palm (34%), followed by the index finger (28%). Different materials were involved: Grease (53%), Paints (25%), Air (13%) and chemicals (9%). The average delay in presentation was 25(range 3-96)hrs. Average Hospital stay was 5.8 days. Paint injuries needed a higher number of surgeries (average 2)and were responsible for the only amputation case and the two cases with the need for skin coverage. The most common late complication was chronic pain 9%, and reach 18% if the injury was in the palm.
CONCLUSION: HPI can lead to significant morbidity depending on many factors: The material viscosity and toxicity, the ejection pressure and the location of the injury. Early decompression by a specialised hand surgeon is a need but can be challenging when the material disseminates to the neurovascular bundle. Early rehabilitation and long-term follow up are essential parts of the management plan.

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S11-7 **Otoplasty Art For Improved Results**

The surgical goals in autoplasty are to establish a permanent, symmetric setback of the ears which possess gentle, natural contours and an anti helix which does not obscure the helical rim in frontal view. The surgical techniques aims to correct these anomalies by reshaping and reposition to restore the normal size and appearance.
Objective: The focus of my presentation is how to do otoplasty without complications as Haematoma, infection, necrosis and recurrence.
Methods: Many surgical techniques have been described using one or a combination of three basic methods. Cartilage cutting, cartilage weakening, and cartilage sparing techniques. The ideal technique should yield a natural correction of the deformity, with lower recurrence rate and little risk of complications. Certain surgical maneuvers will be discussed and drawn in each patient which can help to overcome some of complications. Many cases will be presented to demonstrate these tips and updating points of this art.
Results: There were harmonies and sustainable with no major complications as skin necrosis, Infection, and Haematoma
Conclusion: Success is dependent upon proper analysis of the underlying deformity and application of surgical techniques customized to individual anomaly. A learning curve should be required to reach excellent outcomes

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S5'-7 Biomimetics In Plastic Surgery A Concept Already Applied ?
Wassim Raffoul, Sebastien Durand*

Since its appearance as a specialty in its own right plastic surgery has always been very creative thanks to the talents of its pioneers who have found many tips and invent surgical techniques often complex to solve varied and often difficult problems.
If we look in more detail at different plastic surgical techniques we can easily make a simple statement. These interventions were inspired by anatomy, physiology, physics, mathematics ...
If we observe carefully the results of our procedures we can also clearly see that the best results are obtained when we get closer to what is natural, what biology has built.
This is the basis of thinking about bioinspiration and biomimicry, and this is even more true and obvious when talking about cell therapies.
A new way of seeing plastic surgery is emerging. It will allow selection and classification of techniques. The most bioinspired will probably allow the best results.
In this presentation we will show with concrete examples the principles of bioinspiration, results and future perspectives.

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S1-2 Use Of The SPY Elite Imaging System To Evaluate Tissue Perfusion & Associated Complications Following Free DIEP Breast Reconstruction
Natalie Redgrave, N. Haram, D. Masud, W. Albadry, P. Mohanna*

Background: Autologous free tissue transfer using the DIEP flap is most frequently used method for breast reconstruction in our UK plastic surgery unit. Free flap failure and tissue necrosis are well recognised complications of these procedures. Nationally, the free flap total and partial failure rate is estimated to be on average 2.18 % (95 % CI 1.37 to 3.28) and 1.98 % (95 per cent CI 1.21 to 3.04), respectively. The return to theatre rate is estimated to be 11.8 %. These complications directly relate to tissue ischaemia during and post procedure. Intra-operative analysis using laser-assisted indocyanine green fluorescence angiography such as with the SPY Elite system has been suggested to reduce these complications by identifying and managing areas of ischaemia intra-operatively. We designed a prospective study to investigate whether use of the SPY Elite Imaging System in our unit would reduce the observed rates of these complications.
Materials & Methods: Patients undergoing breast reconstruction with free DIEP flaps in our trust between May 2015-April 2016 were prospectively invited to join the study. These patients were randomised to receive either routine treatment or to the addition of intra-operative analysis with the SPY Elite florescence imaging system. Post-operative outcomes were compared between the groups including partial or total flap failure, return to theatre rate, rates of fat necrosis/skin necrosis and length of hospital stay.
Results: During the study period 37 patients were recruited to the SPY group and 40 patients to the control group. The overall total flap failure rate was low in this group (2.60%). There were no cases of total flap failure in the SPY group compared to 2 in the control group. There were 2 cases of partial flap failure in the SPY group. Slightly higher rates of mastectomy skin flap necrosis were observed in the SPY group. However, lower rates of fat necrosis were seen in this group. The rate of return to theatre for exploration of

the flap during the immediate post-operative period was lower in the SPY group – 5.40% compared to 17.5%. The length of inpatient stay was not significantly different between the groups.
No patients suffered any complications from the use of the SPY Elite system (e.g. anaphylaxis).
Conclusions: There is conflicting evidence in the literature regarding whether the use of the SPY Elite imaging system significantly reduces ischaemic complications in breast reconstruction patients. Our study suggests that there is a possible beneficial effect on rates of flap loss, return to theatre and fat necrosis. However, this is limited by our small sample size. Further studies with much larger numbers are still required to demonstrate whether the use of this technology confers a significant benefit over standard clinical assessment.

