

INFORMED CONSENT FOR

BREAST IMPLANT REMOVAL

LEFT IMPLANT REMOVAL
 WITH CAPSULECTOMY

RIGHT IMPLANT REMOVAL
 WITH CAPSULECTOMY

PLEASE REVIEW AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE

PATIENT NAME _____



KAROL A. GUTOWSKI, MD, FACS

AESTHETIC SURGERY

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

Patient Initials _____

INSTRUCTIONS

This is an informed-consent document that has been prepared to help inform you about breast implant removal, 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.

INTRODUCTION

The removal of breast implants that have been placed either for cosmetic or reconstructive purposes is a surgical operation. Breast implant removal may be performed as a single surgical procedure or combined with additional procedures such as:

- Removal of scar tissue surrounding the breast implant
- Breast biopsy
- Removal of silicone gel
- Secondary breast augmentation
- Breast lift (mastopexy)

Implants that are found to be damaged or ruptured cannot be repaired; surgical removal or replacement is recommended. There are options concerning general versus local anesthesia for breast implant removal.

There are both risks and complications associated with this operation.

ALTERNATIVE TREATMENT

Alternative forms of non-surgical management consist of not undergoing breast-implant removal or additional procedures.

RISKS of SURGERY for BREAST-IMPLANT REMOVAL

Every surgical procedure involves a certain amount of risk and it is important that you understand the risks involved with surgery to remove breast implant(s). An individual's choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although 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 breast implant removal.

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 or blood transfusion. Do not take any aspirin or anti-inflammatory medications for ten days before surgery, as this may increase the risk of bleeding. Non-prescription "herbs" and dietary supplements can increase the risk of surgical bleeding.

Infection- Infection is unusual after surgery. Should an infection occur, treatment including antibiotics or additional surgery may be necessary.

Change in nipple and skin sensation- Your breasts will be sore after surgery, and you may experience a change in the sensitivity of the nipples. This usually resolves in 3 to 4 weeks. To have decreased sensation is rare. However, decreased or permanent loss in nipple sensation is more likely to occur if extensive surgical dissection is needed to remove scar tissue or silicone gel from a broken implant.

Skin scarring- Although good wound healing after a surgical procedure is expected, abnormal scars may occur both within the skin and the deeper tissues. Excessive scarring is uncommon. Additional treatments including surgery may be necessary to treat abnormal scarring.

Firmness- Excessive firmness of the breasts can occur after surgery due to internal scarring. The occurrence of this is not predictable.

Seroma- Tissue fluid may accumulate in the space where the breast implant was located. Additional treatment or surgery may be necessary to remove this fluid.

Implants- As with any man-made object implanted in the human body, device failure can occur. It is possible that an implant can rupture causing silicone gel to be released from the implant. Implants also can rupture during the removal process. If implant rupture has occurred, it may not be possible to completely remove all of the silicone gel that has escaped. Implant shell material of textured breast implants may be impossible to completely remove. Calcification around implants can occur and may require removal of the scar tissue surrounding the implant. It may not be possible to completely remove the scar tissue that has formed around a breast implant or silicone gel.

Capsulectomy – Surgical removal of the capsule or tissue around the implant may be part of the procedure. In some cases, it may not be safe to remove all of the scar tissue and this will be determined at the time of surgery. It is possible that some capsule tissue may be left behind.

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.

Mammography- It is important to continue to have regular mammography examinations and to perform periodic breast self-examination. Should a breast lump be detected with either mammography or self-examination, please contact your physician.

Psychological/appearance changes- It is possible that after breast implant removal you may experience a strong negative effect on your physical appearance, including significant loss of breast volume, distortion, and wrinkling of the skin. Your appearance may be worse than prior to your surgery for the placement of the breast implants. There is the possibility of severe psychological disturbances including depression. It is possible that you or your partner will lose interest in sexual relations.

Other- Breast asymmetry may occur after surgery. You may be disappointed with the results of surgery. Additional surgery may be necessary to reshape breasts after implant removal. Scars resulting from breast-implant removal may complicate future breast surgery.

Health disorders alleged to be caused by breast implants- Currently there is insufficient evidence to state that the removal of breast implant(s) and capsule(s) will alter the course or prevent autoimmune or other disorders alleged to be caused by breast implants.

The removal of breast implants may be of no health benefit to you.

Breast disease- Current medical information does not demonstrate an increased risk of breast disease or breast cancer in women who have breast implant surgery for either cosmetic or reconstructive purposes. Breast disease can occur independently of breast implants. It is recommended that all

women perform periodic self examination of their breasts, have mammography per American Cancer Society guidelines, and to seek professional care should they notice a breast lump.

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.

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.

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic surgical operations such as the augmentation mammoplasty and any complications that might occur from surgery. Most insurance covers the first breast reconstruction operation. Insurance coverage for future revision, new breast implants, or additional doctor's visits may not be covered, depending on the policy. Health insurance premiums may be dropped, premiums may increase, or future coverage may be denied in patients with breast implants. Please carefully review your health insurance subscriber information pamphlet and underwriting policies.

ADDITIONAL SURGERY NECESSARY

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 augmentation mammoplasty; 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.

FINANCIAL RESPONSIBILITIES

The cost of surgery involves several charges for the services provided. The total includes fees charged by your doctor, the cost of implants and surgical supplies, anesthesia, laboratory tests, and possible outpatient hospital charges, depending on where the surgery is performed. 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 the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.

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 of 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 of your questions answered before signing the consent on the next page.

CONSENT FOR SURGERY/ PROCEDURE or TREATMENT

1. I hereby authorize Dr. Karol Gutowski and such assistants as may be selected to perform the following procedure or treatment: Breast Implant Removal
I have received the following information sheet:
INFORMED-CONSENT FOR BREAST IMPLANT REMOVAL
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 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 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 involves risk and the 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 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 METHODS OF TREATMENT
 - c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED
10. I READ AND UNDERSTAND THIS DOCUMENT. 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 _____	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 Dr. Gutowski or his representatives.

INTRODUCTION

Medical 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 need 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 Dr. Gutowski is also an educator of other physicians, researcher, and medical writer, your images may be used for other purposes as described below.

1. CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOTAPES

I hereby authorize Dr. Gutowski and or his associates to take any images before, during and after my treatments or surgeries.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr. Gutowski and or his 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 purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in supporting documentation for insurance or third-party payer purposes, 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 Dr. Gutowski or to release to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), and the American Board of Plastic Surgery (ABPS) such images. 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, and ABPS. I understand that such images shall become the property of ASPS, ASAPS, and ABPS, 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.

I understand that I will not 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 Dr. Gutowski and all parties acting on his 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 Dr. Gutowski and any employees or agents from all liability, including any claims of libel or invasion or 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 any use of these images and /or my interview.

Patient Name _____

Patient Signature _____ Date _____

Witness or Guardian/Parent _____ Date _____