Dr. **(Removed Privacy)** dictating an operative report dated 3-17. The patient **(Removed Privacy)**.

PREOPERATIVE DIAGNOSES: Status post bilateral submuscular breast augmentation with infralateral descent of implants.
2. Cervical adiposity and skin laxity

POSTOPERATIVE DIAGNOSES: Same procedure performed removal of bilateral breast implants. Infralateral capsulorrhaphy and reaugmentation with ideal structured saline implants.
2. Necklift with liposuction to neck and jowl surgery. Fracture

ANESTHESIA: After Xylocaine with adrenaline, and 0.25% Marcaine with adrenaline, local infiltration, and tumescent infiltration of lateral thorax, and neck

COMPLICATIONS: None.

PROCEDURE: The patient upright preoperatively, midline of the chest was carefully marked. Inframammary creases were carefully marked. Excess adiposity, lateral thorax, was marked. The planned lateral capsulorrhaphy was marked on the skin surface. The a 3 cm submental incision was marked just posterior to the submental crease, and bilateral postauricular and retrotragal incisions were carefully marked. Symmetrically the area of excess adiposity of the bilateral talus in the submental area was marked. The patient was taken to the operating room, placed supine on the operating room table, her arms were abducted onto padded arm boards and carefully secured, and after intravenous line, EKG monitor, blood pressure cuff, and pulse oximeter had been secured. The patient was administered small divided doses doses of intravenous Versed for sedation. The anterior chest was sterilely prepped with chlorhexidine and sterilely draped. Infiltrative anesthesia of both breasts was accomplished with infiltration of the anesthetic solution. At the inframammary crease incision site and in the lateral aspect of the breast, tumescent anesthesia of the lateral thorax, was accomplished bilaterally using the, tumescent solution, potential for short-term of right breast with the inframammary crease incision measuring 6 cm in length was carried sharply through skin. Dissection was continued through the subcutaneous tissues to the level of the periprosthetic capsule was opened, and the indwelling 650 cc smooth saline implant was removed and the lateral capsule marked for imbrication. The lateral capsule was scored on the chest wall and on the lateral tissues planned and imbricated. The distance of approximately 3-1/2 cm, the intervening capsule was scar, 5 of the electrocautery. Capsulorrhaphy was then accomplished with multiple interrupted figure-of-eight sutures of 0 Ethibond, and a running 0 Ethibond was used to reinforce repair. The pocket was irrigated with triple work solution, and augmentation was accomplished with the ideal structured saline implant of the total volume of 710 cc. Closure of the breast was accomplished with 2-0 Vicryl deep capsular sutures 2-0 Vicryl subcutaneous and subcuticular sutures, and a running intracuticular 3-0 Vicryl was used to approximate the skin edges were separate stab incision, suction lipectomy of the lateral thorax, was accomplished. This incision was closed with 3-0 Vicryl subcuticular suture. Attention was then directed to the opposite breast where the same procedure was carried out the chest was washed and dried, the incisions taped with half-inch Steri-Strips, and dressed with Tegaderm, and the patient was placed in a supportive bra with rest on foam pads of the lateral thoracic areas. The patient's arms were then removed, and the arm boards intact undersides, and reposition the patient hair was carefully prepared for surgery and silicone ear plugs placed in the ears and Lacri-Lube eye ointment placed in the eyes and face were then sterilely prepped with Betadine and sterilely draped. Infiltrative anesthesia of the retroauricular and postauricular incisions, and the ear lobule area was accomplished with the anesthetic solution. The submental incision was

also infiltrated, using, tumescent, and infiltration. The neck, and submental areas were anesthetized. Attention was first turned to the right of the face where the postauricular and retroauricular incisions were carried sharp through the skin. The correction. Using a 1.7 mm trifenestrated cannula, suction lipectomy of the jowl. The lateral, and the lateral neck was then accomplished. Temperature to the opposite side of the face, where the same procedure was carried out. The submental incision was then carried sharp through the skin and, suction lipectomy. The anterior neck was also accomplished. The submental skin was then elevated in the subcutaneous plane and bleeding controlled with electrocautery. The platysma muscle was elevated bilaterally, and the submuscular fat was carefully resected. The muscle was divided at the level of the hyoid bilaterally and imbricated in midline with multiple interrupted 2-0 Vicryl figure-of-eight sutures, and a running inverting 2-0 Vicryl was used to further reinforce the repair. Attention check to the left side of the neck, where. Dissection was continued in the subcuticular plane releasing the skin attachments to allow complete mobilization. The skin posteriorly. The skin was then advanced posteriorly and superiorly, an appropriate amount of skin for resection was carefully determined, and marked, and resected. Closure was then accomplished over cords Penrose drain brought out posteriorly. Closure was accomplished with 2-0 Vicryl subcutaneous sutures, and the retroauricular sulcus, and postauricular scalp, interrupted stainless steel staples in the hair bearing scalp. 3-0 Prolene cuticular sutures were used to approximate the skin in the non-hair bearing areas. The preauricular skin, which was in excess was carefully trimmed and then inset beneath ear lobule with interrupted 3-0 Vicryl subcutaneous sutures, and interrupted 5-0 nylon cuticular sutures. Attention check to the opposite side of the neck with the same procedure was carried out. The submental incision was closed with interrupted 3-0 Vicryl subcutaneous sutures, and interrupted 5-0 nylon cuticular sutures. The patient tolerated the procedure well. Abduction face were washed and dried. Ear plugs were removed. A facelift dressing was carefully secured, and the patient was returned to the recovery room in excellent condition