S1-3 Evaluation Of Mastectomy Skin Flap Necrosis Following Breast Reconstruction In A Uk Plastic Surgery Unit

Natalie Redgrave, Katie Lancaster, Pari-Naz Mohanna, Marlene See, Victoria Rose, Helen Mcevoy, Joannis Constantinides, Mark Ho-Asjoe, Jian Farhadi, David Ross, Paul Roblin*

PURPOSE: Mastectomy skin flap necrosis is a commonly recognised complication of immediate breast reconstruction. The incidence in the literature ranges from 5-30%. Development of mastectomy skin flap necrosis has significant impact on patients with effects on adjuvant oncological therapy, cosmetic outcome, patient satisfaction and quality of life. Notably, the UK guidance from the National Institute of Clinical Excellence (NICE) states that patients should start adjuvant treatment where indicated within 31 days of completion of surgery. It is imperative therefore that complications of immediate breast reconstruction such as skin flap necrosis do not cause delays to the start of these treatments. We aimed to determine the rates of mastectomy skin flap necrosis following immediate breast reconstruction in our unit and to identify any patient/surgical factors that correlate with increased risk of developing post-operative mastectomy skin flap necrosis.
MATERIALS & METHODS: A retrospective review of patient electronic records was undertaken for all immediate breast reconstruction patients operated in our unit between January – September 2017.
RESULTS: During the study period 100 patients underwent immediate breast reconstruction in our unit. The majority of these (83 patients) had autologous reconstruction with microsurgical free tissue transfer with the remaining 17 having implant-based reconstruction. The overall mastectomy skin flap necrosis rate was 20.0%. In the autologous group the rate was 22.9% (19 patients) and 5.8% (1 patient) in the implant group. In the autologous group there was no significant differences in age, BMI, smoking status, operating surgeon, incision type or axillary surgery between those patients who developed necrosis and those who did not. However, significant differences were seen in mastectomy weight (P=0.001), free flap weight (P=0.002) and healing time (P=0.006).
CONCLUSIONS: Rates of mastectomy skin flap necrosis in our unit correlate with those reported in other units worldwide and are lower in implant-based than autologous reconstruction. We demonstrate significantly higher rates of mastectomy skin flap necrosis in patients with higher mastectomy weight and larger free flap size. We have also shown that the development of mastectomy skin flap necrosis leads to a longer healing time post-operatively and this has the potential to delay adjuvant cancer treatment in these patients. Therefore, in patients with larger breast size who are likely to require adjuvant oncological therapy it would be prudent to consider delayed reconstruction after completion of cancer treatment to avoid potentially compromising oncological outcomes.

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S1-4 **Wide Local Excision Defects of the Breast – A Treatment Algorithm Based on Oncological Resection Patterns**
Paul Roblin, Nadine Hachach-Haram, A. Bashir, M. See, P. Mohanna*

Introduction: Reconstruction of wide local excision (WLE) defects can be performed using various autogeneous and alloplastic techniques. Options include lipofilling, oncoloplastic reductions, TDAP flaps, LICAP flaps, free flaps and silicone implants. We present an algorithm based on the breast quadrant involved, the presence or absence of nipple deviation and the size of the defect which helps in the selection of the most appropriate reconstructive technique.
Methods: From 2008 to date we have reconstructed 28 WLE defects. Patients were categorised according to breast quadrant involved, volume deficit and nipple position. Techniques used included lipofilling (n=7), oncoloplastic reductions (n=9), TDAP flaps (n=8), ICAP flaps (n=1), DIEP flaps (n=2) and implants (n=1).
Results: For UOQ (n=7) and LOQ (n=3) defects with nipple deviation TDAP and DIEP flaps were used. The LIQ (n=1) defect was reconstructed with an ICAP flap. UIQ (n=5) defects without nipple deviation were managed with lipofilling. For central defects (n=1) an implant was utilised. In patients with macromastia or ptosis, oncoplastic breast reduction was possible. One TDAP flap became congested requiring partial debridement and later lipofilling.
Conclusions: Our treatment algorithm aids in the selection of the most appropriate reconstructive option for the treatment of this challenging problem.

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S8'-3 **Soft Tissue Reconstruction Of Open Lower Limb Injuries In A Single Centre: 5 Year Review**
Victoria Rose, Nadine Hachach-Haram, Eunsol Kim, Natalie Redgrave, Irene Cosentini, Michelle Griffin*

Abstract: The management of traumatic lower limb injury has evolved greatly over the last century with the advent of vacuum assisted closure dressing, microsurgical procedures and advanced fixation techniques. Never the less, such injuries remain complex and multi-faceted, requiring a Multi-Disciplinary Team approach to plan and execute the reconstruction. We present a 5 year review of lower limb soft tissue reconstruction from our centre.
Method: The local database was used to identify all lower limb free flap coverage performed at St Thomas' Hospital, London, between April 2013 and April 2018. For each case, data was collected through the Electronic Patient Records (EPR) and for those that had missing electronic data we reviewed the hard copy medical notes. A standardised proforma, in the form of an Excel sheet was used to collect data such as: Demographics; mechanism of injury; injury sustained (Gustillo Anderson classification); type of flap; type of anastomoses; flap survival; surgical site infection (SSI) rate.
Results: We identified 164 cases of lower limb free tissue transfer in 148 patients over 5 years. Of theses 34 were female and 114 were male. The average age of women was 51years and of men was 39 years. The most common type of injury was Gustillo-Anderson 3B (73%). The most common mechanism of injury was road traffic collision followed by fall from height then fall from ground level. The favoured flap in our department was Anterlateral Thigh flap (ALT) (77%), followed by Radial Forearm Flap (RFF) (8%). Flap

failure rate was 11.5% with 19 flap failures in 16 patients. Surgical site infection was 8.5% over the past 5 years.
Discussion: Published free flap failure rates for traumatic lower limb injuries range from 4-20%. Our flap failure rate was within this range. The commonest association with flap failure in our cohort was delayed time to definitive flap and fixation and the administration of noradrenaline in the immediate post operative period to maintain mean arterial pressure. There is a careful balance that needs to be struck in the timing of the soft tissue reconstruction coverage. It is thought that an increase in time to soft tissue coverage is proportional to infection risk. Equally, having a patient fit enough to withstand a 7 hour operation is similarly paramount to the success of a free flap.

