**Wellington Office Based Surgical Practice, PLLC**

**110 East 87th Street**

**New York, NY 10128**

**(212) 828-9906**

**OPERATIVE RECORD:**

**DATE: 8/27/19**

**NAME: Blumberg, Alice DATE OF BIRTH: 04/05/47**

**PREOPERATIVE DIAGNOSIS: 1) Lipodystrophy**

**2) Lower Abdominal Skin Laxity**

**POSTOPERATIVE DIAGNOSIS: 1) Lipodystrophy**

**2) Lower Abdominal Skin Laxity**

**PROCEDURE: 1) Liposuction of the Abdomen and Flanks**

**2) Lower Abdominal Skin Excision**

**3) Fat Grafting Lower Eyelids**

**SURGEON: Richard W. Swift, M. D.**

**ANESTHESIA: Spinal + IV Sedation**

**ANESTHESIOLOGIST: Sanjay Tewari, M.D.**

**SPECIMENS: None**

**CONDITION: Stable**

**COMPLICATIONS: None**

**TOTAL WETTING SOLUTION: 1,750cc (30cc Lidocaine 1% + Epinephrine 1:1000/L Ringers Lactate)**

**TOTAL ASPIRATE: 1,175cc**

**ESTIMATED BLOOD LOSS: Minimal**

**INDICATIONS:**

The patient is a 72 year-old female S/p Cesarean section who is preoperative for liposuction of the jowls, flanks, abdomen with lower abdominal skin excision and fat transfer to her face. The patient complains of excess fat and lower abdominal skin excess. Examination: Abdomen/Flanks: Lower abdominal skin excess, depressed C-section scar. Face: + Jowling, facial volume loss and aging. The procedure, alternatives and risks were extensively discussed with the patient. Risks included but were not limited to infection, bleeding and scarring, increased skin laxity, possible DVT/PE and possible need for additional procedures was discussed. Possible need for lower abdominal skin excision or scar revision was discussed. The patient wants the flattest possible abdomen with liposuction and is aware of possible

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Irregularities. All the patient’s questions were answered to her satisfaction. No treatment was also an alternative discussed with the patient. The patient is aware this is elective surgery. The expectations and limitations of the procedure were discussed. The patient strongly desires the surgery and has agreed to proceed.

**DESCRIPTION OF PROCEDURE:**

The patient’s jowls, abdomen and flanks were carefully marked for liposuction, lower abdominal skin excision and fat grafting to the face in the upright position. The patient confirmed the areas to be liposuctioned. The patient was brought into the Operating Room and underwent a sterile staining preparation with Betadine solution. The patient was then carefully positioned on a sterile sheet in the supine position on the operating table. Prior to the induction of anesthesia, the patient received intravenous antibiotics and bilateral venous compression boots were placed. The patient was then repositioned in the left lateral decubitus position. The patient’s right flank was infiltrated using the customary access incisions. The patient was then repositioned in the right lateral decubitus position and the patient’s left flank was infiltrated with the wetting solution using the customary access incisions made with a #15 scalpel.

After allowing the wetting solution to take effect, attention was directed to the patient’s left flank which was liposuctioned using the Microaire 4mm Mercedes PAL and the 4mm and the 3mm Eliminator tip manual cannula. The areas of relative excess adipose tissue were liposuctioned. Care was taken to carefully feather the liposuction areas with the surrounding areas. The endpoint was determined utilizing visual inspection, the pinch test, and comparing it to the surrounding areas. Excellent contour and no irregularities were noted.

The patient was then repositioned in the left lateral decubitus position. The patient’s right flank was then carefully liposuctioned using the identical technique. The areas of relative excess adipose tissue were liposuctioned. Care was taken to carefully feather the liposuction areas with the adjacent areas. Excellent contour and no irregularities were noted. The endpoint was determined utilizing the pinch test, visual inspection and comparing it to the contralateral side.

Next, the patient was repositioned in the supine position. The patient’s abdomen was then re-prepped with Betadine and the lower abdominal markings, were infiltrated with 1/2% Lidocaine + Epinephrine. After allowing the wetting solution to take effect, the patient’s abdomen was liposuctioned using the identical technique. Initially, approximately 8 cc of fat was harvested using the handheld blunt harvesting liposuction cannula. The adipose tissue was then processed on the back table in anticipation of grafting the face. The areas of relative excess adipose tissue of the abdomen was liposuctioned. Care was taken to carefully feather the liposuction areas with the surrounding areas. The endpoint was determined utilizing visual inspection, the pinch test, and comparing it to the surrounding areas. Excellent contour and no irregularities were noted. Next, an incision was made along the proposed markings using a scalpel. The subcutaneous tissue was then dissected at the level of Scarpa’s fascia superiorly, using the electrocautery. The abdominal flap was then advanced inferiorly. The table was flexed and the excess abdominal flap was then sharply excised and the flap was advanced inferiorly and was inset using buried interrupted 2-0 Maxon sutures in Scarpa’s fascia in the midline. The remaining Scarpa’s fascia was closed with buried interrupted 3-0 PDS sutures laterally. The transverse incision was closed with 3-0 buried sutures in the deep dermis. The remaining skin edges were approximated with subcuticular 4-0 Monocryl sutures. All of the access incisions were closed with simple, interrupted, everting 5-0 Nylon sutures.

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Inspection of the abdomen revealed excellent contour and symmetry. The abdominal flap maintained good color. Mastisol and 12mm Steri-Strips were applied. ABD pads and a circumferential abdominal binder was applied.

Attention was directed to the face that was prepped with Betadine. The Submental chin crease and cheek access incisions, which were infiltrated with local anesthetic prior, were made with a #11 blade. A Tulip micro cannula was used to inject and layer a total of 8cc of micro adipose tissue to the cheeks, midface and lower eyelid tear troughs. Excellent contour and symmetry were noted.

A sterile gauze and circumferential chin wrap was applied. Having tolerated the procedure well, the patient was transferred to the recovery area.

**Richard W. Swift, M. D.**