Meeting Handbook 2025

NEW ZEALAND ASSOCIATION OF PLASTIC SURGEONS

ANNUAL SCIENTIFIC MEETING

Breast Body & Face

22-23 August 2025
Hilton Resort · Queenstown
New Zealand

nzaps2025.w.events4you.currinda.com

NEW ZEALAND ASSOCIATION *of* Plastic Surgeons
Te Kāhui Whakamōhou Kiri

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Local Organising Committee

Jess Kenton-Smith

Dylan Wyn James

Kirk Williams

Trish Amos

Meeting Organiser: Sally Boult, Events 4 You Limited

Message from the Convenors

Welcome to Queenstown

Nau mai, haere mai ki Tāhuna

Und herzliche Grüße an unsere deutsche Kollegen

We are delighted to welcome you to the 26th Annual Scientific Meeting of the New Zealand Association of Plastic Surgeons, held at the beautiful Hilton Queenstown Resort & Spa. This year's theme—Breast, Body & Face—highlights innovations and excellence in aesthetic plastic surgery across core areas of our specialty.

We are privileged to host three distinguished international keynote speakers: Dr Jim Grotting (USA), Dr Dirk Richter (Germany), and Dr Maria Wiedner (Germany), each bringing exceptional expertise and insight to our meeting.

Alongside a strong scientific programme, the ASM is a chance to reconnect with colleagues from across Aotearoa, Australia, and beyond. Join us at the Welcome Function for a taste of Central Otago's rich character and cuisine, and don't miss the Conference Dinner on Saturday—an evening of outstanding food, company, and Queenstown's signature alpine charm.

We are deeply grateful to our sponsors for their generous support. Please take time to visit them in the exhibition area.

Queenstown offers the perfect setting to combine professional learning with personal renewal. We look forward to sharing this memorable and rewarding ASM with you.

Jesse Kenton-Smith, Dylan Wyn James and Kirk Willams

Co-Convenors, NZAPS ASM 2025

Association

New Zealand Association of Plastic Surgeons

NEW ZEALAND ASSOCIATION *of* Plastic Surgeons
Te Kāhui Whakamōhou Kiri

The New Zealand Association of Plastic Surgeons /Te Kāhui Whakamōhou Kiri (NZAPS/TKWK), is a non-profit, professional membership association devoted to the maintenance of excellent ethical and professional standards within the field of plastic reconstructive and aesthetic surgery. Established in August 1976 the Association represents the over 90% of Zealand's plastic and reconstructive surgeons. The Association advocates on behalf of members, with health leaders and decision makers within government, the Medical Council of New Zealand, Southern Cross and ACC.

NZAPS/TKWK is committed to upholding the highest standards of ethical practice in which the patient safety and welfare are the first consideration and to upholding the highest standards of surgical excellence. Advocating for equity of patient care and access to services across the motu is of major importance to the Association.

NZAPS/TKWK supports the next generation of plastic and reconstructive surgeons through supporting the New Zealand Board of Plastic and Surgery to deliver the New Zealand Surgical Education and Training programme in Plastic and Reconstructive Surgery.

Royal Australasian College of Surgeons
CPD Approved

This educational activity has been approved in the RACS CPD Program. RACS Fellows, Specialist International Medical Graduates (SIMGs) and surgeons participating in the RACS CPD Program can claim one point per hour in Educational Activities (up to 12 points for the ASM and 4 points for the Thursday Workshop).

Participation in this activity will be entered into your RACS CPD which can be accessed through ehub.

Programme

Thursday 21 August 2025 "Ask the Masters" Workshop

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated (Programme may be subject to change)

Time	Presentation/Presenter	
13:00-17:00	**"Ask the Masters" Workshop** An interactive, informal session designed exclusively for training plastic surgeons and registrars which offers a dynamic discussion covering breast augmentation, breast reduction, facial rejuvenation, and abdominoplasty - with a deep dive into surgical planning, technique selection, and the common pitfalls that can arise.	Jim Grotting, Dirk Richter, Mark Lee, Jesse Kenton-Smith, Dylan Wyn James
13:00	**Welcome**	
13:00-15:00	**Session A: Breast and Abdomen**	
	Tutorials on: - breast augmentation - breast reduction - abdominoplasty	Jim Grotting, Mark Lee, Jesse Kenton-Smith, Dylan Wyn James
15:00-15:30	**Afternoon Tea**	
15:30-17:00	**Session B: Facial Rejuvenation**	
	Basics of facial rejuvenation surgery - **Dirk Richter and Jim Grotting** Treatment of complications of filler on the face - **Dirk Richter** Basics of periorbital rejuvenation - **Dirk Richter**	Jim Grotting, Mark Lee, Jesse Kenton-Smith, Dylan James, Dirk Richter

Friday 22 August 2025

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	
08.15-08:30	Welcome and Mihi Whakatau	
08:30-10:45	**Session 1: Facial Rejuvenation**	Moderator: Jesse Kenton-Smith
08:30-09:00	My journey in facelift surgery - **Dirk Richter**	
09:00-09:30	My journey in facelift - deep plane vs SMAS plication - **Jim Grotting**	
09:30-09:45	The Face-Q: Patient reported outcome measure for facelift surgery. New York to New Zealand - lost in translation?- **Jonathan Wheeler**	
09:45-10:00	Developing a facelift practice in the New Zealand setting - **Zachary Moaveni**	
10:00-10:15	Facelift - the three hour deep plane: tips to reduce operating time - **Mark Lee**	
10:15-10:45	**Panel Discussion:** Difficult cases / managing complications and how to get better results. Deep plane vs SMAS flap vs SMAS plication debate	
10:45-11:15	**Morning Tea and EPosters with Trade Exhibitors**	Barista Sponsored by: PolyNovo® Healing. Redefined.
11:15-13:00	**Session 2: Eyelid and Brows**	Moderators: Zachary Moaveni / Jesse Kenton-Smith
11:15-11:20	A Word from our Gold Sponsor: PolyNovo® Healing. Redefined.	

Friday 22 August 2025 *cont.*

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
11:20-11:35	Ten mistakes in upper eyelid surgery - **Dirk Richter**	
11:35-11:50	The gliding brow lift: How does it hold up over time? - **Jim Grotting**	
11:50-12:05	Lower eyelid malposition - **Dirk Richter**	
12:05-12:20	Ancillary procedures in facial rejuvenation surgery - **Zachary Moaveni**	
12:20-12:30	When not to operate and how to say no - **Glenn Bartlett**	
12:30-13:00	**Panel discussion:** Difficult cases, managing complications and how to get better results	
13:00-14:00	**Lunch and EPosters with Trade Exhibitors**	Trade Exhibition Area
14:00-15:10	**Session 3: Breast Reduction**	Moderators: Jesse Kenton-Smith Michelle Locke
14:00-14:20	My evolution in breast reduction surgery - **Jim Grotting**	
14:20-14:35	Protecting the blood supply to the nipples in large breast reductions, using the delay procedure - **Mark Ashton**	
14:35-14:50	Three quadrant breast reduction. A technique which addresses the lateral breast and improves pedicle safety - **Stanley Loo**	
14:50-15:10	**Panel discussion:** Difficult cases, managing complications and how to get better results	

Friday 22 August 2025 *cont.*

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
15:10-15:40	**Afternoon Tea and EPosters with Trade Exhibitors**	Trade Exhibition Area
15:40-17:35	**Session 4: Mastopexy**	Moderator: Brandon Adams
15:40-15:45	A Word from our Silver Sponsor:  SheffMed NZ Ltd	
15:45-15:55	Breast Implant illness **- Michelle Locke**	
15:55-16:15	Breast implant removal - algorithm for reconstruction with mastopexy and lipofilling - **Maria Weidner**	
16:15- 16:30	Mastopexy with and without lipofilling **- Jesse Kenton-Smith**	
16:30-16:50	Success in augmentation mastopexy in the era of smooth implants - **Jim Grotting**	
16:50-17:05	Glandular reconstruction after Explant - **Mark Lee**	
17:05-17:35	**Panel discussion:** Difficult cases, managing complications and how to get better results	
17:35- 19:00	**Welcome Function**	Trade Exhibition Area

Saturday 23 August 2025

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
08:10-10:30	**Session 5: Massive Weight Loss / Body Contouring**	Moderator: Murray Beagley
08:10-08:25	GLP-1 agonists and plastic surgery - **Dirk Richter**	
08:25-08:45	Diagnosis and treatment options for lipoedema with new devices - **Maria Weidner**	
08:45-09:05	Lipo - body - Lifts in massive weight loss - **Dirk Richter**	
09:05-09:20	Lipoedema: Practical considerations for surgical treatment - **Patrick Lyall**	
09:20-09:35	Surgical treatment of lipoedema in Perth, WA - **Adrian Brooks**	
09:35-09:45	Treatment of the buried penis in massive weight loss - **Dirk Richter**	
09:45-10:10	**Panel Discussion:** Difficult cases, managing complications, how to get better results	
10:10-10:30	**Research Papers 1**	
10:10-10:20	A 10-year review of body contouring operations post massive weight loss within the public sector - **Liz Primulapathi** ***1779***	
10:20-10:30	Rising demand for Skin Cancer Multi-disciplinary Meeting (MDM) discussions: A changing landscape - **Nikita Quinn** ***1796***	

Saturday 23 August 2025

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
10:30-11:00	**Morning Tea and EPosters with Trade Exhibitors**	Trade Exhibition Area
11:00-12:30	**Session 6: Innovations**	Moderator: Dylan Wyn James
11:00-11:05	A Word from our Silver Sponsor: 	
11:05-11:25	Implementing longevity tips and bio hacking in aesthetic surgery clinic - **Maria Weidner**	
11:25-11:40	Hair transplantation - A plastic surgeon's perspective - **Bulent Yaprak**	
11:40-11:55	Lymphoedema - **Simon Chong**	
11:55- 12:05	**Discussion Q&A**	
12:05-12:25	**Research Papers 2**	
12:05-12:15	Digital Papillary Adenocarcinoma: A population based study of a rare but aggressive cancer - **Emma Littlehales** ***1795***	
12:15-12:25	Refining Stener lesion diagnosis: Evaluating ultrasound accuracy and a proposed MRI-based approach - **Sahan Maddumage** ***1767***	
12:25-13:15	**Lunch and EPosters with Trade Exhibitors**	

Saturday 23 August 2025

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
13:15-14:35	**Session 7: Breast**	Moderator: Janek Januszkiewicz
13:15-13:30	Breast augmentation - **Jim Grotting**	
13:30-13:45	My experience with Galaflex mesh in breast surgery - **Adrian Brooks**	
13:45-13:55	**Discussion**	
13:55-14:45	**Research papers 3**	
13:55-14:05	Changing trends in cosmetic breast augmentation by New Zealand plastic surgeons between 2014 and 2024 - **Annelise Neal** ***1783***	
14:05-14:15	A rare and recurrent case of acute fungal breast implant infection - **Brodie de Gouw** ***1782***	
14:15-14:25	A review of breast tissue de-epithelialisation techniques - is there a superior approach? - **Jack Gerrard** ***1813***	
14:25-14:35	Adherence of specialist plastic surgeons and cosmetic surgeons to cosmetic surgery advertising regulations - **Wen Shien Tai** ***1760***	