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S7'-4 New Concepts in Abdominal Wall Reconstruction

Over the last decade there has been a marked increase in the complexity and range of abdominal wounds presenting to both hernia and plastic surgeons. This has been primarily as a result of dramatic increases in obesity, but also the difficulties in managing the acute abdomen in this patient group and others who in the past may have been deemed to be unfit for surgery.
As a consequence plastic surgeons are increasingly being asked to assist our general surgical colleagues in helping to achieve primary closure or reconstruct the abdominal wall after laparostomy.
These reconstructive techniques were initially proposed by Ramirez, but more recently we have seen significant changes in the range and methods of reconstructive techniques available to achieve robust midline closure.
My presentation will review the current state of abdominal wall reconstruction and in particular reflect on the evolution of component separation techniques. The need for providing extra soft tissue cover will also be considered both in terms of tissue expansion, progressive pneumoperitoneum, microvascular reconstruction and lastly abdominal wall transplantation.
This field represents a rarity in that it is one of the few fields that plastic surgeons can meaningfully expand upon within the greater surgical sphere. The aim of this lecture is to provide a status update on the techniques available to the committed reconstructive surgeon.

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S3-4 Mastopexy Augmentation

Plastic surgeons who prefer to perform augmentation mastopexy in 2 stages point out that after a mastopexy, there are changes in the breast over a few months as swelling goes down and the tissues settle into position. They note that the lift can be done with minimal tension on the skin, possibly leading to better scars, as opposed to doing implants where the skin has to be re-draped over the additional volume of an implant.
On the other hand, surgeons like me who prefer one stage augmentation mastopexy point out that staging in two sessions is equivalent to a 100% revision rate since everyone

automatically gets two operations. Each surgery requires downtime for recovery, and the overall expense is higher because there are two anesthetics required and two trips to the operating room.
In this presentation I will present my opinion on the subject, as well as results of both and the superiority of the single stage Mastopexy/Augmentation

INDUSTRY SYMPOSIUM

Cellulite, A Long Lasting Solution

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S2'-4 Treatment of challenging nasal and peri-orbital skin cancer with local flaps

Basal cell cancer (BCC) is the most common non-melanomatous skin cancer in the head and neck region. This is no different for the indigent Lebanese in whom sun exposure is a major risk factor. Mohs micrographic surgery is accepted as standard of care in cosmetically sensitive regions due to lower recurrence rates and smaller resultant defects post-mass excision. However, due to the paucity of Mohs surgeons in our region these lesions are treated with wide local excision (WLE) resulting in larger defects that pose a reconstructive challenge. In this small series, we review six patients with BCC in cosmetically sensitive areas of the face. All underwent staged excision followed by reconstruction with locoregional flaps with good outcomes and no recurrences at a minimum follow-up of one- year. A treatment algorithm is proposed for this ever-increasing patient population.

S5'-3 Evaluating The Safety Of Lipo-Abdominoplasty In The Clinically Obese: A Meta-Analysis

Background: in recent years, several studies have deemed lipoabdominoplasty a safe operation to perform on clinically obese patients whose body mass index (BMI) is 30 kg/m^2 or greater.
Objective: the aim of our study is to assess the safety of lipoabdominoplasty in clinically obese patients by evaluating the frequency of publications that study lipoabdominoplasty in patients with BMI > 30, the short-term complication rates, the long-term follow-up of these patients after the surgery and the status of patient long-term satisfaction with the results.
Methods: a search of the two databases, PubMed and Google Scholar, was carried out using the term "lipoabdominoplasty". Only the studies conducted between January 2008 and May 2018 were included in this paper. The search yielded 144 publications; 52 studies were relevant to the goal of our study and 30 of them were employed in the meta-analysis.
Results: 16% of the published studies addressed lipoabdominoplasty performed exclusively on clinically obese patients (BMI > 30), while 40% of them treated lipoabdominoplasty involving, exclusively, patients with BMI ≤ 30. The rates of short-term complications were low and comparable in clinically obese patients and patients with BMI ≤ 30. However, the status of long-term complications of lipoabdominoplasty in patients with BMI > 30 was null as none of the studies reported any long-term follow up with the patients and none presented the status of the long-term satisfaction of the patients.
Conclusion: the safety of lipoabdominoplasty in clinically obese patients cannot be absolutely assumed in the absence of data on the long-term complications of this procedure. We recommend commitment to regular follow-ups, where the patients' long-term satisfaction is assessed, for at least two years after the surgery.

S7'-3 Reconstructing Melanoma And Non-Melanoma Skin Cancers Below The Knee: The Role Of The Keystone And Perforator Flaps

Skin cancer below the knee is a relatively common entity that poses a reconstructive challenge due to the inelasticity of skin in that region. While skin grafting post-excision is a viable option, it is associated with a few disadvantages, especially when the deep margins of the excision extend to periosteum or tendons. In this case series, we describe our experience with six patients with melanoma (4) and non-melanomatous (2) skin cancers using WLE followed by reconstruction using local random, perforator, or the keystone perforator flaps. All patients underwent single stage reconstruction with no major complications and no recurrences at a minimum of one-year follow-up.

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S4'-2 Upper Eyelid Aesthetics
Shahram G. Sajjadi, Afschin Ghofrani*

Periorbital rejuvenation and occuloplastic techniques have an invaluable effect on the general youthful and fresh look and being the first areas of natural face-to face communication, delicate and detailed surgical approach will result in drastic changes in overall look of a patient.
This paper aims to review the natural and youthful surface anatomy of the upper eyelids and tailoring different surgical techniques to achieve it, such as upper eyelid fat transfer, upper eyelid blepharoplasty with fat preservation and redistribution, brassier suture, and internal brow-pexy.

