My Preferences and Information that I Fully Understand and Accept:

1. I **(please print and sign)**_____ o have o have not read the following materials by Dr. Adams about breast augmentation by in their entirety:

- Dr. Adams Website Information on Breast Augmentation
- Patient Preferences Document

Before visiting with Dr. Adams, the following are my preferences and choices. I understand that if Dr. Adams feels that my choices might have negative short-term or long-term effects on my tissues or my chances for the best result with the least risk of complications, he will discuss these issues with me during our consultation.

2. Please Initial:

A)_____ I understand that Dr. Adams can achieve virtually any size breast that I choose, but Dr. Adams is limited by the characteristics of my tissues that we can't change. I also understand that the choices I make, particularly with respect to implant size, can affect the appearance of my breasts as I get older and can affect my risks of having complications or needing additional operations in the future.

3. Please initial one of the following with regard to the BREAST SIZE YOU DESIRE:

A) _____ I want a MINIMAL amount of enlargement.

B) _____ I want to be AS FULL AS I CAN BE AND ACHIEVE A NATURAL APPEARING BREAST THAT IS SAFEST FOR MY TISSUES LONG-TERM. I leave the choice of implant size under these circumstances entirely to Dr. Adams, and will accept the size of breast that he feels is safest for my tissues long-term.

C) _____ I want a SPECIFIC SIZE BREAST—at least a _____ cup size AND at least a ____cc implant. **(Please fill in ALL blanks)**

4. Please initial one of the following with respect to CHOICE OF BREAST SIZE AND RISK OF FUTURE PROBLEMS:

A)_____ I WANT A BREAST SIZE THAT WILL HAVE THE LEAST CHANCE OF CAUSING FUTURE SAGGING, COMPLICATONS, OR NEED FOR ADDITIONAL PROCEDURES SUCH AS A BREAST LIFT. I understand that Dr. Adams will choose an implant that will produce the fullest breast possible that is safest long-term, unless I specify a smaller or larger breast. I leave the choice of implant size entirely to Dr. Adams based on his evaluation of my tissues and body proportions. I understand and accept that Dr. Adams cannot guarantee a cup size of my result, and I will not request a larger implant following my augmentation.

B)_____ I WANT A SPECIFIC BREAST SIZE, EVEN IF IT MIGHT BE LARGER THAN IDEAL FOR MY TISSUES. If I want a larger implant than Dr. Adams feels is optimal for my tissues, I understand that I may not have a natural appearing breast. I am willing to accept all responsibility for appearance and increased risks of reoperations, complications, deformities, and additional costs and time off work and normal activities in the future that may result from my selecting an implant that is larger than ideal for my tissues.

5. Please initial one of the following with respect to HOW YOU WOULD LIKE YOUR BREASTS TO LOOK:

Three to six months after my augmentation (after my tissues relax), I want the upper portion of my breast to appear:

A)_____ Inwardly curved, NOT FILLED IN THE UPPER PORTION OF THE BREAST.

B)_____ FULL IN THE UPPER BREAST, with a straight or slightly outwardly curved profile in side view.

C)_____ EXTREMELY FULL, WITH A VERY BULGING UPPER BREAST. I understand and accept that this choice produces a breast that does not appear natural and may have excessive bulging with an unnatural appearing transition from the upper chest to the breast. I also understand that an excessively large implant can cause damage to my tissues long-term that could cause me to need additional operations or have permanent deformities, but I want the large implant regardless of those possible consequences.

6. Choices and Preferences for Breast Augmentation (cont'd)

A) **IMPLANT SHAPE I prefer:** ____ Shaped or Anatomic ____ Round

B) **IMPLANT SHELL TYPE I prefer:** ____ Textured ____ Smooth

C) **IMPLANT MANUFACTURER I prefer:** ____ Allergan ____ Mentor ____Other: _____

D) **IMPLANT TYPE I prefer:** ____ Saline ____ Silicone ____ Cohesive Gel/ Form Stable/ Gummy Bear

D) ____ I want Dr. Adams to choose and will abide by his choice

7. IMPLANT SIZE I prefer:

A) ____ I want an implant that contains at least _____cc (if you have an opinion). If I do not specify a number of cc's that I want in my implant, I am leaving the decision entirely up to Dr. Adams, and I will accept his judgment regardless of my breast size following surgery.

