

Collaboration-The Key to Meaningful Plastic Surgery Research

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Editorial

Does the use of post-operative antibiotics decrease the risk of infections in implant-based breast reconstruction? Does the use of acellular dermal matrix increase the risk of infections? Does every patient undergoing a cosmetic abdominoplasty need venous thromboembolism chemoprophylaxis? The list goes on. We still don't have a good answer to many important clinical questions in plastic surgery because we don't have convincing data that categorically answers them. Our literature is full of low powered (aka weak) studies that many times conclude diametrically opposing arguments (the examples in the introductory sentences being some of them) [1-6]. The data we base our clinical judgment on is influenced by our own biases and experiences, and also on how we were trained. But is that the correct way of doing things? Though many of us strive to be 'evidence-based', it's hard to live up to those standards when the 'evidence' is not clear, well documented, or frankly, even present. This is especially true for many clinical scenarios in plastic surgery. Though our field has made a concerted effort to move in this direction, the reality is that this lack of actionable research is obvious and this, in my opinion, is a real problem.

How can we fix this issue? Unfortunately, it's not an easy issue to fix. Plastic surgery is a, relatively speaking, small field. Randomized, controlled trials with high power are difficult to conduct in institutions where a division of 5-10 surgeons is considered large. Garnering financial support in an ever-tightening economy is similarly a great hindrance to high quality research. Being a surgical field where most of the plastic surgeons go into private or small group practices, is yet another barrier, where, understandably, the conduction of meaningful, actionable research is not a high priority.

Despite these realities, I still feel the conduction of impactful, high quality, clinical practice changing, Level 1 research is possible in plastic surgery. The key to this success is collaboration. We have to stop practicing our research in institutional silos, and start becoming one large 'national institution'. Beyond that, we should aim for global initiatives that forge

international collaborations on a regular basis rather than the occasional effort we hear about. What is needed is a concerted effort to bring everyone, large and small institutions, private and academic practices, under one goal-oriented research 'tent', which would enable us as a plastic surgery community to answer key clinical questions. Our societies must make this a priority and help garner the support needed for this to become a reality. Our print and on-line publications should demand this, and set an expectation that collaborative research will be preferentially published. Collectively, our research will be stronger, financially sustainable, and impactful.

References

1. Winocour S, Martinez-Jorge J, Habermann E, Thomsen K, Lemaine V. (2015) Early Surgical Site Infection Following Tissue Expander Breast Reconstruction with or without Acellular Dermal Matrix: National Benchmarking Using National Surgical Quality Improvement Program. Arch Plast Surg. 42: 194-200.
2. Ibrahim AM, Shuster M, Koolen PG, Kim K, Taghinia AH, Sinno HH, Lee BT, Lin SJ. (2013) Analysis of the National Surgical Quality Improvement Program database in 19,100 patients undergoing implant-based breast reconstruction: complication rates with acellular dermal matrix. Plast Reconstr Surg. 132: 1057-66.
3. Townley WA, Baluch N, Bagher S, Maass SW, O'Neill A, Zhong T, Hofer SO. (2015) A single pre-operative antibiotic dose is as effective as continued antibiotic prophylaxis in implant-based breast reconstruction: A matched cohort study. J Plast Reconstr Aesthet Surg. 68: 673-8.
4. Clayton JL, Bazakas A, Lee CN, Hultman CS, Halvorson EG. (2012) Once is not enough: withholding postoperative prophylactic antibiotics in prosthetic breast reconstruction is associated with an increased risk of infection. Plast Reconstr Surg. 130: 495-502.
5. Somogyi RB1, Ahmad J, Shih JG, Lista F. (2012) Venous thromboembolism in abdominoplasty: a comprehensive approach to lower procedural risk. Aesthet Surg J. 32: 322-9.
6. Young VL, Watson ME. (2006) The need for venous thromboembolism (VTE) prophylaxis in plastic surgery. Aesthet Surg J. 26: 157-75.