S11-1 Piezo Ultra Surgery In Rhinoplasty, 3 Years Experience
Shahram G. Sajjadi, Afschin Ghofrani*

Piezosurgery technology has been used in dentistry, periodontology and implantology for over 2-3 decades. Recently there has been growing interest of its application in rhinoplasty.
Piezosurgery is a relatively new technique for osteotomy and osteoplasty that utilizes ultrasonic vibration. The piezosurgery device is essentially an ultrasound machine with modulated frequency and a controlled tip vibration range.
By taking advantage of its settings and tips gives a precise bone shaving, rasping, cutting and also can be used as a drill while preserving the surrounding soft tissues.
The author shares his 3-year experience with routine use of Piezosurgery in rhinoplasty, its advantages, disadvantages, the complications he has inquired and how to prevent them.

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S3'-3 Burns Management In Major Trauma Centre (MTC) Getting It Right First Time
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Introduction: The management of burns follows a similar set of pathways to Major Trauma. These are managed either in centres, units or facilities and this is dependent on the

severity of the injury. St. George's Hospital does receive major burns, either as the closest MTC or due to other concurrent injuries. The role of the MTC is the rapid assessment of the extent of the burn, instigating emergency management, stabilising and the safe transfer to a Burns unit. As major burns are not a daily occurrence in a MTC, the aim of this study was to identify problems in the management pathway of these cohort of patients and to put in place protocols and management guidelines to streamline care.
Materials and Methods: A retrospective review of all trauma calls involving burns between 2015 and 2016 was performed. Patient characteristics and standard recorded burns data was analysed.
Results: There were 29 patients identified, of whom 16 were male and 13 female. Burns ranged from 2% -70% Total body surface area (TBSA) with 19 cases being classified as major burns with >15% TBSA. Plastics were not recorded to have been present at any of the trauma calls. The Mean initial temperature was 35.9^{o}C and mean last temperature of 36.2^{o}C. The time from Arrival at Accident and Emergency (A&E) to a burns Unit referral ranged between 7-161 minutes. The time from referral to the burns unit and burns unit acceptance ranged between 0-403 minutes, whilst the time between burns unit acceptance and transfer out ranged between 0-290 minutes and total time from A&E arrival and transfer out 86-622 minutes.
Conclusions: We have devised and introduced a Major burns protocol/management pack into St. Georges Hospital to standardise and streamline the management of Major Burns in a MCT.

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MOTIVA SYMPOSIUM

Rationale Why To Move From Anatomical Textured Implants To Round Smooth/Nanotextured In Breast Augmentation And/Or Mastopexy

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S1'-2 3rd digit bone and joint reconstruction in a 7 year old by combining Masquelet, Ilizarov and microsurgical transfer techniques
Elias T. Sawaya; B. Sommier

A 7 year old male infant was addressed secondarily to a ballistic trauma of the right hand resulting in complete loss of bony and cutaneous tissue of the dorsal aspect of the 3 metacarpal. In particular the 3 rd metacarpophalangeal joint was destroyed, and the loss of bony scaffolding resulted in a 3 rd digit retracted to the distal 3 rd of the dorsal aspect of the hand. A combination of three techniques successively allowed restoration of proper length and function of the 3 rd radius in particular and the child's right hand in general. Masquelet's cementing technique associated with à cutaneo-adipous rotation flap enabled retrieval of proper alignment of the remaining base of the 3 rd metacarpal with the three phalanxes. The Ilisarov technique helped retrieve physiological length of the 3 rd metacarpal. And finally, a microsurgical transfer of the metatarsophalangeal joint from the second toe of the right foot achieved retrieval of flexion and extension of the 3 rd radius at a satisfactory functional level.

S1'-3 Lipofilling In The Digital Pulp: Indications, Technique And Results
Elias T. Sawaya; B. Sommier

Background: Hand injuries in the pulp are very frequent and follow up after wound healing often shows sequels in terms of allodynia in the scars and cold intolerance leading to alteration of patient quality of life, despite adequate and early physiotherapy.
Autologous adipose tissue grafting techniques are well documented and various applications have been developed in the field of plastic and reconstructive surgery.
Lipofilling applied to the hand has not been described until recently. And different applications have become possible thanks to the development of micro-lipofilling.
Method: The authors assess the results of micro-lipofilling in a prospective study of patients with a history of pulp injury that had occurred at least 12 months previously and presenting residual allodynia and cold intolerance.
Evaluation was based on the variation of the QuickDASH score, the Simms-Weber sensitivity test, patient-reported cold intolerance and physician evaluation of pulp curve. These criteria were assessed at 3, 6, 12 and 18 months follow up.
Results: The preliminary results of this study appear to be encouraging. The 3 patients included showed a fast amelioration of quality of life scores, allodynia in the scars and cold intolerance were significantly improved.
Conclusion: This study suggests that micro-lipofilling could have very efficient, safe and cost-effective applications in pulp surgery.

S4-5 Reconstruction Of Extensor Pollicis Longus Tendon by a Combined Hunter and Dermal Regeneration Template Procedure
Elias T. Sawaya, B. Sommier, V. Casoli

Background: The authors report the case of 21 year old male patient presenting with traumatic pluri-tissular defects of the dorsal aspect of the hand and forearm as well as a 10 cm avulsion of the extensor pollicis longus tendon.
Material And Method: Following a first phase of debridement and negative pressure therapy, it was decided to proceed with skin coverage by means of a dermal regeneration template. The first stage of extensor pollicis longus reconstruction by grafting was combined with this step by placement of a silicone rod beneath the template.
Three weeks later, the neo-dermis had completely covered the skin defect including the silicone rod, and was ready for split-skin grafting. The graft take was total on the fifth day and the patient was admitted to a rehabilitation centre for regular physiotherapy. Five months after the initial trauma, the patient underwent the second stage of extensor pollicis longus reconstruction by replacing the silicone rod in the induced membrane with a plantaris longus graft, according to the Hunter principle.
Results: With a follow up of 9 months after tendon grafting, the functional as well as cosmetic result was satisfactory, with a 15° extension of the thumb and a 8/10 score on the Kapandji scale for thumb movement.
Discussion and Conclusion: Katrana et al. had previously described a staged extensor pollicis longus reconstruction beneath an already mature and grafted neo-dermis. This case report suggests that it is possible to proceed with the silicone rod placement as early as the first step of skin coverage, beneath the none yet colonized dermal regeneration template.