B)____ I have absolutely no specific preference for the number of cc's in my breast implant, and I want Dr. Adams to choose based on his evaluation of my tissues and proportions. If I ask Dr. Adams to choose the appropriate size implant that is best for me, I will abide by his choice, understanding that he will fill my breast as much as he feels it can be filled safely, without producing additional risks or tradeoffs.

8. . _____I have been informed, and I understand that NO IMPLANT, REGARDLESS OF SIZE OR SHAPE, can guarantee upper breast fullness long-term, and the larger the implant I select, the more likely stretch of the lower breast envelope will allow loss of upper fullness.

9. Request for Implant or Size Change after Surgery:

A)____ If, after surgery, for any reason I desire a different size implant, I understand and accept that I must specify the exact type and size of implant in cc's, and that I am totally responsible for all costs associated with changing my implants, including surgeon fees, anesthesia fees, laboratory costs, and surgical facility fees

10. IMPLANT POCKET LOCATION I prefer:

A)____ I prefer my implant be placed UNDER the muscle. I have read and fully understand and accept the tradeoffs of placing an implant under muscle.

B)____ I prefer my implant be placed ABOVE the muscle. I have read and fully understand and accept the tradeoffs of placing an implant above muscle, and I understand and accept that I may see visible implant edges or other irregularities if the implant is placed above the muscle.

C)____ I do not have a preference for over or under muscle, and I want Dr. Adams to choose according to my tissue requirements. I have read and fully understand the tradeoffs of placing an implant either over or under muscle.

11. INCISION LOCATION I prefer:

A)____ Under the breast B)____ Around the areola C)____ In the armpit

D)____ I would like Dr. Adams to choose my incision location based on his assessment of my needs and optimal control during the operation, and I will abide by his decision.

Factors Following My Augmentation that Dr. Adams Cannot Control

12. I **(please print and sign)**_____ have read Dr. Adams' educational materials accessed on www.dr-adams.com and have had an opportunity to visit with Dr. Adams' patient educator, Christy Aguilar The following is essential information that I must understand and accept before having Dr. Adams perform my breast augmentation. I have discussed each of these items with my patient educator and fully understand and accept the tradeoffs, risks, costs, and outcomes associated with each item.

13. _____ From my reading of Dr. Adams' educational material, and after my patient educator consultation, I understand and accept that there are several factors related to my individual tissue characteristics, how I heal, and how my tissues respond to my breast implants that Dr. Adams cannot predict by tests before surgery, and cannot control after surgery.

INFECTION

14. _____ I fully understand and accept that if I develop an infection following my augmentation, Dr. Adams will remove one or both my breast implant. If an implant(s) is/are removed secondary to infection Dr. Adams will discuss the pros and cons of replacement with me. Never replacing implants may also be an option to minimize further reoperations, risks, and costs to me. If I decide to replace the implant, a period of time will be required following removal to allow my breast tissue to heal and soften. This usually is 3- 6 months. I further understand and accept that, if implant removal is ever required for any reason, that deformities may result that may not be totally correctable.

15. _____ I understand and accept that Dr. Adams must work with what I bring him to work with, and that he cannot change the qualities of the tissues of my breasts that affect stretch following surgery or how I will heal. I also understand and accept that Dr. Adams cannot perform tests before surgery, or in any other way predict 1) how my skin will stretch following my augmentation, and 2) how my body will heal or not heal following my augmentation.