Saturday 23 August 2025

Location: Remarkables Room, Level 1, Hilton Resort Queenstown unless otherwise stated

Time	Presentation/Presenter	Location
14:35-14:45	The brain drain: Why are we training Australia's next plastic surgeons - **Kristy Toy** ***1830***	
14:45-15:00	**Judging / Prizegiving / Announcement of 2026 ASM and Closing**	Prizes Sponsored by: SheffMed NZ Ltd Financial Independence Part of the ICIB Group
15:00-15:30	**Afternoon Tea and EPosters with Trade Exhibitors**	Trade Exhibition Area
15:30-17:30	New Zealand Association of Plastic Surgeons Annual General Meeting	
19:30-Late	**Meeting Dinner (ticketed)**	Wakatipu Grill, Hilton Resort

Poster Display

ID	Title	Presenting Author
1754	*Exploring the surgical management of solitary necrobiosis lipoidica*	**Grace Boyd**
1759	*When glomus isn't the answer: Diagnostic pitfalls and management of three atypical benign fingertip tumours*	**Yang Gao**
1761	*Veinless victory: A case report and literature review of single-artery ear replantation*	**Shelley Hubley**
1762	*Implications of GLP-1 agonists in plastic and reconstructive surgery - a literature review*	**Priyal Patel**
1772	*A rare case of osteomyelitis following dogbite: Schaalia canis WITHDRAWN DID NOT ATTEND*	**Michelle Jia Ni Ling**
1773	*An unexpected cause of tissue expander rupture: Surgical clip erosion in immediate breast reconstruction WITHDRAWN DID NOT ATTEND*	**Michelle Jia Ni Ling**
1775	*Breast implant associated B-cell lymphoma - A rare but growing*	**Jade Lau Young**
1776	*Abstracts to articles: Examining the publication of presentations at NZAPS ASM*	**Daniel Wen**
1777	*Septic arthritis and secondary necrotising fasciitis in an infant:a novel case requiring free flap reconstruction*	**Kirsty Toy**
1778	*Surgical management of epidermolytic hyperkeratosis - a role for surgical excision and transfer grafting*	**Toby Ball**
1780	*First case of nuchal-type fibroma in the hand - Case report*	**Eric Kim**
1784	*Missed and mismanaged: The clinical fallout of delayed management of doxorubicin port-a-cath extravasation*	**Teresa Liew**
1787	*Microbiology and surgical treatment of native joint septic arthritis of the hand*	**Sara Uhrle**
1790	*Paediatric craniofacial reconstruction following frontal sinus tumour resection: A case of juvenile psammomatoid ossifying fibroma*	**Harry Wu**
1791	*Not just a haematoma: Persistent paediatric facial swelling leading to surgical removal of foreign bodies*	**Harry Wu**
1793	*Where does Matriderm fit in the reconstructive ladder?*	**Lydia Park**

ID	Title	Presenting Author
1797	*Mallet thumbs: A review of management outcomes*	**Nikita Quinn**
1798	*A rare case of neglected BCC with pulmonary metastasis*	**Nikita Quinn**
1799	*Case report: Vascularised fibular graft as a reconstructive option for osteosarcoma of the paediatric pelvis*	**Samantha Handforth**
1801	*The growth and development of Dunedin's Plastic and Reconstructive Surgery Department*	**Brodie de Gouw**
1802	*Incidental finding of an exceedingly rare tumour at sentinel lymph node biopsy*	**Tea Williams**
1806	*A scoping review: Recommended VTE prophylaxis for bilateral breast reduction surgery without concurrent abdominal surgery*	**Rachael McKinna**
1807	*Applications of artificial intelligence in pPostoperative breast reconstruction: A scoping review*	**Rachael McKinna**
1808	*AI as a study tool for the FRACS Fellowship Examination*	**Oliver Jensen**
1810	*Surgical site infections in local anaesthetic flap/graft procedures: Review of the Hutt Experience*	**Oliver Jensen**
1811	*Reviewing management guidelines for traumatic facial lacerations in Australasian Emergency Departments*	**Jack Gerrard**
1826	*Ka Mau, Ka Muri: Breast reconstruction Hutt Hospital Plastic Surgery Department 2019-2024*	**Kate Hippolite**

Keynote Speakers

Dr. James C Grotting MD

James C. Grotting, M.D., is past chairman of the American Board of Plastic Surgery, past chairman of the Board of Trustees of the American Society of Plastic Surgeons, and Past President of the American Society for Aesthetic Plastic Surgery (ASAPS). He is a clinical professor of plastic surgery at the University of Alabama at Birmingham and the University of Wisconsin-Madison, and operates a private practice in Birmingham, Alabama. In addition to being President of ASAPS, Grotting has served as chair of the Society's Education Commission, serves on multiple Society committees and is a former board member of the Aesthetic Surgery Education and Research Foundation (ASERF), the nonprofit research and education arm of ASAPS. He serves on the editorial board of The Aesthetic Surgery Journal and is the author of five major textbooks in the specialty of plastic surgery. Dr. Grotting has directed a fellowship in aesthetic and breast surgery for the past 25 years. Dr. Grotting is a member of the prestigious American Association of Plastic Surgeons, past-president of the Southeastern Society of Plastic and Reconstructive Surgeons and a traveling Professor for both the Plastic Surgery Foundation and ASAPS. Dr. Grotting is also a fellow of the American College of Surgeons.

Dr. Grotting is the founder of CosmetAssure, an insurance program that covers unexpected financial expenses for patients from complications of cosmetic surgery. The data regarding complications from aesthetic surgery from this program has been published in over 23 manuscripts in various peer reviewed journals. He has provided free plastic surgery for children with facial deformities in developing countries, through Operation Smile, since 1987.

Dr. Grotting is a private pilot who enjoys skiing, ice hockey, and sailing. He and his wife Ann, have two boys, Jimmy and Ben. Ben and his wife, Kelly, have two children J.R. and Josephine Ann. Jimmy and his wife, Claire, have one son, William.

Dr. Dirk F Richter MD

Dr. Dirk Richter is an international renowned plastic surgeon. He received his training in Brazil the US and worked among others with Professor Olivari, a pioneer in the field of eyelid and facial surgery. He then served as his successor for 21 years as the Chief of the Department in Germany.

Dr. Richter set his focus in complicated eyelid surgery and facelifts and has extensive experience in treating complication cases. He served as president of the International Society of Aesthetic Plastic Surgery (ISAPS), the largest international professional society for aesthetic plastic specialists, until 2020 and is President Elect of the German Society of Plastic, Reconstructive and Aesthetic Surgery (DGPRAEC).

In recent years, Dr. Richter has evolved more holistic treatment approaches in aesthetic surgery by using regenerative medicine, anti-aging techniques, and high-level aesthetic surgery. Therefore, Dr. Dirk Richter, together with Dr. Maria Wiedner, has founded the new private INSTITUT UNIQ for holistic regenerative medicine and aesthetic surgery, in Castle Bensberg / Germany. The institute will offer innovative and holistic treatments and organize specific scientific trainings and congresses.

Dr. Maria Wiedner MD

Dr. Maria Wiedner, MD, is a double board-certified specialist in Plastic and Aesthetic Surgery who served as Head of the Department of Plastic, Aesthetic, and Reconstructive Surgery at Malteser Hospital in Bonn until 2019. She now practices at Institut Uniq at Bensberg Castle, where she specializes in state-of-the-art plastic and aesthetic procedures.

After completing her medical degree in 2004 at the Medical University of Graz, she pursued specialist training at the Medical Universities of Vienna, Innsbruck, and Graz. Following specialization, she worked as a senior physician at the University Hospital in Graz for three years before relocating to Bonn, where she assumed the role of Head of Department.

With extensive training in all areas of plastic, aesthetic, and reconstructive surgery, Dr. Wiedner has specialized in body contouring and breast surgery. A key focus of her work is the treatment of lipedema through gentle WAL liposuction of the arms and legs. Before transitioning to her current position, she further expanded her expertise with a two-year specialized training in aesthetic facial surgery at the Dreifaltigkeits Hospital in Wesseling.

Academically, she is an active member of the International Society of Aesthetic Plastic Surgery (ISAPS), the world's largest society for board-certified plastic surgeons, as well as the Austrian and German Societies for Plastic, Aesthetic, and Reconstructive Surgery.

General Information

Website

nzaps2025.w.events4you.currinda.com

Address (ASM venue)

The Hilton Queenstown Resort & Spa is located at Kawarau Village, 79 Peninsula Road, Queenstown 9300. Reservations Desk: +64 3 450 9400

ASM Registration and Information Desk - Level 1

The registration desk is situated at Booth 9 in the Trade Exhibition. The Plenary sessions (including the Workshop) will all take place in the Remarkables Room on Level 1.

We welcome your enquires on any conference detail. The desks will be open at the following times:

Thursday	11 am - 5 pm
Friday	7.30 am - 7.00 pm
Saturday	7.30 am - 4.00 pm

Contact Phone Numbers

Registration Desk Staff: 027 562 5949

Queenstown Taxis (Bluebubble): 03 450 3000

Airport Shuttle: www.supershuttle.co.nz

Queenstown Medical Centre: 03 441 0500

Abstracts

Abstracts for the presentations and posters are both available in this handbook and also electronically (delegates have been sent a link for the e-poster dashboard).

Attendee List

There is a list of conference attendees available at the registration desk. Please note this only includes delegates who have consented to having their information included.

Certificate of Attendance & Evaluation

A certificate of attendance will be emailed directly to delegates following the conclusion of the conference along with a delegate survey.

COVID-19 Considerations

This event will comply with the current Government COVID-19 regulations that apply at the time of the conference. Attendees should not attend this event if they have symptoms. Hand sanitiser has been provided. Any change in COVID-19 levels may require a change in the advertised programme and/or venue layout at short notice.

Internet Access

Wireless internet: HiltonHonorsMeeting Password NZAPS2025

Toilets

There are toilets located off the Trade Exhibition Area to the left before the lifts.

Mobile Phones/Devices

Mobile phones are allowed in the conference rooms, however please turn all devices to silent mode. Delegates are not permitted to take any photographs or screen shots in the conference room.

Name Badges

All conference attendees and industry representatives are requested to wear their name badges at all times during the conference and social functions. It is your official entrance pass to the sessions and conference catering.

We invite you to return your name badge to the registration desk at the end of the conference for recycling.

Parking

The Hilton offers valet parking $40 per day or $16 per day self-parking - see Hilton Reservations Desk for more information.

E-Poster Display

E-Posters will be displayed on two display screens in the trade exhibition area - they will also be available online via the livestream dashboard.

Please take time to view the poster displays during refreshment breaks.

Water Taxi

There is a water taxi service Hilton-Queenstown CBD-Hilton. Water taxi cannot be booked in advance - we suggest that you are at the jetty 15 minutes prior to departure. Crossings are subject to weather conditions. Please see the website for the timetable: queenstownferries.co.nz

Prizes: Registrar Presentations

NZAPS Prizes include Best Presentation NZ$800, 2nd Best Presentation NZ$400, Best Poster NZ$300. Presentations take place on Saturday afternoon.