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S2-5 Breast Implant Infections After First Stage Breast Reconstruction: What Have We Learned After 135 Infections In 10-Years At The Mayo Clinic?

To determine risk factors for surgical site infections (SSI) after first stage implant-based breast reconstruction, a retrospective review identified 135 patients with breast implant infections between 2006 and 2016. Inclusion criteria encompassed patients who developed infection after first stage implant-based breast reconstruction following therapeutic or prophylactic mastectomy. Only infections requiring hospital admission or surgical intervention were included. We matched 135 non-infected breast reconstruction patients by age and date of surgery. Patient demographics, medical comorbidities, and peri-operative surgical variables were examined. The Centers for Disease Control and Prevention definition of SSI was utilized. Univariate and Multivariate logistic regression models were constructed using STATA 16.0 software. A total of 270 patients were evaluated. Univariate analysis demonstrated a significant correlation to infection when obesity, hypertension, history of smoking; neoadjuvant chemotherapy, previous radiation were present. Patients with heavier breasts, stage ≥I breast cancer, Nottingham score ≥2; and those requiring axillary lymph node dissections were also significantly associated with infection. Post-operative duration of drain use was also associated with infection for every additional week of drain presence. After multivariate analysis, patients with obesity (odds ratio [OR], 1.12; 95% confidence interval [CI] 1.02 to 1.23; p=0.02), hypertension (OR, 6.5; 95% CI, 1.9 to 22.3; p=0.002), neoadjuvant chemotherapy (OR, 2.5; 95% CI, 1.03 to 6.33; p=0.04), lymph node dissection (OR, 7.1; 95% CI, 1.76 to 29.23; p=0.006) and seroma formation (OR, 15.31; 95% CI, 3.75 to 62.49; p=0.0001) were significantly associated with SSI. These results will help develop a predictive score to aid in counseling patients regarding their risk of developing SSI after immediate breast reconstruction. Further measures to reduce risks of SSI and patient management are being considered, with emphasis on modifiable peri-operative risk factors.

S11-4 Endoscopic Brow Lift Revisited: What have we learned since its initial description in 1992?

Following its initial description, the endoscopic brow lift gained significant popularity. This popularity, however, was tempered later by lack of consistent long-term brow elevation. The technique however has seen recent resurgence in its popularity among facial aesthetic surgeons. Technical nuances and long-term data following endoscopic a brow lift will be presented with the aim on optimizing outcome

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S2-1 Breast Reconstruction - An overview

The presentation will provide an overview of currently available breast reconstruction methods. This will include Tissue expander and implant based reconstruction, Latissimus muscle and implant based reconstruction as well as various types of autologous tissue based reconstructions. Various factors that influence the patient's decision making process will be discussed. These include patient specific factors such as body habitus, BMI, smoking status, comorbidities etc. as well as tumor specific factors such as size and nodal status in relation to radiation therapy and how this affects decision making.
The audience should gain a general understanding of various types of breast reconstruction options and specifically develop an algorithm to assist patients with their decision making process.

S5-3 Surgical Management Of Lymphedema

The presentation will provide an overview of available surgical techniques for

lymphedema. This will include a short discussion of ablative procedures such as the Charles' Procedure and liposuction. The majority of the presentation will focus on the physiologic procedures of lymphovenous bypass and vascularized lymph node transfer. It will also include a discussion about pre-operative work-up and the use of ICG lymphography.
The audience will gain a better understanding of indications and techniques of lymphedema surgery.

S9-5 CAD/CAM Technology In Head And Neck Reconstruction

The presentation will provide an overview of computer aided design (CAD) and computer aided manufacturing (CAM) as it pertains to bony head and neck reconstruction. Specifically, the evolution and state of the art of virtual surgical planning will be discussed. A short introduction to potential future directions will also be included.
The audience will gain an understanding of indications and technique for virtual surgical planning and its translation into the operating room.

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S10'-5 Reconstruction Of Extensive Scalp And Skull Defects With Dural Exposure. Our 10 Years Experience
F. Sleilati*, S. Abou Zeid, N. Hokayem, M. Nasr

A Large scalp and calvarial defect with dural exposure is a life threatening situation and a reconstructive challenge. Etiology can be tumor related (surgical resection or radio-necrosis) or traumatic. We present our series over a decade, how we dealt with these rare cases, and the results that were achieved.

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KN1' Osteoarthritis Of The CMC Joint Of The Thumb: Evidence, Techniques And An Algorithm For Management Based On The St Andrews Experience

In this presentation I present an algorithm for the management of osteoarthritis (OA) of the thumb based on my experience of 250 procedures for arthritis of the CMC joint of the thumb including 120 trapeziectomies, 108 CMC joint replacements and other procedures including selective denervation of the CMC joint.
The carpometacarpal (CMC) articulation of the thumb is unique in terms of its construct and its ability to permit rotational movement. Axial loading of the thumb transmits significant forces through this joint and can result in symptomatic osteoarthritis with a prevalence of 22.4% in the adult population over the age of 50 years. Niu et al (2003) reported that 39.7% of men and 57.7% of women with clinical symptoms also had radiographic OA but of the joints with radiological OA only 8.3% in men and 16.7.5 in women had clinical symptoms. As the signs and symptoms correlate poorly with radiological findings, decision-making can be difficult in the management of osteoarthritis of the CMC joint.
The management of isolated carpometacarpal (CMC) joint arthritis needs to be different from that of arthritis of the scaphotrapezial (ST) joint or a combination of CMC and STT

(scaphotrapeziotrapezoid) arthritis. In addition, the stage of arthritis at which the patient presents also has an impact on selection of treatment.

