Pelosi Medical Center

Abdominoplasty Operative Report

Date of Procedure: _____ **Surgeon/Assistant**: _____

Anesthesia/Anesthesiologist: _____

EBL: _____ ml **Drains**: _____

The patient consented verbally and in writing to the procedures described below.

Liposuction under tumescent local anesthesia was performed prior to the abdominoplasty per the Liposuction Operative Note. The patient was then prepped and draped in the usual sterile fashion for abdominoplasty and an intermittent pneumatic compression device was applied to the lower extremities. Prophylactic antibiotics were administered (orally/ intravenously). Surgical markings were made on the skin of the abdominal wall to define the incision lines. An adequate level of anesthesia was confirmed.

The skin and subcutaneous fat were incised with a scalpel to expose ☐ Scarpa's fascia/ ☐ the rectus fascia beneath the marked incision lines. Undermining was carried out in this plane to mobilize the flap using blunt and sharp dissection and the excess tissue was excised. Scar tissue ☐was/ ☐was not present in the tissues that were undermined. Hemostasis was achieved with Bovie electrocautery and suturing with Vicryl No. 2-0 as necessary.

☐ The excised tissue flap included a previous abdominplasty scar.

☐ The excised tissue flap included the umbilicus. The umbilicus was excised for aesthetic reasons due to its color and skin texture. Umbilical excision was done with care taken to avoid peritoneal entry and was carried out uneventfully. The umbilical stump was reinforced with mattress sutures of PDS II No. 0.

☐ The excised tissue flap did not include the umbilicus.

☐ A circumferential skin incision was made around the umbilical skin and the umbilical stalk was mobilized from the surround abdominal wall skin, fat and rectus fascia with blunt and sharp dissection. A small amount of fat was left on the umbilical stalk to maximize blood supply to this structure.

☐ Excess skin and fat from the lower abdomen were excised below the level of the umbilicus. The umbilicus was not dissected at all.

☐ No umbilical hernia was present.

A ☐ small/ ☐ large, ☐ non-incarcerated/ ☐ incarcerated umbilical hernia was noted and repaired in standard fashion with mattress sutures of PDS II No. 0.

☐ The rectus fascia of the upper abdomen demonstrated minimal diastasis and was considered to be best addressed indirectly by a transverse rectus fascia plication line along the lower abdominal wall employing the TULUA technique. Therefore, undermining of the abdominal flap to expose the upper abdomen rectus fascia was not necessary.

☐ The rectus fascia of the upper abdomen demonstrated a significant diastasis. Therefore selective central undermining of the abdominal flap was carried out to expose the entire diastasis and it's borders while preserving the majority of the perforator blood vessels. The diastasis was repaired by rectus fascia plication using Maxon No. 0 running and interrupted sutures. Excellent approximation was achieved. Hemostasis was confirmed.

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☐ The rectus fascia of the lower abdomen demonstrated ☐ minimal/ ☐ significant diastasis and was repaired employing a ☐ transverse / ☐ vertical rectus fascia plication line. The plication was carried out in 2 layers with Maxon No. 0 running sutures. Excellent approximation was achieved. Hemostasis was confirmed.

The abdominal flap was placed on traction and excess skin and fat tissue was removed sharply to achieve an aesthetic contour along the incision line. The flap was then closed in layers beginning with Scarpa's fascia which was closed with PDS II No. 0 interrupted sutures and Quill PDO No. 2 running sutures. The subcutaneous layers were closed with Quill PDO No. 0 running sutures. Excellent skin-to-skin apposition was achieved. No additional suturing was needed.

☐ A surgical drain was not required. ☐ A Jackson-Pratt closed-suction surgical drain was placed prior to flap closure and exited through the main incision line. It was sutured into place with suture material from the flap closure.

☐ No umbilicoplasty was performed.

☐ A transposition umbilicoplasty was performed. The desired position was marked anatomically on the skin of the abdominal flap. A circular window of skin and fat was made at this site with sharp dissection to expose the umbilical stalk. Hemostasis was confirmed. The umbilical stalk was delivered through this incision and sutured in place with subcutaneous interrupted sutures of Vicryl No. 2-0. The umbilical skin was fixed to the flap with running sutures of Biosyn No. 4-0.

☐ An open neo-umbilicoplasty was performed. The desired position was marked anatomically on the skin of the abdominal flap. A circular window of skin and fat was made at this site with sharp dissection to expose the rectus fascia. Hemostasis was confirmed. The skin along the edges of the window was sutured to the rectus fascia with multiple interrupted sutures of Biosyn No. 2-0 placed circumferentially to create the desired contour. A partial thickness skin graft was harvested from the excised tissue flap and sutured into place to cover the rectus fascia at the center of the neoumbilicus.

☐ A closed neo-umbilicoplasty was performed prior to flap closure. The desired position was marked anatomically on the skin of the abdominal flap and on the rectus fascia. A cruciate incision was made through the fat of the flap undersurface at this position to expose a small area of dermis and to create four flaps of fat. A suture of PDS No. 2-0 was placed through the dermis and through the rectus fascia at the site of the planned umbilical center, but not yet tied. At the corner of each flap of subcutaneous flap, a suture of Biosyn No. 2-0 was passed then sutured to the dermis off-center from the umbilical center slightly, the to the rectus fascia off center slightly. Hemostasis was confirmed. All of the sutures were then tied to create the desired umbilical cup.

Dressings were placed over all incision lines including ☐ Dermabond ☐ Steri-Strips. A compression garment was then applied. This concluded the procedure. The patient tolerated the procedure well and was in stable condition at the conclusion of the procedure.

_____ _____

Surgeon Signature Date