TISSUE STRETCH

My tissue characteristics and stretch of tissues following my augmentation: How they can affect my results, need for additional surgery, and costs

16. _____ If my tissues stretch excessively in any area following my augmentation, deformities can result which Dr. Adams has no control. These deformities include the following:

1) excessive sagging or "bottoming out" of the breast with the implant too low and the nipple pointing excessively upwards,
2) shift of the implants to the sides with widening of the gap between the breasts,
3) thinning of tissues over the implant allowing the implant to become visible or palpable (able to be felt) in any area, and
4) visible rippling in any area that can result when the implant pulls on the overlying tissues.

17. _____ I understand and accept that any or all of these deformities can occur in one or both breasts, and do not occur equally on the two sides. I also understand and accept that the larger breast implant I choose or my breasts require for optimal aesthetic results, the greater the risk of these deformities occurring. Although breasts never match exactly on the two sides, if any of these deformities occur, differences in the two breasts may be more noticeable and may not be correctable.

18. _____ I understand and accept that if any or all of the deformities caused by tissue stretch listed above should occur, even though the deformity may be visible, that Dr. Adams alone will determine whether additional surgery is needed. Dr. Adams will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery and whether he feels I will get predictable improvement from additional surgery. I agree to abide by Dr. Adams' decisions in all matters pertaining to whether or not additional surgery is performed.

19. _____ I understand and accept that if my tissues stretch excessively for any reason following my augmentation, that additional surgery will not change the qualities of my tissues that allowed them to stretch in the first place. As a result, additional surgery to correct stretch deformities is unpredictable at best due to the limitations my tissues impose, and that surgery for any of the stretch deformities listed above may not successfully correct the deformity, and that any or all of these deformities can occur again if my tissues stretch again.

WOUND HEALING/ CAPSULAR CONTRACTURE CONSIDERATION CHARACTERISTICS

My healing characteristics following my augmentation: How they can affect my results, need for additional surgery, and costs

20. _____ I understand and accept that Dr. Adams has absolutely no control over how my body heals following my breast augmentation, and that he cannot predict (by tests prior to surgery) or control my individual healing characteristics.

21. _____ I understand and accept that my body will form a lining (capsule) around my breast implant following my augmentation, and that the capsule around the implant may contract (tighten) excessively, causing a variety of deformities that may require additional surgery and despite additional surgery, may be uncorrectable and require implant removal. The capsules that form and the amount that they tighten are never equal on both sides, so the effects of the capsule on each breast are usually different.

22. _____ I understand and accept that there are no tests or medical information that can accurately predict whether my capsules will tighten excessively and that following my augmentation, Dr. Adams has no control over how my body forms the capsule or how much the capsule will tighten or cause deformity.

23. _____ I understand and accept that any or all of the following deformities can result from how the capsule forms and tightens, and that Dr. Adams cannot predict, prevent, or control the occurrence of any of these deformities:

1) Closing of a portion of the lower implant pocket (can be mild or severe), causing slight or significant upward displacement of the implant, and raising the fold under the breast leaving the incision scar below the fold (if the incision was made under the breast)
2) Closing of a portion of the outside of the implant pocket, causing flattening of areas of the outside contour of the breast and inward displacement of the implant.
3) Excessive firmness of the implant or breast
4) Visible edges or bulging deformities in any area of the breast
5) The quality of the scar that I will form wherever my incision is located.
6) The effects of my body healing and scarring in the area of the incision, adjacent areas to the incision or breast, or any area of the breast.
7) Discomfort or pain in areas of the breast
8) Change in sensation or loss of sensation in any area of the breast or adjacent areas.
9) Occurrence of lymph node enlargement or small bands near the incision caused by incision or obstruction of small lymph vessels (both of which usually subside without treatment in 3-6 weeks).

24. _____ I understand and accept that any or all of these deformities can occur in one or both breasts, and do not occur equally on the two sides. Although breasts never match exactly on the two sides, if any of these deformities occur, differences in the two breasts may be more noticeable and may not be correctable.