Early osteoarthritis, which is localised to the CMC joint of the thumb, can be treated by arthroscopy, which can be used both as a diagnostic and a therapeutic procedure (Badia 2007). Washout of the joint, synovectomy, capsular shrinkage and partial trapeziectomy with arthroscopic interpositional arthroplasty have been reported (Slutsky 2014).

In early osteoarthritis of a relatively stable CMC joint, the denervation procedure as described by Lorea in 2003 has proven to be very effective in properly selected cases. The technique does not disturb the osteoarticular column of the thumb and permits early mobilisation and quick return of function. It can be expected to give good pain relief in up to 70% of patients lasting between 3 and 5 years.

In the event that the arthritis is confined to the CMC joint and is not responsive to conservative or arthroscopic treatment, a carpometacarpal replacement arthroplasty has been shown to be an effective procedure (Cootjans et al 2017, Toffoli and Tissier 2017).

Trapeziectomy, with or without a ligament reconstruction and tendon interposition or a suspension arthroplasty between the 1st and 2nd metacarpals has been the standard treatment for pan-trapezial arthritis (Gervis 1947, Davis et al 2004 &2009, Sirotakova et al 2007). The ligament reconstruction procedures have the advantage of correcting the dorsal radial subluxation of the 1st metacarpal and thereby result in a secondary correction of the hyperextension of the MCP joint which is a compensatory phenomenon for the dorsal radial subluxation.

The 1-2 intermetacarpal ligament is responsible for the stability of the 1st metacarpal and preventing proximal subluxation. In the event that there has been significant synovitis or there is a large osteophyte between the 1st and 2nd metacarpals, the intermetacarpal ligament may be stretched and lax and therefore cannot prevent proximal migration. This can also be the case if the ligament is damaged during a trapeziectomy while removing the osteophyte between the 1st and 2nd metacarpals. In this situation a suspension arthroplasty using the flexor carpi radialis or abductor pollicis longus tendon can be useful. In order to avoid harvest of the flexor carpi radialis tendon or the abductor pollicis longus tendon, a CMC Arthrex Mini Tightrope can be a useful technique.

Salvaging a failed procedure for carpometacarpal arthritis can be quite a difficult problem. In the event that there is proximal subluxation of the metacarpal, which causes pain due to contact with the scaphoid, interposition arthroplasty using autologous tissue (palmaris longus tendon or fascia lata) can be quite effective along with suspension of the base of the metacarpal to the 2nd metacarpal.

With a failed CMC replacement arthroplasty it may be possible to salvage the situation by carrying out a simple trapeziectomy to include removal of the cup and the neck of the implant. It may not be necessary to remove the metacarpal stem if it is recessed below the base of the metacarpal. In this situation there is usually sufficient pericapsular fibrosis to prevent proximal migration of the metacarpal.

Severe osteoarthritis of the CMC joint in young patients with a high demand hand can be treated arthrodesis of the CMC joint but is contra-indicated in the presence of STT arthritis. Fusion of the CMC joint does not allow the hand to be placed flat on a plane surface and the natural movement of opposition is lost. The loss of movement of the CMC joint can, to some extent, be compensated for by normal MP and ST joints. However, there is a significant rate of failure of arthrodesis of the CMC joint as evidenced in the literature (6-12.5 %) but not all non-unions are symptomatic (Rizzo et al 2009).

S4-3 Microsurgical Reconstruction Of Single Digit Amputations With Immediate Toe Transfer

This standard teaching in hand surgery a generation ago was that a distal amputation of a single digit was best treated by terminalisation at an appropriate level to allow a “working man” to return to work as soon as possible. With the advent of microsurgery and refinement in the techniques of replantation it became possible to carry out distal replants with good results including at the level of the midnail. The benefits of distal digital replantation beyond the FDS tendon insertion showed that replantation was favoured by patients for sensory and motor as well as cosmetic reasons (Elliot, Sood et al 1997).

Del Pinal (JHS(B) 2003) emphasised the importance of restoration of the ‘harmonious’ arcade in the hand to minimise impairment of function in labourers pointed out that individuals with amputations of two fingers that were not restored to length very rarely return to work. He further enunciated the indications for toe transfers after ‘minor finger

injuries' (JHS(B)2004).
In this talk I present the development of a philosophy of single digit reconstruction for distal amputations with immediate toe transfer. With the passage of time the indications for surgery of this nature have become better defined. Technical tips and the benefits and disadvantages of surgery of this nature are discussed. Outcomes from our own series as well as those in the literature indicate that with the proper selection of cases the success rate for surgery of this nature is equivalent to that of elective toe transfers (Yim et al PRS 2004, Woo et al PRS 2004, Woo et al PRS 2006)). Judicious application of this technique in appropriately selected patients can result in restoration of good motor and sensory function, maintenance of digital length and 'a harmonious' arcade, with a good aesthetic outcome and a reduction in physical and psychological dysfunction with very little morbidity at the donor site.

S4-4 Reconstructing the persistent scaphoid nonunion: evidence, techniques (including microsurgical reconstruction) and an algorithm based on the St Andrews experience

The majority of scaphoid fractures heal either with conservative treatment or with operative fixation. The incidence of scaphoid non-union is estimated to be approximately 5%. Of these a further 80% will progress to union with surgery. There is therefore a very small group of patients - predominantly of those with long-standing nonunions, those who have had previous failed attempts at reconstruction with non-vascularised bone grafts and those with an avascular proximal pole who present a challenge to the reconstructive hand surgeon.
In this talk I present the evolution of a philosophy of management of persistent scaphoid nonunions and the development of the Scaphoid Non-Union Service (SNUS) with a combined Ortho-Plastic approach. I will discuss decision-making based on current evidence and present an algorithm for the management of the persistent non-union based on the presence or absence of radioscaphoid arthritis, the vascularity of the proximal pole of the scaphoid and the size of the proximal pole.
Significant radioscaphoid arthritis seen on wrist arthroscopy at the start of the procedure precludes scaphoid reconstruction and such patients proceed to a four corner fusion.
In the absence of radioscaphoid arthritis, the vascularity and size of the proximal pole determines the nature of the reconstruction. If the proximal pole is of a good size and bleeds well, the scaphoid can be reconstructed with a nonvascularised bone graft. If however a good sized proximal pole is avascular after curettage and release of the tourniquet, the scaphoid is reconstructed using a vascularised bone graft from the medial femoral condyle (Larson et al 2007, Jones et al 2009) in preference to local vascularised bone grafts from the radius.
In the event that the proximal pole is avascular and very small and is therefore likely to shatter, it is excised and is reconstructed using a rib costochondral graft
(Sandow 1998, Veitch et al 2007) or a vascularised osteochondral medial femoral trochlea graft (Burger et al 2013).
Each of these techniques is illustrated with a clinical case, and the benefits and disadvantages of each procedure along with outcomes in the scientific literature is discussed.

