Plastic Surgery

ATTENDINGS

Kerri Woodberry, MD, MBA - Chief and Program Director
Jack Gelman, MD – Associate Program Director
Sebastian Brooke, MD
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PLASTIC SURGERY INTEGRATED RESIDENTS

Joshua Henderson, MD PGY6:859-324-1145
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ADVANCED PRACTICE PROFESSIONALS

Zach Bragano, PA: 412-519-4975
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Allison Heenan, PA: 717-645-7713

CONFERENCES

M&M (General Surgery) at 0700 in 2118 HSC (Pathology Amphitheater)
Wednesdays at 0800 in the 7607 HSC-S

TIPS FOR SERVICE

ROUNDING/FLOOR MANAGEMENT:

- Residents (PGY-1-5) and students meet in the 9E work room at 0530.
- Between 0530 and 0600, obtain updated vitals, labs, imaging, micro results, and changes on all patients
- This is also the time during which the dressing supply bag is refilled and nurses are contacted to request premedication for patients who will require potentially uncomfortable dressing changes.
- The chief resident (PGY-6) joins the team before 0600 once all charts are checked. We briefly huddle and then round as a team at 0600.
- One resident will be assigned to be on call each day and night.
- All the inpatient PAs are immensely helpful and assist with rounds, seeing consults and holding the pager during the day.

    - Dressing changes: place “dressing change” orders on all patients, whether primary patients or consults. Specify the exact dressing and topical cream/ointment/antibiotic to be applied to each wound. Specify the frequency of dressing change and whose responsibility it is to perform the dressing

change (plastic surgery service, wound care, nurse, etc.)

- Wound Vacuums
  - If your patient has a wound vac covering a skin graft or a wound, ask the attending how frequently the vac should be changed.
    If there are exposed tendons or major blood vessels, use white-foam to cover that first before using the black foam.
  - If an irrigating wound vac is utilized, input the volume (100 cc), dwell time (10 minutes), frequency(Q1 hour). The irrigating solution is typically either 0.025% Dakin's or Sulfamylon (staff preference).
  - The Prevena vacuum is a purple incisional vacuum with which the patient can be discharged
  - Wound vacuum supplies may be found in materials on the fourth floor of Ruby.
- Drains
  - Always order, "JP drain care" in orders. Specify how frequently the nurse should empty and record output. This is to make sure drains are emptied ina timely manner and numbers are accurate.
  - Pay attention to drain output and quality: sanguinous (bloody), serosanguinous (blood and serous
    fluid) or purulent (pus).
  - Strip the drains during rounds.
  - When is the typical time at which a drain can be pulled? When the output has decreased to less than 30 cc per day for two consecutive days

- Does the attending want antibiotic therapy while the drains remain? Occasionally yes, especially if implants or foreign bodies are in the wound.

- Flaps
  - Always thoroughly examine the flaps yourself.
  - Document flap color, capillary refill, relative temperature (warm vs cool to touch), signs of swelling (hematoma vs. seroma).
  - In-person examination of a flap with comparison to previous exam is the most likely way to identify early compromise of a flap.
- Pain control
  - Understand the concept of combining analgesics with different mechanisms of action to control pain (multimodal pain control).
    We prefer to maximize the Tylenol independent of narcotic. Usually this is done by scheduling Tyleno while also offering non-tylenol narcotic "as needed"
  - Non-opioid: Tylenol, Ibuprofen, Toradol. Can be scheduled or "as needed". Use caution with the daily limits of Tylenol and the bleeding risk associated with Toradol.
  - Opioids: Oxy, possibly Norco or Percocet
  - Anti-spasmodic: Flexeril or robaxin for muscle flaps. If you're unsure or not explicitly told, ask the attending at the end of the case if one of these should be ordered.
  - Neurontin can be added for neuropathic pain.

- Antibiotics
  - Always check culture and sensitivity results regularly if OR cultures were obtained. Call the microbiology lab for questions on sensitivities.
  - Always place the end date when ordering antibiotics in EPIC.
  - If long-term IV antibiotics are planned, the patient will likely need a PICC line. Talk with care management regarding home health services for antibioticinfusions.

DISCHARGES:

- Be specific with dressing changes when discharging patients. Communicate with the patient the plan, an d makesure they are comfortable performing the dressing changes or that home health is arranged for someoneto help them. Be sure to provide supplies if needed.
- Be specific about when or if they can shower. This instruction varies depending on the procedure and the attending.
- Use the “Plastic Surgery” discharge order set.

FOLLOW UP

- Nearly every plastic surgery patient discharged from the hospital (except for potentially a hand surgery or minor lesion excision patient) should get 1 week follow up.

- All pediatric patients (less than age 18) are to be scheduled in the Pediatric Plastics Clinic
- General plastic and reconstructive surgery: POC (4th floor)
- Hand surgery: follow up should be arranged at UTC (University Town Center).

TIPS

- As with any case in any field, know the patient, the indication for their surgery, medical and surgical history and relevant meds/labs
- The most important preparation for any PRS case is to know the anatomy. Always know the innervation and blood supply of any flap and landmarks for dissection.
- Pre-op markings are one of the keys to successful reconstruction.Be present while the attending is marking the patient.
- Focus on quality suturing over suturing at a fast pace.
- Closely adhere to each attending's postoperative management and instructions following placement of tissue expanders or implants