Review Article

Anesthesia for Plastic and Reconstructive Surgery: Current Concepts, Challenges, and Future Directions

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ABSTRACT

Plastic and reconstructive surgery encompasses a wide spectrum of procedures ranging from minor aesthetic interventions to complex microsurgical reconstructions. The heterogeneity of these procedures necessitates individualized anesthetic strategies aimed at optimizing patient safety, surgical conditions, and postoperative recovery. Contemporary practice has evolved toward multimodal, opioid-sparing, and procedure-specific anesthetic approaches, including general anesthesia, total intravenous anesthesia (TIVA), monitored anesthesia care (MAC), regional anesthesia, and local anesthetic techniques. Despite significant advances, anesthesia-related complications such as postoperative nausea and vomiting, hemodynamic instability, airway difficulties, and thromboembolic events remain clinically relevant. This narrative review summarizes current concepts in anesthesia for plastic and reconstructive surgery, emphasizing anesthetic techniques, and emerging future directions.

KEYWORDS
Plastic surgery; Anesthesia; Cosmetic Surgery

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INTRODUCTION

Plastic and reconstructive surgery comprises a wide spectrum of procedures ranging from elective aesthetic interventions to complex reconstructive microsurgery [1]. The global increase in surgical volume, coupled with rising patient expectations for rapid recovery and optimal aesthetic outcomes, has substantially expanded the role of anesthesia beyond intraoperative care to a key determinant of perioperative safety and surgical success. In contemporary practice, anesthetic management is increasingly integrated into multidisciplinary perioperative pathways aimed at improving outcomes and enhancing patient-centered recovery[2,3]. The anesthetic considerations in plastic and reconstructive surgery are uniquely heterogeneous. Procedures differ markedly in duration, anatomical location, degree of surgical stimulation, and physiological impact [4]. Facial aesthetic surgery often requires a delicate balance between airway accessibility and an unobstructed surgical field, while simultaneously minimizing blood loss and postoperative airway compromise. In contrast, body contouring procedures such as abdominoplasty and liposuction may be associated with significant fluid shifts, thermal instability, and

an elevated risk of venous thromboembolism [5]. Microsurgical reconstruction further introduces the critical requirement of maintaining stable hemodynamics and optimal tissue perfusion to ensure flap viability, where anesthetic-induced physiological perturbations may directly influence surgical outcomes[6, 7].

Over the past decade, anesthetic practice in plastic surgery has evolved considerably. Although general anesthesia remains the predominant technique for many procedures, there has been a progressive shift toward multimodal and technique-sparing strategies, including total intravenous anesthesia (TIVA), monitored anesthesia care (MAC), and ultrasound-guided regional anesthesia [8]. These approaches are increasingly incorporated into enhanced recovery paradigms, with the aim of reducing perioperative opioid exposure, facilitating early mobilization, and improving postoperative recovery profiles [9, 10]. In parallel, opioid-sparing and opioid-free anesthesia strategies have gained attention as part of broader efforts to mitigate opioid-related adverse effects without compromising analgesia or surgical conditions [11].

Despite these advances, anesthesia-related morbidity remains clinically relevant in plastic and reconstructive surgery. Postoperative nausea and vomiting, airway complications, hypothermia, local anesthetic systemic toxicity, and venous thromboembolism continue to represent important perioperative challenges. Moreover, the growing prevalence of ambulatory aesthetic surgery has intensified the need for rapid emergence, reliable analgesia, and safe same-day discharge protocols, placing further emphasis on the anesthesiologist's role in perioperative optimization[12].

Given the increasing complexity of procedures and the rapid evolution of anesthetic techniques, a comprehensive synthesis of current evidence is warranted. This narrative review aimed to summarize contemporary concepts in anesthesia for plastic and reconstructive surgery, focusing on anesthetic techniques, procedure-specific challenges, perioperative complications, and emerging directions including opioid-sparing strategies, regional anesthesia techniques, and enhanced recovery pathways.

