

contracture. Capsular Contracture is the most common complication following primary augmentation mammoplasty, yet its etiology remains cryptogenic.

METHODS: PubMed was searched for publications from January 1 of 2000 through October of 2015. Studies with the following criteria were included: primary breast augmentation with implants; use of antimicrobial irrigation; and documentation of capsular contracture. Our primary outcome was incidence of capsular contracture. The quality of included studies was assessed independently. Studies were meta-analyzed to obtain a pooled odds ratio describing the effect of antimicrobial irrigation on capsular contracture.

RESULTS: The meta-analysis included eight studies and a total 7901 patients. 5216 patients received antimicrobial irrigation and 5824 patients did not. Analysis revealed that combined antimicrobial irrigation, the antibiotic irrigation subgroup and iodine subgroup were associated with an increased propensity for capsular contracture (OR 2.60; 95% CI, 2.3–2.94; OR 1.41; 95% CI, 1.17–1.70; OR 3.19; 95% CI, 2.23–4.56; $p < 0.00001$; $I^2 = 99.9$) respectively.

CONCLUSION: Antimicrobial irrigation of implant pockets fails to reduce the propensity for capsular contracture. The authors recommend that further prospective multicenter trials be conducted to further elucidate the role of antibiotic irrigation in capsular contracture.

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SMOKING AS A PERIOPERATIVE RISK FACTOR IN PLASTIC AND GENERAL SURGICAL PROCEDURES; IS THERE A DIFFERENCE IN COMPLICATION PROFILE? A PROPENSITY-SCORE MATCHING ANALYSIS OF 294,903 PATIENTS FROM THE NSQIP DATABASE
Rose H. Fu, M.D., Yoshiko Toyota, BA, Lu Li, MS, Christine H. Rohde, M.D., David Otterburn, M.D.

New York Presbyterian/Cornell-Columbia, New York City, NY, USA.

PURPOSE: Smoking is an established modifiable risk factor for perioperative complications. This is especially relevant in elective plastic surgical (PS) than in urgent general

surgical (GS) procedures. From 2005 to 2014, smoking rate among U.S. adults decreased from 20.9% to 16.8%. This study compares smoking prevalence in patients undergoing plastic and general surgical procedures, and the postoperative complication profile when smoking is isolated as an independent risk factor.

METHODS: We used the American College of Surgeons National Surgical Quality Improvement Program (ACS-NSQIP) database to examine smoking and 30-day postoperative complications for plastic and general surgical procedures. Patients were propensity matched for demographics and comorbidities to isolate smoking and minimize confounders.

RESULTS: We examined 294,903 patients from 2005–2014. Smoking rates in GS followed the national trend ($R = 0.85$). Rates in PS were significantly lower ($p < 0.01$). GS smokers had more comorbidities than respective nonsmokers. After propensity matching, GS cohort had less wound complications than PS cohort (p -value). Neither GS nor PS smokers had increased bleeding, graft failure, sepsis, nor DVT compared to nonsmokers. Superficial surgical site infections (SSI) ($p < 0.01$), PE ($p < 0.01$) and MI ($p = 0.02$) were increased for GS compared to non-smokers but not for PS smokers. Both PS and GS smokers had increased incisional dehiscence, deep SSI and return to OR ($p < 0.01$).

CONCLUSION: The contrast in smoking rates between GS and PS highlights the differences in patient selection for urgent versus elective procedures. Our data suggests smoking may have a different risk factor profile for postoperative complications between PS and GS patient populations.

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TRENDS & FREQUENCY OF SURGEON-REPORTED CONFLICTS-OF-INTEREST IN THE PLASTIC SURGERY LITERATURE
Joseph Lopez, M.D. MBA¹, Leila Musavi, BS¹, Amy Quan, MPH¹, Nicholas Calotta, BA¹, Ilona Juan, BA¹, Angela Park, BS¹, Anthony P. Tufaro, DDS M.D.¹, James W. May, Jr., M.D.², Amir H. Dorafshar, MBChB¹

¹Johns Hopkins Hospital, Baltimore, M.D., USA, ²Massachusetts General Hospital, Boston, MA, USA.

