May 9, 2025

The University Club of Toronto
380 University Avenue, Toronto, Ontario M5G 1R6
8:00 a.m. – 3:00 p.m.

Surgery
UNIVERSITY OF TORONTO

The

Division of Plastic, Reconstructive & Aesthetic Surgery

University of Toronto

Welcomes

Richard A. Hopper, MD, MS
Medical Director, Plastic Surgery, Austin Campus, Samuel Stal MD Endowed Chair and Professor of Surgery, Division of Plastic & Reconstructive Surgery, Michael E. DeBakey Department of Surgery, Baylor College of Medicine.

HOYLE CAMPBELL
VISITING PROFESSOR

May 8-9, 2025

Richard A. Hopper, MD, MS

Dr. Richard Hopper is the Samuel Stal Endowed Chair of Plastic Surgery and Professor with tenure at Baylor College of Medicine, USA. He is the Medical Director of Plastic Surgery at the new Texas Children's Hospital in Austin, Texas.

For the past 22 years he practiced at the University of Washington in Seattle where he was the Marlys C. Larson Chair in Pediatric Craniofacial Surgery and Chief of the Division of Plastic Surgery at Seattle Children's Hospital. Dr. Hopper completed his plastic surgery residency training in Toronto, Canada and his craniofacial fellowship at New York University, under Dr. Joseph McCarthy. His clinical practice in Austin focuses on sub-cranial distraction procedures for complex upper airway obstruction with a general interest in all surgical treatments of craniosynostosis, cleft Q lip and palate. His research interests include image-based outcome studies for craniosynostosis and complex craniofacial procedures as well as device design for cleft Q and craniofacial care. Dr. Hopper is the Immediate Past - President of the International Society of Craniofacial Surgery and past President of the American Society of Craniofacial Surgery. He serves on the Global Medical Advisory Board for Smile Train International.

We would like to thank all of our sponsors for their generous support of our Division of Plastic, Reconstructive & Aesthetic Surgery Research Day

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Contents

Dr. H. Hoyle Campbell
1915 - 1998

Dr. Campbell was born in Toronto. After attending the University of Toronto Schools, he entered the University of Toronto medical school, concealing the fact that he was only 16. Despite this being discovered, he was allowed to continue, and he graduated with his M.D. in 1936 at age 21. Due to his age, he could not get a position in Toronto, so he worked for some time as a locum tenens in Muskoka and in Bala, Ontario. He also spent a considerable period studying anatomy and physiology at the Banting Institute. During his years as a practicing surgeon, his knowledge of surgical anatomy was legendary.

After first considering going into pathology, he entered general surgical training. He was immediately appalled by the mutilating procedures with horrendous healing problems, equally horrendous scarring, and loss of function he encountered daily. This inspired him to pursue a career in plastic surgery. He started his training in Toronto with Dr. A. W. Farmer, Canada's second plastic surgeon, and then went on to work with the famous Dr. Robert Ivy in Philadelphia.

When WWII began, he was still in Philadelphia. He was shocked by American isolationism and resolved to return to Canada to join the armed forces. On his return, he found that there was little action taking place, and that if he wanted to really do something positive, it was necessary to do it on one's own. So he and his wife Ruth set off for England as passengers on a leaky old cattle boat and experienced a very rough passage during which Mrs. Campbell suffered a fractured nose when the ship was in a storm. On his arrival, he joined the Emergency Medical Services and had many adventures with them, while he became a first-class trauma surgeon. His wife went into war work as well.

When the Canadian forces arrived in England, he transferred to the Royal Canadian Army Medical Corps. He spent the remainder of the war with them, treating many complex wounds and devising new treatment methods. For instance, he was doing toe-to-thumb transfers in 1944! He was a member of the elite army plastic surgery team at Basingstoke, U.K., which included Dr. Stuart Gordon, Canada's third plastic surgeon.

At war's end, he returned to Toronto and, after working at Toronto General Hospital and Wellesley Hospital, established the plastic surgery service at St. Michael's Hospital, where he served for many years.

He quickly established a reputation as an innovator and a fine teacher. He had the ability to see through superficialities and get to the root of a problem. His theories on muscle co-ordination in the face and back were his favourite topics.

He was known for his many 'Hoylisms.' To name a few, "do what you know first," "always save something to sew to," "always remember the muscle balance."

He practiced spinal manipulation on his patients with considerable skill and success, and all of his residents were required to learn the technique. He not infrequently practiced hypnotism as well.

He saw very early that many of the surgical procedures done in hospitals did not necessarily require full hospital facilities. With this thought in mind he established the Institute of Traumatic Plastic Restorative Surgery in Toronto in 1956, where he performed surgery on an outpatient basis that had formerly been done only in hospital. This was truly radical thinking at that time. This new establishment was the precursor of the many such facilities we see today.

Dr. Campbell was not a large man, but he was possessed of considerable courage. On one occasion, he talked a suicidal army veteran into peacefully surrendering a loaded shotgun, and on another, single-handedly disarmed and subdued a violent patient who was threatening to kill him with a crossbow, which he had aimed at his head. The latter event occurred when he was 72 years old!

Dr. Campbell was associated with Branson, Humber, Peel Memorial, Doctors and Central Hospitals as well as St. Michael's. He was a consultant to the government of Costa Rica on health planning.

He was also a highly successful cattle farmer and operated a large and efficient dairy farm north of Toronto.

He was one of the twelve founders of the Canadian Society of Plastic Surgery in 1947, and its eleventh president.

Dr. Campbell died in 1998.

While in medical school, he had been a member of the Tau Omicron chapter of Phi Chi fraternity. When the chapter closed, the remaining chapter funds were given to Dr. Campbell in trust. He invested the money and, like all of his ventures, the result was a profitable one. He turned the funds over to the University of Toronto in 1982 to

establish the Tau Omicron Phi Chi Visiting Professorship and the Hoyle Campbell Lectureship.

Dr. Campbell was one of the most innovative, visionary and skilled surgeons, as well as one of the most charismatic ones in the history of Canadian plastic surgery. He was always happiest when he was teaching and working with young surgeons. It is thus most appropriate that his name lives on in association with this professorship.

Dr. Campbell manifested an irrepressible enthusiasm, and met every aspect of life as a welcome challenge. His attitude is well expressed in these few lines of Eastern philosophy by the sixth century poet Kalidasa, which he often quoted:

Look to this day, for it is life.
In its brief course lie all the verities
And realities of our existence.
The bliss of growth, the glory of action and
The splendour of beauty,
For yesterday is but a dream and tomorrow
Is only a vision
But today, well lived, makes every yesterday
A dream of happiness
And every tomorrow a vision of hope.
Look well, therefore, to this day.