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S11'-3 Microvascular Reconstruction Of Soft Tissue Defects Of Foot And Ankle: Minimizing Deformities And Avoiding Long-term Complications

Background: Extensive soft tissue defects of the foot and ankle after road traffic accidents are becoming increasingly common. Reconstruction of those defects by free tissue transfer is an efficient solution to provide a stable soft tissue cover and avoid

longterm complications.
Methods: From March 2015 till April 2018, a total of twenty two patients underwent soft tissue reconstruction of foot and ankle. Reconstruction was performed by Free anterolateral thigh flap (ALT) in ten patients, free latissimus dorsi flap (LD) in eight patients, free parascapular flap in two patients and free gracilis flap in two patients.
Results: All flaps survived completely. Small area of distal necrosis was observed in one LD flap and it was managed by dressing changes. Donor site complications observed in two patients with free LD flaps managed by secondary sutures.
Conclusion: Soft tissue reconstruction of foot and ankle defects by free tissue transfer provides stable soft tissue cover with good longterm function and minimal donor site morbidity.

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S5-5 Robot-assisted harvesting of mesenteric lymph nodes for lymphedema treatment
Karl Waked, Assaf Zeltzer, Randy De Baerdemaeker, Moustapha Hamdi*

Introduction: Lymph node transfer is an effective option in the treatment of lymphedema. However, the ideal donor site has yet to be found. The omental flap offers a reliable source of lymph nodes (based on the right gastroepiploic vessels), while avoiding donor site iatrogenic lymphedema.
Material and methods: Robotic-assisted surgery (RAS) has the benefit of reducing donor-site morbidity, facilitating microsurgical vessel dissection, pursuing a more minimally invasive approach, and overall improve the aesthetic and functional outcome of the patient. We present the first European case of a robotic-assisted harvesting of a right gastroepiploic lymph node flap for the treatment of upper limb lymphedema after breast conservative surgery.
Results: The total lymph node harvesting time was 90 minutes and was performed by two abdominal surgeons. The complete dissection was done using the da Vinci Robotic System. A lymph node flap, based on the right gastroepiploic artery, was successfully harvested and anastomosed on a thoracodorsal artery side branch and on the thoracodorsal vein. The micro-anastomosis was done by two plastic surgeons. The total operating time was 6 hours.
Conclusion: This first European case of robotic-assisted lymph node harvesting proves that it is a feasible technique that fully embraces the main advantage of both RAS and the right gastroepiploic lymph node flap: it is a truly minimally invasive surgical approach without any donor site iatrogenic lymphedema.

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S3-3 Lower Breast Pole Dermal Fixation In Mamopexy: The Hammock Technique
William Watfa, Pietro Di Summa*

Background: Mastopexy is one of the most performed cosmetic surgery procedures in the U.S. Despite the numerous mastopexy techniques that have been published in the past decades, preventing pseudoptosis to insure long lasting result remains the principal challenge.

Objectives: This paper describes a new mastopexy technique developed for moderate to severe ptosis associated with upper pole deflation. We aimed to evaluate long-term outcomes of this technique by measuring changes in key parameters of the breast shape over time. The effect of risk factors associated with worse outcomes such as massive weight loss, multiple pregnancies, skin quality, smoking, and age was also assessed.
Methods: At our institution, we reviewed 12 patients that were operated by a same senior surgeon with the hammock mastopexy technique using inferior demal flaps to support the breast glandular reshaping (6 bilateral mastopexies and 6 unilateral mastopexies for contralateral symmetrisation after breast reconstruction). Patient's characteristics such as smoking, massive weight loss or multiparity with consequent inelastic skin, age, and lengthy nipple-areola complex lift were considered as independent risk factors for ptosis recurrence and bottoming out. Patients were divided into 3 subgroups according to their number of risk factors. Changes in post-op breast measurements were assessed for each patient by breast measurements and a superposition of the standardised breast photographs. A visual analogue scale (VAS) was used to assess aesthetic results.
Results: Our results demonstrated maintenance of shape over time. NAC position remained stable at 12 month regardless of the number of risk factors. Statistically significant difference was found in lower pole lengthening between patients with more than 2 risk factors compared to those with less than 2 risk factors. Aesthetic measurement results were consistent between the patient and surgeon reporting a satisfying cosmetic result.
Conclusions: This mastopexy technique improves projection and reinforces the lower pole support with lateral and medial dermal flaps. The technique is safe, reliable and provides easily reproducible results for patients with multiple high risk factors for post-operative pseudoptosis.

