

HAND & PLASTIC SURGERY CENTRE, P.L.C.

Ronald D. Ford, M.D., F.A.C.S.
William T. Cullen, M.D., F.A.C.S.
Paul A. Luce, M.D.
Shannon D. Armstrong, M.D.
Matthew D. Martin, M.D.

Surgery of the Hand & Upper Extremity
Microvascular Surgery
Plastic & Reconstructive Surgery

245 Cherry Street, S.E., Suite 302
Grand Rapids, MI 49503
Phone (616) 459-4131 Fax (616) 459-6030

2373 64th Street, Suite 2700
Byron Center, MI 49315
Phone (616) 301-0240 Fax (616) 301-0250

LIPOSUCTION POST-OP INSTRUCTIONS

NORMAL SYMPTOMS: It is normal to experience soreness, bruising and swelling for the first few days following surgery. These conditions will lessen each day. Apply ice packs for the first 48 hrs only to those areas treated by liposuction. Looseness of the skin is normal following liposuction. It may take a few weeks for your skin to shrink into its new shape. A small amount of bloody drainage on your dressings is normal. Replace them with dry dressings as needed.

COMPRESSION GARMENT: After surgery, you will be placed in a support garment. This should be worn continuously for three weeks after surgery.

DRESSINGS/SHOWERING: You may shower the next day if you feel able. Remove the girdle, and discard dressings. After showering, gently pat dry the tape over the incisions and cover with gauze dressings to control drainage. Due to decreased sensation, be very cautious with the water temperature.

SOAKING: Do NOT get into a bathtub, hot tub or swimming pool for 8 weeks following surgery because soaking can cause wound healing issues.

DRIVING: You may begin driving after your 1st postoperative appointment ONLY if you are no longer taking prescription pain medication (narcotics).

ACTIVITY: After returning home we ask that you take it easy for the first week. Avoid heavy lifting for the first couple weeks. As you begin to feel stronger, gradually increase your activity, stopping when you get tired or if anything hurts. Sexual activity: as soon as you are comfortable with it.

RETURNING TO WORK: Depending on what your job entails returning to work will be different for everyone. Generally, our patients are off work 5-7 days. You can discuss this issue at the time of your first post-op visit and get the paperwork you may need at that time.

SCARS: Scars take at least 1 year to fade and flatten. During this time, it is better that you protect them from the sun. NO exposure for the first 3 months. Even through a bathing suit, sunlight can reach the skin and cause damage. It is imperative that you wear a sunscreen with a skin-protective factor (SPF) of at least 30 at all times.

NAUSEA/CONSTIPATION: It is important for you to have someone stay with you the day of the procedure. Nausea and/or vomiting may occur while taking oral antibiotics or pain medications. Should this happen, take your medications with food. If you experience

constipation, we suggest eating foods that are high in fiber and drink plenty of water (You may try over-the-counter stool softeners). Call our office if these symptoms persist.

WHEN TO CALL (616) 459-4131:

- If you develop redness (like a sunburn) around your incisions
- Fever of 100.5 or greater
- Persistent vomiting
- Unusual swelling, bleeding or increased pain
- Develop hives, diarrhea or other reactions to medicine
- Any other questions or concerns

Please remember that for the vast majority of patients the goal is significant improvement, not perfection. Please call our office at (616) 459-4131 should you have any questions or concerns.

POST-OP APPOINTMENT: _____

PRESCRIBED MEDICATION(S): _____

Please take Narcotic/OTC medication as directed and as needed. DO NOT drive or operate machinery if you are taking a narcotic. If you are prescribed antibiotics, take as directed until gone. Taking an incomplete course can lead to recurrence of infection. Please take antibiotics with food as this may cause upset stomach. Please ask physician before you begin taking aspirin, motrin/ibuprofen or other anti-inflammatory medications, as these can increase risk of bleeding.

****IF NAUSEATED, TRY NON-ACIDIC LIQUIDS, DRY TOAST OR OTHER BLAND FOODS****

Patient Signature: _____ **Date:** _____

Hospital Staff Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____