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Original Research Article

Beyond Aesthetics: Quality of Life Outcomes following Breast Implant Surgery—A Critical Review of Patient-Reported Outcomes and Emerging Systemic Concerns

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Abstract:

Aim: Breast implant surgery has traditionally been judged through technical outcomes and aesthetic assessment, yet modern evaluation increasingly prioritizes patient-reported outcomes, longitudinal quality of life, and safety transparency. This critical review aims to synthesize current evidence on quality-of-life outcomes after breast implant surgery, evaluate the strengths and limitations of patient-reported outcome measures, and examine the growing significance of systemic concerns in shared decision-making.

Materials and Methods: A narrative critical review approach was undertaken using contemporary peer-reviewed evidence and registry-based analyses focused on patient-reported outcome measures after breast implant surgery. Core source material included a 2024 systematic review and meta-analysis of Breast-Q augmentation outcomes involving 39 studies, 53 cohorts, and 18,322 patients, together with a 2022 registry-based qualitative analysis from the Australian Breast Device Registry examining 268 open-ended patient responses after augmentation. The review prioritized domains relevant to health-related quality of life: satisfaction with breasts, psychosocial well-being, sexual well-being, physical well-being, complications, revision burden, and patient perceptions of systemic illness.

Results: Breast implant surgery often produces substantial improvements in patient-reported psychosocial well-being, sexual well-being, and satisfaction with breast appearance. In the 2024 meta-analysis, psychosocial well-being improved by a mean difference of 38.10 points, sexual well-being by 40.20 points, and satisfaction with breasts by 47.88 points, whereas physical well-being improved only slightly and inconsistently. Registry-based qualitative data deepen this picture by showing that satisfaction frequently depends not only on appearance but also on surgeon communication, aftercare, and the natural feel of implants. At the same time, dissatisfaction arose from asymmetry, rippling, pain, altered sensation, tightness, rupture, revision surgery, and perceptions of inadequate counseling. Emerging systemic concerns included self-reported fatigue, joint pain, cognitive complaints, hair loss, and other symptoms interpreted by some patients as breast implant illness.

Conclusion: The strongest lesson from current evidence is that aesthetic success alone is an insufficient endpoint. High-quality breast implant care requires long-term surveillance, standardized patient-reported outcome measures, transparent disclosure of device-specific risks, and a consent process that addresses both proven complications and uncertain systemic concerns without dismissing patient experience. The future of implant evaluation therefore lies in integrating surgical outcomes, registry surveillance, symptom monitoring, and person-centered counseling rather than relying on appearance-based judgments alone.

Keywords: Breast Implant Surgery; Patient-Reported Outcomes; Quality Of Life; BREAST-Q; Breast Implant Illness.

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Introduction

Breast implant surgery remains one of the most widely performed procedures in aesthetic and reconstructive plastic surgery, and its popularity has ensured that outcome assessment is no longer limited to technical success, implant position, scar quality, or surgeon-rated appearance. Patient-reported outcome measures have therefore become critical in breast implant research. Tools such as the BREAST-Q and the BREAST-Q Implant Surveillance module were developed to capture domains that matter directly to patients, including satisfaction with breasts, psychosocial well-being, sexual well-being, physical well-being, pain, tightness, rippling, and overall experience after surgery. Their value lies in bypassing sole dependence on clinician interpretation and recognizing that a technically satisfactory result may still leave the patient distressed, uncomfortable, or disappointed. Conversely, some patients report high levels of confidence and satisfaction despite minor objective imperfections.

Recent evidence supports the importance of this patient-centered model. This distinction matters because breast implants are not lifetime devices and may require surveillance, revision, or removal. Registry analyses and clinical follow-up studies show that patients continue to report issues such as pain, tightness, loss of sensation, implant malposition, rippling, capsular contracture, rupture, and dissatisfaction with shape or symmetry. Such experiences can erode initial satisfaction and complicate the simplistic narrative that augmentation is either purely beneficial or purely harmful. Instead, the literature suggests a dynamic trajectory in which early gains in confidence may coexist with later physical concerns or the need for repeat procedures.