Sponsored by:

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Catering and Special Diets

Catering includes morning tea, lunch, afternoon tea on the days of registration which will be served in the Trade Exhibition Area outside the Remarkables Room. The meeting dinner is not included with registration, please see the registration desk to purchase tickets.

Vegetarian options are included in all refreshment breaks. If you have advised any special dietary requirements on your registration these would have been notified to the caterers. All lamb, beef, chicken served at the main conference venue is certified Halal. Please make yourself known to the catering staff if you require help finding your meal.

Barista Coffee will be available in the Trade Exhibition Area and has been sponsored by:

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Suggestions for Dining Queenstown CBD:

The Bunker, 43 Ballarat Street thebunker.co.nz
ph: 03 442 6060

Botswana Butchery, 17 Marine Parade botswanabutchery.co.nz
ph: 03 442 6994

Jervois Steak House, 8 Duke Street jervoissteakhouse.co.nz
ph: 03 442 6263

Rata, 43 Ballarat Street ratadining.co.nz
ph: 03 442 9393

More dining options: queenstownnz.co.nz

Presentation Information

Oral Presentations

All presenters will have provided their presentation slides in advance. All presentations will take place in the Remarkables Room on Level 1. A dedicated AV technician will be managing the presentations. Presenter View will be available to all presenters so they can view their notes during their presentation from the lectern. Presentations must not exceed the allotted time which includes Q&A. A timekeeper will indicate 2 minutes and 1 minutes remaining.

E-Poster Presenters

All posters will be electronic this year. Poster authors will have submitted their Powerpoint files previously. E-posters will be available to view on screens in the trade exhibition/refreshment break area outside the Remarkables Room. These will also be available to view online - all delegates have been sent the link for the E-Poster Dashboard.

Late Changes

With such a high volume of presentations, oral and poster presentations, files cannot be changed once submitted.

If for any reason, a presenter can no longer be available to present, we ask them to contact the Meeting Organiser immediately by email sally@events4you.co.nz or by reporting to the Registration Desk located in the Trade Exhibition area. Any last minute changes to the programme will be reflected on the online programme on the Meeting website.

Social Events

Welcome Function

Venue Trade Exhibition, Level 1, Hilton

Date Friday 22 August 2025

Time 5.30 pm - 7.00 pm

Dress Smart Casual

Price Included in registration (partners NZ$60)

Join our Trade Exhibitors at the Welcome Function which will be held on Friday in the Trade Exhibition Area outside the Remarkables Room on Level 1. Information on the Trade Exhibitors including a floorplan is available on Page 64.

Meeting Dinner

Venue Wakatipu Bar & Grill, Hilton Queenstown Resort

Date Saturday 23 August 2025

Time 7.00 pm for 7.30 pm

Dress Smart Casual

Price NZ$150

The Meeting dinner will be held at the conference venue this year in the Wakatipu Bar & Grill, Level 1. Dinner includes 3 course meal and drinks. Tickets can be purchased from registration - delegates, their partners and registered exhibitor staff are welcome to attend.

Abstracts: Oral

In Alphabetical Order
(presenting author surname)

id #1782

A rare and recurrent case of acute fungal breast implant infection

Brodie J M de Gouw[1], Emma Littlehales[1], Patrick Lyall[1]

1. Plastic and Reconstructive Surgery, Dunedin Hospital, Dunedin, Otago, New Zealand

Introduction

Breast implant infection is seen in 1.1-2.5% of patients[1], but fungal infection is rare. We report an acute left breast tissue expander infection from *Scedosporium apiospermum*

Case

A 53-year-old Māori female underwent bilateral risk reducing mastectomies and immediate implant-based reconstruction with a dermofascial sling. She presented acutely unwell on the 25th postoperative day with a left sided seroma that was drained. Aspirates cultured *Scedosporium apiospermum* and she proceeded for left tissue expander explantation and washout of the expander pocket. She was treated with 3 months of voriconazole with clinical resolution. Eighteen days after finishing treatment she represented with malaise, left chest wall swelling and discomfort. An ultrasound of the left chest wall showed oedema with no collection. Three weeks later she developed an open wound of the left mastectomy scar and subsequently returned to theatre for a washout and debridement where *Scedosporium apiospermum* was isolated. She had a further 5 months of voriconazole treatment.

Discussion

Scedosporium apiospermum is a rare fungal pathogen in breast augmentation/reconstruction surgery with only two prior cases of breast implant infections in the literature. Once as a disseminated infection in an immunocompromised patient following lung transplant[2] and the other as a delayed subacute infection found on explanation in an immunocompetent patient[3]. This is the first recorded case of acute infection in the early postoperative period.

1. Pyfer B, Chatterjee A, Chen L, et al. Early Postoperative Outcomes in Breast Conservation Surgery Versus Simple Mastectomy with Implant Reconstruction: A NSQIP Analysis of 11,645 Patients. Ann Surg Oncol. 2016;23(1):92-98. doi:10.1245/s10434-015-4770-2

2. Sahi H, Avery RK, Minai OA, et al. Scedosporium apiospermum (Pseudoallescheria boydii) Infection in Lung Transplant Recipients. J Heart Lung Transplant. 2007;26(4):350-356. doi:10.1016/j.healun.2007.01.011

3. Koan C, Venegas RJ, Murphy RA. A surprising complication of breast augmentation surgery. JPRAS Open. 2022;31:62-66. doi:10.1016/j.jpra.2021.10.010

id #1813

A review of breast tissue de-epithelialisation techniques - is there a superior approach?

Jack Gerrard[1], Robert Toma[1]

1. Warrnambool Plastic & Reconstructive Surgery, South West Healthcare, Warrnambool, Victoria, Australia

Background

In cosmetic and reconstructive breast surgery, de-epithelialisation involves removing epidermis to allow tissue to move beneath areas of retained skin whilst maintaining the subdermal plexus to support vascularity of a tissue flap and nipple areola complex (NAC). The process of de-epithelialisation can be tedious, time intensive and requires an assistant to maintain skin tension. To ensure the underlying vasculature within the dermis and subcutaneous tissue is preserved, the process must be exact with the average thickness of breast tissue epidermis about 0.3mm. Inadequate de-epithelialisation can lead to skin necrosis, poor flap healing, seroma, infection, and suboptimal aesthetic outcomes.

Aim

This scoping review endeavours to synthesize existing evidence investigating the different techniques used to de-epithelialise skin during breast surgery and determine if one technique is superior.

Methods

A comprehensive search was performed using Pubmed, Scopus, Google Scholar and the Cochrane library databases. Studies included reported the use of one or more techniques for breast tissue de-epithelialisation with the comparative value of the technique(s) discussed.

Results

The findings revealed variation between de-epithelisation tools utilised and a lack of comparative literature to determine if any practice is superior to another. There are numerous techniques described, including: sharp dissection with a scalpel, scissors or novel devices such as EpiCut; electrocautery; laser; dermatome; hydrosurgery systems and intradermal infiltration of local anaesthetic. While some articles compare the time or cost of two or more techniques, there was no study comparing all techniques in significant detail.

Conclusion

This review provides an overview of existing techniques used for breast tissue de-epithelialisation and some of the benefits of certain techniques. Ultimately, there is lack of comparative research that analyses the different techniques. Further research could help guide surgeon decision making and improve efficiency, cost and surgeon satisfaction when de-epithelialising breast tissue.

id #1795

Digital Papillary Adenocarcinoma: A population based study of a rare but aggressive cancer

Emma Littlehales[1], **Patrick Lyall**[1]

1. Dunedin Hospital, North East Valley, Dunedin, New Zealand

Introduction

Digital papillary adenocarcinoma (DPA) is a rare tumour of sweat gland origin, usually presenting in the hands, and less commonly in the feet. It is frequently misdiagnosed and behaves aggressively with a high metastatic rate (14%)[1]. There is a high recurrence rate of 50% with no further treatment versus 5% in those who undergo WLE/amputation[1]. There is no population-based study looking at incidence, management and outcomes in the literature

Methods

The New Zealand Cancer Registry was searched for all instances of DPA from 2003-2023, and patient

health records were retrieved, including referral and clinic letters, operation notes, histology reports and imaging reports.

Results

19 cases were identified with an incidence of 0.19 cases per 1,000,000 person years, which increased over the study. The male:female ratio was 2.8:1, with a median age of 65. Lesions had been present for a mean of 22.2 months prior to diagnosis. 10.5% (2/19) lesions were excised with margins >/= 1mm, and further surgery was performed in 94% (16/17) of the remaining cases. Wide local excision with >5mm margins was performed in seven, and amputation in eight. Sentinel lymph node biopsy (SLNB) was performed in four cases. There was one incidence of recurrence (5.1%), and two cases of metastatic disease (10.5%). Mortality rate was 5.1%.

Conclusion

Digital papillary adenocarcinoma is commonly misdiagnosed clinically, with a history of trauma in 42.1%, meaning all finger lesion excisions should be sent for histological examination. All patients should undergo a wide local excision or digital amputation. There is a rate of metastatic disease at presentation, and SLNB can be considered. Given the high rate of metastatic disease, patients should be followed up for a prolonged period, both clinically and with screening chest x-rays.

1. 1. Duke WH, Lupton GP. Aggressive Digital Papillary Adenocarcinoma. Am J Surg Pathol. 2000;24(6).

id #1767

Refining Stener lesion diagnosis: Evaluating ultrasound accuracy and a proposed MRI-based approach

Sahan Maddumage[1], Eric Kim[1], Blair York[1]

1. Christchurch hospital, Christchurch, Canterbury, New Zealand

Background

The accurate diagnosis of Stener lesions in ulnar collateral ligament (UCL) injuries of the thumb is critical for determining the need for surgical intervention. While international literature[1] reports high ultrasound (USS) sensitivity (95%) for detecting Stener lesions, clinical experience at Christchurch Hospital suggests a high false positive rate.

Methods

A retrospective analysis was conducted on all UCL repair operations performed at Christchurch Hospital between January 2022 - January 2025. Patient demographics, ultrasound results, Intra-operative findings were recorded. Cases with incomplete data and non UCL-repair operations were excluded.

Results

There were 95 UCL repairs performed over a 36 month period. 31 were excluded due to incomplete data or complex injuries. There were 41 males and 23 females. The median age was 42.5 (range 12 to 82) and 56% had their UCL repaired on their dominant hand. 51 (80%) of the 64 patients were true Stener lesions intra-operatively. This was only 60% in patients aged 60 or greater.

Conclusion

A positive predictive value of 80% suggests that up to 20% of patients may undergo unnecessary surgical intervention. This study highlights the limitations of USS in diagnosing Stener lesions in our

clinical setting and presents a new diagnostic pathway incorporating MRI (sensitivity 96-100%) for select patients. We propose a stratified approach: patients under 60 years of age with USS-proven Stener lesions should proceed directly to surgery, while those aged 60 and above should undergo MRI confirmation before surgical intervention. This approach may reduce surgical morbidity and healthcare costs.