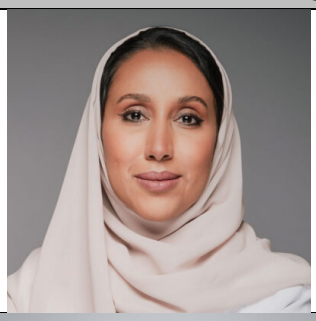
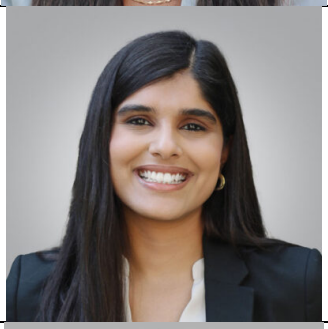
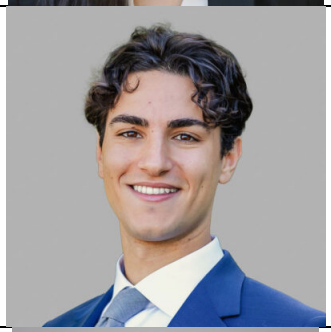
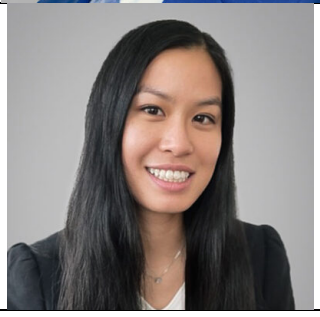
Leith G. Douglas
(1931 – 2011)

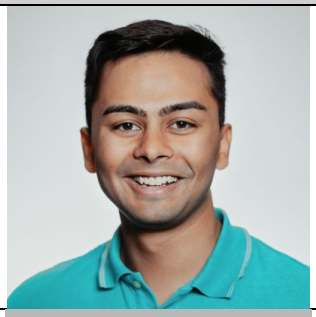
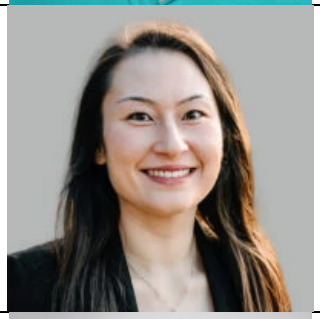
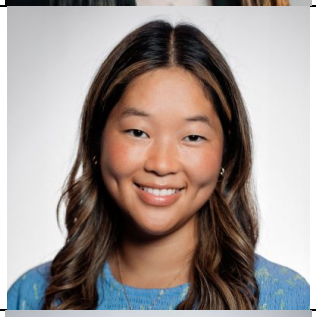
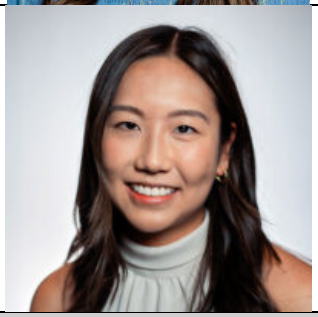
Visiting Professors

1985 – 2025

1985	Dr. Luis Vasconez	2005	Dr. Steven Morris
1986	Dr. Charles Lumsden	2006	Dr. William M. Kuzon Jr.
1987	Dr. Colin Baylis	2007	Dr. John A. Persing
1988	Dr. Stephen Miller	2008	Dr. Steven J. McCabe
1989	Dr. V. I. Kalnins	2009	Dr. Donald H. Lalonde
1990	Dr. Richard Weisel	2010	Dr. Douglas C. Ross
1991	Dr. Dale Birdsell	2011	Dr. Joseph E. Losee
1992	Dr. Earl Bogoch	2012	Dr. Michael L. Bentz
1993	Dr. Winston Parkhill	2013	Dr. Michael W. Neumeister
1994	Dr. Carolyn Kerrigan	2014	Dr. Paul S. Cederna
1995	Dr. William Lineweaver	2015	Dr. Susan E. Mackinnon
1996	Dr. Paul Manson	2016	Dr. Gary Burget
1997	Dr. Robert Goldwyn	2017	Dr. G. Patrick Maxwell
1998	Dr. Fu-Chan Wei	2018	Dr. Andrea L. Pusic
1999	Dr. Scott Spear	2019	Dr. Rodney J. Rohrich
2000	Dr. Neil Ford Jones	2020	Dr. Michael J. Klebuc
2001	Dr. Mary H. McGrath	2022	Dr. James Chang
2002	Dr. Stephen J. Mathes	2023	Dr. Peter Neligan
2003	Dr. Ian T. Jackson	2024	Dr. Paris Butler
2004	Dr. David M. Evans	2025	Dr. Richard Hopper

Our Residents

PGY1	
	Basma Bamakhrama
	Tega Ebeye
	Amna Majeed
	Thomas Milazzo
	Tiffany Tse

PGY2	
	**Shaishav Datta**
	**Jade Park**
	Calandra Li
	**Jane Zhu**
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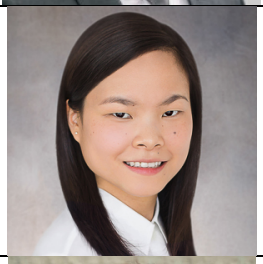
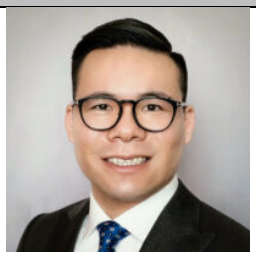
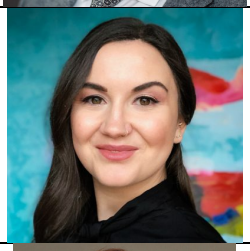
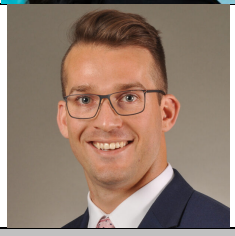
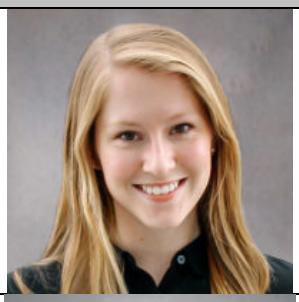
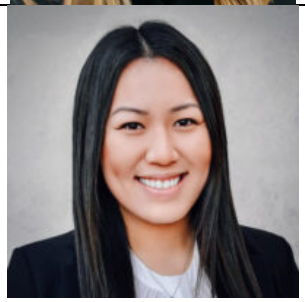
	Ho Yee Wan

	Kate Uhlman
	Rebecca Xu
	Morgan Yuan
	Whitney Quong
	Chantal Valiquette
PGY4	
	George Ho

