We cannot ignore what is all around us. To remain as we were means we are going backwards. To grow and expand and provide the best service we can for our members and for our patients means we need to recognize when change is necessary, and act on it.

The practice of modern aesthetic surgery is evolving rapidly. A professional society such as ISAPS must adapt to this new world of aesthetics in order to produce the best education for its members. Areas of injectables, lasers and other non-surgical aesthetic procedures are increasingly becoming the domain of other aesthetic specialties including dermatology, facial plastic surgery and oculoplastic surgery. Not to listen, not to share, not to learn all we can from each other is not doing a service to our members or to our patients.

With current, rapid market changes, industry has recognized that there is not much they can sell to plastic surgeons so they are now directing their financial support to meetings that include other core specialties. ISAPS recognizes these changes. As a leading international society, we must pay attention to the financial impact of our future meetings as much as to their scientific excellence. It is a fact that we cannot offer effective educational programs without the support of our industry partners.

Therefore, the ISAPS leadership has decided to expand its educational efforts to multi-specialty meetings so that we can cover areas previously not taught. They realize that some topic areas are in fact better taught by distinguished core educators from the specialties of dermatology, facial plastic surgery, and oculoplastic surgery. Adding these “core” specialists to our faculty will broaden the scope and impact of our education programs and improve the content of our courses. Doing so will bring increased corporate support which ultimately allows us to provide the quality scientific programs our members expect from us.

That is the first step. The second step is to slowly begin to offer membership to a select group of these core specialists. Expanding our global membership, while still maintaining our strict admission standards, will give ISAPS the necessary stature to approach industry to work with us on the highest levels.

Only the following three categories of core subspecialty aesthetic groups will be invited to join as Affiliate Members: dermatologists, facial plastic surgeons, and oculoplastic surgeons. Such membership will be by invitation and only to highly qualified, board certified members of their respective societies. Affiliate Members will not have the privilege of voting, will pay the same dues and registration fees as Active Members, and will be invited to attend and teach at ISAPS education programs.

None of these changes were decided without extensive discussion at the board level. Strategic planning for the future of ISAPS is vital for our survival and our ongoing improvement as the largest and most respected international society in our field. These changes will not be easy for some to appreciate at first. We understand this and we ask that our members have an open mind and support the decision of their elected leaders. We have a strong and unified Board of Directors that want only the best for this organization. It takes this depth of vision to accomplish excellence. And that is what we all want for ISAPS.

It is not the strongest or the most intelligent who will survive but those who can best manage change.  
—Charles Darwin

-The ISAPS Board of Directors
MESSAGE FROM THE PRESIDENT

We enjoyed dinner with ISAPS members in Italy during our last board meeting. I greatly appreciated this opportunity that Gianluca Campiglio, Flavio Saccomanno, and Mario Pelle-Ceravolo kindly provided for us.

We heard a favorable report on the ISAPS Rio Congress from Carlos Uebel, Immediate Past President of ISAPS. Rio was a great success with a total 2200 participants including 1800 surgeons. Everyone appreciated the high level of the Scientific Program and the Social Events. I am pleased to offer Carlos Uebel and Jorge Herrera, the Scientific Program chair, my heartfelt compliments and thanks.

One of the important topics in Rome was the state of Aesthetic Plastic Surgery (APS), the ISAPS journal. Dr. William Curtis, Vice President at Springer Publishing, reported on key points such as circulation, readership, revenues, editing and impact factor of our journal. Though Bill told us that the journal is in quite healthy financial condition, some board members were not happy with the second drop in impact factor. We place importance on impact factor as an indicator of our journal’s scientific reputation in the world and feel uneasy about the decreasing number in recent years. I have asked Renato Saltz, chair of the Journal Operations Committee (JOC), to meet with the Editor and Publisher at the beginning of 2015 to review in depth what can be done to improve APS.

I attended the Journal Retreat that took place in New York on January 30 and have asked the JOC chair to summarize that meeting in this newsletter. Personally, I would like to ask for your cooperation. Please submit your papers to this journal — YOUR journal. When you give a conference presentation, you are kindly requested to write a paper based on the presentation and send it to Aesthetic Plastic Surgery. You are also kindly requested to advise your colleagues to do so. That will immediately increase the number of submissions to our journal and possibly the number of citations which will increase the APS Impact Factor. Of course, there are many other positive issues going on that are being addressed by the JOC, Editor-in-Chief and publisher. Another important topic we discussed in Rome was a change in our growth strategy which I reported in my letter to all ISAPS members in January. It has to do with a shift toward multi-specialty meetings and membership.

Needless to say, the new membership category must consist of top-class doctors in each area. Admission will be by selective invitation only. I have the following procedure on my mind: we invite a doctor as faculty; the Education Council evaluates her/his presentation; the Membership Committee and/or National Secretary makes an ethical review of the candidate; and then, only when the doctor’s overall rating is high, we invite him/her to become a member in this new category.

