

DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

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Are 30-Day Outcomes Enough? Late Infectious Readmissions following Prosthetic-Based Breast Reconstruction

Sir:

The quite recent analysis of the timing of resubmission for infectious complications of two-stage prosthetic breast reconstruction¹ delineated early (<30 days) versus late (30 to 90 days). In doing so, the authors emphasize that the conventional time frame of less than 30 days may not be sufficient to define the issue of postoperative infections and implant-based reconstruction. Without definition, the development of comprehensive prophylactic and treatment regimens will not be possible. The authors cited our work² as an early effort to describe the early limitation of the 30-day window to quantify the issue and we duly appreciate the citation. A correction, though, since the authors' article quoted "Luce and Pierce report that within a cohort of 346 patients (517 reconstructions), 19 percent [italics ours] of tissue expanders were explanted...". Actually, our overall explantation rate was 10.7 percent.

Of further interest and parallel to the findings of Collier et al., although our numbers were too small for statistical comparison, mastectomy skin necrosis was the most frequent adverse variable for explantation in the early (<30 days) group. In contrast, the presence of a seroma was the most important factor in the late group. The novel use of a large database (nationwide readmissions) enabled the authors to draw some statistically significant difference in variables between early and late readmissions and should be applauded for doing so.

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Reply: Are 30-Day Outcomes Enough? Late Infectious Readmissions following Prosthetic-Based Breast Reconstruction

Sir:

I thank Dr. Luce for his comments. His work has increased our awareness of the need to examine more critically the limitations of outcomes research using large databases. The use of 30-day outcomes has become the convention of these large databases, but they may not be ideal for understanding some clinically significant postoperative complications. I appreciate Dr. Luce's correction regarding his overall explantation rate cited in the Discussion of our article,¹ and sincerely apologize for the mistake. I hope that this body of work can help to better inform researchers and encourage those managing large databases to consider capturing outcomes beyond the traditional 30-day period.

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Enhanced Recovery after Surgery Protocols Decrease Outpatient Opioid Use in Patients Undergoing Abdominally Based Microsurgical Breast Reconstruction

Sir:

We had the great pleasure of reading the interesting article by Rendon et al. entitled "Enhanced Recovery after Surgery Protocols Decrease Outpatient Opioid Use in Patients Undergoing Abdominally Based Microsurgical Breast Reconstruction,"¹ and we

congratulate the authors on their study. Despite recent gains in the popularity of implant-based breast reconstruction, autologous microvascular tissue transfer remains a popular option for breast reconstruction after mastectomy, and abdominally based microvascular breast reconstruction remains the most frequent form of autologous breast reconstruction. However, these procedures involve a second surgical site that contributes significantly to postoperative pain in a population already susceptible to developing chronic pain after surgery,² preventing more widespread adoption of autologous reconstruction for significant donor-site pain.

This discomfort is often more severe than recipient-site pain, particularly in cases of delayed reconstruction. Therefore, in this surgical population, effective analgesia is critical to postoperative functional recovery. Failure to achieve adequate postoperative pain control leads to decreased patient satisfaction and increased length of stay and costs. Opioids have historically been the primary form of postoperative pain control, but their significant side effects have gained national attention, and physicians are increasingly searching for nonopioid forms of postoperative analgesia.³ We would like to report our protocol with transversus abdominis plane block and share our experience that allows us to drastically reduce or even avoid opioid consumption.⁴

Transversus abdominis plane blocks are performed by diluting 20 cc of 1.3% liposomal bupivacaine with 80 cc of injectable saline. The plane between the transversus abdominis and internal oblique muscles was identified under ultrasound guidance, and 40 cc of diluted liposomal bupivacaine is injected on each side of the abdomen. The remaining anesthetic is injected subcutaneously into the abdominal flaps.

Postoperatively, a multimodal analgesic regimen is administered consisting of intravenous scheduled acetaminophen 1000 mg three times daily, ketorolac 30 mg three times daily, and patient-controlled analgesia pumps with morphine until only the second postoperative morning.

From the third postoperative day, acetaminophen and ketorolac are administered orally and continued after hospital discharge by postoperative day 4 in the majority of patients with gradual suspension. The inclusion of an additional nonnarcotic modality of pain control such as liposomal bupivacaine serves to decrease the need for opioid medications, and our experience showed significant reductions in total narcotic consumption in patients who received blocks.

The negative effects of narcotics can range from milder symptoms such as nausea, dizziness, and fatigue to severe constipation, respiratory depression, altered mental status, and dependency.⁵ Reduction of intravenous and oral opioid administration postoperatively decreases the risk of these effects and also promotes return to an overall presurgery lifestyle and reduces concerns about opioid abuse.

In conclusion, postoperative pain remains a critical issue that affects recovery, patient satisfaction, and

psychological well-being, and can also influence patient decision-making preoperatively. Autologous breast reconstruction has the added morbidity of an additional surgical site, which can be a deterrent to patients considering reconstructive options.

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Reply: Enhanced Recovery after Surgery Protocols Decrease Outpatient Opioid Use in Patients Undergoing Abdominally Based Microsurgical Breast Reconstruction

Sir:

My colleagues and I greatly appreciate the commentary regarding our study on the impact of enhanced recovery after surgery protocols on outpatient opioid use in patients undergoing abdominally based microsurgical breast reconstruction.¹ We read with interest the authors' experience with transversus abdominis plane nerve block in this setting, and commend them on their success in reducing opioid use. We echo their sentiments on the importance of achieving effective