PGY5	
	Moaath Saggaf
	Emma Avery
	Marshall Thibedeau
Research Residents	
	Darby Little
	Chloe Wong

PROGRAM
Visiting Professor: Dr. Richard Hopper
Friday, May 9th, 2025
8:00 a.m. – 3:00 p.m.
University Club of Toronto
380 University Ave, Toronto, ON M5G 1R6

8:00-8:20 **Breakfast**

8:20-8:25 **Welcome – Dr. Joan Lipa & Dr. Kristen Davidge** (Main Ballroom)

Session 1. Moderator: ***Dr. Dale Podolsky***

PGY1 invited talks

8:30-8:32 Dr. Tiffany Tse (PGY1)
Improving Culturally Sensitive Care In Digit Amputations: A Quality Improvement Project

8:33-8:35 Dr. Amna Majeed (PGY1)
Long-term Functional and Aesthetic Outcomes of Labiaplasty: A Review of the Literature

8:36-8:38 Dr. Thomas Milazzo (PGY1)
Pressure in the Operating Room, A Potential Contributor to Hospital Acquired Pressure Injuries (HAPIs))

8:39-8:41 Dr. Tega Ebeye (PGY1)
Beyond the Helmet: Exploring Caregiver Burden in Helmet Therapy following Endoscopic Strip Craniectomy

8:42-8:44 Dr. Basma Bamakhrama (PGY1)
Risk Models to Predict Mortality in Burn Patients: A Systematic Review and Meta-analysis

8:45-8:59 **Discussion**

Research presentations

9:00-9:04 Dr. Whitney Quong (SSTP)
What Does it Mean to Have a Scar? An Multi-Year Detour Searching for Answers

9:05-9:09 Dr. Rebecca Xu (PGY3)
Validation of a Mixed Reality Model for Percutaneous K-wire Fixation of Hand Fractures

9:10-9:14 Dr. Chloe Wong (SSTP)
A Dedicated Trauma Operating Room for Hand Surgery Reduces After-Hours Cases Without Affecting Wait Times: A Retrospective Single-Center Cohort Study

9:15-9:29 **Discussion**

Session II. Research presentations
Moderator: Dr. Anne O'Neill

9:30-9:34 Dr. Chantal Valiquette (PGY3)
Everyone Wants to Pass the Buck": Understanding Access to Gender Affirming Surgery in a Universal Health System

9:35-9:39 Dr. Jade Park (PGY2)
Lived Experiences of Black Women with Breast Cancer in Canada: a Francophone Perspective

9:40-9:44 Dr. Moaath Saggaf (PGY5)
The Effect of Carpal Tunnel Release on Cold Sensitivity in Patients with Carpal Tunnel Syndrome

9:45-10:00 **Discussion**

10:00-10:29 Group Photo sessions & Morning Coffee Break

Session III. Research presentations
Moderator: Dr. Mark McCrae

10:30-10:34 Dr. Kate Uhlman (PGY3)
Soft Tissue Masses In The Paediatric Upper Limb: A 23-Year Review

10:35-10:39 Dr. Jane Zhu (PGY2)
Oro-Zygomatic Nerve Transfer: An Anatomical Study And Application To Facial Synkinesis

10:40-10:44 Dr. Calandra Li (PGY2)
Assessing Resting Lower Face Symmetry after Masseter Nerve Transfer for Facial Palsy

10:45-10:49 Dr. Shaishav Datta (PGY2)
Nasal Tip Deprojection in Rhinoplasty

10:50-11:04 **Discussion**

Hoyle Campbell Visiting Professor Keynote Lecture

11:05-11:07 Introduction to Dr. Hopper (K. Davidge)

11:08-12:09 **Richard Hopper, MD, FRCSC, FACS**
Surfing The Bone Pressure Wave In The First Year Of Syndromic Synostosis

12:10-1:09 LUNCH

Session IV. Moderator: ***Dr. Alan Rogers***

Research presentations

1:10-1:14 Dr. Darby Little (SSTP)
Early Primary Care Follow-Up and Mortality in Burn Survivors: A Population-Based Cohort Study

1:15-1:19 Dr. Hoyee Wan (PGY3)
Surgical Education For Pressure Injuries: What Are Residents Learning In Ontario?

1:20-1:24 Dr George Ho (PGY4)
Resident And Program Director Perspectives On Point Of Care Ultrasound (POCUS) For Plastic Surgery - A Survey Study

1:25-1:29 Dr. Morgan Yuan (PGY3)
Atypical Soft Tissue Manifestations Of Pediatric Invasive GAS Infections: A Case Series

1:30-1:44 **Discussion**

PGY5 invited talks

1:45-1:47 Dr. Emma Avery (PGY5)
Fellowship

1:48-1:50 Dr. Moaath Saggaf
Ten Years In Two Minutes Or Less

1:51-1:53 Dr. Marshall Thibedeau
Residency Is Done, Long Live Fellowship

1:54-2:04 **Discussion**

Young Investigator Award

2:05-2:07 Introduction (Dr. K. Davidge)

2:08-2:18 **Dr. Alan Rogers**
Quality Improvement Interventions in Burns and Complex Wounds

2:19-2:24 **Awards Panel Discussion**

2:25-2:45 **Awards Presentations**

Abstracts

WHAT DOES IT MEAN TO HAVE A SCAR? A MULTI-YEAR DETOUR SEARCHING FOR ANSWERS

CanMeds Role: Scholar, collaborator, leader, health advocate, communicator, medical expert

Purpose: To explore and answer: A) what does it mean to have a scar, and which factors are associated with outcomes; B) is the SCAR-Q able to detect change in children undergoing scar therapy; and C) is steroid tape effective for pathologic scars.

Methodology: A three-part PhD thesis. Objective A was explored through a large-scale, crowdsourced, online survey involving participants from Amazon Mechanical Turk. Objective B was investigated in an observational longitudinal questionnaire-based study of children undergoing scar therapy at a pediatric hospital. Objective C was evaluated in an adult Japanese sample with pathologic scars utilizing a look-back design. The SCAR-Q was used as the scar outcome measure in all studies.

Results:
A: 25,000 participants from a non-clinical sample were recruited. Better scar outcomes were observed in those with a Latino background; older scars; traumatic scars; and hand, thigh, and lower leg/calf scars. Poorer scar outcomes were associated with Middle Eastern and Indigenous ethnicity; identifying as religious; burn scars; and shoulder, neck, and back scars. Hiding your scar, or wanting to change/remove your scar was associated with poorer outcomes.
B: The SCAR-Q Appearance and Symptom scales were responsive (able to detect change) in children undergoing scar therapy. The Psychosocial Impact scale was limited by a ceiling effect.
C: Steroid tape use is a simple conservative pathologic scar treatment, that is associated with both patient-reported scar improvement (Japanese SCAR-Q), and clinician-reported improvement (VSS). Poor correlation between patient- and clinician-reported outcomes supports the distinctness of these scar assessment tools, and supports their paired use.

