INFORMED CONSENT FOR

# BREAST REDUCTION

**PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PRE-OPERATIVE APPOINTMENT**

PATIENT NAME _____

## KAROL A GUTOWSKI, MD, FACS
## ANDREA MARTIN, MD
## (THE PHYSICIANS)

**Based on my discussions with my surgeon, I understand and agree to the following:**

_____ My surgeon is not able to predict a specific breast or bra size after this procedure.

_____ My surgeon will do his/her best to minimize the incisions and scars but I expect there will be a scar around my nipple and areola, a scar from my areola to the crease on my chest at the bottom of my breast, and a scar in the breast crease extending to the side of my chest.

_____ My surgeon and I discussed a different scar pattern.

At my request, my surgeon WILL / WILL NOT send the breast tissue removed to the pathology lab for examination.

**Patient Signature** _____ **Date** _____

## INSTRUCTIONS

This is an informed-consent document that has been prepared to help your plastic surgeon inform you about reduction mammaplasty 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

Women who have large breasts may experience a variety of problems from the weight and size of their breasts, such as back, neck, and shoulder pain, and skin irritation, or women may have a significant breast asymmetry. Breast reduction is usually performed for relief of these symptoms rather than to enhance the appearance of the breasts. The best candidates are those who are mature enough to understand the procedure and have realistic expectations about the results. There are a variety of different surgical techniques used to reduce and reshape the female breast. There are risks and complications associated with reduction mammaplasty surgery.

## ALTERNATIVE TREATMENT

Reduction mammaplasty is an elective surgical operation. Alternative treatment would consist of not undergoing the surgical procedure, physical therapy to treat pain complaints, or wearing undergarments to support large breasts. In selected patients, liposuction has been used to reduce the size of large breasts but is typically NOT covered by insurance and does NOT remove excess skin. Risks and potential complications are associated with alternative surgical forms of treatment.

## RISKS of REDUCTION MAMMAPLASTY SURGERY

Every surgical procedure involves a certain amount of risk. It is important that you understand the risks involved with reduction mammaplasty. An individual's choice to undergo a surgical procedure is based on the comparison of the potential risks to benefits. Although the majority of women do not experience the following complications, you should discuss each of them with your plastic surgeon to make sure you understand the risks, potential complications and consequences of breast reduction.

**Pain**- A breast reduction may not improve musculoskeletal pain in the neck, back and shoulders, particularly if that pain is not related to the weight of the breasts. Abnormal scarring in skin and the deeper tissues of the breast may produce pain.

**Bleeding**- It is possible, though unusual, to experience a bleeding episode during or after surgery. Should post-operative bleeding occur, it may require emergency treatment to drain accumulated blood (hematoma). Hematoma can occur at any time following injury to the breast. Do not take any aspirin or anti-inflammatory medications (NSAIDS) for two weeks before surgery, as this may increase the risk of bleeding. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding (See "Medications To Avoid" instructions).

**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 mammaplasty in one or both nipples. Nipple sensation and projection may be lost if a nipple graft technique is used for breast reduction.

**Breast feeding**- Although some women have been able to breast feed after breast reduction, in general this is not predictable. If you are planning to breast feed following breast reduction, it is important that you discuss this with your plastic surgeon prior to undergoing reduction mammaplasty.

**Asymmetry**- 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 a reduction mammaplasty.

**Firmness**- Excessive and focal areas of 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 imaging, biopsy or additional surgical treatment.

**Skin scarring**- All surgical incisions produce scarring. The quality of these scars is unpredictable. Abnormal scars (thick, wide, raised, pigmented) may occur within the skin and deeper tissue. In some cases, scars may require surgical revision or other 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.**

**Unsatisfactory result**- There is the possibility of a poor result from the reduction mammaplasty surgery. You may be disappointed with the size and shape of your breasts. Asymmetry in nipple location, unanticipated breast shape and size may occur after surgery. Unsatisfactory surgical scar location may occur. It may be necessary to perform additional surgery to improve your results or remove implants.

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

**Existing breast cancer** – Although rare, it may be possible that a breast cancer could be found during or after the surgery. If this happens, the surgery may not be completed or only partially completed. Other treatment may be necessary.

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

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

**Death or serious injury** – In very rare cases, serious complications such stroke, heart attack or even death have resulted from surgery.

**ADDITIONAL SURGERY**

There are many variable conditions that may influence the long term result of reduction mammaplasty. 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 breast reduction surgery. 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 reduction surgery may be considered a covered benefit. There may be additional requirements in terms of the amount of breast tissue to be removed, the degree of physical problems caused by large breasts, and previous treatment you have tried. Breast reductions involving removal of small amounts of tissue may not be covered by your insurance. Please review your health insurance subscriber-information pamphlet, call your insurance company, and discuss this further with your plastic surgeon. Many insurance plans exclude coverage for secondary or revisionary surgery.

**FINANCIAL RESPONSIBILITIES**

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of surgical supplies, laboratory tests, anesthesia, and hospital charges, depending on where the surgery is performed. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

**DISCLAIMER**

Informed consent documents are used to communicate information about the proposed treatment of a 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.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

**It is important that you 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. Gutowski and/or Dr. Andrea Martin, and such assistants as may be selected to perform the following procedure or treatment:

**Breast Reduction**

I have received the following information sheet:

**INFORMED CONSENT - BREAST REDUCTION**

2. I recognize that during the course of the operation and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician(s) and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician(s) 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 risks, and the possibility of complications, or injury.

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 and video recording of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided 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 Social Security number 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:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED
10. I READ AND UNDERSTAND THIS DOCMENT. I ACCEPT THE RISKS EXPLAINED IN THIS DOCUMENT.

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-10). I AM SATISFIED WITH THE EXPLANATION.

_____

Patient or Person Authorized to Sign for Patient

Date & Time _____ Witness _____

## AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by The Physicians or their representatives.

**INTRODUCTION**
For your medical records, images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since The Physicians are also educators of other physicians, researchers, and healthcare providers, your images may be used for other purposes as described below.

**1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOGRAPHY**
I hereby authorize The Physicians and/or their associates to take any images before, during and after my treatments or surgeries.

**2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/ VIDEOGRAPHY**
I hereby authorize The Physicians and their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc.) or electronic media (television, internet, etc.).

**3. CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS**
I further authorize The Physicians and their associates to release such images to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Board of Plastic Surgery (ABPS), the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS). I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as *Plastic and Reconstructive Surgery, Annals of Plastic Surgery, Aesthetic Plastic Surgery)*, textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, ABPS, AAFPRS and ABFPRS. I understand that such images shall become the property of ASPS, ASAPS, ABPS, AAFPRS and ABFPRS and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS and ABFPRS.

I understand that I will <u>not</u> be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge The Physicians and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above-mentioned manner.

I also release The Physicians and any employees or agents from all liability, including any claims of libel or invasion of privacy, directly or indirectly connected with, arising out of or resulting from the taking and authorized use of these images or recorded interviews.

I understand that I have the right to request cessation of recording or filming at any time. I understand that I will not be entitled to monetary payment or any other consideration as a result of use of these images and /or my interview.

Patient Name _____

**Patient Signature** _____ Date _____

Witness or Guardian/Parent _____ Date _____