In parallel, the safety discourse around implants has expanded. Regulatory attention has increasingly focused on BIA-ALCL, a rare but serious lymphoma associated particularly with textured implants, and on the broader group of systemic symptoms reported by some women with implants. Current patient decision checklists emphasize the need to discuss known risks, silent rupture surveillance, and reports of symptoms such as fatigue, joint pain, muscle aches, memory or concentration problems, and rash. Although causal mechanisms for many systemic complaints remain uncertain, these symptoms have become too prominent in clinical conversation to ignore.

The term “breast implant illness” has emerged from this context, largely as a patient-driven descriptor rather than a single formally defined disease entity. Registry-based qualitative work has shown that some women attribute extreme fatigue, joint pain, digestive disturbance, night sweats, brain fog, and mood changes to their implants. More recent systematic reviews have attempted to define the syndrome and identify commonly reported symptom clusters, but methodological heterogeneity, selection bias, inconsistent definitions, and confounding by pre-existing conditions remain major challenges. A second major issue concerns the interpretation of satisfaction data themselves. Quality-of-life benefit in one domain can coexist with persistent negative outcomes in another. Another important consideration is that breast implant surgery occurs in diverse contexts. Aesthetic augmentation, postmastectomy reconstruction, and revision surgery involve different motivations, baseline distress, and expectations.

The move toward transparent consent has therefore become central to ethical practice. Regulatory labeling reforms and patient decision checklists reflect recognition that patients need clear information not only about aesthetic possibilities but also about device longevity, monitoring needs, revision burden, BIA-ALCL, and systemic symptom reports. In modern implant care, the quality of counseling and aftercare is itself a determinant of quality of life because disappointment often emerges when patients feel unprepared for complications, appearance changes, or the possibility of future surgery.

This review critically examines breast implant surgery beyond aesthetics. Its purpose is to synthesize the evidence on patient-reported quality-of-life outcomes, analyze the utility and limits of PROM-based assessment, describe common complication patterns reflected in patient narratives, and evaluate the growing significance of systemic concerns in contemporary breast implant practice. By centering both measurable quality-of-life gains and unresolved safety questions, this review argues for a more balanced framework in which success is defined by informed, longitudinal, patient-centered outcomes rather than appearance alone. [cite:1] [cite:2]

Materials & Method

Review Design: The review followed a structured evidence synthesis approach suitable for clinical narrative reviews. Emphasis was placed on studies and materials that directly addressed patient-reported outcomes after breast augmentation or implant-based breast procedures, particularly those using validated or registry-oriented PROMs such as the BREAST-Q and BREAST-Q Implant Surveillance module.

Data Sources: The main evidence base consisted of two core contemporary sources. The first was a 2024 systematic review and meta-analysis of Breast-Q augmentation outcomes that synthesized 39 studies, 53 cohorts, and 18,322 patients, providing pooled estimates for psychosocial well-being, sexual well-being, physical well-being, and satisfaction with breasts. The second was a 2022 analysis of open-ended comments collected through the Australian Breast Device Registry, which evaluated 268 responses from augmentation patients and identified thematic domains of satisfaction, dissatisfaction, complications, symptoms, and emerging concerns such as rippling and breast implant illness.

Eligibility Framework: Studies and documents were considered relevant if they fulfilled most of the following criteria:

- Focused on breast augmentation or implant-based breast surgery.
- Reported patient-reported outcomes, health-related quality of life, satisfaction, symptom burden, or patient narratives.
- Addressed postoperative benefits, harms, or both.
- Included data useful for evaluating emerging systemic concerns, device surveillance, or patient counseling.

Conceptual domains

1. Satisfaction with breasts and overall appearance.
2. Psychosocial well-being, including confidence, self-image, and social comfort.
3. Sexual well-being.
4. Physical well-being and symptom burden.
5. Complications and revision-related quality-of-life effects.
6. Systemic concerns, including reported symptom clusters and regulatory communication.
7. Implications for informed consent and longitudinal surveillance.

This domain-based framework was selected because breast implant outcomes are multidimensional and may diverge across domains.

Data Extraction: Key findings were manually extracted and thematically grouped. Quantitative data extracted from the meta-analysis included sample size, number of studies, principal Breast-Q domains, magnitude of postoperative score change, and temporal interpretation where available. Qualitative data extracted from registry-based material included dominant themes of patient satisfaction, dissatisfaction, symptoms, long-term device concerns, surgeon communication, aftercare, and self-attributed systemic complaints.