In summary, only the following categories of “core” subspecialty aesthetic groups will be invited to join as Affiliate Members: dermatologists, facial plastic, and oculoplastic surgeons. This new category of members will not be allowed to vote and will pay the same dues and registration fees as Active Members. All members of the “core” specialties will be allowed to register and to teach at ISAPS education programs.

Regardless of this expansion, ISAPS educational events will only be open to board certified doctors in their respective specialties and even among these, non-plastic surgeons will not be allowed in every session. For example, only plastic surgeons can enter a breast session.

I have received many emails of support and some negative comments after my initial letter to the membership regarding our new multispecialty strategy. As to this new direction, we need to bring the whole of ISAPS together and change our By-laws.
MESSAGE FROM THE EDITOR

It is my pleasure to welcome you to this issue of ISAPS News. In this edition, you will learn about our society’s efforts to move toward multispecialty collaboration to the benefit of our members and our patients. These plans are outlined in a message from the Board of Directors and further elaborated upon by our president, Dr. Takayamagi, in his message to the membership.

Consistent with our mission of patient safety and excellent standards of care, Ivar van Heijningen reports on the new European Standard in relation to Aesthetic Surgery services (EN 16572) that encompasses all aspects of practice. Dr. Lina Triana, Chair of the Education Council, gives a wonderful update on all of the exciting educational plans for ISAPS. We also present a report from our journal editor, Dr. Henry Spinelli, highlighting the successful growth of our journal, Aesthetic Plastic Surgery.

Our Global Perspectives Series in this issue focuses on trends in non-invasive treatments. This is a great opportunity to read about practice patterns in different regions of the globe as presented by our members. This global perspectives topic is complemented by an informative article on the psychosocial aspects of minimally invasive procedures by Dr. David Sarwer. Our regular history section this time focuses on the fascinating story of Jaques Rivendar, a pioneer in skin grafting, presented by Dr. Denys Montandon.

I hope you enjoy this issue of ISAPS News where you can read about these topics, as well as several humanitarian efforts, past and upcoming educational programs, and much, much more. Warmest regards,

J. Peter Rubin, MD, FACS
ISAPS News Editor

photo Bruce D. Jones, 1937
CEN UPDATE

Ivar van Heijningen, MD – Belgium
ISAPS National Secretary for Belgium and Membership Committee Chair

It is with great joy that I welcome the CEN press release on the European Standard for Aesthetic Surgery services. My membership in ISAPS helped me a lot with this standard. The ISAPS safety diamond was taken as the basis and the AAAASF-I accreditation manual was also used as a base for discussion. In this sense ISAPS contributed a lot to this standard which finally took form thanks to the input of many people in the standard institutes of most European countries whom I thank for this.

— Ivar van Heijningen

CEN publishes standard on Aesthetic Surgery services

Brussels, 20 January 2015 — CEN is pleased to announce the publication of a new European Standard in relation to Aesthetic Surgery services (EN 16372). It is expected that this standard will help to improve the quality of these services, enhance the safety and satisfaction of patients, and reduce the risk of complications.

The market for aesthetic surgery interventions has grown over the last few years. The increased availability of affordable travel and the internet mean that medical tourism in relation to aesthetic surgery has become a reality. There is a rising need to ensure that patients are fully informed and able to rely on safe aesthetic surgery interventions, whether at home or abroad.

The new European Standard (EN 16372) addresses requirements for surgical services provided to patients who wish to change their physical appearance. This new voluntary standard provides requirements and recommendations in relation to services provided by aesthetic surgery practitioners. These recommendations concern various aspects such as: ethics and marketing, information provided to patients, competences of the surgeons, the consultation procedure, requirements for clinical facilities and post-operative follow-up.

The new European Standard (EN 16372) was developed by CEN’s Project Committee on “Aesthetic Surgery and Aesthetic Non-surgical Medical services” (CEN/TC 403), which was set up in 2010. This Committee includes practitioners nominated by CEN Members as well as other stakeholders including ANEC, which represents consumer interests in standardization.

The new European Standard (EN 16372) was formally approved by CEN in October 2014 and the final version of the standard was made available to all CEN Members (National Standardization Bodies) on 17 December. Before the end of June 2015 (at the latest), this standard will be published at national level by CEN Members in 33 European countries.

The Project Committee CEN/TC 403 is chaired by Dr Johann Umschaden from Vienna (Austria), who is a Specialist in Plastic, Aesthetic and Reconstructive Surgery. Dr Umschaden states: “The new European Standard defines a high level of quality for aesthetic surgery services and provides the basis for optimal patient safety.”

The Belgian Plastic Surgeon Ivar van Heijningen was one of those who initiated the project to develop a European Standard for Aesthetic Surgery services, alongside Dr Umschaden. According to Dr van Heijningen: “This European Standard is a landmark for health care services, especially considering the cross-border mobility of patients in Europe.”

“Whether they are being treated in their own country or abroad, patients expect to be treated by competent practitioners in a safe environment and to be informed about relevant issues related to their treatment, including risks. These expectations are addressed by the new European Standard for aesthetic surgery services,” continues Dr van Heijningen.

