

POST-SURGERY INSTRUCTIONS: LIP AUGMENTATION with GRAFT

Patient Name _____

Date _____

Surgery Date _____

Once your surgery is completed, you must follow all the instructions given to you in order to heal properly and have a good outcome.

The following instructions are your obligation. Use this as a checklist of progress as you heal. Included are normal post-surgical experiences and key health considerations that may be a cause of concern.

TYPICAL POST-OPERATIVE SYMPTOMS

Typical symptoms of lip augmentation with a graft, and signs to watch for following a lip augmentation include:

Swollen, tight and bruised lips: A firm feeling over your lips and around your mouth. These are normal experiences as the skin, tissues and sensory nerves heal. Pain medication will help you cope with any discomfort. **Consistent sharp pain should be reported to our office immediately.**

CALL THE OFFICE IMMEDIATELY IF YOU EXPERIENCE ANY OF THE FOLLOWING:

- **A high fever, (over 101°) severe nausea and vomiting, continued dizziness or incoherent behavior, such as hallucinations.**
- **Any pain that cannot be controlled by your pain medication.**
- **Excessive bleeding or fluid seeping through the incisions.**
- **A severely misshapen appearance excessive bruising or fluid retention that is localized to one region of your lips.**

To alleviate any discomfort, and to reduce swelling, you may apply cool (not cold) compresses to your lips. Do not apply ice or anything frozen directly on the skin. Soak soft plain white washcloths or gauze squares in ice water and wring out well. Apply directly to the lips, but do not apply any pressure. Apply cool compresses for no longer than 20-minute intervals. Do not apply any heat.

DAY OF SURGERY INSTRUCTIONS

You will only be released to the care of a responsible adult. All of these instructions must be clear to the adult who will monitor your health and support you following surgery.

_____ **Rest, but not bed rest:** While rest is important in the early stages of healing, equally important is that you are ambulatory: meaning that you are walking under your own strength.
Spend 10 minutes every 2 hours engaged in light walking indoors as you recover.

_____ **Recline, do not lie down:** This will be more comfortable for you, and can reduce swelling.
Always keep your head elevated. Do not bend forward or over.

_____ **Good nutrition:** Fluids are critical following surgery. Stick to cool, non-carbonated, non-alcoholic, caffeine-free and green tea-free beverages including fruit juices and water, milk and yogurt drinks. Do not drink anything hot or frozen. Drink from a sip cup, not a straw. You must consume at least 8 ounces of fluid every 2 hours. Stick with soft, bland, nutritious food for the first 24 hours.

_____ **Take all medication, exactly as prescribed.** Oral pain medication, antibiotics and other medications you must take include:

Antibiotic	_____	mg	_____	x per day
Pain medication	_____	mg	_____	x per day
Ointment	_____	_____	_____	_____
Supplements	_____	_____	_____	_____

_____ **Keep your lips clean and moist with lip balm or ointment.** Do not remove any crusting near your stitches. Do not remove any sutures. Use an oral rinse as directed, after every meal, before bedtime, and at least 6 times per day.

_____ **Do not smoke.** Smoking can greatly impair your safety prior to surgery and your ability to heal following surgery. You must not smoke.

_____ **Relax.** Do not engage in any stressful activities. Let others tend to you.

TWO TO SEVEN DAYS FOLLOWING SURGERY

During this time you will progress with each day that passes. Ease into your daily activities. You will receive clearance to begin driving or return to work at your post-operative visit, or within:

_____ days

Your post-operative visit is scheduled for: _____

- **Continue to use your oral rinse and use of lip balm or ointment as directed.**
- **Apply skincare cautiously.** Do not allow glycolic, retinoid or other potentially irritating skincare products near your lips until you receive clearance to do so.
- **Take antibiotic medications and supplements as directed.** Take pain medication only as needed. You may wish to switch from prescription pain medication to acetaminophen or ibuprofen.
- **Continue to keep your head elevated, including when sleeping.**
- **Do not resume any exercise other than regular walking.** Walking is essential every day to prevent the formation of blood clots.
- **Maintain a healthy diet. Do not smoke. Do not consume alcohol.**

ONE to FOUR WEEKS FOLLOWING SURGERY

As you resume your normal daily activities, you must continue proper care and healing.

- **Continue to use lip balm, and keep your lips soft and moist.**
- **Refrain from direct sun exposure.** If you are outdoors, apply at least an SPF 30 at least 30 minutes prior to sun exposure. Your lips and the skin surrounding them are highly susceptible to sunburn or the formation of irregular, darkened pigmentation.
- **Do not smoke.** While your lips may have healed, smoking deprives your body of necessary oxygen that can result in poorly healed, wide, raised scars.

- **You may begin sleeping in a modified reclining position.** However do not sleep lying flat or on your stomach. If you are a side sleeper, two pillows under your head and a soft pillow under your mid-back and shoulders may offer more comfort.

Follow-up as directed. Your second post-operative visit is scheduled for: _____

SIX WEEKS FOLLOWING SURGERY

Healing will progress; swelling continues to diminish.

- **Discomfort or tightness and tingling in your lips will resolve.**
- **You may ease into your regular fitness routine.**
- **No need to resume smoking.** You have now gone 10 weeks (4 weeks prior to surgery and 6 weeks following) without a cigarette. For your long-term health, there is no need to resume smoking.

YOUR FIRST YEAR

Your appearance will change with age. Your lips may change too. You may wish to undergo injectables treatment to refine or revise your results, or complementary revision surgery at a later date to help maintain your appearance throughout life. Contact our office with any of your questions or concerns, at any time.

I have read and understand all of the above instructions. I understand that following these instructions is solely my responsibility. I understand that it is also my responsibility to ask my doctor and his or her staff any questions I have related to these instructions or about my procedure, health and healing.

Patient Signature

Date

Printed Name of Patient

Signature of Practice Representative and Witness