Synthesis Method: The final synthesis was interpretive rather than purely descriptive. Evidence was compared across domains to assess where quality-of-life gains were most consistent, where outcomes were ambivalent, and how emerging systemic concerns intersected with traditional metrics of success.

Outcome Presentation: To align with conventional academic paper structure, the review presents observations in narrative form and in four summary tables. These tables condense key findings related to quality-of-life domains, complications, systemic concerns, and implications for patient counseling.

Observation Tables

Table 1: Core Evidence Base and Study Characteristics

Source	Design	Population/sample	Main outcome focus	Key relevance to review
2024 systematic review and meta-analysis	Systematic review and meta-analysis	39 studies, 53 cohorts, 18,322 patients	Breast-Q psychosocial, sexual, physical well-being, satisfaction with breasts	Provides pooled quantitative estimate of postoperative quality-of-life change after augmentation
2022 Australian Breast Device Registry study	Qualitative descriptive registry analysis	268 open-text responses from augmentation participants	Satisfaction, dissatisfaction,complications, symptoms, emerging concerns	Captures lived patient experience beyond structured PROM scores
Contemporary regulatory/patient checklist materials	Safety communication and consent framework	Patient-facing implant counseling context	BIA-ALCL, rupture surveillance, systemic symptom disclosure	Demonstrates current expectations for risk communication and informed consent

Table 2: Patient-Reported Quality-Of-Life Domains After Augmentation

Domain	Pre/post trend	Quantitative or thematic finding	Interpretation
Satisfaction with breasts	Marked improvement	Mean difference +47.88 in meta-analysis; many patients describe being highly pleased with look and feel	Strongest evidence of benefit lies in aesthetic satisfaction
Psychosocial well-being	Marked improvement	Mean difference +38.10; comments link surgery to confidence and improved self-image	Breast augmentation often improves body image and social confidence
Sexual well-being	Marked improvement	Mean difference +40.20; many patients report enhanced femininity and sexual confidence	Intimate and relational dimensions are important gains
Physical well-being	Inconsistent/slight improvement	Mean difference +6.97 and non-significant pooled p value; registry comments report pain, tightness, and altered sensation	Physical comfort is the least consistently improved domain

Table 3: Frequent Adverse Experiences Reported By Patients

Adverse issue	Patient-reported pattern	Likely quality-of-life effect
Pain and tightness	Chronic discomfort, pain with activity or menstruation, persistent tightness	May reduce physical well-being despite aesthetic satisfaction
Rippling and visibility	Recurrent concern in registry comments, sometimes causing embarrassment in clothing or swimwear	Impairs body image and social confidence
Capsular contracture and malposition	Reports of hardening, deformity, implant movement, need for correction	Can trigger dissatisfaction and revision surgery
Rupture/revision burden	Implant rupture, repeat surgery, dissatisfaction after reoperation	Undermines long-term benefit and adds financial/emotional cost
Loss of sensation or nipple sensitivity	Numbness or marked sensory loss after surgery	Affects both physical and sexual well-being

Table 4: Emerging Systemic Concerns and Clinical Implications

Issue	Current Evidence Signal	Clinical Implication
Breast implant illness symptom reports	Patients describe fatigue, joint pain, cognitive symptoms, digestive issues, night sweats, and malaise in association with implants	Requires respectful evaluation, documentation, and balanced counseling despite uncertain causality
BIA-ALCL	Recognized serious safety concern addressed in patient counseling materials	Mandatory discussion during consent, especially for device-specific risk awareness
Silent rupture surveillance	Ongoing monitoring emphasized in modern implant guidance	Highlights that implants are not lifetime devices and need follow-up
Shared decision-making deficits	Dissatisfaction often linked to inadequate preoperative counseling or aftercare	Communication quality becomes a determinant of postoperative quality of life

Result

The reviewed evidence indicates that breast implant surgery can deliver substantial quality-of-life improvement, but these benefits are domain-specific and not universally durable. The most consistent positive outcomes occur in satisfaction with breasts, psychosocial well-being, and sexual well-being. In the 2024 meta-analysis, pooled postoperative improvements were large and statistically robust in each of these areas, suggesting that many patients experience benefits extending well beyond visible cosmetic enhancement.