Some EU member states have specific regulations on aesthetic surgery, but most countries don’t have. This gap can now be closed by the voluntary European Standard for the mutual benefit of practitioners and patients,” adds Dr van Heijningen, who is the National Secretary of ISAPS (International Society of Aesthetic Plastic Surgery) in Belgium. According to the chair of CEN/TC 403, Dr Johann Umschaden: “Even if there are specific regulations in some EU Member States on aesthetic surgery, some of them are lacking in terms of hygienic, technical issues, or they don’t include a risk analysis. Recent reports on incidents in the context of Aesthetic Surgery emphasize the need for higher quality standards.”

The ISAPS leadership is demonstrating a straightforward message and offering an open invitation for all ISAPS members to take an active role in plastic surgery expansion to include all aesthetic procedures worldwide that will ultimately enhance our practices and allow us all to grow.

I want to thank my EC Team and our ISAPS National Secretaries and especially to our United Board of Directors for their brave efforts to help ISAPS grow and maintain our excellence in education into the future.

ISAPS EDUCATION EXPANSION PLANS

Lina Triana, MD – Colombia
Chair, Education Council

We are living today in a globalized world where strategic alliances are very important to stay on board in any business. We see this in different industries and now it is time for us as plastic surgeons to catch up with this flow.

ISAPS members have read in my past articles in this newsletter and in a recent letter sent by our president, Dr. Takayanagi, how ISAPS is expanding its mission in education.

Now I want to once more bring to you our updated ISAPS goals. We are expanding from our initial mission of surgical education only to more comprehensive aesthetic procedure education worldwide.

To pursue and achieve these goals, we must extend our strategic alliances to include core specialties that perform both aesthetic surgical and non-surgical procedures. By doing so, we will become a more inclusive society sharing and enriching each other in our areas of expertise. We must always keep in mind that this can only be done with those who have true, formal education in aesthetic procedures. This includes only those specialists who have completed their residency and advanced training and who have experience in the specific surgical or non-surgical aesthetic procedure they claim to do. These are the core specialists with whom we truly share competencies in aesthetic procedures.

We must never forget why we are here: for our patients. If we want to offer them the best in aesthetic procedures, we must become an inclusive society where we ALL work together and learn from each other. The times when isolation was best have changed. ISAPS is stepping in with these alliances to expand our plastic surgery universe. Today we have the responsibility to lead in this globalized world of aesthetic procedures.

Following this new ISAPS trend that has been mandated by our Board of Directors led by our president, Dr. Takayanagi, the EC team has a big responsibility and will play an active role in these changes.

We are now open to learn from those in the core specialties by including them in our scientific programs and by sharing the floor in our meetings with them. The entire ISAPS leadership is also working out how we can make them feel like part of our family. Following this strategy, we are introducing a new affiliate membership category about which you can read in this issue.

The EC team and our ISAPS National Secretaries are still working according to the high standards established by Dr. Nazim Cerkes for our ISAPS courses, symposia and meeting endorsements throughout the world. Recent courses in Pattaya, Thailand and Liege, Belgium have been very successful and I invite you to maintain this good energy so that we can continue with what past ISAPS EC Chairs had achieved — providing education in plastic surgery worldwide, but now expanded to all aesthetic procedures.

Following this new ISAPS trend, which is still happening, the ISAPS EC team would like to encourage those who present at our meetings to further share their knowledge by submitting papers to our ISAPS journal, Aesthetic Plastic Surgery. We invite you to become ISAPS ambassadors not only during ISAPS scientific meetings, but at any meeting you attend. Be open to recruiting interesting new information and concepts to be submitted to our journal.

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14th OSAPS Meets in Thailand Combined with ISAPS Symposium

Kamol Wattanakrai, MD – Thailand
Sanguan Kunaporn, MD – Thailand

On October 27-29, 2014, the 14th International Congress of the Oriental Society of Aesthetic Plastic Surgery (OSAPS) met in Pattaya, Thailand with 262 local delegates and 194 international participants. In all, 24 countries were represented. Scientific sessions covered 10 topic areas with Live Surgery demonstrations on Mammaplasty and Rhinoplasty. The opening address was the Seiichi Ohmori Memorial lecture given by US Prof. Gordon H. Sasaki from USA.

Free papers were presented in the areas of mammaplasty, rhinoplasty, breast, facial, eyelid, and cosmetic surgery with 25 oral presentations and eight posters. There were 27 faculty members from nine countries. Social events included a welcome reception at the beautiful infinity-edge swimming pool of The Royal Cliff Beach Resort Hotel, a presidential dinner for faculty and speakers, a banquet and 22 posters, and 27 sponsor booths. Notable examples were Professors Fu-Chan Wei, Yu-Ray Chen, Yilin Cao, Lee L.Q. Pu, David T.W. Chiu, and Dae-Hwan Park, and too many others to mention.