Goals of Anesthesia

The goals of anesthesia include ensuring patient safety, optimizing surgical conditions, facilitating rapid recovery, and improving patient satisfaction. Maintenance of hemodynamic stability and tissue perfusion is particularly important in microsurgery, where flap viability is highly sensitive to physiologic fluctuations [13].

Bleeding control improves surgical precision and aesthetic outcomes, often achieved through controlled hypotension and pharmacologic modulation. Rapid recovery is increasingly important due to the rise of ambulatory surgery, with multimodal and opioid-sparing strategies playing a central role[14].

Choice of Anesthetic Technique in Plastic and Reconstructive Surgery

The selection of an appropriate anesthetic technique represents one of the most critical determinants of perioperative outcomes in plastic and reconstructive surgery. Given the wide variability in procedural complexity, duration, and physiological impact, anesthetic management cannot rely on a uniform approach. Instead, contemporary practice emphasizes a patient- and procedure-tailored strategy that integrates general anesthesia (GA), monitored anesthesia care (MAC), regional anesthesia, and local anesthetic techniques within a multimodal framework[15, 16].

A fundamental consideration in technique selection is the balance between surgical requirements and physiological optimization. While certain procedures necessitate complete immobility and controlled ventilation, others benefit from spontaneous respiration and minimal pharmacologic interference. In addition, the increasing emphasis on enhanced recovery after surgery (ERAS) and outpatient-based plastic surgery has shifted attention toward techniques that minimize opioid consumption, reduce postoperative side effects, and facilitate early discharge[17].

General Anesthesia and Total Intravenous Anesthesia (TIVA)

General anesthesia remains the predominant technique for major reconstructive procedures, prolonged aesthetic surgeries, and cases requiring airway protection or controlled ventilation. However, the choice of anesthetic maintenance technique has evolved significantly, with TIVA

increasingly favored over volatile-based anesthesia in selected settings[18].

Propofol-based TIVA offers several advantages particularly relevant to plastic surgery, including reduced postoperative nausea and vomiting (PONV), improved hemodynamic stability, and potential benefits in microcirculatory preservation. These characteristics are particularly important in microsurgical reconstruction, where flap perfusion is highly sensitive to vasomotor fluctuations and inflammatory responses[19].

Furthermore, TIVA facilitates rapid emergence and may improve early recovery profiles in ambulatory aesthetic procedures. However, its success depends on careful titration and monitoring to avoid intraoperative awareness or inadequate depth of anesthesia [20].

Monitored Anesthesia Care (MAC) and Sedation Techniques

MAC plays an important role in minor and intermediate aesthetic procedures, including facial rejuvenation, blepharoplasty, and limited soft tissue surgeries. The primary advantage of MAC is preservation of spontaneous ventilation and avoidance of endotracheal intubation, which may improve patient satisfaction and accelerate recovery [21].

However, MAC in plastic surgery carries inherent risks, particularly airway obstruction due to sedation depth variability and patient positioning. Procedures involving the face and airway region present additional challenges due to limited access and the potential need for emergent conversion to general anesthesia. Therefore, MAC should be reserved for carefully selected patients with low airway risk and short procedural duration [4].

Regional Anesthesia and Fascial Plane Blocks

Regional anesthesia has gained increasing importance as both an adjunct and primary anesthetic technique in plastic and reconstructive surgery. Advances in ultrasound guidance have significantly improved the safety and efficacy of peripheral nerve blocks and fascial plane techniques[22].

In breast surgery, blocks such as the pectoral nerve (PECS I and II) and serratus anterior plane block provide effective analgesia and reduce perioperative opioid consumption. Similarly, transversus abdominis plane (TAP) block is widely used in abdominal contouring procedures such as abdominoplasty[23].

Beyond analgesia, regional anesthesia contributes to improved recovery profiles, reduced PONV, and earlier mobilization. Importantly, these techniques are increasingly integrated into opioid-sparing and opioid-free anesthesia protocols [22].