1. 1. Qamhawi, Z. et al. (2021) 'Diagnostic accuracy of ultrasound and magnetic resonance imaging in detecting Stener lesions of the thumb: Systematic review and meta-analysis', Journal of Hand Surgery (European Volume), 46(9), pp. 946–953. doi:10.1177/1753193421993015.

id #1783

Changing trends in cosmetic breast augmentation by New Zealand plastic surgeons between 2014 and 2024

Annelise Neal[1], Rahul Jayakar[2], Janek Januszkiewicz[2]

1. Te Whatu Ora Counties Manukau, Middlemore Hospital, Auckland, New Zealand

2. New Zealand Institute of Plastic and Cosmetic Surgery, Remuera, Auckland, New Zealand

Background

Breast augmentation practice in New Zealand over the past decade has been influenced by a number of factors including cosmetic tourism and BIA-ALCL. Anecdotally the number of cosmetic breast augmentations performed by plastic surgeons has decreased during this time.

Objectives

The aim of our study was to utilise an online survey to analyse changing trends in breast augmentation surgery by New Zealand plastic surgeons over the last 10 years.

Methods

An online survey was distributed to all active members of the New Zealand Association of Plastic Surgeons with at least 10 years of consultant level experience.

Results

26 of a total eligible 41 respondents completed the questionnaire. Results show that the number of surgeons offering cosmetic augmentation has significantly decreased from 92% in 2014 to just 57% today. The number of patients seeking consultation for augmentation from plastic surgeons as well as the number of cosmetic augmentations performed has declined with explantation only procedures increasing. The ratio of primary to revision procedures has also changed to favour revision.

Conclusions

The number of plastic surgeons offering CBA in New Zealand has significantly decreased over the past 10 years. BIA-ALCL, BII and changing public and patient perceptions may have all contributed to this.

id #1779

A 10-year review of body contouring operations post massive weight loss within the public sector

Terry Creagh[1], Liz Primulapathi[1], Nicholas Brougham[1]

1. Christchurch plastics, Christchurch, Canterbury, New Zealand

Background

Body contouring operations after massive weight loss have a significant impact on the quality of life of patients. There is very limited funding and accessibility to these operations in the public sector, and currently patients are only accepted after a panel review process. We present a series over a 10-year period in constrained public hospital environment.

Methods

We reviewed the experience of a single tertiary centre public hospital in New Zealand (Waitaha Canterbury), looking at all patients who met criteria to be reviewed by the selection panel for body contouring operations performed from 2016 to February 2025. We reviewed wait times and procedures, presenting data on procedures and outcomes.

Results

There were 53 patients who met criteria for panel review. 36 cases then went on to have an operation. 26 of these cases were post bariatric surgery. The average wait time from referral to FSA was 285 days (range 8 days to 880) The average time from FSA to surgery was 514 days, The average maximum BMI was 52.7 and the average BMI at time of operating was 33.5. Patients had an average length of stay of 4.8 days and a total complication rate of 27.8%. Overall patients were very satisfied with their results with an average post op Body Q score of 89.5%.

Conclusion

We conclude body contouring is a very valuable operation to be offered in the public sector, and one that can be performed safely with excellent patient satisfaction.

id #1796

Rising demand for Skin Cancer Multi-disciplinary Meeting (MDM) discussions: A changing landscape.

Nikita Quinn[1], Andrew Davidson[1]

1. Te Whatu Ora, Canterbury, Christchurch, New Zealand

Introduction

New Zealand has one of the highest rates of skin cancer worldwide.[1,2] Previous research has shown the prevalence of squamous cell carcinoma is rising, whilst rates of invasive melanoma appear to have plateaued.[1,2] With an aging population and changing skin cancer trends within New Zealand, we were interested to see how the demographics of patients discussed at the Canterbury - West Coast Major Skin Malignancy MDM has changed over the last decade. To the best of our knowledge, no other similar research has been published across Australasia.

Method

This was a retrospective review of all patients listed for MDM discussion from 2015 to 2024. Data including age, type of skin cancer and total number of patients listed were reviewed.

Results

The number of patients discussed has more than doubled over the last 10 years, rising from an average of 7.4 patients per fortnightly meeting in 2015, to 17.2 in 2024. The annual median age has remained largely unchanged (ranging between 70.5-77 years). Further analysis of how age trends vary between melanoma and non melanoma sub-cohorts is ongoing.

Conclusion

There has been a substantial rise in the number of patients discussed at Canterbury's Major Skin Malignancy MDM, while the median patient age has remained unchanged. The increasing demand for multi-disciplinary discussion may mean additional resourcing is needed in the future, in order to keep pace with demand.

1. Paul, S., Chen, Y. & Mohaghegh, M. Analysis of Prevalence, Socioeconomic and Disease Trends of Non-Melanoma Skin Cancer in New Zealand from 2008 to 2022. J Epidemiol GlobHealth 14, 1012–1021 (2024). https://doi.org/10.1007/s44197-024-00250-4
2. Wen D, Pullman JS, Sharma A et al. Exploring melanoma shifts: a two-decade analysis in New Zealand. NZ Med J. 2024 Jun 7;137(1596):35-42. doi: 10.26635/6965.6430. PMID: 38843548.

id #1760

Adherence of Specialist Plastic Surgeons and Cosmetic Surgeons to Cosmetic Surgery Advertising Regulations

Wen Shien Tai[1], James Briffa[1], Michelle JN Ling[1], Cheng Hean Lo[1]

1. Plastic and Reconstructive Surgery, Western Health, Melbourne, VIC, Australia

Introduction

On 1st July 2023, new advertising regulations were implemented in Australia to more closely oversee cosmetic surgery advertisements. These guidelines apply to all cosmetic surgery practitioners and were introduced to ensure patient safety. The majority of medical practitioners practising cosmetic surgery in Australia are members of three professional organisations: the Australian Society of Plastic Surgery (ASPS), the Australian Society of Aesthetic Plastic Surgeons (ASAPS), and The Australian College of Cosmetic Surgery and Medicine (ACCSM). The purpose of this study was to assess how well these practitioners comply with the new advertising regulations.

Method

This study involved reviewing the websites of medical practitioners listed on the ASPS, ASAPS, and ACCSM association websites in Victoria, Australia, between 1st and 30th September 2023. Three reviewers conducted the audit. The study used the "Guidelines for Registered Medical Professionals Who Advertise Cosmetic Surgery", issued by the Medical Board of Australia, which became effective on 1st July 2023, as the reference for evaluating compliance.

Result

A total of 158 practitioners were identified, with 120 qualifying for the audit. Among these, 18% of ASPS

members, 33% of solo ASAPS members, and 71% of ACCSM members were found to be in violation of at least one guideline.

Conclusion

In Victoria, ASPS members were found to be more compliant with the newly updated advertising regulations compared to ACCSM members. It is recommended that all cosmetic surgery practitioners review their advertising practices to ensure they comply with the updated regulations.

id #1830

The Brain Drain: Why are we training Australia's next plastic surgeons?

Kristy Toy[1], Blair York[1]

1. Health NZ Te Whatu Ora - Waitaha Canterbury, Christchurch, NEW ZEALAND, New Zealand

Background

It has been estimated that given the expected population growth and increasing disease demands in an ageing population, New Zealand would need 83.3 practicing plastic surgeons by 2027 (1). More alarmingly, this figure was based on a population of 5 million people, a number which was surpassed in 2020. Contributing to this issue is the fact that of the 34 New Zealand-trained plastic surgical fellows of the Royal Australasian College of Surgeons (RACS) since 2015, only 62.5% are currently working in New Zealand. Due to the increasing demand for plastic surgeons in New Zealand, it is of the utmost importance to identify the causes of the brain drain of New Zealand-trained plastic surgeons and how to keep them in New Zealand.

Method

A survey was distributed to the current RACS trainees in plastic surgery throughout New Zealand, reviewing their career plans post training. The aim was to identify barriers to working in New Zealand post training.

Results

Of the 22 current trainees, 94.5% (21 of 22) completed the survey. 76.2% of trainees were intending on working in NZ post training, with 23.8% being unsure. Barriers to working in NZ included remuneration and lack of transparency regarding consultant positions available post training. Only 52.4% of trainees have been approached by a plastic surgery department regarding a position post training, yet 95.2% said that they would be open to having a discussion regarding this. 47.6% of trainees said they would be open to working in a rural centre, with the main barrier being the isolation and lack of collegial support.

Discussion

The survey was successful in identifying some of the key barriers for current plastic surgery trainees regarding working as a surgeon in New Zealand post training. By identifying these

barriers, we can aim to address these in order to improve access to plastic surgery in New Zealand.

1. Adams, B. M. et al(2013). The future of the New Zealand plastic surgery workforce . The New Zealand Medical Journal, 126.

Abstracts: Posters

In Alphabetical Order
(presenting author surname)

id #1778

Surgical management of epidermolytic hyperkeratosis – a role for surgical excision and transfer grafting

Toby Ball[1], Kristy Toy[2], Deirdre Seoighe[1]

1. Plastic and Reconstructive Surgery, Waikato Hospital, Hamilton, Waikato, New Zealand

2. Plastic and Reconstructive Surgery, Christchurch Hospital, Christchurch, Canterbury, New Zealand

Background

Epidermolytic hyperkeratosis is a rare autosomal dominant condition affecting 1 in 2-300,000 people worldwide. There is very little evidence for surgical intervention, with management largely through dermatological treatments. This is a case of a 31-year-old patient with epidermolytic hyperkeratosis, who is wheelchair-bound as a result of restriction of movement from keratosis of both hands and feet. They have varying degrees of hyperkeratosis over their body, with reduced keratosis of their abdomen. They have previously undergone excision of the hyperkeratotic layers from their hands and feet, with recurrence over the course of six months. Further excision was warranted in light of the restoration of function and improvement of quality of life. The aims of treatment were to restore functional movement, including the release of a first webspace contracture of their left hand with a full thickness skin graft.

Methods

Excision of the keratotic tissue in the sub-keratotic plane was completed as previously, along with the contracture release, with the graft taken from their left inguinal region.

Results

At five months post-excision and contracture release, the grafted webspace remains patent, with significantly less disease recurrence at the grafted site compared to recurrence in the surrounding native tissue. The donor site healed with no complications. Hyperkeratosis of their feet has slowly recurred.

