Consent Form- Bilateral Breasts Mastopexies.

Surgical Incisions:

Around the areola, vertically downward and including the level of the fold in the region where the Bra wire sits. An Anchor shaped extensive scar.

I_____; request and authorise: Ali Juma to perform a **Bilateral Breasts Mastopexies.** The nature and effects of the procedure, the risks, ramifications, complications involved, as well as alternative methods of treatment have been fully explained to me by Mr. Juma and I fully understand them. I have also been given the opportunity to ask questions for which the answers have been clear. During the pre surgical consultations, with the appropriate cooling off period; I have been thoroughly and completely advised regarding the objectives of the procedure. I am also aware that to do nothing was also an option to consider.

Because I understand that the practice of medicine and surgery is not an exact science, hence, no results have been guaranteed. I acknowledge that visible imperfections might ensue and that the operative result may not live up to my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) I have requested and authorised. I understand that, in the case were significant imperfection results secondary to clinical complications, and I, the patient, and the doctor determine the necessity of a secondary procedure, any revisional surgery will incur further hospital and anaesthetic costs.

I understand that the possible adverse effects may include bleeding leading to a collection of blood warranting a return to theatre, infection of variable severity, Keloid/hypertrophic scarring which will mar the cosmetic outcome and are symptomatic, skin contour irregularities, seroma, chronic seroma, visible asymmetry, chronic pain, nipple height mismatch, surgical shock, deep vein thrombosis, pulmonary complications and in rare occasions life threatening complication, allergic reaction and anaesthesia related complications can occur and should be discussed and understood.

If asymmetry was present prior to the surgery, this is likely to continue after the surgery to varying degree even though every effort would have been made to improve it. This was discussed at the pre-operative consultations. The breasts will descend and will not stay at the same level they were in the first 3 months following the surgery. You will still need to wear a bra as was discussed before the surgery unless you feel you do not need to. In some patients pain following the surgery can persist and can become chronic so can the swelling.

I also fully understand that neither the breast cup/ size nor the cleavage size, shape, or the symmetry could be guaranteed in any way nor this was made clear during the pre-surgery consultations. Breasts size could alter following this surgery, however, no cup could be guaranteed, which was discussed. Numbness of the breasts skin and nipples is expected after this surgery, in some cases the sensation may return to the nipples. Breast-feeding ability is unlikely to happen after this procedure. Pain control on the ward, and at home with painkillers, however please refrain from using products like Aspirin, Brufen, Voltoral, Ponstan (Mefenamic Acid), or similar tables, a group known as NSAID.

I understand that the fullness of the breasts in the upper poles cannot be guaranteed and is likely to warrant further management with either staged fat transfer and/or silicone breasts implants which was discussed in the pre surgery consultations.

Other risk and potential complications include the loss of the skin of the nipple areola complex, and/or the skin envelope elsewhere. This will mean a longer recovery period with repeat dressings and possibly further surgical interventions. Painful lumps may appear after surgery known as fat necrosis. This latter process in a large number of patients is self-limiting but may take a number of months to resolve, and can become chronic.

Fullness in the breasts in the cleavage area and/or the outer aspect may, on rare occasions, need to be adjusted if not resolved after nearly one year, this swelling may be called “dog ears”. Swelling is expected after this surgery, which will take up to three months to settle, but in some individuals it may take much longer. This has been explained to me and I understand the explanation fully.

I understand the importance of pre-treatment and post-treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I recognise that during the course of the operation unforeseen conditions may necessitate additional or different procedures other than those above. I therefore further authorise and request the above named surgeon, to perform the procedures that are in his professional judgment necessary and desirable.

Photographs will be taken of the region of treatment, before and after the surgery, on occasions also during the treatment. I give my permission for these photographs to be used for the purposes of professional publications, training, educational or sales purposes. If I do not agree to being photographed, it will in no way affect my present or future care.

I agree to have photographs taken YES___, No___

I agree to allow the use of these photographs for:

Scientific publication and presentations, Yes___, No___

Informative talks, Yes___, No___,

Internet publication Yes___, No___

I agree to have Video recordings taken YES___, No___

I agree to allow the use of these Video recordings for:

Scientific publication and presentations, Yes___, No___

Informative talks, Yes___, No___,

Internet publication Yes___, No___

I certify that I have read the above authorisation, that the explanations referred to therein were made to my satisfaction, and that I fully understand such explanations and the above authorisation.

Patient Name: _____

Patient Signed: _____

Date: _____

Surgeon: _____

Date _____