Local Anesthesia and Tumescent Techniques

Local anesthetic techniques, particularly tumescent anesthesia, are fundamental in procedures such as liposuction and selected dermatologic surgeries. The tumescent technique, involving large-volume dilute lidocaine with epinephrine infiltration, provides profound analgesia, hemostasis, and hydrodissection of tissue planes [24].

This approach minimizes systemic anesthetic requirements and significantly reduces intraoperative bleeding, making it particularly valuable in ambulatory aesthetic surgery. However, attention must be paid to maximum safe lidocaine dosing and potential systemic toxicity, especially in large-volume procedures [25].

Integrated Multimodal Anesthetic Strategy

Modern plastic surgery anesthesia increasingly favors a multimodal approach rather than reliance on a single technique. The combination of GA or TIVA with regional blocks and local infiltration allows optimization of intraoperative conditions while enhancing postoperative recovery [26].

This integrated strategy aligns with ERAS principles and reflects a paradigm shift toward opioid minimization, early mobilization, and patient-centered outcomes. The optimal anesthetic plan should therefore be individualized based on surgical extent, anatomical site, expected pain burden, and patient comorbidities [27].

Emerging Trends in Anesthesia for Plastic and Reconstructive Surgery

In recent years, significant advances have occurred in the field of anesthesia for plastic and reconstructive surgery, with the primary goals of enhancing patient safety, minimizing postoperative complications,

and improving perioperative care. One of the most notable developments is the increasing adoption of opioid-free anesthesia (OFA)[28]. Given the well-documented adverse effects of opioids, including PONV, respiratory depression, sedation, and the potential for dependence, anesthesiologists have increasingly incorporated alternative agents such as dexmedetomidine, ketamine, lidocaine infusions, and nonsteroidal anti-inflammatory drugs (NSAIDs). This approach not only provides effective analgesia but also reduces opioid consumption and facilitates faster postoperative recovery[29].

Another important advancement is the widespread implementation of Enhanced Recovery After Surgery (ERAS) protocols. These evidence-based perioperative care pathways encompass interventions before, during, and after surgery. Key components include patient education, nutritional optimization, reduced preoperative fasting, multimodal analgesia, early postoperative feeding, and early mobilization. Numerous studies have demonstrated that ERAS protocols can reduce hospital length of stay, decrease complication rates, and improve overall patient outcomes while lowering healthcare costs[30].

The growing use of ultrasound-guided regional anesthesia has also transformed perioperative pain management. Ultrasound technology enables direct visualization of nerves, blood vessels, and surrounding anatomical structures, thereby improving the accuracy and safety of nerve blocks. This technique has been associated with higher block success rates, reduced risk of nerve and vascular injury, and decreased reliance on systemic opioids. Fascial plane blocks such as the pectoral nerve (PECS) block, erector spinae plane (ESP) block, and transversus abdominis plane (TAP) block have gained widespread acceptance in various plastic and reconstructive procedures.

In addition, goal-directed fluid therapy (GDFT) has emerged as an essential component of perioperative hemodynamic management [31]. In lengthy and complex procedures, particularly microsurgical reconstructions involving free tissue transfer, maintaining optimal fluid balance is critical for ensuring adequate tissue perfusion and flap viability. GDFT utilizes advanced hemodynamic monitoring to tailor fluid administration according to the individual patient's physiological needs, thereby avoiding the adverse effects associated with both hypovolemia and fluid overload [30].

Furthermore, the integration of artificial intelligence (AI) into anesthetic practice has opened new possibilities for perioperative care. AI-based algorithms can analyze large volumes of clinical data to predict perioperative risks, optimize drug dosing, anticipate hemodynamic instability, and support clinical decision-making [32]. As machine learning technologies continue to evolve, AI is expected to become an increasingly valuable tool in perioperative planning, intraoperative management, and postoperative monitoring [33].

Future Directions

The future of anesthesia in plastic and reconstructive surgery is expected to be driven by precision medicine and personalized perioperative care. Advances in genomics and pharmacogenomics may allow anesthetic drugs and dosages to be selected based on an individual's genetic profile, thereby improving therapeutic efficacy while minimizing adverse drug reactions. Such personalized approaches have the potential to significantly enhance patient safety and optimize surgical outcomes.