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S2'-2 The ALT Flap: Is It The Ideal Soft Tissue Flap?
Yehia Zakaria (Egypt), Qutaibah Al-Kandari (Kuwait)*

The ALT (Antero-Lateral Thigh) flap was first described by Song et al., in 1984. The flap gained popularity and was widely used in head & neck reconstruction, abdominal wall reconstruction and limb reconstruction.
The flap was reported to be reliable, versatile with large skin paddle, has a long vascular pedicle of good caliber and the donor site in many instances can be closed primarily minimizing morbidity. So, it became one of the most preferred options for soft tissue reconstruction.
We report our experience with the use of ALT flap in reconstruction of soft tissue defects in different areas of the body. From June 2012 to January 2017, 36 ALT flaps were transferred to reconstruct various soft tissue defects. All patients were operated by two teams. The mean operative time was 4.8 hours. Mean hospitalization time was 7.4 days. Flap size ranged between 15-35 cm in Length (mean 28.7 cm) and 10- 15 cm in width (mean 13.3 cm). The majority of the flaps (87%) were supplied by musculocutaneous perforators, while the rest (13%) were supplied by septocutaneous perforators. In case of musculocutaneous perforators, flaps were raised as true perforator flaps by intramuscular dissection in 10 cases.
The overall success rate was 97.2% with one flap of partial necrosis.
Non vascular complications included Haematoma in 1 case, 3 cases developed infection at the flap recipient site.
The flap donor site was closed primarily in 5 patients and was skin grafted in the remaining.
The follow-up period ranged from 7-40 months

S8'-4 Microvascular Reconstruction Of Complex Lower Extremity Defects; Orthoplastic Approach

Yehia Zakaria (Egypt), Qutaibah Al-Kandari (Kuwait)*

Patients with complex lower extremity defects may not receive the optimum treatment if orthopedic and plastic surgeons do not work together to provide the service. This may lead to prolonged hospital stay, repeated surgeries and delayed rehabilitation of these patients. The use of microsurgical techniques enabled reconstruction of complex defects in a single stage. Also the introduction of modern microsurgical techniques and the concept of perforator flaps enabled reconstruction of severe defects with good functional and aesthetic outcome and also with reduced donor site morbidity.
We reviewed our cases in the last 5 years and in included 52 patients with complex defects mostly of the foot dorsum (42%), followed by the pretibial area (27%). The main cause of these defects was RTA (38%) followed by burns (21%). The Latissimus dorsi flap was the most commonly used flap (38%) followed by the ALT flap (29%). The anterior tibial vessels were used as the recipient vessels in (58%) of cases and the arterial anastomoses were done in an end-to-side fashion in (75%) of cases. We present our results and highlight the complications. We recommend the use of microsurgical flaps in reconstruction of complex lower extremity defects and these patients to be managed by co operation between orthopedic and plastic surgeon to improve the outcome.

S9-6 Microsurgical Flap Reconstruction Of The Head And Neck Following Tumor Ablation

Yehia Zakaria (Egypt), Qutaibah Al-Kandari (Kuwait)*

Background: tissue defects following tumor ablation in the head and neck region represent a major challenge for reconstructive surgeons because of the complexity of the anatomy, function and aesthetics in this region. Microsurgical tissue transfer enabled the reconstruction of such complex defects with different tissue components and different anatomical units at the same time.
The aim of this work is to evaluate the reliability of free tissue transfer in reconstruction of different tissue defects in the head and neck region following tumor ablation in terms of functional and aesthetic outcome.
Patients and Methods: this is a prospective study conducted on 75 patients attending the outpatient clinic in Zagazig University hospitals, Egypt and Al-babtain centre for burs and microsurgery, Kuwait, referred from oral and maxillofacial department during the period from April 2010 to June 2016. The initial disease required surgical ablation in these patients was malignancy. Their ages ranged from 24 years to 74 years old. They were 55 males (73.3%) and 20 females (26.7%). The surgical defect involved different anatomical structures including mucosa, bone and skin. Various microsurgical flaps were used for reconstruction.
Results: the overall success rate was 97.1%. There was 1 (1.3%) total free fibular flap loss. Surgical complications at the recipient site occurred in 5 patients (6.7%) including vascular related complications in 1 patient (1.3%), other 4 patients (5.3%) had non vascular related complications; hematoma in 3 patients (4 %) and wound infection in 1 patient (1.3%). Complications in the donor site occurred in 4 patients (5.3%) including; partial skin graft loss (ALT flap and radial forearm flap) in 2 patients (2.7%), hematoma in 1 patient of ALT flap (1.3%) and wound infection in 1 patient of fibula flap (1.3%). Functional and aesthetic outcome were satisfactory in 65 patients (86.7 %), in the remaining 10 patients (13.3%) the outcome was less satisfactory.
Conclusions: microvascular flap reconstruction of head and neck defects following tumor ablation has proved to be a very good, safe and reliable option for reconstruction of such defects with good outcome that helps to improve the quality of life in such patients.x

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S1-1 How To Perform Efficiently SGAP Flap Based Breast Reconstruction

Paul Roblin, Giovanni Zoccali, Jian Farhadi*

Introduction: SGAP flap is one of the alternatives for autologous breast reconstruction when more common flaps are not available. Since its first description it has not gained wide adoption due to its difficult dissection, short pedicle, time demanding surgery and associated donor site morbidity.
Often surgeons do not offer this possibility although this flap is available in patients with lower BMI compared to the DIEP flap patients.
The aim of this study is to identify the key points in SGAP flap surgery in order to perform efficient breast reconstruction.
Materials and methods: A retrospective preliminary study had been conducted at St. Thomas' Hospital in London (UK). Patient (age, BMI, smoke habitus, comorbidities, cancer site, previous breast surgery) and surgery data (patient position, surgery length, ischemia time, position and number of perforator) have been investigated. Complications and outcome had been also examined. Results have been used to find the key points in SGAP surgery.
Results: 125 cases (148 flaps) had been analysed: patient positioning, flap marking according to tissue anatomy, Doppler perforator mapping, perforator selection and microscope assisted deep dissection have been identified as pillars in SGAP surgery.
It is also important to note that coordination and in theatre organization is core to efficient execution of the surgery.
Conclusions: Despite SGAP being considered as a second choice and a difficult flap, if it is well planned and the surgery is performed meticulously whilst following the fundamental criterions it can lead to satisfactory results.