Conclusions: The scar experience is complex and multifaceted, with multiple influential patient- and scar-related factors. As surgeons, we owe it to patients to understand the impact and gravity of these permanent skin marks. We should continue striving for better scar treatment and optimization strategies, while routinely and rigorously measuring relevant outcomes.

TITLE: What Does It Mean To Have A Scar? A Multi-Year Detour Searching For Answers
AUTHORS: Whitney Quong, Aaron Drucker, Cornelia Borkhoff, Neil Bulstrode, Rei Ogawa, and Joel Fish
PRESENTER: Dr. Whitney Quong
SUPERVISORS: Dr. Joel Fish
PRESENTER STATUS: RESEARCH RESIDENT
FUNDING: *Canadian Institutes of Health Research Plastic Surgery Foundation/Plastic Surgery Research Council, Pediatric Dermatology Research Alliance, Physicians' Services Incorporated Foundation, Ministry of Health and Long-Term Care, Great Britain Sasakawa Foundation, Skin Investigation Network of Canada, Nippon Medical School Hospital Foundation, Mentor Medical Systems Canada, University of Toronto: School of Graduate Studies, Department of Surgery, and Division of Plastic, Reconstructive & Aesthetic Surgery*

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 9:00 AM

VALIDATION OF A MIXED REALITY MODEL FOR PERCUTANEOUS K-WIRE FIXATION OF HAND FRACTURES
CanMeds Role: Health Advocate, Collaborator, Scholar, Communicator

Purpose: Surgical simulation enhances skill acquisition for residents, especially given duty-hour restrictions and competency-based education. High-fidelity models improve technical skills and knowledge retention. This study aimed to validate a mixed reality model for metacarpal fracture reduction and K-wire fixation in plastic surgery residents.

Methodology: A digital model of a life-sized Bennett's fracture was created from a reference CT scan, and a K-wire driver was designed based on physical instrument measurements. These components were 3D-printed and embedded with electromagnetic sensors for real-time tracking. The fracture site was maintained with compressible foam to allow for reduction, and the entire hand was cast in silicone. A trigger-equipped K-wire driver monitored activation during fixation attempts.

Ten plastic surgery residents participated, each performing five attempts at reduction and K-wire fixation after completing a self-paced simulation module. A hand surgeon assessed fixation quality; proficiency metrics including K-wire position and time to fixation were recorded. Residents rated the model's utility using a five-point Likert scale.

Results: Residents improved in both outcomes and efficiency of their K-wire fixation after training with this Bennett's fracture model in a single learning session. One of ten residents achieved an acceptable fixation on their first attempt; this improved to 6/10 by their fifth attempt. The time required for reduction and fixation decreased by 21% by the fifth attempt, suggesting improved competency within the model. Resident feedback of the model was very positive: 10/10 residents "would recommend the model as a training tool" and thought "the model is a valuable training tool."

Conclusions: This mixed reality model improved K-wire fixation skills among residents and was highly rated as a training tool. Future studies will assess whether training in this model translates to improved proficiency in a cadaveric fracture model.

TITLE: Validation Of A Mixed Reality Model For Percutaneous K-Wire Fixation Of Hand Fractures
AUTHORS: Rebecca Xu MD, Trinette Wright, Jimmy Qiu, Daniel Lin, Joseph Catapano MD PhD FRCSC, Stefan Hofer MD PhD FRCS(C), Blake Murphy MD PhD FRCSC
PRESENTER: Dr. Rebecca Xu
SUPERVISORS: Drs. Blake Murphy, Joseph Catapano and Stephan Hofer
PRESENTER STATUS: PGY3 _ RESEARCH RESIDENT__ FELLOW_____
FUNDING: Nil

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____TIME OF PRESENTATION: 9:05 AM

A DEDICATED TRAUMA OPERATING ROOM FOR HAND SURGERY REDUCES AFTER-HOURS CASES WITHOUT AFFECTING WAIT TIMES: A RETROSPECTIVE SINGLE-CENTER COHORT STUDY

CanMeds Role: Scholar

Background: After-hours hand trauma care is associated with surgeon fatigue, higher risk of complications, and increased staffing costs. Dedicated trauma operating rooms (DTORs) have been established in orthopedic and trauma surgery to improve access to care and patient outcomes. This purpose of this study is to measure the impact of a DTOR for hand surgery on the proportion of after-hours cases and wait times from consultation to surgery at an urban tertiary-care center in Toronto, Ontario.

Methods: This retrospective cohort study included adult patients undergoing hand trauma surgery at Toronto Western Hospital during two periods: pre-DTOR implementation (August 1, 2018 - January 31, 2020; N=599) and post-DTOR implementation (August 1, 2022 - January 31, 2024; N=541). The main outcomes were the proportion of emergency cases performed after-hours and the wait times from consultation to surgery. Multivariable logistic and negative binomial regression were used to estimate associations with binary and continuous outcomes, respectively. Other outcomes, including caseload, surgical complications, and revision surgeries, were assessed using univariate analysis.

Results: After DTOR implementation, after-hours cases decreased from 18% (N=109/599) to 8% (N=45/541). Adjusting for covariates, DTOR implementation was associated with fewer emergency hand surgeries being performed after-hours (Odds Ratio=0.47, 95% CI 0.23-0.95, p=0.03). Wait times were similar before and after-DTOR implementation (6 days vs. 8 days, pre vs. post-DTOR; Rate Ratio=1.03, 95% CI 0.91-1.16, p=0.64). There was no difference in the hand trauma caseload pre vs. post-DTOR implementation (p=0.09). There were fewer complications (5% vs. 2%, pre vs. post-DTOR; p=0.03) and revisions (10% vs. 3%, pre vs. post-DTOR; p<0.0001) following DTOR implementation.

Conclusions: The implementation of DTOR was associated with reduced proportions of emergency hand surgeries being performed after-hours, without compromising wait times. Additionally, there were lower complication and revision rates after DTOR implementation. The results of this study support the use of DTORs to enhance surgical efficiency and improve patient outcomes in hand surgery centers.