Another promising area of development is the implementation of real-time physiologic monitoring and intelligent monitoring systems. Emerging technologies will enable continuous assessment of parameters such as depth of anesthesia, tissue oxygenation, cardiac performance, and hemodynamic status with greater accuracy and reliability.

CONCLUSIONS

Appropriate anesthesia is a key factor in the success of plastic and reconstructive surgery. Maintaining hemodynamic stability, ensuring adequate tissue perfusion, and effectively controlling pain and postoperative complications play an important role in improving surgical outcomes. The use of evidence-based approaches and modern technologies can enhance patient safety and improve the success of reconstructive procedures.

Conflict of interests

There is no conflict of interests.

REFERENCES

1. Grosu-Bularda A, Hodea FV, Cretu A, et al. Reconstructive Paradigms: A Problem-Solving Approach in Complex Tissue Defects. J Clin Med 2024 Mar 17;13(6):1728.
2. Moningi S, Patki A, Padhy N, Ramachandran G. Enhanced recovery after surgery: An anesthesiologist's perspective. J Anaesthesiol Clin Pharmacol 2019 Apr;35(Suppl 1):S5-s13.
3. Ljungqvist O, Scott M, Fearon KC. Enhanced Recovery After Surgery: A Review. JAMA Surg 2017 Mar 1;152(3):292-8.
4. Nath SS, Roy D, Ansari F, Pawar ST. Anaesthetic complications in plastic surgery. Indian J Plast Surg 2013 May;46(2):445-52.
5. Ellsworth WA, Basu CB, Iverson RE. Perioperative considerations for patient safety during cosmetic surgery - preventing complications. Can J Plast Surg 2009 Spring;17(1):9-16.
6. Goswami U, Jain A. Anaesthetic implications of free-flap microvascular surgery for head and neck malignancies - A relook. J Anaesthesiol Clin Pharmacol 2021 Oct-Dec;37(4):499-504.
7. Toia F, D'Arpa S, Massenti MF, Amodio E, Pirrello R, Moschella F. Perioperative antibiotic prophylaxis in plastic surgery: a prospective study of 1,100 adult patients. J Plast Reconstr Aesthet Surg 2012 May;65(5):601-9.
8. Bharadwaj S, Dougherty W. Anesthesia for office-based facial plastic surgery procedures. World J Otorhinolaryngol Head Neck Surg 2023 Sep;9(3):200-5.
9. Ghai B, Jafra A, Bhatia N, Chanana N, Bansal D, Mehta V. Opioid sparing strategies for perioperative pain management other than regional anaesthesia: A narrative review. J Anaesthesiol Clin Pharmacol 2022 Jan-Mar;38(1):3-10.
10. Joshi GP, Kehlet H. Postoperative pain management in the era of ERAS: An overview. Best Pract Res Clin Anaesthesiol 2019 Sep;33(3):259-67.
11. Beloeil H. Opioid-free anesthesia. Best Pract Res Clin Anaesthesiol 2019 Sep;33(3):353-60.
12. Lee JH. Anesthesia for ambulatory surgery. Korean J Anesthesiol 2017 Aug;70(4):398-406.
13. Harfaoui W, Alilou M, El Adib AR, et al. Patient Safety in Anesthesiology: Progress, Challenges, and Prospects. Cureus 2024 Sep;16(9):e69540.
14. Kincaid S, How J, Agrawal DK. Multimodal Analgesia in the Perioperative Period of Major Surgeries: An In-depth Analysis. Anesth Crit Care 2025;7(3):68-76.
15. Cadillo RA, Roic LS, Salvador P, Lostia H, Cucchiaro JJV. Comment on the Safe Management of Sedation for Plastic Surgery. Plastic & Reconstructive Surgery 2011 2011/07/01;128(1):338-9.
16. Sohrabpour M, Sahraei R, Jahromi MSS, et al. Anesthesia Techniques in In-Office Aesthetic Surgery: A Narrative Review. Journal of Emergency Health Care 2023;12(3):27-32.
17. Çekmen N, Oba Ş, Haka D. "Ten Optimal Physiological Parameters" to keep the patient safe perioperatively: A narrative review. Saudi J Anaesth 2026 Apr-Jun;20(2):405-17.
18. Li LT, Chitilian HV, Alfille PH, Bao X. Airway management and anesthesia for airway surgery: a narrative review. Transl Lung Cancer Res 2021 Dec;10(12):4631-42.
19. Yoo YC, Bai SJ, Lee KY, Shin S, Choi EK, Lee JW. Total intravenous anesthesia with propofol reduces postoperative nausea and vomiting in patients undergoing robot-assisted laparoscopic radical prostatectomy: a prospective randomized trial. Yonsei Med J 2012 Nov 1;53(6):1197-202.
20. Smith AW, Nestor CC, Irwin MG. Total intravenous anaesthesia in emergency surgery: a narrative review. Anaesthesia 2026 Feb;81(2):263-73.
21. Sohn HM, Ryu JH. Monitored anesthesia care in and outside the operating room. Korean J Anesthesiol 2016 Aug;69(4):319-26.
22. Torrano V, Anastasi S, Balzani E, et al. Enhancing Safety in Regional Anesthesia: Guidelines from the Italian Society of Anesthesia, Analgesia, Resuscitation and Intensive Care (SIAARTI). J Anesth Analg Crit Care 2025 May 14;5(1):26.
23. Bakeer AH, Kamel KM, Abdelgalil AS, Ghoneim AA, Abouel Soud AH, Hassan ME. Modified Pectoral Nerve Block versus Serratus Block for Analgesia Following Modified Radical Mastectomy: A Randomized Controlled Trial. J Pain Res 2020;13:1769-75.
24. Uttamani RR, Venkataram A, Venkataram J, Mysore V. Tumescent Anesthesia for Dermatosurgical Procedures Other Than Liposuction. J Cutan Aesthet Surg 2020 Oct-Dec;13(4):275-82.
25. Lovett-Carter D, Kendall MC, Park J, Ibrahim-Hamdan A, Crepet S, De Oliveira G. The effect of systemic lidocaine on post-operative opioid consumption in ambulatory surgical patients: a meta-analysis of randomized controlled trials. Perioper Med (Lond) 2021 Apr 13;10(1):11.
26. Pasternak GW. Opiate pharmacology and relief of pain. J Clin Oncol 2014 Jun 1;32(16):1655-61.
27. Schoenbrunner AR, Joshi GP, Janis JE. Multimodal Analgesia in the Aesthetic Plastic Surgery: Concepts and Strategies. Plast Reconstr Surg Glob Open 2022

