

Laurence Kirwan M.D., F.R.C.S
Plastic Surgeon
INFORMED-CONSENT REDUCTION MAMMAPLASTY

INSTRUCTIONS

This is an informed-consent document that has been prepared to help your plastic surgeon inform you of reduction mammoplasty surgery, its risks, and alternative treatment.

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. 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 both risks and complications associated with reduction mammoplasty surgery.

ALTERNATIVE TREATMENT

Reduction mammoplasty 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. 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 mammoplasty. 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 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.

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 three weeks before surgery, as this may increase the risk of bleeding.

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 reduction mammoplasty surgery. You may be disappointed with the size and shape of your breasts.

Pain- A breast reduction may not improve complaints of musculoskeletal pain in the neck, back and shoulders. Abnormal scarring in skin and the deeper tissues of the breast may produce pain.

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2.

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 biopsy or additional surgical treatment.

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 a reduction mammaplasty.

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.

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.

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 involve 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 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 and duration of physical problems caused by large breasts. 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.

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3.

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, blood bank, anesthesia, and 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.

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 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 .

1. I hereby authorize Laurence Kirwan, MD, FRCS, FACS and such assistants as may be selected to perform the following procedure or treatment:

I have received the following information sheet: INFORMED CONSENT SURGERY (specific procedure)

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 involve 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.
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 that 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.

Patient's Signature: _____

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4.

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
- SIGN AND CIRCLE A OR B

A. I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I HAVE BEEN ASKED IF I WANT A MORE DETAILED EXPLANATION, BUT I AM SATISFIED WITH THE EXPLANATION AND DO NOT WANT MORE INFORMATION.

I understand and agree that any dispute or litigation with respect to the treatment or procedure of the above listed items (1-9) will be heard and settled in the city in which the procedure occurred in the United Kingdom, and the law of the United Kingdom shall govern all aspects of such dispute or litigation.

B. I CONSENT TO THE TREATMENT OR PROCEDURE AND ABOVE LISTED ITEMS (1-9). I REQUESTED AND RECEIVED, IN SUBSTANTIAL DETAIL, FURTHER EXPLANATION OF THE PROCEDURE OR TREATMENT, OTHER ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT AND INFORMATION ABOUT THE MATERIAL RISKS OF THE PROCEDURE OR TREATMENT.

I understand and agree that any dispute or litigation with respect to the treatment or procedure of the above listed items (1-9) will be heard and settled in the city in which the procedure occurred in the United Kingdom, and the laws of England and Wales shall govern all aspects of such dispute or litigation.

Patient or Person Authorized to Sign for Patient

Date _____ Witness _____

NOTHING BY MOUTH AFTER MIDNIGHT / RELEASE FROM RESPONSIBILITY / PEER REVIEW

Date: _____ Time: _____

_____(Name of patient or myself) has not had anything to eat or drink, including water, since midnight, in preparation for surgery scheduled today. (Pre-operative medications can be taken with a sip of water). I authorize Mr. Kirwan to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until date of conclusion of such treatment, to those individuals who in Mr. Kirwan's sole determination, are required to receive such information for the purposes of *medical treatment, medical quality assurance and peer review.*

Patient

Parent Or Guardian If Applicable

Witness: _____

Signature: _____

Patient's Signature: _____