Is Reoperation Rate a Valid Statistic in Cosmetic Surgery?

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"Beauty in things exists merely in the mind which contemplates them."

—David Hume

Reoperation rates are being introduced into the plastic surgery literature and marketing as a basis for judging the effectiveness of a surgical procedure, the safety of an implantable device, and even the quality of an individual surgeon. They may have value in some medical procedures where results and complications are purely objective, but in cosmetic surgery, there is a subjective component to the indication for secondary surgery that can affect reoperation rates.

In cosmetic surgery, there are two primary indications for secondary surgery. First, as in all surgery, there is the occurrence of a true, recognized complication, such as a hematoma or an infection. These complications are generally irrefutable and a second operation is usually mandatory. Although complications such as these can happen even with the best care, a high reoperation rate due to complications is an objective measure that a problem exists.

Second, there are indications for reoperation that are subjective in nature, and whether a particular patient ever has a secondary surgery can be affected by a variety of factors. As the old saying goes, "beauty is in the eyes of the beholder," and this, too, is true for the aesthetic quality of a surgical result. We have all experienced the postliposuction patient who wants a little more fat removed or a breast augmentation patient who wants to be a little bigger. These are subjective aesthetic issues that may or may not lead to reoperation, based on a variety of factors. First, the surgeon must agree with the patient's concerns, believe that secondary surgery can improve the result, and be willing to reoperate. While one surgeon may have a higher rate of secondary surgery simply by trying to attain a more perfect result, another may choose to avoid reoperations.

Patients may be discouraged from revisional surgery in other ways. For example, a surgeon's financial policy that makes reoperation costly may prevent the patient from having a revision (at least with that surgeon). Insurance companies have clearly demonstrated the effectiveness of financial disincentives in the use of copayments and deductibles. The surgeon may also dissuade the patient by overemphasizing the risks of reoperation. We all know the influence we, as physicians, can have in patients' decision making.

In addition, there are some complications that may have subjective indications for reoperation. Capsular contracture is the perfect example. A patient may have firm breasts, but her breasts might maintain an attractive appearance. The patient may complain about the firmness, and the surgeon may choose to address it surgically or may advise the patient to avoid surgery. If the patient does not undergo corrective surgery, the reoperation rate will not reflect this complication, despite its presence.

In cosmetic surgery, the aesthetic success of a procedure is subjective, and thus the indications to revise that surgery for cosmetic reasons are also subjective. The existence of an indication for secondary surgery only translates to a "reoperation" if the patient undergoes surgery. Reoperation rates may be artificially high or low based on a surgeon's assessment of the result, practice policy, and personal philosophy. Therefore, comparing reoperation rates for cosmetic procedures is not a valid analysis of the safety or efficacy of an operation, device, or surgeon.

Received for publication December 14, 2006.

DOI: 10.1097/01.prs.0000267635.38892.1d

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