**INFORMED CONSENT – REDUCTION MAMMAPLASTY**

**(Breast Reduction Surgery)**

**INSTRUCTIONS**

This is an informed-consent document that has been prepared to help inform you concerning reduction mammaplasty surgery (breast reduction), its risks, as well as alternative treatment(s). 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 Dr. Cashio and agreed upon by you.

**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 for surgery 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 mammaplasty surgery.

**ALTERNATIVE TREATMENTS**

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. 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 and it is important that you understand these risks and the possible complications associated with them. In addition, every procedure has limitations. An individual’s choice to undergo a surgical procedure is based on the comparison of the risk to potential benefit. Although the majority of patients do not experience these complications, you should discuss each of them with your plastic surgeon to make sure you understand all possible consequences of reductionmammaplasty.

**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. Intra-operative blood transfusion may also be required. Hematoma may contribute to capsular contracture, infection or other problems. Do not take any aspirin or anti-inflammatory medications for ten days before or after surgery, as this may increase the risk of bleeding. Many herbal supplements such as garlic, ginkgo biloba, omega 3 fatty acids, and others may also increase bleeding and should be discontinued as well.

**Infection**

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

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**RISKS OF REDUCTION MAMMAPLASTY SURGERY, CONT’D**

**Skin Scarring** All surgical excision produce scarring. The quality of these scars is unpredictable. Abnormal scars may occur with the skin and deeper tissue. In some cases, scars may require surgical revision or other treatments.

**Unsatisfactory Results** There is the possibility of a poor result from reduction mammoplasty surgery. You may be disappointed with the size and shape of your breasts.

**Pain** Many conditions and medical problems have the ability to cause the symptoms that may be associated with large breasts. Due to this, a breast reduction may not improve complaints of musculoskeletal pain in the neck, back and shoulders. Abnormal scarring in skin and 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 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 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.

**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 mammoplasty.

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

**Breast Feeding** Although some women have been able to breast feed after breast reduction, in general that is not predictable. If you are planning to breast feed following breast reduction, it is important that you discuss this with Dr. Cashio prior to undergoing reduction mammoplasty.

**Surgical Anesthesia** Both local and general anesthesia involve risk. There is a possibility of complications, injury, and even death from all forms of surgical anesthesia and 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.

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**RISKS OF REDUCTION MAMMAPLASTY SURGERY, CONT’D**

**SMOKING, SECOND-HAND SMOKE EXPOSURE, NICOTINE PRODUCTS (PATCH, GUM, NASAL SPRAY, etc.)**Patients who currently smoke, use tobacco products, or nicotine products (patch, gum, nasal spray, etc.) are at a greater risk for significant surgical complications of skin dying, delayed healing and additional scarring. Individuals exposed to second-hand smoke are also at potential risk for similar complications attributable to nicotine exposure. Additionally, smoking may have a significant negative effect on anesthesia and recovery from anesthesia, with coughing and possibly increased bleeding. Individuals who are not exposed to tobacco smoke or nicotine-containing products have a significantly lower risk of this type of complication. Please indicate your current status regarding these items below:

\_\_\_\_\_\_\_ I am a non-smoker and do not use nicotine products. I understand the risk of second-hand smoke exposure causing surgical complications.

\_\_\_\_\_\_\_ I am a smoker or use tobacco/nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products. It is important to refrain from smoking at least 4-6 weeks before surgery and until Dr. Cashio states it is safe to return, if desired.

**FEMALE PATIENT INFORMATION**- It is important to inform Dr. Cashio if you use birth control pills, estrogen replacement, or if you believe you may be pregnant. Many medications including antibiotics may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy.

**HEALTH INSURANCE** Breast reduction surgery may be covered by your insurance company depending on your particular policy’s details and requirements. Most health insurance companies exclude coverage for cosmetic surgical operations or any complications that might occur from surgery. Please carefully review your health insurance subscriber-information pamphlet.

**FINANCIAL RESPONSIBILITIES** The cost of surgery involves several charges for the services provided. The total includes fees by your doctor, the cost of 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 copayments, deductibles, and charges not covered. Additional cost may occur should complications develop from the surgery. **Secondary surgery or hospital day-surgery charges involved with revisionary surgery would also be your responsibility.**

**PATIENT COMPLIANCE** Follow all physician instructions carefully; this is essential for the success of your outcome. It is important that the surgical incisions are not subjected to excessive force, swelling, abrasion, or motion during the time of healing. Personal and vocational activity needs to be restricted. Protective dressings and drains should not be removed unless instructed by your plastic surgeon. Successful post-operative function depends on both surgery and subsequent care. Physical activity that increases your pulse or heart rate may cause bleeding, bruising, swelling, fluid accumulation, and the need for the return to surgery. It is important that you participate in follow-up care, return for aftercare, and promote your recovery after surgery.

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**RISKS OF REDUCTION MAMMAPLASTY SURGERY, CONT’D**

**INTIMATE RELATIONS AFTER SURGERY**- Surgery involves the coagulating of blood vessels and increased activity of any kind may open these vessels leading to bleeding. Increased activity that increases your pulse or heart rate may cause additional bruising, swelling and the need for a return to surgery and control of bleeding. It is wise to refrain from sexual activity until Dr. Cashio states it is safe

**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 treatments. 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 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**

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**INFORMED CONSENT FOR REDUCTION MAMMAPLASTY**

1. I hereby authorize Dr. Richard V. Cashio Jr., M.D. and such assistants as may be selected to perform the following procedure or treatment:

**Reduction Mammaplasty Surgery (Breast Reduction)**

and I have received the following information sheet: **Informed Consent Reduction Mammaplasty Surgery.**

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 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 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 PROCEDURES OR METHODS OF TREATMENT

c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

**I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION AND ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION**.

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Patient or Person Authorized to Sign for Patient Date

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Witness Date