One could easily feel excited being a part of this meeting because we saw legendary authorities everywhere, speaking, passing by, talking to someone, having a cup of coffee or visiting the exhibition booths. Notable examples were Professors Fu-Chan Wei, Yu-Ray Chen, Yilin Cao, Lee L.Q. Pu, David T.W. Chiu, and Dae-Hwan Park, and too many others to mention.

Some 300 delegates came from Mainland China, Taiwan, USA, Singapore, UK, Canada, Ireland, Korea, Australia, France, India, Israel, Macau, Malaysia, New Zealand in addition to Hong Kong (Figure 2).

The scientific program included comprehensive coverage of all current and important aspects of plastic surgery. Concurrent reconstructive and aesthetic sessions took place in two adjoining theatres. Twenty panel sessions were interspersed with nine plenary sessions with speakers of extraordinary caliber. There were 82 invited speakers, 86 oral paper abstracts and 22 posters, and 27 sponsor booths. Each mid-day there was a sponsored lunch symposium.

One could easily feel excited being a part of this meeting because we saw legendary authorities everywhere, speaking, passing by, talking to someone, having a cup of coffee or visiting the exhibition booths. Notable examples were Professors Fu-Chan Wei, Yu-Ray Chen, Yilin Cao, Lee L.Q. Pu, David T.W. Chiu, and Dae-Hwan Park, and too many others to mention. Several specially invited speakers added extra highlights. Sir Gordon Wu, an entrepreneur, philanthropist, and successful engineer delivered a speech on China’s role in the world. That stimulated a lot of views from the audience. Prof. KM Chan, founding Secretary General (1994-2006) and president (2006-2009) of the Chinese Speaking Orthopedic Society, generously shared how our orthopaedic counterpart has joined the effort to develop their specialty to greater heights and to deliver better care for patients.

Faculty and Congress Dinners took place off the coastline aboard the Lantau and the Jumbo. Both involved a boat cruise to allow participants to experience the autumn breeze. The former was a special restaurant next to the waters and the latter a floating marine vessel. Deliciously cooked fresh seafood and fine wine helped wash away the tension of the
GLOBAL SURVEY REPORT

David Daehwan Park, MD – Korea
Chair, Ad Hoc Survey Committee, ISAPS Assistants Chair of National Secretaries

Collection of data for the ISAPS Global Statistics Study for procedures in 2014 began on January 8, 2015. We expect to have results ready by June. The information generated from these annual surveys is important to all plastic surgeons, the international press, industry and the public. The international media eagerly awaits our results.

Our committee is composed of eight members including me. They include the chair of the Communications Committee, Arturo Ramirez-Montana (Mexico); ISAPS Board Member Sami Saad (Lebanon); two members of the Industry Relations Committee, Grant Stevens (USA) and Wayne Perron (Canada); and Asian members Yuzo Komuro (Japan), Sudin Wu (China), and Yong-ho Shin (Korea).

The company charged with collection and analysis of the data, Industry Insights, is the same. They have refined the survey questions based on what we learned last year. In head and neck cosmetic surgery, for example, fat grafting and facial bone contouring are important procedures; however, these were omitted in previous surveys and have been added. Chin augmentation is also included under facial bone contouring procedures.

A very important issue is how to increase participation. Our survey analysts tell us that 50 responses per country is sufficient for the data to be statistically valid. In some countries, surgeons customarily under report their procedural information to their government which means that they simply ignore our survey. Group emails from ISAPS are systematically blocked by powerful spam filters in some countries.

Our committee encourages sending all plastic surgeons e-mails in their country to ISAPS where this is permitted. We also encourage national secretaries to send the survey again to ISAPS members in their countries from their own email address to avoid these distribution problems. Asking national societies to forward the survey to their members will also help us.

We will focus on East Asian countries this year as China, Japan and Korea are very strong in cosmetic surgery with many patients and procedures. China, Japan and Korea could be in the top ten in the world in the number of cosmetic surgical procedures; however, China, Japan and Korea were excluded from last year’s survey because their response rate was too low to provide valid statistics. Survey Committee members will contact via telephone or e-mail our friends, colleagues, graduates, and fellows in Korea, Japan and China and in other Asian countries using our network to encourage participation. We urge all national secretaries and survey committee members to help us generate much higher response rates in their respective countries.

Finally, our committee wants all ISAPS members to use personal e-mail and telephone to encourage their friends, colleagues, graduates, fellows and all plastic surgeons in their country, including non-members, to respond to the ISAPS survey. The link to the one page survey is: www.issecure.com/ISAPS/survey.asp Thank you very much.

ISAPS PATIENT SAFETY SURVEY

Lokesh Kumar, MD – India
ISAPS Board Trustee, Acting Chair, ISAPS Patient Safety Committee

ISAPS recently circulated a survey to all National Secretaries asking their opinion about issues pertaining to patient safety in their country. Sixty-one (71%) National Secretaries responded. The results are included here.