These quantitative gains are reinforced by qualitative registry data. However, the evidence also reveals a clear limit to the "success" narrative. Physical well-being showed only modest and statistically non-significant pooled improvement in the meta-analysis, in contrast with the pronounced benefits seen in psychosocial and sexual domains. This discrepancy suggests that emotional or body-image gains may coexist with pain, tightness, sensory change, and other physical complaints that materially affect long-term satisfaction.

An especially important result of the review is that current outcome assessment must include systemic concern reporting. A subset of patients described symptoms such as fatigue, joint pain, cognitive impairment, digestive disturbance, rash, and malaise, which they attributed to implants and labeled as breast implant illness. Even where causation remains uncertain, these reports influence quality of life, health anxiety, trust in clinicians, and decisions regarding explantation.

Overall, the findings support a nuanced interpretation: breast implant surgery often improves self-perceived attractiveness, psychosocial functioning, and sexual confidence, yet it does not guarantee improved bodily comfort or freedom from future harm. The most accurate description of postoperative quality of life is therefore conditional and longitudinal rather than universally positive. Benefit is maximized when patient selection is appropriate, expectations are realistic, counseling is transparent, and postoperative surveillance remains active.

Statistical Analysis

The principal quantitative data in this review derive from pooled Breast-Q outcomes reported in a systematic review and meta-analysis. That analysis included 39 studies, 53 cohorts, and 18,322 patients, providing a large aggregated sample for estimating postoperative changes in patient-reported quality-of-life domains. The reported mean differences were +38.10 for psychosocial well-being, +40.20 for sexual well-being, and +47.88 for satisfaction with breasts, each with p values below 0.00001, indicating highly statistically significant postoperative improvement in these domains.

By contrast, physical well-being improved by only +6.97 in pairwise analysis with a p value of 0.42, indicating no statistically significant pooled improvement. In the single-arm analysis, physical well-being rose from 75.8 preoperatively to 83.9 postoperatively, an increase of 8.1 points, but this also remained statistically non-significant at $p = 0.17$. Statistically, this pattern shows a dissociation between psychosocial/aesthetic benefit and physical symptom outcomes. From an interpretive standpoint, the large magnitude and highly significant p values in psychosocial, sexual, and satisfaction domains support a real and clinically meaningful benefit for many patients.

Discussion

Breast implant surgery should no longer be evaluated as a procedure defined solely by cup size, projection, scar placement, or surgeon-rated aesthetic symmetry. The strongest contemporary evidence demonstrates that implantation can substantially improve patient-reported satisfaction with breasts, psychosocial well-being, and sexual well-being, and these gains are clinically important because they reflect how patients feel, function, and participate socially after surgery. For many women, augmentation offers a meaningful increase in confidence, femininity, body image, and intimate well-being. Any serious review of implant outcomes must acknowledge these benefits. Our study examines patient-reported outcomes after breast augmentation with a focus on satisfaction, quality of life, and implant-related concerns, and this overall direction is strongly aligned with the contemporary literature that places the patient voice at the center of breast surgery outcome assessment

At the same time, the evidence clearly rejects a simplistic celebratory narrative. Physical well-being does not improve as consistently as psychosocial or aesthetic domains, and this asymmetry is one of the most important findings in the current literature. Patients may be happier with appearance while continuing to experience pain, tightness, altered sensation, rippling, implant malposition, hardening, rupture, or repeated surgery. In practical terms, an implant can be psychologically beneficial and physically troublesome at the same time.

Knoedler et al. synthesized 39 studies comprising 53 cohorts and 18,322 patients and showed substantial postoperative gains in psychosocial well-being, sexual well-being, and satisfaction with breasts, while physical well-being showed smaller and more variable change. When compared with that evidence base, our study can be interpreted within a well-established framework in which aesthetic breast surgery is expected to generate pronounced psychosocial and satisfaction benefits, but more heterogeneous physical symptom outcomes. If our findings demonstrated stronger gains in satisfaction and psychosocial domains than in physical comfort, they would be concordant with the broad pattern identified by Knoedler et al. and with the conceptual domains originally established by Klassen et al. for women undergoing breast surgery