25. _____ I understand and accept that if any or all of the deformities caused by my healing characteristics or the characteristics of the capsule (lining) around my implants occur, even though the deformity may be visible, that Dr. Adams alone will determine whether additional surgery is needed. Dr. Adams will base this decision on whether he feels the potential benefits outweigh the potential risks of additional surgery and whether he feels I will get predictable improvement from additional surgery. I agree to abide by Dr. Adams' decisions in all matters pertaining to whether or not additional surgery is performed.

26. _____ I understand and accept that if any of the deformities listed above occur following my augmentation, that additional surgery will not change the qualities of my tissues and healing characteristics that caused the deformity in the first place. As a result, additional surgery to correct these deformities a) is unpredictable at best due to the limitations of my tissues and healing characteristics, b) that surgery for any of the deformities listed above may not successfully correct the deformity, and c) that any or all of these deformities can occur again after additional surgery because of my healing characteristics.

RESPONSIBILITY FOR COSTS ASSOCIATED WITH ADDITIONAL SURGERIES

27. _____ Since Dr. Adams cannot predict or control my tissue characteristics or healing characteristics and how they will affect my chances of developing any of the deformities listed above related to tissue stretch and thinning or capsule or scar tissue formation following my augmentation, I understand and accept that should any of the deformities listed above (1-9) occur, if surgery is necessary to try to improve any of the following conditions, that *I will be personally responsible for all costs associated with any surgery that is performed (please initial beside each number indicating your complete understanding and acceptance of all costs associated with surgery for each deformity):*

1) excessive sagging or "bottoming out" of the breast with the implant too low and the nipple pointing excessively upwards,
2) shift of the implants to the sides with widening of the gap between the breasts,
3) thinning of tissues over the implant allowing the implant to become visible or palpable (able to be felt) in any area, and
4) Visible rippling in any area that can result when the implant pulls on the overlying tissues.
5) Closing of a portion of the lower implant pocket (can be mild or severe), causing slight or significant upward displacement of the implant, and raising the fold under the breast leaving the incision scar below the fold (if the incision was made under the breast)
6) Closing of a portion of the outside of the implant pocket, causing flattening of areas of the outside contour of the breast and inward displacement of the implant.
7) Excessive firmness of the implant or breast
8) Visible edges or bulging deformities in any area of the breast
9) The effects of my body healing and scarring in the area of the incision, adjacent areas to the incision or breast, or any area of the breast.
10) Discomfort or pain in areas of the breast
11) Change in sensation or loss of sensation in any area of the breast or adjacent areas.
12) Occurrence of lymph node enlargement or small bands near the incision caused by incision or obstruction of small lymph vessels (both of which usually subside without treatment in 3-6 weeks).

28. _____ I understand and accept that Dr. Adams does not accept insurance or any third party reimbursement for any type of additional surgery that may be necessary following my augmentation, and that I will be personally responsible for prepaying all costs of any additional surgery at least two weeks prior to the scheduled surgery. If I choose to pay by credit card, I understand and accept that I agree to sign additional documents authorizing full payment by my credit card company. Dr. Adams will provide me with copies of my operative note from my surgery, but I assume all responsibility for any filing of insurance and understand that Dr. Adams and his staff will not pursue payments from any third party.

29. _____ I understand and accept that costs of any additional surgery following my augmentation will likely exceed the costs of my original augmentation surgery, and that costs are determined by the complexity and length (time) of the surgery required. Fees for additional surgery will include laboratory fees, electrocardiogram fees if I am over 50 or have any heart condition, possible mammogram or MRI imaging fees, Dr. Adams' surgeon fees, anesthesia fees, surgical facility fees, and costs of prescriptions. I accept personal responsibility for all of these fees, and in addition, I understand and accept that I may have additional costs associated with time off work or normal activities.