• 26 responded that malpractice insurance is required as a condition of licensure, while 14 said it was not.
• 48 said that hospital privileges are not required as a condition of practicing plastic surgery; 13 said that they are.
• The majority reported that surgeons practice in private surgical clinics, while half mentioned that surgeons in their country also practiced in third-party surgical clinics.
• 35 reported that surgeons must operate in an accredited facility. 24 said that this is not required.
MEMBERSHIP COMMITTEE REPORT
Ivar van Heijningen, MD – Belgium
ISAPS National Secretary for Belgium and Membership Committee Chair

Since meeting during the Congress in Rio, we have created a Membership Committee Team to address all issues with respect to membership. We organized the team in such a way that each of us oversees a continent. James Grotting (US) was kind enough to oversee North America; Maria Isabel Cadena (Colombia); South America; Sufan Wu (China) addresses issues in Asia and Australasia; and Bouraouii Kotti (Tunis) covers Africa and the Middle East. As chair, I will cover Europe. Ex officio members Catherine Foss, our Executive Director, and Peter Scott (South Africa), the chair of National Secretaries, complete the team.

During the board meeting held in Rome in November, changes over the last year and current membership status were reported. Of 2,843 current members, 2,473 are Active, 178 are Associate, 186 are Life and 6 are Honorary. The growth was steady over the last months with an average of 35 new members per month. The procedure has been improved to admit applicants on a monthly basis and we now archive applications that have not been finished within a year. The fast-track procedure allows countries to admit larger groups of pre-selected members of an Aesthetic Plastic Surgery Society saving the cost of the application fee. This has worked well.

After discussion in the board meeting, it was decided that membership in multiple countries is not allowed. Members are free to work in more than one country, but they must choose under which country they want to be listed and pay only one membership fee.

Affiliate Membership. After a long discussion, the board decided to open membership and meeting attendance to doctors from other specialties. See separate article. Growth of our membership should come more from the younger generation, so promoting Associate Membership for those in training and just finished is a priority. Internet modules for e-learning (e.g., webinars, video streaming of courses) need to be developed and senior members are encouraged to be open to contacts from the younger generation.

CME accreditation of ISAPS courses and the ISAPS biennial congress is a goal for the future, so we can offer these credit points to surgeons from countries that need them to maintain their registration.

MEMBERSHIP COMMITTEE REPORT

I

SAPS has been a plastic surgeons’ society from the beginning. But 44 years ago we were basically the only specialty doing procedures to enhance the aesthetics of the human body. We have devoted ourselves to training plastic surgeons to be the best aesthetic surgeons in the most ethical way possible with a focus on patient safety. Things have changed, whether we like it or not. Other specialties have embraced aesthetic procedures and the majority of these procedures are no longer surgical. Besides other specialties, non-core doctors are doing aesthetic procedures and even a lot of non-doctors, nurses being the best of these. We may not like it, but it is the current reality.

Now, we can hang on to the fond memories of the good old days and hope that they return, or we can face reality and acknowledge that others are out there and embrace the best of them.

If we wish to continue to lead in the field of aesthetic medical procedures, then we must acknowledge that dermatologists in general do better laser treatments than most of us, that many ENT surgeons do good rhinoplasties, and that there are maxillofacial surgeons who achieve amazing aesthetic results with midface advancements.

Having said that, what are our options?
1. Remain a plastic-surgeon-only society, with teaching done by plastic surgeons only;
2. Remain a plastic-surgeon-only society, but allow some experts from other specialties to teach us;
3. Allow members of other specialties to become members of our society; or
4. Allow everybody with an interest in aesthetic treatments to join our society.

Option 4 is clearly unacceptable. Worldwide endangering of patient safety is the result of non-core doctors who do procedures without any training and we are clearly not going to teach them. But we do want to be the gold standard. Membership in ISAPS should be something to which the best of the board-certified specialties would aspire.

We have already let go of option 3 and said that we will allow other specialties to teach us. So will it just be option 2, or are we opening our doors wider? Let’s consider option 3 seriously for a moment. What are the pros and cons?

Pros:
- We can attract the best from other specialties;
- We gain knowledge in areas that are less core plastic surgery such as non-surgical medical treatments and teach that better;
- We can be the first large international multi-specialty society;
- We will have more paying members;
- We will have more submissions to our journal, Aesthetic Plastic Surgery;
- We can continue to lead the way in aesthetic medical procedures;
- We can emphasize patient safety and ethics across specialties;
- We will have more reaches for our courses and congresses;
- We will stand stronger when creating standards and negotiating with governments; and
- We can offer more to industry partners who in turn help support our educational programs.

Cons:
- We will give up where we come from originally;
- We start to teach the competition; and
- Our membership might object to this.

From my work on the European Standard for Aesthetic Surgery Services I have learned that we are not the only ones doing good aesthetic procedures. I still think we are best placed, but our number is limited, especially where non-core doctors are concerned, so we might be better off to join forces with core-specialists who at least had well-defined proper training. We can form a front with them and still hold the key position if we start it.
In fact, without admitting it, we have already done so. Some of our members are non-plastic surgeons doing only aesthetic plastic surgery, some of them are faculty in our courses and are very well respected.