Conclusions

After five months, surgical excision has provided symptomatic relief for epidermolytic hyperkeratosis in this patient. This previously undocumented technique of skin grafting from a less keratotic area has significantly reduced recurrence compared to native skin. Further surgery is planned, including more transfer grafting to establish whether disease progression can continue to be slowed.

id #1754

Exploring the surgical management of solitary necrobiosis lipoidica

Grace E Boyd[1], Arunan Jeyakumar[1], Oliver Hovav[1], Sheramya Vigneswaran[1], Alexa McNaught[1], David Sparks[1, 2]

1. Gold Coast University Hospital, Southport, QLD, Australia

2. Gold Coast Private Hospital, Gold Coast, QLD, Australia

Necrobiosis lipoidica (NL) is a rare inflammatory granulomatous skin disorder of collagen degeneration with a risk of ulceration. There is a known association with diabetes mellitus. NL most commonly presents at 30-40 years of age, is more common in women, and frequently appears on the pre-tibial

regions as erythematous papules that can unite to form telangiectatic plaques. Given the underlying pathological mechanism remains unclear, there is no uniform treatment pathway and there is no single treatment modality that has proven to be completely suitable in treating NL. In this report and literature review, we describe a case of a 31-year-old female with type-1 diabetes mellitus with biopsy proven NL of the dorsal left foot, refractory to multiple medical therapies and phototherapy. She proceeded to a wide local excision down to deep fascia and split thickness skin grafting. She progressed well post-operatively and has had no evidence of NL recurrence thus far. There is a paucity of reported literature describing the effectiveness of surgical management in NL, and this case adds to the literature available. While management of NL is nuanced and patient-dependent, excision and grafting can be considered and discussed with patients when counselling regarding management options. This has proven an effective strategy for patients with disease refractory to medical therapies, with low rates of recurrence when excised down to deep fascia. It is necessary to continue describing cases in this field and their management to aid in standardising the medical and surgical treatment and optimising outcomes for patients.

id #1801

The growth and development of Dunedin's Plastic and Reconstructive Surgery department

Brodie J M de Gouw[1], Patrick Lyall [1]

1. Plastic and Reconstructive Surgery, Dunedin Hospital, Dunedin, Otago, New Zealand

Introduction

Dunedin, the longstanding seat of medical education in New Zealand and the birthplace of two of the "Big Four" fathers of plastic surgery[1], has in relative terms a recently established Plastic and Reconstructive Surgery department. This account of the development of the department from its infancy through childhood and adolescence focuses on the growth of the acute service provided over 18 years.

Findings

Starting with a sole surgeon in 2007 the department has grown to include five surgeons, two registrars and a clinical nurse specialist. Through the development of the service growth has been strong especially when measured in volumes of acute procedures performed. These have been recorded from the outset of the department and show there to have been a greater than eightfold increase in the acute operating over 18 years.

Numbers of cases have increased in a steady fashion as the full time equivalent of the department has grown. The addition of a plastic surgery trainee in 2023 allowed for more acute operations resulting in a doubling of cases over two years. Despite not being the primary hands service in Dunedin, hand related acutes make up a sixth of all acute operating. Likewise burns make up a fifth of all acute operations.

Discussion

The future is bright for plastic surgery in Dunedin and the department looks forward to a full complement of registrars on an isolated roster, the possibility of a shared hands service with orthopaedics and perhaps even a regional burns unit within the new Dunedin hospital.

1. Meikle MC. The evolution of plastic and maxillofacial surgery in the twentieth century: the Dunedin connection. Surgeon. 2006;4(5):325-334. doi:10.1016/s1479-666x(06)80010-7

id #1759

When glomus isn't the answer: Diagnostic pitfalls and management of three atypical benign fingertip tumours

Yang Gao[1], Danielle Yong[2], Sandhya Deo[3], Agneta Fullarton[3]

1. Plastic and Reconstructive Surgery, Middlemore Hospital, Auckland , New Zealand

2. School of Medicine, University of Auckland, Auckland, New Zealand

3. Plastic and Reconstructive Surgery, Hutt Valley Hospital, Lower Hutt, New Zealand

Background

Fingertip tumours encompass a spectrum of predominantly benign pathologies. While many exhibit pathognomonic features, atypical presentations may lead to diagnostic inaccuracy or delay. This study elucidates the clinical, radiological, and histopathological characteristics of rare benign fingertip tumors to broaden diagnostic consideration.

Methods

We present a case series of three patients with histologically confirmed rare benign fingertip tumors. Demographic data, clinical presentation, and radiological findings were systematically analyzed, with definitive diagnosis established through histopathological examination. All cases underwent surgical excision.

Results

The series includes an intraosseous epidermal inclusion cyst, intravascular papillary endothelial hyperplasia, and a superficial acral fibromyxoma. Each case demonstrates distinct clinical, radiological, and histopathological profiles. Surgical excision was performed in all instances, with excellent postoperative outcomes and high patient satisfaction.

Conclusion

Comprehensive knowledge of the diverse differential diagnoses for fingertip tumours—including their clinical and radiological hallmarks—is critical to minimize diagnostic errors and optimize timely intervention. This series underscores the importance of considering rare entities in the evaluation of fingertip masses.

id #1811

Reviewing management guidelines for traumatic facial lacerations in Australasian emergency departments

Jack Gerrard[1], Rachael McKinna[2], Robert Toma[1]

1. Warrnambool Plastic & Reconstructive Surgery, South West Healthcare, Warrnambool, Victoria, Australia

2. Warrnambool Rural Clinical School, Deakin University School of Medicine, Warrnambool, Victoria, Australia

Background

Facial lacerations are a common presentation to emergency departments in Australia and Aotearoa New Zealand. Numerous factors may influence management, such as age, patient preference, local practices, staff experience, guidelines, and more. It is known that facial lacerations closed with glue or steristrips experience a significantly higher rate of wound dehiscence compared to closure using sutures. Poor management and scarring of facial wounds can have a profound impact on facial aesthetics. Review by a health professional experienced in wound care can help ascertain the degree of injury and guide suitable management. This may include simple dressings, steri-strips, glue, sutures or referral to a surgical team.

Aim

This literature review aims to examine publicly available Australasian hospital guidelines to determine whether there is appropriate guidance for facial laceration management.

Methods

A comprehensive search was conducted using Pubmed, Scopus, Google scholar and Australasian health databases. Literature included discusses facial lacerations in Australasian Emergency Departments and management techniques.

Results

Findings reveal a paucity in available guidelines for the management of facial lacerations. Available guidelines are often non-specific regarding wound assessment and discuss management generally without specifying what repair technique is indicated for differing injury types. Furthermore, not all guidelines discuss referral to a surgical specialty. As a result, health professionals may inadvertently make decisions that are not in the best interests of wound healing when experienced colleagues are not present and the injury is not discussed with a surgical specialty.

Conclusion

This review provides an overview of the available guidelines for health professionals when caring for a patient with traumatic facial lacerations. This research highlights the need for the introduction of simple, accessible, evidence-based guidelines to help guide the management of face lacerations. This may prevent health professionals initiating inappropriate management rather than referring to surgical teams.

id #1799

Case report: Vascularised fibular graft as a reconstructive option for osteosarcoma of the paediatric pelvis

Samantha Handforth[1], Andrew Graydon[1], Keith Lee[1]

1. Paediatric Orthopaedics, Starship Hospital, Auckland, New Zealand

Background

Telangiectatic osteosarcoma is a rare, aggressive malignancy in paediatric patients, often requiring extensive resection and resulting in significant bony defects. Vascularised fibular grafts are a method of restoring skeletal stability and facilitating bone healing after such procedures. This case report aims to illustrate the distinctive use of a vascularised fibular graft for iliofemoral arthrodesis in a patient with ischial tuberosity osteosarcoma.

Methods

A 14-year-old male with ischial tuberosity osteosarcoma underwent a type 2/3 internal hemipelvectomy. Following tumour resection, a contralateral 20 cm vascularized fibula graft was harvested. A unique

surgical technique was used where the fibula was split in two segments while maintaining a single vascular supply. The graft was rotated 50° to attach from the pubic ramus to the ASIS and femur. Microvascular anastomosis was performed using the peroneal artery and a branch of the superficial femoral artery. Postoperative management included radiographic imaging and clinical evaluations.

Results

The patient had an estimated intraoperative blood loss of 5L necessitating significant blood transfusion. A 3-day ICU stay with vasopressor support was required to target a mean arterial pressure of 80 to facilitate flap perfusion. Pain was initially managed with an epidural, followed by a patient-controlled analgesia pump. On postoperative day 4, the patient returned to theatre for a wound check and drain removal. Surgical margins were clear on macroscopic examination. The patient remained neurovascularly intact distally, retaining ankle full motion (70°). At 1 week post op VAS pain score was 1. Early post-operative imaging showed stable graft position. Functional recovery and bony union continue to be followed up.

Conclusion

This case demonstrates the distinctive use of a vascularised fibula graft for iliofemoral arthrodesis following a Type 2/3 internal hemipelvectomy in a paediatric patient. The graft's rotation provided increased skeletal stability, and early results suggest successful surgical technique and postoperative recovery.

id #1826

Ka Mau, Ka Muri: Breast reconstruction Hutt Hospital Plastic Surgery Department 2019-2024

Kate Hippolite[1], Febe Minogue[1], Charlotte Blau[1]

1. Plastic Surgery Department, Hutt Hospital, Wellington, New Zealand

Background

Te Whatu Ora Hutt Hospital Plastic Surgery Department provides the breast reconstruction service for patients from Te Ikaroa (Central) and Te Tauihu (Top of the South Island) regions. Audit of our mastectomy reconstruction outcomes has not been carried out for longer than a decade. Reviews of this nature monitor surgical performance standards, provide quality assurance, and allow for reflection and service improvement. Our intention is for this audit is to demonstrate local adherence to international standards, reveal areas for improvement, and be a living document for ongoing reference.

Methods

This audit reviewed all delayed, immediate, and prophylactic breast reconstruction patients. Reconstruction methods from 2019 to 2024 include: a range of autologous (free and pedicled) flaps, breast implants (single and 2-stage), and combined autologous with implant reconstruction. Data, inclusive of demographics, operative specifics, complications, number of operations and surgeons, was collected retrospectively from all hospitals in the catchment area in an effort to reliably demonstrate outcomes. Exclusion criteria: patients who did not have follow-up for a minimum of 1 year.

Results

266 reconstructions (244 women) included: 76 free flaps (9 bilateral), 31 pedicled flaps, 67 expanders, 94 implants, 29 flap plus implant. Outcomes reviewed include: intraoperative complications, total or partial flap/implant loss, haematoma, seroma, necrosis of skin, arterial occlusion, venous congestion, ischaemic time, infections, hernias, complications at 1 year, unexpected ED presentations, and

complications post radiation.

Conclusion

There is great value in maintaining an audit of service provision. At this stage of data collection, our free flap failure, hernia, and complicated seroma rate conforms to international standards. Number of total free flap reconstructions has fallen compared to previous audit, which may reflect the impact of COVID-19 over this audit period. Further analysis including implant based outcomes currently in progress.

id #1761

Veinless victory: A case report and literature review of single-artery ear replantation

Shelley Hubley[1], Sally Langley[1]

1. Christchurch Hospital, Christchurch, New Zealand

Background

Ear replantation is a time-sensitive and technically complex procedure which provides the most optimal aesthetic and functional reconstruction. Unfortunately, most ear amputations result from avulsion injuries, which can attenuate and cause severe damage to small vessels, hindering successful replantation.

Methods

A single-artery replantation, without venous anastomosis, was performed on a 26-year-old male with complete auricle avulsion caused by a human bite. The entire avulsed ear, aside from a small intact portion of lobe, was reattached using microvascular repair techniques. Postoperative venous congestion was managed with leech therapy.

Results

Single-artery replantation was successful, yielding an excellent aesthetic outcome despite a near-total ear amputation. Significant postoperative venous congestion was effectively circumvented with hirudotherapy. The only complication was a small <1cm posterior pinna dehiscence which required repair under local anaesthetic on day twelve.

Discussion

The absence of salvageable veins is not an absolute contraindication for ear revascularization. Single-artery replantation has proven to be a viable option for patients with ear avulsion. Leech therapy is crucial for relieving venous congestion and can temporarily compensate for the total absence of venous outflow until new veins reestablish circulation. Nonetheless, careful selection of candidates for auricular replantation remains essential.

