

case surgery have been published, demonstrating a low complication rate and good safety profile. Balkrishnan et al carried out a United States-wide study of complication rates in office based aesthetic surgery over a three-year period between 1999 and 2001, involving several hundred thousand cases.<sup>4</sup> The authors identified a very low complication rate, with only 26 serious adverse events reported, including 6 mortalities.

The American Society of Plastic Surgeons (ASPS) guideline on ambulatory surgery advises that provision of inpatient hospital care should be routine for patients with a BMI of 40 or over.<sup>5</sup> We do not have individual BMI data for the patients in this cohort, but in the authors' experience, patients with a BMI over 40 seeking aesthetic surgery form a very small part of their practice.

Our data demonstrates a very low complication rate, equating to less than one patient per year requiring either unplanned overnight admission or return to theatre. Our findings suggest that the low complication rates of aesthetic day surgery described in the US literature translate well to UK practice. Day case aesthetic surgery is safe with well selected patients and procedures, carried out by appropriately qualified surgeons and anaesthetists.

Having an arrangement to safely admit and care for patients overnight when complications arise is important. This highlights an area for development in UK cosmetic surgery guidelines, where currently no guidance on this subject exists. In addition, future guidelines may focus on identifying patient groups which are not suitable for day case surgery—such as patients with a high BMI—who may be more safely managed in an inpatient setting.

## Conflict of interest

Peter Hodgkinson sits on the Medical Advisory Committee for Ramsay Healthcare North East. None of the authors are employees of Ramsay Healthcare or any other non-NHS healthcare employer.

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## Can you tell the difference: Round vs anatomical implants – A real-time global ballot



Dear Sir,

Round and anatomical implants are used throughout the world for breast augmentation. However, controversy persists as to which provides the most aesthetically pleasing results, with a paucity of evidence comparing the cosmetic outcome of the two shapes. Many argue that in the majority of patients it is impossible to tell whether augmentation has been carried out using anatomical or round implants. We performed a live global ballot at the London Breast Meeting 2016 to determine whether delegates from around the world could determine the shape of implants used to augment 50 patients.

Delegates attending and viewing online at the London Breast Meeting 2016 were shown fifty consecutive photographs showing face on and lateral, pre- and post-operative images of patients having undergone breast augmentation with round and anatomical implants. All patients had a BMI of between 18 and 25, with implants between 200 and 320 ml and a starting cup size of A or B. Delegates were asked to determine what shape of implant had been used for each patient using the online voting system via the London Breast Meeting mobile app. Thirty-one patients had anatomical implants and 19 had round implants. Shape of implant was guessed correctly on average 58% of the time. Round implants were guessed correctly 63% of the time while anatomical implants were guessed correctly 54% of the time. Almost half of clinicians were unable to accurately identify implant shape. This is a finding consistent with other similar studies.

At the American Society of Aesthetic Surgeons Meeting 2014, 250 Board-certified Plastic Surgeons were shown 20 sets of pre- and post-operative patient photographs and asked to vote electronically on whether implants were round or anatomical. Delegates were correct 46% of the time.<sup>1</sup> Al-Ajam et al performed a blinded study asking 22

Plastic Surgeons to review pre- and post-operative photographs of 60 consecutive patients (33 round; 27 anatomical implants) that had undergone breast augmentation by a single surgeon. 63% of round and 49% of anatomical implants were correctly identified (mean 56%).<sup>2</sup> Friedman et al<sup>3</sup> asked eleven plastic surgeons to identify between round and anatomical implants after looking at photographs of 30 breast augmentation patients (15 round; 15 anatomical). 64% of round and 47% of anatomical implants were identified correctly (mean 55%).

Although subjective in their outcome analysis, studies have shown good aesthetic results with both round and anatomical implants. Bronz compared round textured non-cohesive gel filled implants with naturally shaped implants and found that on photographic examination it was nearly impossible to determine any aesthetic difference between the two.<sup>4</sup> In their recent randomised controlled trial, Hidalgo and Weinstein found no observable difference in breast aesthetics between anatomical and round implants when assessed by either Plastic Surgeons or lay individuals.<sup>5</sup>

Our study and others demonstrate the difficulty in determining whether breast augmentations have been carried out using round or anatomical implants, even amongst experienced Plastic Surgeons. We believe that the achievement of a desirable aesthetic outcome is not dependent upon the shape of the implant used. This is supported by Hamas<sup>6</sup> who demonstrated radiologically that both round and anatomical implants had similar shapes when standing. As many as 50 different factors influencing results in breast augmentation have been identified highlighting that careful physical examination combined with a detailed assessment of the patient's desires are central to achieving a good result. It is clear that in the hands of experienced surgeons, the shape of implant is not the determining factor in aesthetic outcome with both round and shaped devices able to produce a natural aesthetic outcome.

## Conflicts of interest

The authors declare no conflict of interest.

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## Can't touch this



Dear Sir,

According to the data of American Society for Aesthetics Plastic Surgery breast augmentation is the second most common surgical aesthetic procedure of 2016. Complications of breast augmentation in early period are hematoma/seroma formation, asymmetry, scarring, implant rippling, and malposition; whereas late-term complications consist of inadequate satisfaction, capsular contracture glandular atrophy and a newly recognized complication: Anaplastic Large Cell Lymphoma.<sup>1</sup> It has been discussed in the literature that the biofilm that forms around the implant, mostly around the textured ones, is one of the most important reasons leading to ALCL.<sup>2</sup> To reduce this complication, there are various techniques defined in the literature for preoperative, peroperative and postoperative precaution. One hour preoperatively empiric antibiotic coverage, peroperative triple antibiotic irrigation and postoperative antibiotic prophylaxis are some of the routines.

We would like to introduce you our own "hands-off technique". The aim of our technique is to minimize hand, glow, air and skin contact with the implant. It starts with close system irrigation of the implant with the classical triple antibiotic solution (rifampicin, gentamycin and bacitracin) via an angiocatheter. Initially we stick the needle of the angiocatheter to create a hole on the outside package of the implant, and afterwards we introduce only the Teflon cannula (without the needle) and irrigate the implant. This maneuver does not only enable safe and contactless irrigation but it also balances the pressure inside the package of the implant with atmosphere pressure; thus disabling the rapid movement of the surrounding bacteria on the initial opening of the implant. After irrigating the implant, an assistant holds funnel above the incision and the implant is transferred to funnel directly from its package without any contact to glows, breast skin and with minimal air contact. (See [Video 1](#), which shows the irrigation and transfer of the implant.) The operator implants the implant to its pocket and the incision is sutured. Thus, with this technique no one touches the implant, including the main operator.

Our technique also includes the standard cares to reduce bacterial contamination from the pocket, surrounding skin and surgical instruments. Irrigation is made to the pocket and the surrounding skin first with iodine solution and afterward with combined antibiotic solutions. Afterwards, a sterile skin drape is applied allowing only the incision to be left opened. While the assistant doctors prepare the field, the