PURPOSE: The purpose of this study was to identify the trends, frequency, and nature of industry sponsorship of plastic surgery research since the establishment of conflicts of interest (COI) reporting policies.

METHODS: We analyzed the frequency and types of self-reported COI in three major plastic surgery journals since the adoption of reporting policies in 2007. All original articles that were published in three major plastic surgery journals from 2008 to 2014 were included. The type of self-reported COI was characterized into the following categories: research or institutional support, royalties/stock options, consultant/employee, or miscellaneous funding. A multivariate regression analysis was performed to determine what study-specific variables increase the likelihood of COI being disclosed.

RESULTS: A total of 3722 articles met the inclusion criteria and were included in the analysis. The incidence of COI steadily decreased from 24% in 2009 to 9% in 2013. The types of COI also significantly changed from 2008 to 2013 ($p < 0.001$). In 2008, 71% and 17% of COI were categorized as research support and consultant/employee, respectively. However by 2013, 34% and 57% were categorized as research support and consultant/employee, respectively. A multivariate regression analysis revealed that article subspecialty topic was associated with disclosure COI ($p < 0.0001$).

CONCLUSION: If self-reporting of COI are assumed to be accurate, the number of surgeon-reported COI in plastic surgery declined overall. Our analysis also suggests that industry has steadily increased the number of consultancies rather than direct research support over this period.

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WALKING ON SUNSHINE: CONTINUED SURVEILLANCE OF INDUSTRY'S PAYMENTS TO PLASTIC SURGEONS

Rizwan Ahmed, MD¹, Joseph Lopez, MD MBA², Kate Buretta, MD¹, Sunjae Bae, MPH KMD², Rachel Anolik, MD¹, Jeffrey Marcus, MD¹, Justin Sacks, MD MBA³, Dorry Segev, MD PHD²

¹Duke University, Durham, NC, USA, ²Johns Hopkins, Baltimore, MD, USA, ³Johns Hopkins, Maryland, MD, USA.

PURPOSE: The Physician Payment Sunshine Act (PPSA) is a government initiative requiring all biomedical companies to publicly disclose payments to physicians. There continues to be misinterpretation and a lack of awareness amongst plastic surgeons, the public, and the media regarding these financial transactions. The goal of this study is to evaluate changes in the PPSA data since its implementation in 2014.

METHODS: Using PPSA data (Jan 2014-Dec 2015), we studied and compared the distribution of non-research industry payments made to plastic surgeons nationally.

RESULTS: During the 2015 and 2014 fiscal years, industry paid \$28,876,097 and \$22,215,693, respectively, to ~6,500 plastic surgeons. In both fiscal years, ~25% of all plastic surgeons received <\$100, ~50% between \$100 and \$999, ~15% between \$1,000 and \$9,999, 3.1% between \$10,000- \$99,999, and 0.4% in excess of \$100,000. The four largest payment categories were: royalty or licensing fees (\$7,626,632 to 280 individuals in 2015, \$14,408,952 to 27 individuals in 2014); speaker fees (\$4,985,035 to 350 individuals in 2015, \$5,307,153 to 272 individuals in 2014); consulting fees (\$3,404,913 to 360 individuals in 2015; \$3,481,382 to 361 individuals in 2014); and meals (\$2,652,261 to 6,585 individuals in 2015; \$2,203,663 to 6,366 individuals).

CONCLUSION: During 2014–2015, ~75% of plastic surgeons received industry payments of <\$1,000. The largest payment category was royalty and licensing fees, paid to <0.005%. Over the two-year period, our analysis revealed changes in payments amounts and types. Awareness and continued surveillance of the PPSA data are critical to better understand industry payments to plastic surgeons.

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THE SAFETY OF PREOPERATIVE VERSUS POSTOPERATIVE ENOXAPARIN CHEMOPROPHYLAXIS IN AUTOLOGOUS MICROSURGICAL BREAST RECONSTRUCTION

Brian Bassiri-Tehrani, M.D.¹, Irena Karanetz, M.D.², Stephanie F. Bernik, M.D.¹, Wojciech Dec, M.D.¹, Oren Z. Lerman, M.D.¹