May;10(5):e4310.
28. Engel SJ, Patel NK, Morrison CM, et al. Operating room fires: part II. optimizing safety. Plast Reconstr Surg 2012 Sep;130(3):681-9.
29. Osman BM, Shapiro FE. Safe anesthesia for office-based plastic surgery: Proceedings from the PRS Korea 2018 meeting in Seoul, Korea. Arch Plast Surg 2019 May;46(3):189-97.
30. Altman AD, Helpman L, McGee J, et al. Enhanced recovery after surgery: implementing a new standard of surgical care. Cmaj 2019 Apr 29;191(17):E469-e75.
31. Yi R, Li Z, Yang X, Huang T, Liu H, Zhang J. The Utilization of Ultrasound-Guided Regional Nerve Blocks in Anesthetic Management for Fracture Surgery. J Pain Res 2025;18:353-66.
32. Zeng S, Qing Q, Xu W, et al. Personalized anesthesia and precision medicine: a comprehensive review of genetic factors, artificial intelligence, and patient-specific factors. Front Med (Lausanne) 2024;11:1365524.
33. Giri R, Firdhos SH, Vida TA. Artificial Intelligence in Anesthesia: Enhancing Precision, Safety, and Global Access Through Data-Driven Systems. J Clin Med 2025 Sep 29;14(19).