A major strength of comparing our study with the published references is that the BREAST-Q has become the dominant and most rigorously developed patient-reported outcome instrument in augmentation research. Klassen et al. identified six central themes relevant to breast surgery outcomes: satisfaction with breasts, satisfaction with overall outcome, psychosocial well-being, sexual well-being, physical well-being, and satisfaction with the process of care, and these themes later informed BREAST-Q content. Therefore, if our study assessed domains such as aesthetic satisfaction, confidence, sexual self-image, symptoms, and care experience, it is not merely methodologically similar to prior studies; it is conceptually anchored in the same patient-derived framework. Compared with older studies that relied more heavily on ad hoc questionnaires, a study using structured PROMs offers greater comparability with international literature and allows the findings of our series to be interpreted against pooled evidence rather than isolated institutional impressions.

The comparison with Jayasinghe et al. is particularly important because that study used the BREAST-Q Implant Surveillance module within the Australian Breast Device Registry and analyzed patients' free-text experiences after augmentation. Jayasinghe et al. examined 268 randomly selected open-ended responses from women who underwent augmentation between 2015 and 2018, drawing attention not only to satisfaction but also to device-related symptoms and emerging concerns such as rippling and breast implant illness. If our study similarly found that most patients were satisfied overall yet still reported selected bothersome symptoms or anxieties, then our results would closely mirror the ABDR experience, where positive global impressions coexisted with mention of complications and newer implant-related worries. In contrast, if our patients reported very low concern regarding rippling or implant-related illness, that difference could reflect variation in implant type, counseling, follow-up duration, local information ecosystems, or social media exposure rather than a true contradiction of the Australian data.

The registry literature is especially useful for situating our findings in a real-world surveillance context rather than a narrowly controlled academic cohort, however, if our symptom burden was higher, that may suggest our cohort captured later follow-up, higher-risk implants, or a population more sensitized to implant-related adverse experiences. Another valuable comparison concerns the feasibility and acceptability of PROM implementation, which is addressed in the Australian registry work and in broader PROM methodology literature. Chow et al. argued that patient satisfaction is a crucial endpoint in surgery and should be considered an essential component of quality assessment, not a secondary soft outcome. Accordingly, if our study prioritized patient-reported satisfaction alongside clinical variables, it would be methodologically consistent with current quality-improvement thinking; if it relied only on clinician-rated cosmesis or complication counts, it would be weaker than the registry and PROM-centered references in capturing what matters most to patients.

The distinction between PROMs and objective measures, emphasized by Morley and Leech, is central when comparing our results with the cited literature. Their review concluded that no single assessment tool is sufficient. Compared with studies focusing only on aesthetic appearance or only on complication rates, a combined approach would better explain why some patients remain highly satisfied despite minor objective irregularities, whereas others report disappointment even in the absence of major surgical complications. Sarwer et al. found that women seeking augmentation, compared with physically similar controls, had greater dissatisfaction with their breasts, greater investment in appearance, more appearance-related distress, and more frequent teasing experiences, indicating that augmentation candidates often begin from a distinct psychosocial baseline. In comparison with Sarwer's preoperative profile, strong postoperative satisfaction in our cohort would suggest that augmentation can substantially reduce the gap between body-image distress and perceived appearance, a trend also supported by the postoperative improvements summarized by Knoedler et al.

At the same time, our findings should be interpreted against the literature on implant-specific adverse experiences, because positive satisfaction scores do not eliminate the relevance of device-related complications. Pantelides and Srinivasan highlighted rippling as an important postoperative issue with multiple etiologic factors and a need for severity-based assessment, while Jayasinghe et al. identified rippling as one of the emerging concerns raised by patients in registry comments. Similarly, reviews on breast implant-associated anaplastic large cell lymphoma describe BIA-ALCL as a rare but increasingly recognized disease associated predominantly with textured implants and often presenting with late peri-implant seroma. Therefore, if our study reported high satisfaction but also documented isolated concerns about rippling, swelling, or fear of malignancy, that pattern would be entirely compatible with the literature, which shows that patient-reported success and safety vigilance must coexist rather than be treated as mutually exclusive outcomes.

Jayasinghe et al. specifically noted that breast implant illness was an emerging issue in open-ended patient responses after augmentation, indicating that patient-reported surveillance can identify concerns before they are fully resolved in conventional clinical literature. Deva et al. described the long and controversy-laden history of breast implants, underscoring how recurrent crises have shaped public trust in these devices. If our study population expressed concern about systemic symptoms, safety, or misinformation despite satisfactory cosmetic outcomes, such findings would be consistent with a modern environment in which patient experience is influenced not only by the physical result of surgery but also by regulatory debates, online narratives, and highly visible safety controversies.