TITLE: A Dedicated Trauma Operating Room For Hand Surgery Reduces After-Hours Cases Without Affecting Wait Times: A Retrospective Single-Center Cohort Study
AUTHORS: Chloe R. Wong, MD1; Mauz Asghar, BEng2; David R. Urbach, MD, MSc, FRCSC, FACS3; Heather L. Baltzer, MD, MSc, FRCSC, FACS1
PRESENTER: Dr. Chloe Wong
SUPERVISOR: Dr. Heather Baltzer
PRESENTER STATUS: SSTP
FUNDING: None

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 9:10 AM

EVERYONE WANTS TO PASS THE BUCK": UNDERSTANDING ACCESS TO GENDER AFFIRMING SURGERY IN A UNIVERSAL HEALTH SYSTEM
CanMeds Role: Health Advocate, Medical Expert, Scholar, Professional

Purpose: Canada has a universal federalist health system where medical care and procedures are publicly funded and the responsibility of provincial health authorities. Despite this, many barriers for transgender and gender diverse (TGD) patients persist in trying to access gender affirming surgery (GAS). Understanding how patients experience these barriers can identify where health system level changes are necessary to improve patient experiences and outcomes.

Methodology: An institutional ethnography was conducted consisting of iterative observation, interviews, and document review. A total of 18 interviews and 7 clinical observations of TGD patients and healthcare providers (HCPs) were conducted using purposive stratified and maximum variation sampling. Participants included 10 TGD patients seeking top and bottom surgery, and 8 HCPs from a variety of clinical backgrounds (e.g., plastic surgery, urology, gynecology, nursing, physiotherapy). Interviews were audio recorded, transcribed, deidentified, and validated. They were then indexed, along with observational notes and document review. Documents related to Canadian provincial funding policies, institutional practice guidelines, patient resources, community resources, and historical accounts were collected and analyzed. These documents were used to inform key topics to explore in interviews and understand GAS referral pathway development.

Results: An Ontario provincial funding map was developed to visualize barriers experienced along the GAS health system pathway. Findings demonstrate that at all points along the pathway, TGD patients face barriers to care. Navigating these barriers is often left to patients, as one participant stated, "everyone wants to pass the buck". Not having a knowledgeable primary care provider can prevent patients from being diagnosed with gender dysphoria, prescribed hormone therapy (if desired or required based on GAS type), or getting necessary paperwork (e.g., letters of support) completed. This may be exacerbated by walk-in clinic or ED practitioners refusing or unable to provide care. Not being able to afford private care can prevent patients from accessing these requirements from nurse practitioners in the private healthcare system when they are unable to access care in the public system. Being on a waitlist for a provider (referring provider or surgeon) can further result in delays to care. Having inadequate supports can make the requirement of living in one's gender role continuously burdensome or dangerous for patients. Additionally, surgical centres may not allow surgery to move forward if a patient does not have good supports post-operatively. In terms of funding approval, wanting an established GAS procedure that is not yet available in Ontario might prevent coverage. Even at the final stage, once approval has been granted, patients may need to travel to providers when none are available locally.

Conclusions: While there has been increased provision of GAS with development of dedicated programs many barriers to accessibility persist. Efforts to increase accessibility should recognize the importance of understanding patient and provider experiences navigating referral pathways to develop comprehensive solutions that optimize patient care.

TITLE: Everyone Wants To Pass The Buck": Understanding Access To Gender Affirming Surgery In A Universal Health System
AUTHORS: Kathleen Armstrong, Beverley M. Essue, Mitchell Brown, Milo McAlister, Robyn Hodgson, Amelia Smith, Eric Nauenberg, Daniel Grace
PRESENTER: Dr. Chantal Valiquette
SUPERVISOR: Dr. Mitch Brown
PRESENTER STATUS: PGY3
FUNDING: CIHR CSG-M, CIP-MOH, 2SLGBTQ+ Research and Knowledge Mobilization Grant, Rutka SSTP Scholarship, Surgical Alumni Scholarship

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 9:30 AM

LIVED EXPERIENCES OF BLACK WOMEN WITH BREAST CANCER IN CANADA: A FRANCOPHONE PERSPECTIVE
CanMeds Role: Scholar, Health Advocate

Rationale: While disparities in the care and outcomes of Black women with breast cancer are well established in the United States, this foundation of research is lacking in the Canadian context. It is therefore critical that we better understand the barriers, deficiencies, and inequities in breast cancer care faced by Black women in Canada to better inform program and policymaking. The aim of this study was to bridge this critical gap. This project specifically focused on French speakers as this makes up an important proportion of Black women in Canada, different from other racialized populations in the country. Three specific aims were identified: (1) understand how race and sociocultural factors impact the experiences of French-speaking Black women living with breast cancer in Canada, (2) identify inequities and barriers in the prevention, diagnosis, and treatment of breast cancer in this population, and (3) to propose solutions and strategies to these barriers and deficiencies.

Methods: This study undertook a narrative inquiry qualitative approach. Participants were recruited through purposive and snowball sampling. Included participants were currently or had previously experienced breast cancer, were French-speaking, and identified as Black, African, or Caribbean. Participants were engaged in one-on-one semi-structured interviews. Interview transcripts underwent both inductive and deductive coding, followed by thematic analysis using a grounded theory approach.

Results: Participants overall expressed a lack of exposure to and knowledge surrounding breast cancer prior to their diagnosis. Many attributed this to illness being a taboo within the Black community. This spurred many participants to purposefully be more vocal about their experiences, aiming to be health advocates within their community. In terms of the impacts of their cancer, these were multifactorial including emotional, self-image, and financial strain, but many women also reported significant personal growth. When discussing their healthcare experiences, most women felt overall confident in their cancer care and did not feel they experience discrimination, though a couple cited potential microaggressions. This contrasts with a separately analyzed anglophone Toronto cohort, where many women did feel they experienced medical racism. Cited barriers to care included the Covid-19 pandemic, language, poor health literacy, and general difficulty navigating the healthcare system. Meanwhile, social supports, including religious communities, were an important protective factor. Interdisciplinary supports, public health campaigns targeted at the Black community, improved openness about cancer within the Black community, specific healthcare provider sensitization, and higher representation of Black community members among healthcare providers were proposed as interventions or changes that could help to improve the experiences of Black women with breast cancer in Canada.

Conclusion: While Black women undergoing breast cancer care do report instances of discrimination within the Canadian healthcare system, our francophone cohort overall did not feel their ethnicity played a role in their care. They did, however, highlight an important lack of dialogue, knowledge, and representation around breast cancer within the Black community. Targeted public health education, improved representation, and training on culturally-sensitive care for providers may therefore help to improve the experiences and outcomes for Black women with breast cancer in Canada.

