Sir:

I read with interest Dr. Spear’s editorial on revisions and reoperations. 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. 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.

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.
- Revisinal 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

*Total postoperative complication rate
Postoperative Complications *
(Sample- Breast Implant Related)

Minor Complications (Non-operative)
- Cellulitis Responding to Antibiotics
- Small Seroma – Non-operative
- Hypertrophic Scar – Laser Treatment
- Allergic Reaction to Medicine
- Numbness
- Mondor’s Bands
- Other...

Major Complications (Requiring Revisional Surgery)

Elective (Patient Request)

Required (True Complication)
(Medically Indicated)

Implant Involvement

No Implant Involvement

Caput Serous
Capsular Contracture
Capsular Calcification
Capsular Calcification
Rupture

Narrows
Rotating
Deep Pocket Infection
Lower Pole Stretch

Minimal Nipple Asymmetry or
Inflammammary Fold Skin
Minimal Breast Asymmetry –
Patient Desires Revision

Size Change
Wrinkling-Rippling
Implant Visibility
Implant Pulpability
Other...

DOI: 10.1097/PRS.0b013e31816b14f1

Bradley P. Bengtson, M.D.
Plastic Surgery Associates
Medical Education Research Center
Grand Rapids, Mich.
plastb@aol.com

DISCLOSURES

The author is a consultant for Allergan Corporation, a Core and adjunct breast implant studies Allergan and Mentor investigator, and a Core and Continued Access Style 410 cohesive gel implant investigator.

REFERENCES

2. Bengtson, B. P. How to stay out of trouble using the Style 410 highly cohesive gel implants: What’s the same, what’s different? Presented to the Canadian Society of Plastic Surgeons, Banff, Canada, June 2, 2007.