Conclusion: While robust arterial inflow and venous outflow are ideal in ear replantation, both this case and contemporary evidence demonstrate that artery-only replantation can yield excellent results when venous congestion is managed proactively with hirudotherapy.

id #1808

AI as a study tool for the FRACS Fellowship Examination

Oliver M Jensen[1]

1. Plastic, Maxilliofacial and Burns Unit, Hutt Hospital, Lower Hutt, Wellington, New Zealand

Background

Artificial intelligence (AI), particularly large language models (LLMs), is emerging as a tool in surgical education. While prior studies have shown that AI can simulate clinical reasoning and support exam preparation—such as ChatGPT's near-passing performance on the USMLE (Kung et al., 2023) and improved candidate confidence in AI-assisted mock oral exams (Choudhury et al., 2023)—its role in FRACS examination preparation remains unexplored.

Objective

To evaluate the quality of AI-generated FRACS-style questions and answers, and determine whether senior examiners can distinguish AI-generated responses from those written by near-complete senior registrars.

Methods

Two senior FRACS examiners assessed FRACS-style questions generated by ChatGPT for clinical relevance, structure, and appropriateness. They then scored anonymised responses to similar questions, half written by AI and half by senior registrars, and attempted to identify their origin.

Results

AI-generated questions were rated as clinically relevant and well-structured in 85% of cases. Examiner accuracy in identifying AI-generated responses was 54%, with AI answers scoring comparably to registrar responses in structure, factual accuracy, and reasoning. Subtle differences were noted in surgical nuance and context-specific judgment.

Conclusion

AI-generated questions and answers demonstrate potential as an adjunct in FRACS exam preparation. While not a substitute for clinical mentorship or operative experience, AI tools may support trainees by simulating examiner questioning, reinforcing clinical reasoning, and providing rapid feedback. Further development and surgical-specific refinement are warranted

id #1810

Surgical site infections in local anaesthetic flap/graft procedures: Review of the Hutt experience

Oliver Jensen[1], **Gabriella Marchitelli**[1], **Chris Adams**[1]

1. Plastic, Maxilliofacial and Burns Unit, Hutt Hospital, Lower Hutt, Wellington, New Zealand

Background

Local anaesthetic skin surgery is a cornerstone of the service offered in all NZ PRS units.. Surgical site infections in skin surgery affect patient recovery, increase demand on hospital resources and may require unplanned readmission. Rates vary but between 2-10% is quoted within the worldwide literature 1

Traditionally, worldwide data suggests more complex procedures such as grafts of local flaps conveys an increased risk of infection, although this is most commonly seen in an outpatient dermatological setting

We audited 12 months of patients to determine the risk factors for SSI

Methods

Patient electronic records were retrospectively assessed from April 2023 – April 2024

Hospital codes for those procedures were searched for

Demographic data was collected

Infection was defined as the presence of clinical signs of infection on review and positive wound cultures

Simple statistical analysis was performed on the data collected to determine risk factors associated with infection in our population

Results

556 patients had a Flap/SSG

Mean age 73

60:40 M:F

140 Flaps, 416 Graft

Surgical sites 50% Head/Neck, 30% Lower Limb, 15% Upper limb, 5% Upper limb

56 Patients had an identified SSI

38 graft infections, 18 flap infections

Identified risk factors were lower limb graft, ear graft, smoking, diabetes, age >75

Discussion

We were able to demonstrate that SSI in the Hutt population is at 10% for the 12 months period sampled in this study.

Our small sample size in comparison to larger studies may affect data, but this could be borne out by sampling a longer time period.

Risk factors identified generally followed those seen in worldwide data

Future prospects would be to determine a risk stratification system to determine safe prophylactic antibiotic use.

1. Schlager, et al. 2023, Surgical Site Infection in Skin Surgery – an observational study, International Wound Journal, November 20 (9)

id #1780

First case of nuchal-type fibroma in the hand - Case report

Eric Kim[1], Jeremy Simcock[1]

1. Canterbury DHB, Christchurch, Canterbury, New Zealand

Nuchal-type fibroma (NTF) is a benign fibrous tumour that commonly occurs in the nuchal region such as the posterior neck. It is associated with Gardner syndrome (familial adenomatous polyposis), diabetes mellitus and repetitive blunt trauma [1]. Nuchal-type fibromas can occur in the extra-nuchal sites including the shoulders, face, and buttocks, but has never been reported in the hands. On ultrasound, NTFs can appear as hypoechoic masses, while MRI typically shows low signal intensity on T1-weighted imaging. Histologically, they are strongly CD34-positive and negative for SMA and beta-catenin. In some cases, NTFs contain localised nerve proliferation, similar to post-traumatic neuromas.

We present a first ever case of NTF in a hand in a 32 year-old builder. Nuchal-type fibroma should be considered as a differential diagnosis of hand masses.

1. [1] Enzinger FM, Weiss SW. Benign tumors and tumorlike lesions of fibrous tissue. In: Soft tissue tumors. 2nd edition. St.Louis: C. V. Mosby, 1988:102–35

id #1775

Breast implant associated B-Cell Lymphoma - A rare but growing concern

Jade Lau Young[1], Stuart Johnson[2], Heather Greig[1]

1. Plastic and Reconstructive Surgery, Hutt Hospital, Wellington, NZ

2. Awanui Labs, Wellington, New Zealand

Background

Textured breast implants are well recognised in the development of breast implant-associated anaplastic large cell lymphoma (BIA-ALCL). Further concern around safety has increased with more recent reports of BIA-squamous cell carcinoma(1). This case reports New Zealand's first BIA-EBV positive B-cell lymphoma, captures its clinical and histological features, and supplements the 14 previously reported cases worldwide.

Clinical Case

A 56-year-old woman with previous breast augmentation presented to Plastic Surgery Outpatients clinic with Baker Grade 4 capsular contracture. Her initial augmentation was performed in 2008 with Eurosilicone textured implants. She underwent routine bilateral capsulectomy and implant removal under general anaesthetic. The left side revealed a double capsule but was otherwise unremarkable. The right was thickened but had no other macroscopically suspicious elements. Suction drains were placed in each surgical pocket, and she underwent an uneventful recovery. Histological analysis of her right breast capsule revealed fibrin associated large B-cell lymphoma (FA-LBCL). Immunohistochemistry was positive for CD30, CD20, EBER, MUM1, BCL2 and Ki67. Postoperatively a whole-body PET-CT and an MRI of the right breast were both negative for metastatic disease. She did not require adjuvant chemoradiotherapy but given the rarity of the diagnosis continues clinical surveillance with Medical Oncology.

Discussion

This is the first case of fibrin associated large B-cell lymphoma (FA-LBCL) reported in New Zealand. There are no cases of biopsy-proven FA-LBCL progressing to disseminated disease, and most cases are indolent and resolve with complete removal of the underlying lesion(2). This report adds to the collective understanding of this extremely rare disease.

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id #1784

Missed and mismanaged: The clinical fallout of delayed management of Doxorubicin Port-a-Cath extravasation

Teresa Liew[1], Lisa Davenport [1], John Nguyen[1], Veneshree Nair[2]

1. Plastic and Reconstructive Surgery PHO, Cairns Base Hospital, Cairns North , QLD , Australia

2. Plastic and Reconstructive Surgeon, Cairns Base Hospital , Cairns North , QLD, Australia

Background

Doxorubicin is an anthracycline used in a wide range of anti-cancer regimens including breast cancer. Extravasation in chemotherapy, especially of vesicant cytotoxic drugs such as anthracyclines, is a dreaded complication that should be promptly recognised and managed. It can induce extensive tissue damage, ulceration, and necrosis. Implanted central venous access such as Port-a-Cath is increasingly used in the administration of chemotherapy to minimise risk. However, studies report extravasation rates of up to 4.7%.[1] Within Australia, there are 161 regional hospitals administering chemotherapy.[2] Whilst protocols may include immediate management through infusion cessation, aspiration, and initialising medical management, most do not include guidelines defining failure of conservative therapy, and when to escalate to Plastic Surgery.

Case Report

We present a case of a 69-year-old woman from Atherton on adjuvant chemotherapy for locally advance right breast cancer. Delayed management of doxorubicin extravasation from her Port-a-Cath resulted in extensive tissue necrosis and inflammation. This involved the chest wall and breast parenchyma, with an overlying ulcerated and necrotic non-healing wound present for 9 months post extravasation.

Management

The patient underwent radical debridement 10 months post extravasation. This led to a rapid improvement in wound healing. She was temporarily reconstructed with a split thickness skin graft 2.5 weeks post debridement with good outcome.

Discussion

This case demonstrates a failure in recognition and missed opportunity for early management of Doxorubicin extravasation injury, which could have been mitigated with robust local guidelines and early consultation with surgical specialty. The extent of injury following vesicant extravasation cannot be reliably predicted by the superficial appearance of the wound as demonstrated in the serial clinical photographs provided. There should be a low threshold for treatment, and management should be early and aggressive to prevent extensive tissue damage. Radical debridement to healthy viable tissue is key in cases of delayed management.[3]

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id #1806

A scoping review: Recommended VTE prophylaxis for bilateral breast reduction surgery without concurrent abdominal surgery

Rachael McKinna[1], Jack Gerrard[2], Robert Toma[2]

1. Warrnambool Rural Clinical School, Deakin University School of Medicine, Warrnambool, Victoria, Australia

2. Warrnambool Plastic & Reconstructive Surgery, South West Healthcare, Warrnambool, Victoria, Australia

Background

Venous thromboembolism (VTE) is a significant perioperative complication that must be considered in major surgeries, including breast reduction surgery. Breast mammoplasty, especially as a bilateral procedure, carries a similar risk of VTE to other major surgical procedures due to operative factors, reduced postoperative mobility and patient-specific risk factors. There is limited direction in Australasian guidelines and literature specific to VTE prophylaxis in bilateral breast mammoplasty without concurrent abdominal procedures. This scoping review aims to synthesise existing evidence and recommendations regarding VTE prophylaxis in patients undergoing bilateral breast reduction.

Methods

Due to the paucity of Australasian literature and procedure-specific guidance, this review draws on international studies and Australasian hospital protocols to identify best practices, highlight inconsistencies, and examine gaps in the current literature. A comprehensive database search was conducted using PubMed, Scopus, Google Scholar, and Australasian health databases. Studies included report VTE incidence, associated risk factors, VTE prophylaxis protocols and relevant guidelines for breast surgery.

Results

Findings reveal significant international variation in thromboprophylaxis practices, particularly regarding the duration of pharmaceutical prophylaxis. While international bodies broadly recommend risk stratification tools, mechanical prophylaxis and pharmaceutical prophylaxis for high-risk individuals, no universally accepted approach exists. Australasian VTE prevention guidelines, including those published by state health departments and surgical colleges, primarily offer general surgical recommendations and do not specifically address breast reduction surgery. Consequently, clinical decisions in Australasia often rely on hospital-based protocols or clinician judgement.