TITLE: Lived Experiences Of Black Women With Breast Cancer In Canada: A Francophone Perspective
AUTHORS: Jade Park, MD, MPH; Indira Fernando, M.Ed.; Andrea Covelli, MD, PhD
PRESENTER: Dr. Jade Park
SUPERVISOR: Dr. Andrea Covelli
PRESENTER STATUS: PGY2
FUNDING: N/A

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 9:35 AM

THE EFFECT OF CARPAL TUNNEL RELEASE ON COLD SENSITIVITY IN PATIENTS WITH CARPAL TUNNEL SYNDROME

CanMeds Role : Scholar, Health Advocate, Medical Expert

Purpose: This study aimed to assess the impact of open carpal tunnel release on cold sensitivity in patients with carpal tunnel syndrome (CTS). We hypothesized that CTR would decrease the severity of cold sensitivity, when compared to non-operative treatment with nighttime splinting, as measured by patient-reported outcomes.

Methodology: Using a prospective cohort design, we enrolled adult patients with CTS and cold sensitivity from two academic hand clinics and excluded patients with polyneuropathy, insulin-dependent diabetes mellitus, previous upper extremity surgeries and traumatic peripheral nerve injuries. Patients were treated with either nighttime splinting or surgery. Before and after the intervention, we assessed CTS severity using the Boston Carpal Tunnel Questionnaire (BCTQ) and cold sensitivity using the Cold Intolerance Symptom Severity (CISS) scale. We adjusted for confounding by indication by using an inverse probability of treatment weighting (IPTW) model.

Results: There were 88 patients included in the study: surgery (n=50); splinting (n=38). Figure 1 summarizes the study enrollment. The mean age was 55 years (SD=12.9), and 61 participants were females (69.3%). The mean baseline CISS scores were 41 (SD=19.9) for the surgical cohort and 44 (SD=20.0) for the splinting cohort. Compared to nighttime splinting, open carpal tunnel release improved CISS scores by a mean of 23.7 points (95% CI 17.1 to 40.8) in the unadjusted model. After adjustment using IPTW, surgical patients improved by 21.0 (95% CI 10.0 to 32.0) points on the CISS compared to splinted patients.

Conclusions: Carpal tunnel release is associated with decreased cold sensitivity at follow-up compared to splinting, beyond the minimal clinically important difference. Early carpal tunnel release has a role in CTS patients reporting a high degree of cold sensitivity.

TITLE: The Effect Of Carpal Tunnel Release On Cold Sensitivity In Patients With Carpal Tunnel Syndrome
AUTHORS: Saggaf M, Drucker A, Novak C, Dengler J, Robinson L, Anastakis DJ, Feldman BM
PRESENTER: Dr. Moaath Saggaf
SUPERVISOR: Dr Dimitri Anastakis, Brian Feldman
PRESENTER STATUS: PGY5 RESEARCH RESIDENT X FELLOW_____
FUNDING: AFSH Clinical Grant, PSF/ ASPN Grant, AFSH Resident Grant

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 9:40 AM

SOFT TISSUE MASSES IN THE PAEDIATRIC UPPER LIMB: A 23-YEAR REVIEW
CanMEDS Role: Scholar

Purpose: Upper limb masses present frequently to the paediatric outpatient clinic. However, there is little in the published literature to help guide management. The purpose of this study is to determine the common histological diagnoses, the incidence of malignancy, and the rates of recurrence of upper extremity soft tissue masses in children.

Method: This is a retrospective analysis of all pediatric patients who underwent surgery for an upper extremity soft tissue mass, at one academic institution, between January 1, 2000 and December 31, 2023. Lesions arising from the bone, or the skin surface were excluded. The primary outcome is the nature and frequency of histopathological diagnoses. Secondary outcomes include: the incidence of intermediate or malignant potential, rate of recurrence and rate of reoperation.

Results 266 patients met inclusion criteria. The median age at presentation was 9 years (range: 2 weeks - 18 years). Masses were most commonly within the digit (97, 36.5%). Masses were present for a median of 12 months and most had a slow growth pattern (167, 62.8%). 143 cases (53.8%) were soft tissue neoplasms, of which the most common category was vascular tumours (18.4%). The most common 'pseudotumour' was ganglion cysts (21.1%)

The incidence of diagnoses with intermediate and malignant potential were 5.6% and 1.9%, respectively. The incidence of recurrence and reoperation is 7.9% and 5.6%.

Conclusions Upper limb masses in children are commonly benign, with low rates of recurrence and reoperation. This study provides further insight into spectrum of diagnoses, the presentation patterns and clinical course to help guide clinical management of pediatric upper extremity masses.

Learning Objectives Attendees will: 1) better understand the range of diagnoses in pediatric upper extremity soft tissue masses, and 2) recognise clinical patterns of presentation with common masses in the pediatric upper extremity

TITLE: Soft Tissue Masses In The Paediatric Upper Limb: A 23-Year Review
AUTHORS: Dr Kathryn Uhlman, MD MBA MSc(HQ); Mr Olamide Dinah; Dr Kristen Davidge, MD MSc FRCSC; Dr Molly Jakeman, MBChB FRCS(Plast) FRCSC
PRESENTER: Dr. Kate Uhlman
SUPERVISOR: Dr. Kristen Davidge
PRESENTER STATUS: PGY 3 RESEARCH RESIDENT_____ FELLOW_____
FUNDING: N/A

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 10:30 AM

DEPRESSOR ANGULI ORIS TO ZYGOMATICUS NERVE TRANSFER: AN ANATOMICAL STUDY FOR FACIAL SYNKINESIS
CanMeds Role: Scholar

Purpose: Facial synkinesis with depressor anguli oris (DAO) hypertonicity results in significant facial asymmetry with volitional smile. Little research exists surrounding the use of synkinetic facial nerve branches to reanimate selective muscles which contribute to smile. During selective neurectomy, transferring a nerve branch of the synkinetic DAO to a nerve branch of the zygomaticus major may improve commissure excursion. We present a cadaveric study to establish the anatomical feasibility of a DAO to zygomatic nerve transfer for treatment of synkinesis.

Methodology: Ten embalmed hemi-faces were dissected. Facial nerve branches innervating DAO and zygomaticus major were identified. Measurements included number of sub-branches innervating each muscle, and swing distance from the zygomaticus major branch to masseter and DAO branch to the angle of the mandible. An end-to-end nerve transfer was then performed by transferring the nerve to DAO (donor nerve) to the nerve to zygomaticus major (recipient nerve). Descriptive statistics were used for data analysis.

Results: The number of sub-branches innervating zygomaticus major was 2.1 ☐ 0.5. Innervation to the DAO was found to be derived from the marginal mandibular branch, and sub-branches innervating DAO was 2.38 ☐ 0.86 for 8 specimens and could not be identified in 2 specimens. Swing distance was 4.09 ☐ 0.89 cm for the DAO branch, and 2.47 ☐ 0.59 cm for the zygomaticus major branch. Nerve transfer was successfully performed in all cadavers where a DAO nerve branch could be identified.