Chow et al. emphasized that satisfaction should be treated as a legitimate quality endpoint in surgery, while Cella and colleagues, as well as Weldring and Smith, characterized PROs and PROMs as structured means of capturing the patient's health status, symptoms, and treatment experience directly from the patient perspective. Within that framework, the relevance of our findings extends beyond aesthetic surgery because they contribute to performance measurement and patient-centered evaluation of care. If our study demonstrated that patient satisfaction tracked closely with psychosocial benefit but less closely with isolated physical symptoms, this would support the broader PROM literature showing that patient judgment of success is multidimensional and cannot be inferred reliably from technical outcomes alone.

If our study included a qualitative component, its comparison with the referenced qualitative methods papers becomes especially important. Hsieh and Shannon described conventional, directed, and summative approaches to qualitative content analysis, while Tong et al. developed the COREQ 32-item checklist to improve transparency in reporting interviews and focus groups. Jayasinghe et al. used qualitative descriptive analysis of open-ended responses from the BREAST-Q IS, illustrating how even very brief narrative comments can reveal themes that fixed-response scales may miss. Thus, if our study used patient narratives to contextualize numerical satisfaction scores, it would align well with current best practice; compared with purely quantitative studies, such an approach offers a richer explanation of why patients report satisfaction, dissatisfaction, reassurance, or anxiety after augmentation.

Overall, the references collectively suggest that the most credible interpretation of our study is one that balances strong evidence of postoperative satisfaction and psychosocial benefit with continued attention to symptoms, complications, and evolving safety concerns. Compared with the systematic review by Knoedler et al., our study is likely most convincing when it confirms substantial gains in satisfaction, psychosocial well-being, and sexual well-being while acknowledging that physical well-being may improve less dramatically or inconsistently. Finally, compared with conceptual and methodological references on PROMs, our study is strongest when it demonstrates that breast augmentation outcomes should be judged not only by surgeon-observed appearance or complication rates, but by the patient's own integrated assessment of body image, comfort, confidence, and satisfaction with care.

A further lesson from the literature is that emerging systemic concerns have altered the ethical landscape of breast implant surgery. Reports of fatigue, joint pain, cognitive complaints, rashes, digestive problems, and other symptoms attributed by some patients to implants cannot be ignored simply because mechanistic certainty is incomplete. Whether all such symptoms constitute a single causal syndrome remains unresolved, but their presence affects patient trust, perceived health, and decisions about explantation. Likewise, the recognized risk of BIA-ALCL has made device-specific counseling and long-term surveillance essential rather than optional.

The modern implant consultation must therefore move beyond marketing language and beyond narrow discussions of shape and size. Patients need balanced counseling that explains likely benefits, variable physical outcomes, long-term monitoring requirements, revision burden, and the difference between established complications and still-debated systemic symptom associations. Transparent counseling is not a medicolegal formality; it is a quality-of-life intervention in itself because it reduces expectation mismatch and helps patients interpret future symptoms without confusion or betrayal.

This review also highlights a methodological point for future research. Average postoperative score improvement, while encouraging, is not sufficient to define overall success. Longitudinal studies should integrate PROM trajectories, adverse event surveillance, explant outcomes, implant-specific factors, and patient subgroups such as aesthetic versus reconstructive populations. Better evidence is especially needed to clarify which patients sustain long-term benefit, which are most vulnerable to physical dissatisfaction or revision, and how systemic symptom reports should be prospectively evaluated.

Conclusion

In summary, the quality-of-life impact of breast implant surgery is best understood as multidimensional, conditional, and time dependent. Many patients experience real psychosocial and sexual benefit, but these gains are moderated by complications, symptom burden, and safety uncertainty. The central message of this critical review is that "beyond aesthetics" is not a rhetorical phrase; it is the correct clinical framework. Breast implant outcomes should be judged by how well surgery improves a patient's lived experience while minimizing avoidable harm through careful selection, rigorous follow-up, standardized outcome measurement, and fully informed shared decision-making.

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