30. ____ I understand and accept that Dr. Adams alone sets his fees for all surgeries he performs, that these fees are not negotiable for any reason by any party, and must be prepaid at least two weeks prior to surgery.

31. _____ To reserve a surgery date a non-refundable $500.00 preparation fee is due at the time of scheduling surgery. The $500 preparation fee will be applied to the surgeon's fee. The remaining balance is due two weeks prior to the date of your surgery. I**f payment is not received on time, your surgery will be flagged for cancellation** and **your deposit will not be refundable**. In order to keep your deposit you may call and reschedule or cancel your surgery prior to the due date.

If the consult and surgery occur within the 14 day window the full surgery fee is due at the time of scheduling. If the surgery is cancelled subsequently a partial refund may be given depending on the circumstances, this does not pertain to the non-refundable $500 deposit.

32. _____ If following my breast augmentation, any additional surgery for the reasons listed above becomes necessary, and I later choose to dispute any of the items above for which I have indicated my full understanding and acceptance, I agree to pay any and all of Dr. Adams' costs, including any attorney's fees, court costs, or any other costs associated with resolving the dispute.

33. _____ I have read all of Dr. Adams' informational materials and have had an opportunity to visit with Dr. Adams' patient educator, Christy Aguilar I have had an opportunity to ask questions and have had all of my questions answered to my satisfaction. I will have an additional opportunity to ask Dr. Adams questions during our consultation.

I feel fully informed, and have had an opportunity to have all of my questions answered to my satisfaction.
Signed this _____day of the month of _____, year _____

_____	_____
Patient: (Please print)	Patient: (Please sign)
_____	_____
Witness: (Please print)	Witness: (Please sign)

_____ I have been given a copy of this document for my personal records.

How Did We Do Informing You? (Document 4)

34. I **(please print and sign)**_____ have read Dr. Adams' informational materials and have had an opportunity to visit with Dr. Adams' patient educator, Christy Aguilar I have had an opportunity to ask questions and have had all of my questions answered to my satisfaction. I will have an additional opportunity to ask Dr. Adams questions during our consultation.

To assure that I thoroughly understand and accept the essential information about risks and tradeoffs, I am asked to answer the following questions and initial my answers.

Please initial the following ONLY IF YOU FULLY UNDERSTAND AND ACCEPT THE INFORMATION WE HAVE GIVEN YOU:

35. _____ I fully understand and accept that perfection is not an option, improvement with tradeoffs is the best we can hope for. No choice we can make is without tradeoffs and risks.

36. _____ I fully understand and accept that no woman has two breasts that match, and that no surgeon can produce two breasts that exactly match. I understand and accept that Dr. Adams will try his best to equalize my breasts as much visually possible given my tissues and their limitations, but my breasts will not match after surgery.

37. _____ I fully understand and accept that the larger we make my breasts, the worse they will look as I get older, the greater the risks of tissue thinning and/or visible rippling, and the greater the risk of additional surgeries with additional risks and costs.

38. _____ I fully understand and accept that Dr. Adams cannot and will not guarantee me a specific cup size breast, because cup size is not a consistent or predictable clinical measurement, cup size varies among bra manufacturers, and I may choose to wear a bra that is larger or smaller to produce a certain look of my breasts or for comfort or style reasons.

39. _____ I fully understand and accept that if I have thin tissues in any area, that I will likely feel the edge or the shell of my implant. If I can feel my ribs with my finger beneath my breast, I may feel the edge of my implants. If my tissues are extremely thin, I may even see a portion of the implant shell or an implant edge. Dr. Adams will make every effort to provide as much tissue coverage as my tissues will allow to minimize these risks, but he is limited by the quality and thickness of my tissues.