Conclusions: DAO to zygomaticus major nerve transfer for treatment of synkinesis is an anatomically feasible procedure.

TITLE: Depressor Anguli Oris To Zygomaticus Nerve Transfer: An Anatomical Study For Facial Synkinesis
AUTHORS: Jane Zhu, Tiffany Tse, Hari Iyer, Ronald Zuker, Kevin Zuo, Heather Baltzer
PRESENTER: Dr. Jane Zhu
SUPERVISOR: Dr. Heather Baltzer
PRESENTER STATUS: PGY2 RESEARCH RESIDENT_____ FELLOW_____
FUNDING: Dr. Ajay Virmani Chair Fund
OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 10:35 AM

ASSESSING RESTING LOWER FACE SYMMETRY AFTER MASSETER NERVE TRANSFER FOR FACIAL PALSY

Purpose Masseter nerve (MN) transfer is a common technique to reanimate the lower face in patients with facial paralysis. While MN transfer for smile is well documented, there is little description of its effect on resting symmetry of the lower face. This study aimed to assess the impact of MN transfer on lower facial symmetry at rest in patients with facial palsy.

Method Following research ethics board approval, a retrospective study of all adults who underwent MN transfer for facial reanimation at our institution from 2016-2024 was conducted. Demographic, preoperative, and postoperative data were collected for all study participants. Commissure distance (CD), commissure height deviation (CHD), upper lip deviation (ULD), and lower lip deviation (LLD) were used as determinants of symmetry. These anatomical landmarks on pre- and post-operative frontal photos in repose were analyzed using an open-source machine-learning algorithm (Emotrics).

Results A total of 22 patients (12 males, 10 females, mean age 52.3 ☐ 13.7 years) were included with mean onset of facial palsy to MN transfer of 11.9 ☐ 20.4 months, and mean follow-up post-operatively of 3.2 ☐ 1.9 years. The most common cause of facial palsy was vestibular schwannoma (n=17). Pre-operatively, all patients had significant asymmetry between affected and non-affected upper lip and commissure positions at rest. Statistically significant improvements in asymmetry were noted post-operatively for CHD (p=0.0008, n=18) and ULD (p=0.0002, n=19). CD and LD were not significantly improved following surgery.

Conclusions MN transfer significantly improved resting lower facial symmetry in patients with facial paralysis, specifically through a more cranial position of the commissure and upper lip at rest. The neuromuscular mechanisms by which this occurs are unclear. This information may assist in preoperative counselling and decision-making for patients with facial palsy.

Learning Objectives

1. Participants will be able to describe indications for MN transfer in facial reanimation.

TITLE: Assessing Resting Lower Face Symmetry After Masseter Nerve Transfer For Facial Palsy
AUTHORS: Calandra Li, Chloe Wong, Daniel Antflek, Christine B. Novak, Kevin Zuo, Ronald M. Zuker, Heather L. Baltzer
PRESENTER: Dr Calandra Li
SUPERVISOR: Dr. Heather Baltzer
PRESENTER STATUS: PGY2 RESEARCH RESIDENT_____ FELLOW_____
FUNDING: NA

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 10:40 AM

NASAL TIP DEPROJECTION IN RHINOPLASTY

CanMeds Role: Scholar

Purpose: Rhinoplasty is one of the most commonly performed facial surgeries in the North America. There exist many major and minor nasal tip support structures that impact tip projection. Overprojection may result from anatomic factors, or may occur iatrogenically during primary rhinoplasty. Achieving reliable, reproducible, and stable results is the aim of nasal tip deprojection rhinoplasty. The senior author's technique, detailed here, effectively corrects overprojection while preserving tip strength and minimizing the need for subsequent revisions.

Methodology: A retrospective chart review of 2,003 rhinoplasty cases in the senior author's practice was conducted between July 2014 and June 2022. The inclusion criteria were cosmetic or functional rhinoplasty cases with nasal tip deprojection, with a minimum of 12 months of follow-up. Outcomes of interest included the rate of operative revisions, overall rate of operative take-back, and the rate of postoperative infection.

Results: 447 patients met the inclusion criteria. The mean age of our study group was 32.1 years old, with 409 females. 291 cases were primary rhinoplasties. Mean follow-up period was 22.4 months. Eight patients (1.8%) required empiric antibiotics postoperatively, with 17 patients (3.8%) requiring operative revision.

Conclusions: Our case series demonstrates that combining resection of the medial crura with lateral crural steal and a columellar strut graft allows us to achieve considerable nasal tip deprojection with control over tip rotation and a strong foundation for long-term stability. The comprehensive patient follow-up spanning at least 12 months further supports the reliability of our technique.

TITLE: Nasal Tip Deprojection In Rhinoplasty
AUTHORS: Shaishav Datta, Steven Hanna, David Mattos, Richard Reish
PRESENTER: Dr. Shaishav Datta
SUPERVISOR: Richard Reish
PRESENTER STATUS: PGY2 RESEARCH RESIDENT_____ FELLOW_____
FUNDING: Nil

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 10:45 AM

EARLY PRIMARY CARE FOLLOW-UP AND MORTALITY IN BURN SURVIVORS: A POPULATION-BASED COHORT STUDY

CanMeds Role: Scholar, Health Advocate, Collaboration

Purpose: Individuals who survive major burn injuries are at greater risk of long-term mortality and interventions to improve their long-term outcomes are needed. Early primary care follow-up post-discharge has demonstrated a survival benefit in other hospitalized populations. As such, this study aimed to evaluate the association between early primary care follow-up and long-term mortality in burn survivors.

Methodology: We performed a retrospective, population-based cohort study of adults discharged alive after burn injury-related hospitalization (2010-2022). The exposure of interest was early PCP visit (within 30 days of discharge). The primary outcome was one-year all-cause mortality, with follow-up until death or March 31, 2023. Cox proportional hazards models evaluated the association between early PCP visit and one-year mortality, adjusting for age, sex, comorbidities, rurality, and socioeconomic characteristics.

Results: Among all burn survivors, 86% (n = 1,690) were attached to a PCP, 71% being male with a mean age 48 ± 18 years. Of these, 40% (n = 676) had an early PCP follow-up visit. In the year after discharge, 3% of burn survivors with an early PCP follow-up died, compared to 5% of those without (p = 0.02). After risk adjustment, early PCP follow-up was associated with a 65% reduction in the hazard of one-year mortality (HR = 0.35, 95% CI 0.20–0.62, p < 0.001).

Conclusions: Early primary care follow-up with their own PCP was associated with increased survival in burn survivors. These findings suggest that burn centres should prioritize primary care follow-up when discharge planning and should connect patients without a PCP to appropriate care.