After carefully considering all these arguments, the board has decided that ISAPS wants to lead the way with respect to education of aesthetic medical services. Thus they have decided to invite selected core-specialists with proven teaching quality and ethics to join our new, yet-to-be formed Affiliate Member category.

The following rules apply for this new category:

- Only the following three categories of “core” subspecialties aesthetic groups will be invited to join as Affiliate Members:
  - dermatologists,
  - facial plastic surgeons,
  - oculoplastic surgeons.
- Membership will be BY INVITATION and only to high-level qualified, board-certified members of their respective societies from one of these three specialties.
- Affiliate Members will NOT be allowed to vote.
- Affiliate Members will pay the same dues and registration fees as Active Members.

In addition to the membership rules, in general:

- Selected members of the three “core” specialties will be invited to teach at ISAPS education programs.
- Adding these “core” specialties to our faculty will broaden the scope of our education programs and improve the content of our courses.
- Adding these “core” specialties to our faculty and membership will bring increased corporate support (industry) which ultimately allows us to provide the quality scientific programs our membership expects.
- Members of the three “core” specialties will be allowed to register for ISAPS education programs.

It is the firm belief of the ISAPS leadership that with these changes we can provide the best education for our members so that we can provide better care for our patients worldwide.

With these measures we take the leading role in this new “world of aesthetics” and act proactively on these changes.
REPORT OF THE AD HOC COMMITTEE ON PUBLIC RELATIONS

Dirk Richter, MD, PhD – Germany
ISAPS 1st Vice President

The ad hoc public relations committee was inaugurated at the last meeting of the Board of Directors in Rome, December 2014.

The aim of this committee is to analyze the current situation of ISAPS in terms of public relations, marketing, branding and corporate identity to be sure that it meets the needs of our membership.

We already completed a detailed survey among the committee members asking about the past, present and the possible future situation.

As an international society, the requirements for public relations are challenging and need to be addressed. Social media has been identified as a promising tool especially to maintain contact with the younger generation of plastic surgeons and to inform patients about ISAPS activities and aesthetic surgery in general in order to increase the visibility of our society.

Currently, we are analyzing the experiences of our national societies and what has worked best for them. With these results we will implement potentially good ideas into new concepts of our marketing strategy.

The two-yearly Congresses of the WAPSCD have evolved into regular opportunities for reunion of brothers and sisters of Chinese descent and friends and colleagues of other races. The warm friendship and sincere atmosphere are aspects distinct to these meetings and have certainly given participants a sense of homecoming and reunion.

The next Congress will be held in Chengdu in conjunction with the annual meeting of the Chinese Society of Plastic Surgeons from October 13 to 16, 2016. We are planning to invite another ISAPS professor to our congress and welcome plastic surgeons of Chinese descent or all races from all over the world to attend another magnificent scientific forum of international plastic surgery. Please stay tuned for updates.

Where in the World?

See page 50 for the answer.

ISAPS INSURANCE CHANGES ARE COMING!

Jose Carlos Parreira, MD – Portugal
Chair, ISAPS Insurance Committee

Every year, the ISAPS Insurance scheme has seen positive changes and this year is no exception. The insurance is being split into two types of cover as shown below:

**ISAPS Cross Border Revision Cover**

Similar to the scheme outlined above, this version has the added benefit that the patient may be treated once back in their own country by another ISAPS surgeon if remedial treatment is necessary following a complication. The insurance premium for this cover will be higher than the basic revision cover due to the additional benefits being offered.

The launch of these new types of cover will be within the next few months and each member surgeon will be provided with all the necessary information.

In the meantime, should you have an enquiry or wish to cover a patient, please contact Stephanie@isapsinsurance.com or telephone 0044 207 374 4022 in our London office.

ISAPS Insurance is managed by our partners at Sure Insurance in London and is underwritten by certain underwriters at Lloyd’s.
The majority of aesthetic procedures performed in the UK now occur in the private sector. There is therefore an obvious deficiency in aesthetic surgery exposure during basic plastic surgery training within the National Health Service. This has also been recognized in the United States, but many other countries have had a similar experience. It is difficult for newly-qualified surgeons to fully understand the needs and demands of patients groups to which they have had limited exposure. Whilst many of the skills in their surgical training programs are transferable, there are distinct differences which must be acknowledged.

For example closing a DIEP flap donor is unlike closing a Brazilian abdominoplasty where the seroma complication rate should approximate zero percent, but sadly it is nearer 20%. Similarly, removing a basal cell carcinoma from a lower eyelid or inner arm reduction is a fraction, but at times can be more difficult. Brazilian abdominoplasty where the seroma complication rate now occur in the private sector. This has also been recognized in the United States, but many other countries have had a similar experience. It is difficult for newly-qualified surgeons to fully understand the needs and demands of patients groups to which they have had limited exposure. Whilst many of the skills in their surgical training programs are transferable, there are distinct differences which must be acknowledged.