40. _____ I fully understand and accept that Dr. Adams cannot predict or control the amount that my tissues may stretch following augmentation. The larger the implant we choose, the more the tissues will stretch, but even with an implant that seems appropriate for my tissues, it is possible for my tissues to stretch excessively or unevenly in one breast or the other. If this occurs, breast shape or position may be different on the two sides, nipple tilt or position may be different, and additional surgery may be required to attempt to correct excess stretching deformities. Because this problem cannot be predicted or prevented, costs of additional surgery are totally my responsibility, including surgeon, anesthesia, and surgical facility fees. Additional surgical procedures carry additional risks, and do not guarantee correction of stretch deformities.

41. _____ I fully understand and accept that if I develop infection in either breast at any time, that Dr. Adams will remove one or both implants, and may recommend not ever replacing either implant due to risks of reinfection and/or capsular contracture, either of which could necessitate multiple reoperations and/or permanent deformities.

42. _____I fully understand and permit Dr. Adams to use betadine irrigation (off-label) to reduce implant related complications such as capsular contracture.

43. _____ I fully understand and accept that capsular contracture (contraction of the lining that forms around every breast implant), although not a medical complication, may cause me to need additional surgery. There are no tests or facts in my medical history that will allow Dr. Adams to predict whether I will develop capsular contracture in one or both breasts, and there are no implants or surgical techniques that can assure that I will not develop capsular contracture. If I develop capsular contracture, I fully understand and accept that Dr. Adams will reoperate on my breasts ONLY ONCE to remove or correct capsular contracture. If I develop another capsular contracture after the first reoperation, Dr. Adams will recommend REMOVAL OF BOTH IMPLANTS WITHOUT IMPLANT REPLACEMENT as the safest and best option to prevent an excessive number of reoperations. Additional reoperations could result in greater risks of tissue thinning and/or visible rippling, greater risks of additional surgeries with additional risks and costs, and could result in permanent deformities. I accept full responsibility for all costs associated with correction of capsular contracture, including surgeon, anesthesia, implant costs, laboratory and prescription costs, and surgery center or hospital costs.

44. _____ I fully understand and accept that if my implants ever need to be removed for any reason, the appearance of my breasts will be compromised. The larger the implant that I choose, the worse the appearance of my breasts will be, and the greater the risks of additional surgery with additional costs and risks.

45. _____ I fully understand and accept that if I choose a round shaped implant, that I will then have to choose between filling the implant to manufacturer's recommendations and risking implant shell rippling, folding, or premature failure, OR request that Dr. Adams overfill my implant past manufacturer's recommendations and possibly void the manufacturer's warranty. If I choose a prefilled, round saline implant, I accept that the implant may be under filled and accept the risks of shell rippling, folding, or premature failure.

46. _____ I fully understand and accept that I will be totally responsible for additional surgical, surgery facility, and anesthesia fees, as well as possible additional lost time off work or normal activities for three specific conditions: 1) Capsular contracture (excessive firmness or pocket closure in any area that causes implant displacement or deformity), 2) any deformity caused by excessive stretching of the breast skin in any area, producing excessive "bottoming" or implant displacement, excessive sagging, or other stretch deformity, and 3) any exchange of breast implants for any reason, including a change in breast implant size or shape. If other complications occur, Dr. Adams will not charge any surgical fee for my treatment, but I am responsible for surgery facility, lab test, and anesthesia fees as well as additional time off work and travel costs.

47. _____ I understand and accept that I am fully responsible for all additional charges for Dr. Adams' surgical fees, implant costs, surgery center fees, anesthesia fees, lab and drug fees, and costs of time off work for recovery for the following conditions: 1) treatment of any capsular contracture or pocket closure problem that could result in breast deformity or malposition of my implants, 2) treatment of any problem that may result from excessive stretch of my tissues, causing malposition of my implants or excessive tissue thinning, or 3) any exchange of breast implants for any reason, including a change in breast implant size or shape.

48. ___ I clearly understand and accept that all choices and decisions that Dr. Adams makes will be based ENTIRELY ON MY WRITTEN REQUESTS in the documents that he provides me during our consultation and preoperative communications, NOT ON ANY VERBAL DISCUSSIONS NOT VERIFIED IN MY WRITTEN REQUESTS.