Conclusion

This review provides an overview of VTE incidence and risk factors in breast surgery and compares global and local practices in VTE prevention. Discussion also includes general surgical recommendations including perioperative risk assessment, mechanical prophylaxis and pharmacological prophylaxis. Ultimately, this research emphasises the need for Australasian guidelines tailored to breast reduction surgery. Establishing standardised recommendations will support consistent, evidence-based clinical decision-making and improve patient safety and outcomes.

id #1807

Applications of artificial intelligence in postoperative breast reconstruction:

A scoping review

Rachael McKinna[1], Jack Gerrard[2], Robert Toma[2]

1. Warrnambool Rural Clinical School, Deakin University School of Medicine, Warrnambool, Victoria, Australia

2. Warrnambool Plastic & Reconstructive Surgery, South West Healthcare, Warrnambool, Victoria, Australia

Background

Artificial intelligence (AI) is the simulation of human intelligence by machines and encompasses machine learning (ML), artificial neural networks (ANNs), and natural language processing (NLP). These enable machines to learn data, recognise patterns and analyse large volumes of clinical text. AI is becoming increasingly integrated into plastic surgery. In breast reconstruction, AI is developing rapidly and transforming postoperative care. Clinicians and institutions can benefit from employing AI through improved efficiency, enhanced clinical accuracy and improved patient outcomes. This review explores the current state of AI applications in postoperative breast reconstruction, including its use in predicting surgical complications, enhancing imaging interpretation, optimising follow-up care and guiding clinical decisions.

Methods

This scoping review was conducted using a comprehensive search of PubMed, Google Scholar and Web of Science. Studies were selected based on their focus on AI-driven models in postoperative breast reconstruction.

Results

AI-driven models have demonstrated strong performance in predicting postoperative breast reconstruction complications, outperforming traditional risk assessment methods. These predictive models stratify patient risk and tailor postoperative care, potentially reducing hospital stays and improving outcomes. AI enhances postoperative imaging by distinguishing normal healing from early pathology. AI subsets have been used to extract valuable insights from electronic health records, and predictive analytics can guide personalised patient follow-up care.

Nonetheless, utilisation of AI presents challenges including limited prospective validation, data security concerns, algorithm bias and lack of standardised datasets. Real-world implementation and ethical integration into clinical workflows are crucial next steps to ensure the effectiveness and safety of AI in clinical practice.

Conclusion

AI can enhance postoperative breast reconstruction by improving predictive accuracy, imaging interpretation and personalised follow-up care. However, wider implementation requires addressing challenges including validation, data security, and ethical integration to ensure safe and effective adoption in clinical practice.

id #1793

Where does Matriderm fit in the reconstructive ladder?

Lydia LP Park[1], Richard RWS Wong She [1]

1. Middlemore Hospital, Westmere, Auckland, New Zealand

Background

Matriderm is a single-layer dermal substitute composed of bovine collagen and elastin hydrolysate (1). One of the main advantages of Matriderm is the immediate ability to apply split thickness skin graft as a single staged procedure and the theoretical advantage of less contracture given the elastin component. However, there is still uncertainty regarding indications for Matriderm use. We wanted to look at Middlemore Hospital's experience with use of Matriderm and determine which clinical scenarios are appropriate for its application.

Method

A retrospective study was carried out looking at all patients who obtained a soft tissue reconstruction with Matriderm since its introduction at Middlemore Hospital in December 2017. This included 22 patients over a seven-year period.

Results

Matriderm was used for secondary burn reconstruction (48%), donor site reconstruction post flap harvest (19%), post malignancy reconstruction (14%), traumatic wound reconstruction (10%) and defects secondary to infection (10%). Most cases were done as single stage procedure (62%). Thickness of Matriderm used was 1mm in 75% and 2mm in 19%.

Conclusion

Matriderm seems to be used mainly for secondary burn reconstruction at Middlemore Hospital but there was a wide range of indications for its use. The advantages has been the ability to use it as a single stage procedure and easy contouring of dermal substitute. Also, Matriderm was applied to a small number of non-vascularised wound beds and found to successfully integrate in these patients. Although a larger prospective study will be required to assess this in further detail, this gives an idea as to where the Matriderm fits in the reconstructive ladder.

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id #1762

Implications of GLP-1 agonists in plastic and reconstructive surgery – a literature review

Priyal Patel[1], Jessica Vlok[2]

1. Surgery, CDHB, Christchurch, New Zealand

2. Plastic Surgery, CDHB, Christchurch, New Zealand

Background

Glucagon-like peptide-1 (GLP-1) agonists are medications that mimic the action of GLP-1, a hormone involved in the regulation of glucose homeostasis and appetite.[1] These agents are increasingly utilised in the management of type-2 diabetes and obesity, with growing relevance for surgical practice following Medsafe approval.[1]

Aim

This review will provide an overview of the plastic surgical and perioperative considerations related to

the use of GLP-1 agonists.

Method

A literature search was performed using PubMed and ClinicalKey medical databases.

Findings

Current literature on the impact of GLP-1 agonists on wound healing is limited and somewhat conflicting. Nevertheless, improved glycaemic control and cardioprotective effects may indirectly enhance surgical outcomes through reduced inflammation and enhanced vascular function. Additionally, evidence suggests that these agents may improve flap viability via autophagy and the inhibition of oxidative stress.[2] However, there is a theoretical risk of malnutrition and sarcopenia due to weight loss, which may impair wound healing.[1]

The phenomenon of "Ozempic face," characterised by facial aging from reduced fat deposits and skin composition changes, is emerging as a concern in facial plastic surgery.[2] It is relevant to highlight these side effects and the potential impaired skin barrier function.

GLP-1 agonists can facilitate preoperative weight loss, potentially allowing for higher BMI thresholds for surgery at time of referral. It is essential to ensure that patients maintain a stable weight by the time of surgery, with consideration given to possible weight gain if the medication is discontinued.[2]

Due to delayed gastric emptying and the associated risk of aspiration, the American Society of Anesthesiologists recommends withholding daily-dosed GLP-1 medications on the day of surgery and weekly dosed agents one week prior.[2]

Conclusion

GLP-1 agonists offer potential benefits in optimising postoperative outcomes but further research is needed to fully define their perioperative role in plastic surgery.

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id #1797

Mallet thumbs: A review of management outcomes

Nikita Quinn[1], Emma Littlehales[2], Allen Cockfield[1]

1. Te Whatu Ora, Canterbury , Christchurch , New Zealand

2. Te Whatu Ora Counties Manakau , Auckland

Introduction

While mallet finger is a relatively common hand injury, mallet thumb is a much rarer occurrence, accounting for only 2-3% of all mallet injuries.1 Literature assessing the management and subsequent outcomes of mallet thumb is limited, and little consensus exists as to the optimal treatment of this condition. Both conservative and surgical approaches have been utilised, with a range of techniques within each approach. When managed conservatively, both immobilisation of just the IPJ, as well as hand based splints are employed. Similarly, a range of surgical techniques have been described.1-2

Method

This is a review of the management and outcomes of all non-bony mallet thumbs treated at Waitaha Canterbury over 5 years (January 2019 - December 2024). Patient demographics, mechanism of injury, management technique, complications and functional outcomes were reviewed.

Results

Provisionally 5 cases have been identified (final results to be confirmed), with 2 cases managed operatively and 3 non-operatively. All patients treated non-operatively were managed in a mallet splint with immobilisation of the IPJ only. Both patients treated operatively were managed with a suture repair to remnant tendon distally, at a range of 1-7 days post injury. Range of movement outcomes were similar between all patients, with intact extensor mechanisms

Conclusion

Mallet thumb is a rare clinical entity with little consensus as to the best management approach. This study suggests that non operative management is effective and immobilisation of the IPJ alone is sufficient.

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id #1798

A rare case of neglected BCC with pulmonary metastasis

Nikita Quinn[1], Andrew Davidson[1]

1. Te Whatu Ora, Canterbury , Christchurch , New Zealand

Purpose

While basal cell carcinoma (BCC) is a commonly diagnosed skin cancer, rates of metastasis are estimated to be as low as 0.0028 to 0.55%.[1] Although rare, certain factors such as large tumour size and aggressive histological subtype are known to harbour increased risk.[1] We present a case of a large, neglected BCC with pulmonary metastasis at time of presentation.

Method

A 51 year old male presented with a large, ulcerated axillary mass that had been present for several months. Biopsy showed a poorly differentiated carcinoma, favoured to be BCC. Staging imaging demonstrated extensive local invasion as well as a spiculated lung mass (with histology confirming metastasis). His previous medical history included a BCC excised from the left scapula 12 years prior, as well as a lifelong history of smoking.

Results

The patient proceeded to surgery for wide local excision, axillary dissection and ALT free flap reconstruction. Both the long thoracic nerve and thoracodorsal neurovascular bundle were encased in tumour and required to be sacrificed. A left lung upper lobectomy was performed by Cardiothoracics. At time of writing (two years later), the patient remains well with no evidence of disease recurrence.

Conclusion

While metastatic BCC is rare, it is important to remain aware of it as a possibility, particularly in BCC's with high risk features. Early recognition and appropriate management is essential to improving outcomes.[2]

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id #1777

Septic arthritis and secondary necrotising fasciitis in an infant:a novel case requiring free flap reconstruction

Kristy Toy[1], Andrew Davidson[1]

1. Plastic Surgery, Health NZ - Te Whatu Ora, Christchurch

Septic arthritis is estimated to affect 4-37 in 100,000 children with the knee being the most affected joint (1), and Staphylococcus aureus the most common causative bacteria.

There are minimal case reports published on septic arthritis progressing to a necrotising infection, let alone in a paediatric case.

We present an unusual case of an 8 month old girl, who was diagnosed with necrotising fasciitis secondary to untreated septic arthritis of her ankle, requiring debridement and free flap reconstruction.

She initially presented with an acutely swollen right lower limb and was admitted due to the concern for non-accidental injury to her foot and ankle. On subsequent reviews she was noted to have cellulitis of her foot and ankle, and was commenced on intravenous antibiotics.

An MRI performed on the day of presentation reported findings suspicious for septic arthritis, myositis and fasciitis. She proceeded to theatre for a surgical debridement of the septic ankle joint and surrounding necrotising fasciitis. Staphylococcus aureus was found to be the causative agent and following six surgical debridements the patient underwent a free latisimmus dorsi flap and skin graft for soft tissue coverage of the open ankle joint and surrounding soft tissue defect. There were technical challenges encountered during the reconstruction procedure including vasospasm of the pedicle and the presence of significant fibrosis.

This case not only highlights the possibility of septic arthritis progressing to necrotising infections, but also the difficulties in performing a free flap reconstruction in an infant.

id #1787

Microbiology and surgical treatment of native joint septic arthritis of the

hand

Sara Uhrle[1], Lauren Whearty[2], Stephen McBride[1], Michelle Locke[1]

1. Middlemore, Auckland, New Zealand

2. ADHB, Auckland

Introduction

Native joint septic arthritis (NJSA) of the hand is a seldom studied disease, with data often extrapolated from studies involving large joints (1). Middlemore's catchment has been shown to have a high average incidence of NJSA at 21/1000 Person years (1). To gain further understanding of the microbiology and surgical treatment of NJSA of the hands, a data set from McBride et al (2020) was combined with an updated data set from 2016-2020.