TITLE: Early Primary Care Follow-Up And Mortality In Burn Survivors: A Population-Based Cohort Study
AUTHORS: Darby Little, Elliott Yee, Barbara Haas, Laura Rosella, Gemma Postill, Brandon Zagorski, Lisa Jaakkimainen, Stephanie Mason
PRESENTER: Dr. Darby Little
SUPERVISOR: Dr. Stephanie Mason
PRESENTER STATUS: RESEARCH RESIDENT___X___ FELLOW_____
FUNDING: Nil

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 1:10 PM

SURGICAL EDUCATION FOR PRESSURE INJURIES: WHAT ARE RESIDENTS LEARNING IN ONTARIO?

CanMeds Role: Communicator, Scholar

Purpose: Pressure injuries are common injuries arising from prolonged pressure and shear and friction forces. In cases of severe pressure injuries resulting in infection or extensive soft tissue loss – surgical services are consulted for management.

Methodology: Our study focused on the surgical education of residents enrolled in general, orthopaedic and plastic surgery residency programs in Ontario. We designed and delivered a survey that collected information regarding the education and training received around management of pressure injuries.

Results: A total of 49 responses were obtained. We found that there was limited didactic and clinical exposure to pressure injury management in general and orthopaedic surgery residency programs. The majority of orthopaedic residents and general surgery residents felt that they would not feel comfortable with debriding pressure injuries as part of their career when they graduated. The majority of residents interviewed also reported significant interest in further education around management of pressure injuries.

Conclusions: Overall, our study highlights the need for more education surrounding management of pressure injuries as well as practical experience in doing so.

TITLE: Surgical Education For Pressure Injuries: What Are Residents Learning In Ontario
AUTHORS: Hoyee Wan MD PhD1,2, Romain Laurent MD1,2, Alan Rogers MBChB, MMed MSc1,2, David Wallace MD MSc
PRESENTER: Dr. Hoyee Wan
SUPERVISOR: Dr. Dave Wallace
PRESENTER STATUS: PGY3
FUNDING: N/A

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 1:15 PM

RESIDENT AND PROGRAM DIRECTOR PERSPECTIVES ON POINT OF CARE ULTRASOUND (POCUS) FOR PLASTIC SURGERY - A SURVEY STUDY

CanMeds Role: Scholar

Purpose: Point-of-care ultrasound (POCUS) is transforming medical and surgical care, with expanding applications in plastic surgery for diagnostics and image-guided interventions. Studies have shown improved patient outcomes with ultrasound guidance. This study surveyed plastic surgery residency program directors and residents to assess POCUS utilization and its integration into plastic surgery training programs.

Methodology: A 13-question survey was developed after literature review and a semi-structured approach to survey creation with input from 5 faculty and 4 residents, and distributed in English and French to 13 program directors on the Royal College specialty committee and 178 Canadian plastic surgery residents. The surveys were conducted over a 3-month time period. Research ethics board approval was obtained for this study.

Results: Responses were received from 5 (38%) program directors and 22 (12%) residents, representing 10 out of 13 Canadian training programs. Most respondents reported no formal POCUS training or clinical use. Among those who had used POCUS, training was primarily obtained through conferences or skills labs. POCUS was most commonly used in emergency department and ambulatory settings for drainage of fluid collections, peripheral nerve blocks, and foreign body removal. These were also considered the most relevant applications for integration into residency program training. Reported barriers included limited faculty interest, poor remuneration, equipment cost/access, and lack of training. Notably, 81% of respondents agreed that POCUS should be part of plastic surgery training programs.

Conclusions: Despite limited current training and use, there is strong support among program directors and residents for the integration of POCUS into plastic surgery education. Addressing barriers such as faculty engagement, training opportunities, and equipment availability will be key to expanding its adoption in residency programs.

TITLE: Resident And Program Director Perspectives On Point Of Care Ultrasound (Pocus) For Plastic Surgery - A Survey Study
AUTHORS: George Ho, Natasha Barone, Adam Mosa, Ann-Sophie Lafreniere, Kyle Wanzel, Ryan Austin, Maleka Ramji, Sophocles Voineskos
PRESENTER: Dr. George Ho
SUPERVISOR: Dr. Sophocles Voineskos
PRESENTER STATUS: PGY4___ RESEARCH RESIDENT__X____ FELLOW_____
FUNDING: N/A

OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 1:20 PM

ATYPICAL SOFT TISSUE MANIFESTATIONS OF PEDIATRIC INVASIVE GROUP A STREPTOCOCCUS INFECTIONS
CanMeds Role: Scholar

Purpose: The purpose of this study is to comprehensively report on the different presentations and outcomes of pediatric patients presenting with iGAS infections and associated soft tissue manifestations at the Hospital for Sick Children after the COVID-19 pandemic. Based on our experience, we also make suggestions for the management of these children.

Methodology: A retrospective case series was performed with approval from the Institutional Ethics Committee at The Hospital for Sick Children (SickKids), in Toronto, Canada. The medical records of all patients ages 0-17 years old with iGAS infections consulted to the Burn Team of the Division of Plastic Surgery Team at SickKids between September 1, 2022 and September 1, 2024 were included. Demographic information and relevant clinical data were abstracted, including symptoms at presentation, length of hospital stay, invasive medical intervention (e.g. PICU stay, intubation, ECMO), operative details, and long term outcomes.

Results: A total of 17 children were included in this study. All patients survived until discharge. Among them, 11 had severe soft tissue infections, 4 had evidence of purpura fulminans, and 1 had necrotizing fasciitis. For soft tissue management, 7 required skin grafting, 5 required fasciotomies, and 5 required amputation. We also review three cases for different clinical presentations of iGAS including necrotizing fasciitis, purpura fulminans, and abnormal soft tissue infection refractory to conservative management.

Conclusions: This is the first report of cutaneous manifestations and management of iGAS pediatric patients. We describe the clinical characteristics of this cohort and review three major presentations of the disease. In this cohort, it is pivotal to have early recognition, and early intervention for soft tissue debridement and decompression.

TITLE: Atypical Soft Tissue Manifestations Of Pediatric Invasive Group A Streptococcus Infections
AUTHORS: Dr. Eduardo Gus, Hoyee Wan, Sara Faour
PRESENTER: Dr. Morgan Yuan
SUPERVISOR: Dr. Joel Fish
PRESENTER STATUS: PGY3 RESEARCH RESIDENT_____ FELLOW_____
FUNDING:_____
OFFICIAL USE: AWARDS: CLINICAL_____ BASIC RESEARCH_____
TIME OF PRESENTATION: 1:25 PM