49. ___ I understand and accept that Dr. Adams cannot read my mind, and it is my complete responsibility to be absolutely honest in my written requests. I have absolutely no other requests, expectations, or agendas other than those specifically defined in the written documents I have completed and signed.

50. ___ I am confident and comfortable that I have completely and honestly specified my desires and expectations in the written documents I have completed for Dr. Adams. I also understand if any information changes prior to surgery, it is my responsibility to see that new, written documents are completed and signed by me. I understand and accept that Dr. Adams will NOT consider any verbal communications without written confirmation and documentation signed by me.

51. ____ If, for any reason in the future, I commence, join in, or in any other manner attempt to assert any legal claim or cause of action against Dr. Adams for any item in this form that I have specifically acknowledged responsibility for by my initial or signature, I agree to pay all of Dr. Adams' attorneys fees associated with defending my claim or cause of action.
Please initial on the line and check the appropriate box:

52. _____ I have ❒ I have not ❒ read Dr. Adams website on breast augmentation (www.dr-adams.com) and Dr. Adams' educational guide to breast augmentation.

I feel fully informed, and have had an opportunity to have all of my questions answered to my satisfaction.

Signed this _____day of the month of _____, year _____ in the presence of the witness listed below.

_____	_____
Patient: (Please print)	Patient: (Please sign)
_____	_____
Witness: (Please print)	Witness: (Please sign)

Aesthetic Society Applauds FDA's Effort to Collect Data Concerning a Rare Condition Associated with Breast Implants

New York, NY (January 26, 2014) – The American Society for Aesthetic Plastic Surgery (ASAPS) announces today its support of a new national registry for breast implants that will be compiled by the American Society of Plastic Surgeons (ASPS) in collaboration with the Food and Drug Administration (FDA). This registry will document reported cases of a very rare condition, Anaplastic Large Cell Lymphoma (ALCL), in the presence of breast implants.

As patient advocates, the members of ASAPS applaud the efforts of the Food and Drug Administration (FDA) to ensure that sound scientific practices are the foundation for information and research, including post market surveillance.

ALCL in the presence of breast implants has been noted in sporadic case reports over the past 25 years. To date, ALCL has only been identified in 34 cases out of an estimated 5 to 10 million women with implants worldwide. As opposed to systemic ALCL which can occur anywhere in the body, this condition appears in the scar tissue that forms around the implant. It is encouraging that when this condition occurs in the presence of breast implants the patients have responded to a variety of treatments, including simple removal of the implant and surrounding scar capsule.

ASAPS joins both the FDA and ASPS in its view that breast implants are safe. "Breast implants are the most studied device in medical history. As physicians, our primary commitment is providing safe and effective patient care. We share in the commitment of FDA and ASPS to the continued device evaluation and monitoring," said Felmont Eaves, III, MD, of Charlotte, NC, and ASAPS President.

ASAPS recommends that all women including those with breast implants should follow their normal routine in medical care and follow-up, specifically regular self examination and mammography when appropriate. Any woman should watch for changes in her breasts such as pain and swelling and contact her physician if she has any questions. Further information can be found on www.breastimplantsafety.org

About ASAPS

The American Society for Aesthetic Plastic Surgery (ASAPS) is recognized as the world's leading organization devoted entirely to aesthetic plastic surgery and cosmetic medicine of the face and body. ASAPS is comprised of over 2,600 Plastic Surgeons; active members are certified by the American Board of Plastic Surgery (USA) or by the Royal College of Physicians and Surgeons of Canada and are fully trained in thecomplete spectrum of surgical and non-surgical aesthetic procedures; international active members are certified by equivalent boards of their respective countries. All members worldwide adhere to a strict Code of Ethics and must meet stringent membership requirements. Website:www.surgery.org