Methods

A retrospective coding based study replicated methods used for McBride et al. (1). The time period was from 1 July 2016 to 31st June 2020. Those patients <16 years old and admitted for <24 hours were excluded.

Results

The combined dataset had a total of 447 patients with NJSA of the hand Including, Metacarpophalangeal (MCP, N=160) and Hand inter phalangeal joints (Hand IP, N=202) and the wrist (N=85).

Of those admitted for hand NJSA 92% of IP, 89% MCP and 82% of wrist infection went on to have open washouts. The mean number of washouts for MCP joints was 1.2 and Hand IP 1.26.

Causative organisms were isolated in 85%, the most common was *Staphylococcus aureus* (wrist 42%, MCP 44% and hand IP 63%) and *Streptococcus pyogenes* (wrist 17%, MCP 17% and hand IP 19%). Other streptococci and Eikenella species were the next most common causative agents. Patients requiring 2 or more washouts for clearance showed similar microbiology with *S. aureus* and streptococci being most common.

Conclusion

This dataset gives a well-rounded view of NJSA admission for hands. The most common organisms isolated are *S. aureus* and *S. pyogenes*. This highlights a difference between microbiology of large and SJSA, showcasing the need for further research into the topic.

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id #1776

Abstracts to articles: Examining the publication of presentations at NZAPS ASM

Daniel Wen[1], Hyok Jun Kwon[1]

1. Te Whatu Ora Counties Manukau, New Zealand

Background

The New Zealand Association of Plastic Surgeons (NZAPS) hosts an annual scientific meeting (ASM)

to bring clinicians and researchers together to discuss the latest advancements in plastic surgery and showcase the results of up-to-date research through podium and poster presentations. However, it is unclear if these presentations ultimately achieve publication into a peer-reviewed journal. This study aimed to identify the proportion of conference abstracts which are successfully converted to formal journal articles and specifically investigating the effect of variables such as the presenter's training level and country of origin, presentation type and topic, and time to publication.

Methods

NZAPS ASM conference programs from 2016 to 2021 were reviewed to identify all research presentations. Desired information was extracted such as presentation type, presenting author, the presentation sub-specialty topic and presenting author country of origin.

Results

Out of the 252 abstracts, 24.6% of abstracts had an associated publication with a statistically significant variation depending on the training level of the presenter. Out of the 62 published abstracts, 33.9% were published prior to conference presentation. Accounting for this, the true conversion rate of abstracts to publication after conference presentation was 16.3%.

Conclusion

Abstracts presented at the NZAPS ASM have a modest publication and conversion rate after presentation. The multi-ethnic populations in Australia and New Zealand produce studies that may not be directly applicable to overseas populations; however, this underscores the importance of establishing and maintaining regional journals to facilitate the publication of local research.

id #1802

Incidental finding of an exceedingly rare tumour at sentinel lymph node biopsy

Tea Williams[1], **David Morgan Jones** [2]

1. Hutt Hospital , Lower Hutt, New Zealand

2. Middlemore Hospital, Auckland

Lymphoepithelioma-like carcinoma of the skin (LELCS) is an exceedingly rare tumour with similar morphologic and pathologic features to nasopharyngeal carcinoma. Metastatic potential is low with only 6 cases reported in the English literature. Incidental identification of non-melanoma neoplasms at sentinel lymph node biopsy (SLNB) is a rare but reported phenomenon with incidence estimated at 1%. We present a case of a 66-year-old male presenting for left arm melanoma wide local excision and axillary SLNB. His history included LELCS of the left hand widely excised one year prior. SLNB was negative for melanoma but revealed 3 clinically occult nodes positive for LELCS. The patient received adjuvant axillary radiotherapy and remains in remission. This case adds to the current literature for this rare tumour and highlights the possibility for incidental findings at SLNB, a procedure frequently performed by Plastic Surgeons.

id #1790

Paediatric craniofacial reconstruction following frontal sinus tumour resection: A case of Juvenile Psammomatoid Ossifying Fibroma

Harry Wu[2, 1], Jonathan Wheeler[1]

1. Paediatric Plastic Surgery, Starship Children's Health, Auckland, New Zealand

2. Paediatric Otolaryngology, Starship Children's Health, Auckland, New Zealand

Background

Juvenile psammomatoid ossifying fibroma (JPOF) is a benign yet locally aggressive fibro-osseous lesion of the craniofacial skeleton. Complete excision with thoughtful reconstruction is essential to minimise recurrence and preserve aesthetics in the growing skull.

Case

A 14-year-old boy presented with persistent conductive hearing loss, tinnitus, and recurrent otitis media after rugby trauma. MRI obtained during the otological work-up incidentally demonstrated a 21 × 25 × 29 mm expansile mass in the left frontal sinus extending into the ethmoid sinus. Endoscopic biopsy confirmed JPOF.

Multidisciplinary Planning

The case was reviewed at the National Sarcoma Multidisciplinary Meeting, which recommended radical excision via open craniofacial approach followed by immediate autologous reconstruction to achieve clear margins and restore frontal contour.

Surgical Technique

In conjunction with the neurosurgery service a immediate resection and reconstruction was planned. Through a bicoronal incision, a frontal craniotomy was performed. The tumour was excised en bloc, and the frontal and ethmoid sinuses were cranialised. Immediate reconstruction employed an autologous bone flap harvested from the contralateral medial orbital wall, achieving single-stage restoration of the anterior cranial fossa and forehead contour.

Outcome

Post-operative recovery was uneventful. The patient was discharged post op day 5. Three-month MRI demonstrated no residual or recurrent disease, and the patient achieved an excellent aesthetic result without functional deficits. Annual imaging surveillance has been instituted.

Conclusion

This case underscores the importance of multidisciplinary planning in JPOF, enabling a one-stage strategy that combines oncologic clearance with autologous craniofacial reconstruction. Early collaboration among ORL, neurosurgical, and plastic-surgical teams optimises both disease control and aesthetic outcomes in adolescent patients.

id #1791

Not just a haematoma: Persistent paediatric facial swelling leading to surgical removal of foreign bodies

Harry Wu[1, 2], Jonathan Wheeler[2], Sophia Haeussler[1], Craig McCaffer[1]

1. Paediatric Otolaryngology, Starship Children's Health, Auckland, New Zealand

2. Paediatric Plastic Surgery, Starship Children's Health, Auckland, New Zealand

Paediatric facial trauma without obvious external signs can conceal serious underlying pathology, including chronic infections and retained foreign bodies. This case highlights the diagnostic challenges of occult injuries and the critical role of advanced imaging in both diagnosis and intraoperative planning.

Case Description

A four-year-old boy fell into a flower bed in March 2024, appearing to sustain only a minor facial injury without skin breach. He developed left zygomatic swelling and was admitted under Paediatric Surgery with a presumed infected hematoma. Oral Augmentin was prescribed, and he was discharged. Recurrent swelling occurred in April and May, managed in the community with repeated antibiotics.

In July, the patient presented with left periorbital swelling and was referred to ENT following ophthalmology review. CT imaging in August and MRI in September revealed chronic osteomyelitis of the left zygoma and arch, extensive inflammatory changes in the temporal and infratemporal fossa, and two areas of non-enhancement suggesting retained foreign bodies.

Surgical exploration in September confirmed the presence of multiple foreign bodies within the left temporal fossa and orbital rim, surrounded by inflamed tissue and periosteitis. The presumed trajectory suggested intraoral penetration with migration to the infratemporal region. Intraoperative ultrasound facilitated foreign body localization and removal. Postoperatively, the patient was treated with a six-week course of antibiotics in coordination with the Infectious Diseases team.

Discussion

This case emphasizes the potential for retained foreign bodies and delayed infection following seemingly minor facial trauma. The absence of an entry wound can obscure diagnosis, highlighting the importance of repeat imaging and multidisciplinary assessment. Timely surgical intervention, supported by intraoperative imaging, was critical to source control and resolution.

Conclusion

Occult paediatric facial trauma can result in significant morbidity. Persistent or recurrent swelling warrants escalation and imaging. Early surgical intervention remains key in managing retained foreign bodies and associated infection.

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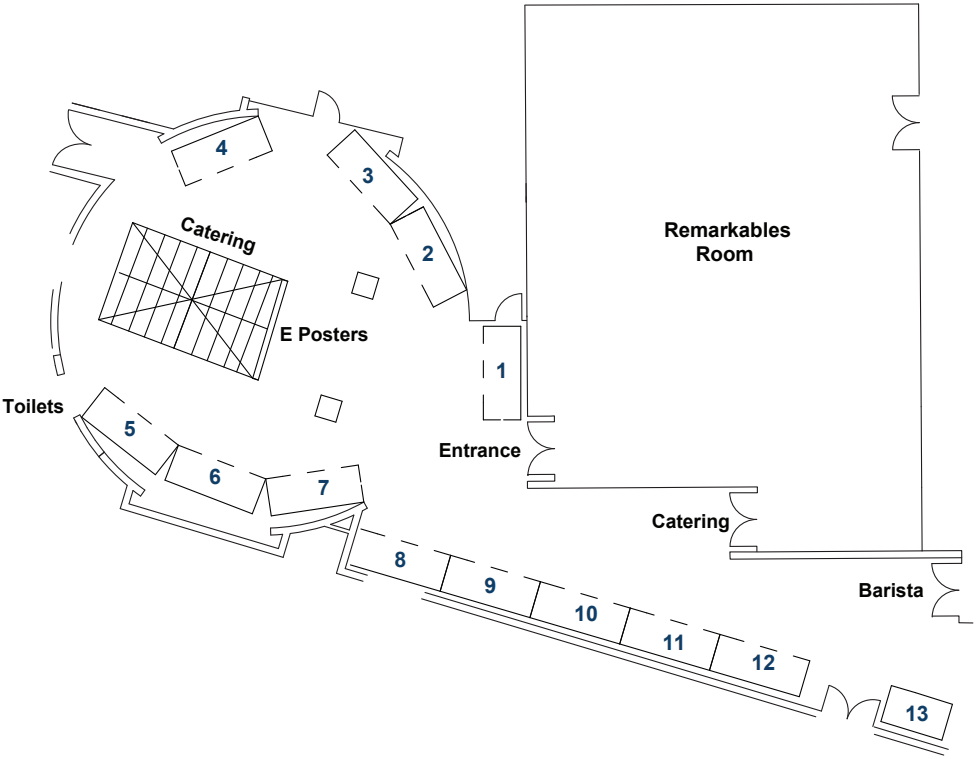
+64 9 590 3962
carmen.maran@mercyships.org.nz
mercyships.org.nz

- Help provide free, life-changing surgeries from our ships
- Serve patients with cleft lips, burn contractures & more
- Volunteer for 2+ weeks, depending on role
- Free return airfares to Africa, food and board for surgeons & nurses

ASM / Trade Exhibition Floorplan Level 1



KEY

1 SheffMed
2 LifeHealthcare
3 BTL NZ
4 Microsurgical Specialties
5 NZAPS
6 ICIB Financial Independence
7 Polynovo
8 DBM Medical
9 **Registration/Information**
10 Device Technologies
11 Focusplan
12 Evolution Healthcare
13 Mercy Ships New Zealand