



INFORMED-CONSENT MASTOPEXY

INSTRUCTIONS – This is an informed-consent document that has been prepared to help your plastic surgeon inform you about mastopexy surgery, its risks, and alternative treatments.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon.

GENERAL INFORMATION – Breast lift, or mastopexy is a surgical procedure to raise and reshape sagging breasts. Factors such as pregnancy, nursing, weight change again and gravity produce changes in the appearance of a woman's breasts. As the skin loses its elasticity, the breasts often lose their shape and begin to sag. Breast lift of mastopexy is a surgery performed by plastic surgeons to raise and reshape sagging breasts. This operation can also reduce the size of the areola, the darker skin around the nipple. If your breasts are small or have lost volume after pregnancy, breast implants inserted in conjunction with mastopexy can increase both firmness and size. The best candidates for mastopexy are healthy, emotionally stable women who have realistic expectations about what this type of surgery can accomplish. Breasts of any size can be lifted, but the results may not last as long in women with heavy, larger breasts. Mastopexy does leave permanent, noticeable scars on the breasts. There are a variety of different surgical techniques used for the reshaping and lifting of the female breast.

ALTERNATIVE TREATMENT – Mastopexy is an elective surgical procedure. Alternative treatment would consist of not undergoing the surgical procedure of wearing supportive undergarments to lift sagging breasts. If breasts are large and sagging, a reduction mammoplasty may be considered. Risks and potential complications are associated with alternative surgical forms of treatment.

RISKS OF MASTOPEXY SURGERY- Every surgical procedure involves a certain amount of risk, and it is important that you understand the risks involved with mastopexy. An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. While the majority of women do not experience these complications, you should discuss each of them with your plastic surgeon to make sure you understand the risks, potential complications and consequences of a mastopexy.

INFORMED CONSENT, CONTINUED

INFECTION- An infection is quite unusual after this type of surgery. Should an infection occur treatment including antibiotics or additional surgery may be necessary.

CHANGE IN NIPPLE AND SKIN SENSATION- You may experience a change in the sensitivity of the nipples and the skin of your breast. Permanent loss of nipple sensation can occur after a reduction mammoplasty in one or both nipples.

SKIN SCARRING- All surgical incisions produce scarring. The quality of these scars is unpredictable. Abnormal scars may occur within the skin and deeper tissue. In some cases, scars may require surgical revision or other treatments.

UNSATISFACTORY RESULT- There is the possibility of a poor result from the surgical procedure. You may be disappointed with the appearance of your breasts.

PAIN- Surgical procedures may not improve complaints of musculoskeletal pain in the body including neck, back and shoulders. Abnormal scarring in the skin and the deeper tissues of the breast may produce pain.

FIRMNESS- Excessive firmness of the breast can occur after surgery due to internal scarring or fat necrosis. The occurrence of this is not predictable. If an area of fat necrosis or scarring appears, this may require additional surgical treatments.

DELAYED HEALING- Wound disruption or delayed wound healing is possible. Some areas of the breast skin or nipple region may not heal normally and may take a long time to heal. It is even possible to have loss of skin or nipple tissue. This may require frequent dressing changes or further surgery to remove the non-healed tissue.

SMOKERS HAVE A GREATER RISK OF SKIN LOSS AND WOUND HEALING COMPLICATIONS.

ASYMMETRY- Some breast asymmetry naturally occurs in most women. Differences in breast and nipple shape, size or symmetry may also occur after surgery. Additional surgery may be necessary to revise asymmetry after the procedure.

BREAST DISEASE- Breast disease and breast cancer can occur independently of any breast procedure. It is recommended that all women perform periodic self-examinations of their breasts, have a mammography according to American Cancer Society guidelines, and to seek professional care should a breast lump be detected.

BREAST FEEDING- Although some women have been able to breast feed after this surgical procedure, in general it is not predictable. If you are planning to breast feed following this procedure, it is important that you discuss this with your plastic surgeon prior to undergoing the surgery.

INFORMED CONSENT, CONTINUED

ALLERGIC REACTIONS- In rare cases, local allergies to tape, suture material, or topical preparations have been reported. Systemic reactions which are more serious may occur to drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

SURGICAL ANESTHESIA- Both local and general anesthesia involves risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia or sedation.

ADDITIONAL SURGERY NECESSARY- There are many variable conditions that may influence the long-term result of this procedure. Secondary surgery may be necessary to perform additional tightening or repositioning of the breasts. Should complications occur, additional surgery or other treatments may be necessary. Even though risks and complications occur infrequently, the risks cited are particularly associated with this procedure. Other complications and risks can occur but are even more uncommon. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained.

HEALTH INSURANCE- Depending on your particular health insurance plan, breast surgery may or may not be a covered health benefit. There may be additional requirements in terms of the amount of tissue to be altered and duration of physical problems caused by the breast tissue. Please review your health insurance subscriber information, call your insurance company, and discuss further with your plastic surgeon. Many insurance plans exclude coverage for secondary or revisional surgery.

FINANCIAL RESPONSIBILITIES- The cost of surgery involves several charges for the provided. The total includes fees charged by your doctor, the cost of surgical supplies, anesthesia, facility charges and in come cases more, depending on the facility. Depending on whether the cost of surgery is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from surgery. Secondary surgery or hospital day-surge charges involved with revisionary surgery would also be the patients responsibility.

DISCLAIMER- Informed consent documents are used to communicate information about the proposed surgical treatment of a disease or condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your plastic surgeon may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advances and as practice patterns evolve.

IT IS IMPORTANT THAT YOUR READ THE ABOVE INFORMATION CAREFULLY AND HAVE ALL YOUR QUESTIONS ANSWERED BEFORE SIGNING THE CONSENT ON THE NEXT PAGE.

CONSENT FOR SURGERY/PROCEDURE OR TREATMENT

1. I hereby authorize Dr.'s Hall/Wrye and such assistants as may be selected to perform the following procedure or treatment. Additionally, I have received and reviewed the following information sheet:

INFORMED CONSENT: MASTOPEXY

2. I recognize that during the course of the operation and medical treatment of anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.
3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and possibility of complications, injury, and sometimes death.
4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
5. I consent to the photographing or televising of the operations(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided that my identity is not revealed by the pictures.
6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.
7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.
8. I authorize the release of my personal information to appropriate agencies for legal reporting and medical-device registration, if applicable.
9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
 - THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN.
 - THERE MAY BE ALTERNATIVE PROCEDURES/ METHODS OF TREATMENT.
 - THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED.

I CONSENT TO THE TREATMENT/PROCEDURE AND THE ABOVE LISTED ITEMS (1-9).

I AM SATISFIED WITH THE EXPLANATION.

PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT

DATE

WITNESS