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Is there therefore an obvious deficiency in aesthetic surgery exposure during basic plastic surgery training? This has also been recognized in the United States, but many other countries have had a similar experience. It is difficult for newly-qualified surgeons to fully understand the needs and demands of patients groups to which they have had limited exposure. Whilst many of the skills in their surgical training programs are transferable, there are distinct differences which must be acknowledged.

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Is there therefore an obvious deficiency in aesthetic surgery exposure during basic plastic surgery training? This has also been recognized in the United States, but many other countries have had a similar experience. It is difficult for newly-qualified surgeons to fully understand the needs and demands of patients groups to which they have had limited exposure. Whilst many of the skills in their surgical training programs are transferable, there are distinct differences which must be acknowledged.

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THE ROAD TO KYOTO:
TWO FESTIVALS ON OCTOBER 22ND
Susumu Takayanagi, MD – Japan
ISAPS President

On October 22nd you will find Kyoto tremendously crowded having two well-known festivals on the same day: Jidai Matsuri during the day and Kurama-no-Himatsuri (Fire Festival) in the evening. The ISAPS Congress will begin immediately after these festivals. If you are interested in taking this opportunity to enjoy them, you are strongly advised to make your hotel reservations early. Our headquarters hotel will be the Westin Miyako Hotel.

Please note that both festivals will be held on the next day if it rains. For inquiries, contact the JTB Western Japan Corporation ISAPS 2016 desk at westec_op2@west.jtb.jp

Jidai Matsuri
This festival includes several related events of which the most famous is the costume parade. Approximately 2,000 people in ancient Japanese costumes, beginning with the late 8th century and ending with the late 19th century, parade in the streets in Kyoto City. Paid seats for the audience are provided, but these are no more than plain folding chairs that allow people to secure a place to seat themselves among a huge crowd. The seats are supposed to be in Kyoto Gyoen National Garden (Kyoto Imperial Palace), Oike Street and Heian Jingu-michi, where the beginning of the costume parade is expected around 12:00, 13:00 and 14:20 respectively. The entire parade takes about two hours. The paid seats are all reserved with advance booking required. To make a reservation, contact JTB at westec_op2@west.jtb.jp

The parade consists of twenty groups representing different eras in the history of Japan. The group representing the latest era is in the lead, and the oldest era is at the end. The two most popular groups are the medi eval ladies and the ladies of the Heian period in which a number of legendary women are represented. Roles of renowned beauties such as Yodo-gimi and Shizuka-gozen are played mainly by apprentice geisha girls (Maiko) from the entertainment quarters of Kyoto. They fascinate the audience with their beauty in the proudest moment of their lives. www.heianjingu.or.jp/english/0301.html

Kurama Fire Festival
To attend the Kurama Fire Festival, you are advised to take a train of the Eizan Electric Railway ahead of time. Toward the end of Jidai Matsuri, there will be a growing crowd around several Eizan-train stations.

This is a solemn shrine ritual performed on a mountain that is about 50 minutes by train from the center of Kyoto City. Despite the inconvenience and danger often found at this event, the Kurama Fire Festival attracts a lot of tourists every year, perhaps because of the mysterious wooden torches blazing up in the darkness.

There is a series of movies called Kurama Tengu including a film titled Kurama-no-Himatsuri in the last eight minutes of which the Kurama Fire Festival is featured. The film was produced over 60 years ago and Kurama Tengu, a masked swordsman, became a very popular hero. You can find a short video extracted from the film on the internet, using search words: Kurama Tengu and Himatsuri.

At 18:00, a bonfire called Iji is built in front of each house in Kurama. About 21:00, people with wooden torches gather around the gate of Yuki Shrine leading to a ritual called Shimenawa-kiri (cutting of Shimenawa, a sacred straw rope). This is the highlight of the festival which tourists don’t want to miss. After this, visitors get ready to go home. However, it is after the end of this part that two sacred palanquins (Mikoshi) show up to be carried around the festival area.

continued on page 21
I was deeply honored and delighted to be invited to Hong Kong as a plenary lecturer for the 4th Congress of the World Association for Plastic Surgeons of Chinese Descent and as ISAPS Visiting Professor at both the University of Hong Kong and the Chinese University of Hong Kong.

After a very long, almost 24-hour, but pleasant journey from Atlanta I arrived in Hong Kong at 10 pm on a Monday night. Even at that time of night, during the ride to the hotel I was introduced to Hong Kong traffic. Wide awake and looking forward to my stay, I saw evidence of the amazing growth since my last visit several years ago. New construction of high rises, roads, and the new underground train system were all too evident. To my surprise, so were Christmas decorations in early November! The vitality and hustle and bustle of Hong Kong we all love was unchanged and all around.

After a comfortable first night, I woke up to the view of Hong Kong Island across Victoria Harbor from the hotel room — a magnificent view, which I could not enjoy for too long as I had to prepare for the busy day ahead. The morning to be spent with Dr. Josephine Mak as our guide, it was time for the 4th Congress of the World Association for Plastic Surgeons of Chinese Descent. I was again humbled and honored to be asked to present a plenary lecture at this prestigious meeting.

