Standardizing Revision and Reoperation Reporting

Sir:

I read with interest Dr. Spear's editorial on revisions and reoperations.[1] Plastic surgeons, as well as our journals, should ideally come to a consensus on both standardizing the terminology and nomenclature and reporting the complications, revisions, and reoperations. There are really two camps of surgeons I have run across: those who believe all reoperations are the same and those who believe they should be listed, qualified, and delineated. First of all, I believe that as surgeons we need to be very careful not to minimize the significance of complications or revisional surgery. However, all complications are not the same or created equally. It has been said that even if there is only a 1 percent complication rate, if it happens to that specific patient, it is 100 percent to him or her.

Next, it is great to "pursue perfection but accept excellence." Using tissue-based implant selection and obtaining the best result possible for the longest time possible with the least number of revisions should be our goal. We certainly should improve over time; for instance, eight out of 10 of my revisions in my first 300 primary Style 410 patients occurred in the first 60 patients; only two out of my 10 revisions occurred in the last 240 patients.[2] Even if we shoot for a 0 percent reoperation rate, unless we simply do not offer a patient a revision, patients will require a reoperation at some point if we perform enough surgery and follow our patients long enough.

Unless surgeons very specifically track, measure, and record, have a CRO review, or get involved in a U.S. Food and Drug Administration trial, much as I did before the Food and Drug Administration reviewed studies, we will overestimate the number (and quality of results, I might add) and underestimate our complications. It's surgeon/human nature. I would make a plea for standardizing complications and recording specifically with regard to breast implant–related surgery (Fig. 1), with potential application to other plastic surgery procedures and areas.[3]

The following are recommendations to consider:

- The nomenclature should be standardized; "revision" and "reoperation" should be discussed and implemented, with "revision" being a more accurate term.
- The delineation or description algorithm shown in Figure 1 is in no way an excuse for any revisional surgery; our long-term goals should focus on minimizing any future surgery.
- Revisional surgery and reconstructive procedures carry a much higher further revision rate (10 times higher in my patient series). Thus, our goals for primary augmentation complication rates should be much lower than those for breast revision or breast reconstruction (i.e., <3 percent at 5 years, primary augmentation).
- Just as in peer-reviewed journal articles, plastic surgeons should be required at regional, national, and specialty meetings to state (just as with our disclosures) the actual number of patients, procedures, or implants they have used with a certain technique, implant, or approach.

  Planned operations or extensions of a procedure, such as exchanging an expander for an implant, should not be considered or listed as a "reoperation," and a planned or staged mastopexy should not be considered a revision or reoperation unless a mastopexy was performed previously.
- Surgeons should delineate specific complication rates and whether or not they were implant related, as well as the percentage of patient follow-up and over what time period (Fig. 1).
- Just as in the complication algorithm (Fig. 1) presented, differences should be made for operative versus nonoperative complications, as well as whether the revision involved the implant or just the skin or parenchyma overlying the device in each category.
- Standardized reporting forms should include the following:

  *Total postoperative complication rate
  - -Major postoperative complications (and minor-nonoperative complications)
  - -Elective or patient-directed revisions
  - -Required medical revisions
  - -Implant and non-implant related revisions

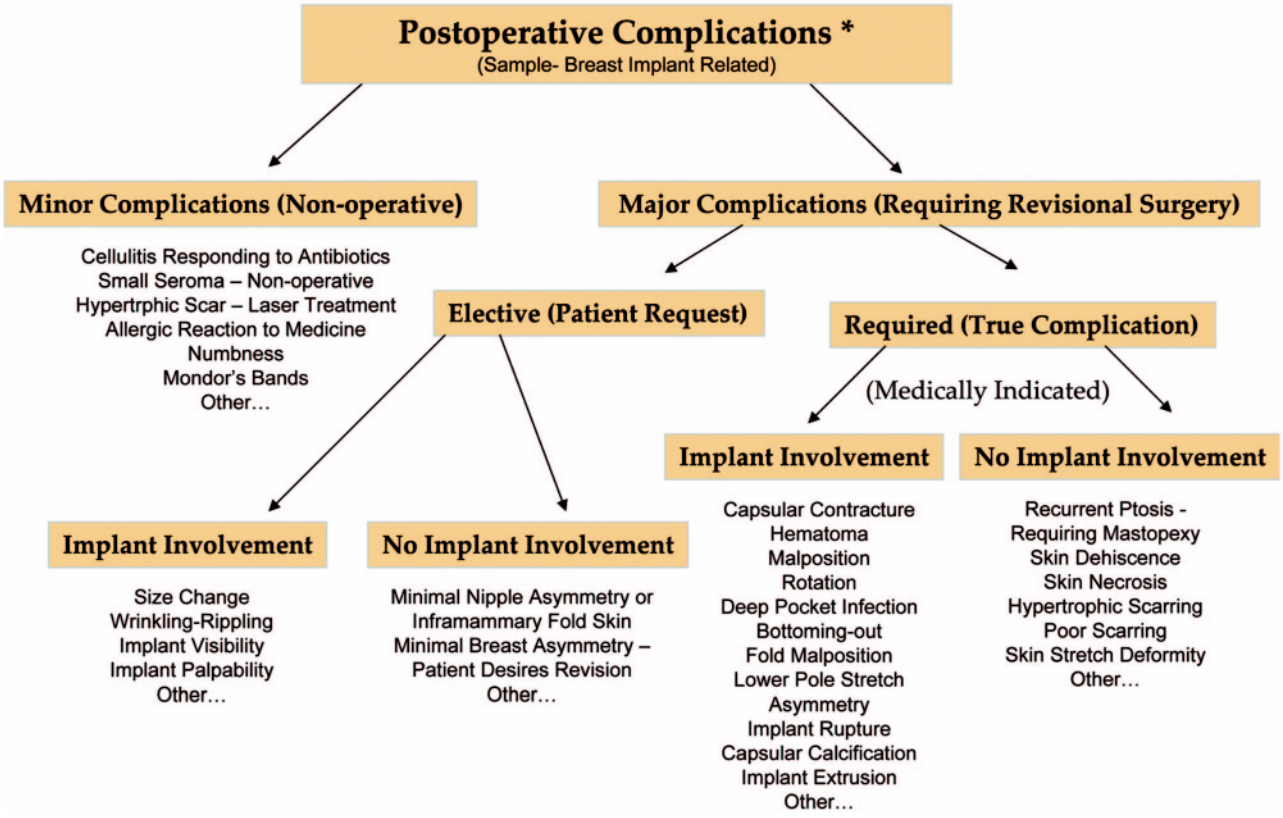

Fig. 1. Postoperative complications related to breast implants. As in our journal publications, during all meeting presentations, surgeons should accurately disclose the total number of patients having a specific procedure, technique, or device and report their total complication rates as well as specific complications in this or a similarly standardized format. *A planned revision, such as mastopexy not previously performed, NAR, expander-to-implant exchange, and so on, should not be considered a revision. Revision, by definition, should be the same as the prior procedure or at least be the same type of procedure; that is, a revision mastopexy should be performed in a patient who has already undergone a mastopexy.

DOI: 10.1097/PRS.0b013e31816b14f1

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DISCLOSURES

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