

PATIENT ADVISORY & INFORMED CONSENT
FOR MALAR AUGMENTATION

PATIENT: _____

DATE: ____/____/____

TIME: _____

I hereby authorize Dr. Rotter to perform a surgical procedure known as Malar Augmentation. The intent of the operation is to improve the appearance of the cheeks and lower face. This usually requires inserting an implant through the malar and submalar region of the mouth. There are many possible complications of this surgery and I am aware of them. The most significant are:

NERVE DAMAGE & MUSCLE DAMAGE: nerve damage, a rare occurrence, **can effect movement of your mouth, eyebrows, and eyelids**, usually full recovery is gained within three to six months. However, any nerve loss that persists more than one-year will most likely be permanent.

Such occurrences could include: a **crooked smile or speech difficulty** from poor movement of the mouth, **droopy eyebrows or eyelids** could lead to severely dry eyes and inability to blink, which can cause **blindness or unsatisfactory appearance**.

Numbness may be noted around the ears, cheeks, and incision areas. Both should be temporary.

ASYMMETERY: Every one has asymmetric facial features. This means that if you compare one half of your face with the other half, they are not the same. This surgery may change or make the asymmetries more noticeable.

INACCURATE PLACEMENT: This could lead to another surgery or removing the implants.

SCARRING: This procedure will result in some scarring. Enlarged scarring called keloids could form; these tend to occur behind the ear. Dr. Rotter will make every reasonable effort to make these scars as inconspicuous as possible.

Necrosis is the loss of skin. A hematoma and/or use of tobacco products usually cause this. Necrosis can lead to scarring.

HEMATOMA: A collection of blood or fluid under the skin that can be removed.

INFECTION: Inflammation could lead to problems; it should be reported to Dr. Rotter immediately.

PAIN: You should have minimal discomfort. The treated areas may “burn” or “sting” for the first 2 or 3 days. Tylenol® or other acetaminophen pain reliever should be all that you need. If stronger medicine is needed, please call Dr. Rotter. **NEVER TAKE ASPIRIN, MOTRIN®, ADVIL® OR SIMILAR PAIN RELIEVERS!**

SOME OTHER COMPLICATIONS INCLUDE:

- Excessive bruising, swelling, lumpiness, dimpling, sagging of the skin, minor depressions.
- Hyperpigmentation (darkening of skin).
- Reactions to anesthesia, telangectasias (broken blood vessels) or redness.
- Cellulitis, possible formation of an abscess

ANY COMPLICATIONS OR DISSATISFACTION MAY REQUIRE A SECOND SURGERY, PROCEDURE, AND/OR MEDICATIONS IN THE FUTURE.

THE FOLLOWING POINTS HAVE ALSO BEEN SPECIFICALLY MADE CLEAR:

1. I realize much depends on how well I comply with pre- and postoperative instruction and my body's ability to heal. I understand that poor healing of the skin is usually associated with cigarette smoking and diabetes.
2. There, of course, are scars as a result of this surgery and these scars are permanent. Every effort will be made to conceal them or to make them as inconspicuous as possible. On occasion, a thickening or spreading of a scar may develop requiring surgical revision.
3. Due to the nature of the procedure, an exact end- result cannot be predicted, and I have not been given any guarantee of specific results.

- ◇ I authorize Steven M. Rotter, MD and assistants to perform any other procedure, which he may deem necessary or desirable in the course of the procedure to improve the outcome or for any unforeseen condition.
- ◇ I am aware that the practice of medicine is not an exact science, and I acknowledge that no expressed or implied guarantees nor warranty has been made to me as to the results of the operation.
- ◇ I agree to keep Dr. Rotter informed of any change of address so that he can notify me of any late findings, and I agree to cooperate with Dr. Rotter in my care after surgery until completely discharged.
- ◇ I consent to be photographed before, during, and after the surgery, that these photographs shall be the property of Dr. Rotter and may be published in scientific journals and/or shown for scientific reasons.
- ◇ I have read the above consent and fully understand it. I fully understand the nature of the surgery I acknowledge that I have been advised to the alternative methods of treatment and have been given an opportunity to ask all the questions regarding the procedure.
- ◆ I am satisfied that I have been fully informed. I authorize Dr. Rotter to perform this surgical procedure on me.

PATIENT SIGNATURE: _____

WITNESS: _____

DATE: _____