Arriving later than planned at the Prince of Wales, we went straight into the conference room. The afternoon was spent in case presentations in aesthetic surgery. I was impressed and pleased to see the level of interest in the aesthetic cases that were presented.

That evening’s lecture and dinner was held at the Hong Kong Golf Club, a beautiful facility with lush gardens. Members of the Hong Kong Society of Plastic Surgeons, staff and trainees from both hospitals were in attendance. I presented a lecture entitled “The Role of Evidence-Based Medicine in Aesthetic Surgery” followed by lively discussion and a multi-course dinner.

After a day of touring Hong Kong, arranged by my hosts with Dr. Josephine Mak as our guide, it was time for the 4th Congress of the World Association for Plastic Surgeons of Chinese Descent. I was again humbled and honored to be asked to present a plenary lecture at this prestigious meeting.

Congratulations, continued from page 18

After you receive this issue of ISAPS News, we will ask you to vote on this change. I urge you to review the reasons why your Board of Directors has decided on these changes — the fact is that the world of aesthetic surgery and aesthetic medicine is changing so fast and just as in our own practices we can not rely on the “status quo.” The international competition by many non-core meetings has increased dramatically in the past few years and we run the risk of quickly becoming obsolete.

In closing, I would appreciate your comments and suggestions and thank you for your kind cooperation.

This is your society and your family. The Board of Directors and I are always working to create a better future for ISAPS. The best is not in the past, but in the future! 

Susumu Takayanagi, MD
ISAPS President 2014-2016
MINIMALLY-INVASIVE PROCEDURES

David B. Sarwer, PhD – United States
Professor of Psychology, Departments of Psychiatry and Surgery Consultant, The Edwin and Fannie Gray Hall Center for Human Appearance Perelman School of Medicine, University of Pennsylvania

O

ver the last several decades, a now relatively large body of research has investigated the psychosocial characteristics of individuals who present for aesthetic surgery. Many of these studies have been undertaken with the larger goal of identifying patients who may be experiencing psychological symptoms or conditions that would contraindicate surgery. While some degree of psychological distress likely motivates the pursuit of an aesthetic surgical procedure, excessive distress or profound psychopathology might contraindicate a procedure at a given point in time. Other studies have focused on the psychosocial changes that occur following aesthetic surgery. Many of these studies have documented improvements in body image and self-esteem in individuals who have undergone the most common surgical procedures, such as cosmetic breast augmentation.

In contrast, surprisingly little is known about the psychosocial characteristics of the millions of individuals who present for minimally-invasive aesthetic treatments. Concerns with changes in facial appearance associated with aging likely motivate the pursuit of minimally-invasive treatments. At the same time, excessive concern and body image dissatisfaction may suggest the presence of body dysmorphic disorder (BDD). Many of these studies have documented improvements in surgical patients who undergo these procedures in general, but we also found a lack of evidence for these changes after specific procedures. The most common procedures — including botulinum toxin and soft tissue augmentation — have the least data suggesting changes in psychosocial functioning.

An unanswered question at this point is how do minimally-invasive procedures impact psychosocial well being. One potential explanation is that patients who undergo these procedures experience improvements in their physical appearance that subsequently enhance their mood, self-esteem, and body image. The improvements in appearance, no matter how subtle, may allow the patient to feel more comfortable and less self-conscious in social interactions, thereby enhancing mood and body image. Another potential explanation comes from the facial feedback hypothesis. The hypothesis, which has a long history in the area of the psychology of emotions, suggests that muscular manipulations that result in more positive facial expressions may lead to more positive emotional states. For example, an individual who forces herself to smile in response to visual stimuli will rate the stimuli more favorably. Other research has suggested that restricting the movement of facial muscles associated with the expression of negative emotions, such as anger or sadness, also can have a positive impact on mood.

This is particularly the case for neuromodulators such as botulinum toxin. Botulinum toxin injections can reduce negative facial expressions and may have a secondary effect of reducing the internal experience of negative emotions. At the same time, some preliminary evidence suggests that botulinum toxin injections may improve depressive symptoms in those with a history of depression. This is a particularly intriguing finding. Clearly, additional research of this issue, as well as research on other minimally invasive facial procedures, is needed to help us understand the psychosocial benefits that accompany them.

The author has no financial relationship with the manufacturer of any product mentioned in this article.

References

CEN, continued from page 6

the importance of this comprehensive European Standard, which was developed through an open, inclusive, multi-disciplinary and evidence-based process.”

Speaking on behalf of ANEC, Stephen Russell, ANEC Secretary-General, says: “ANEC welcomes the publication of EN 16372. ANEC supports the proposal for the development of such a standard during its development and we consider the standard satisfactory from the consumer perspective. Promoting consistently high standards for aesthetic surgery service providers across Europe is increasingly important, as more and more consumers travel abroad for aesthetic treatment.”

According to Mr Russell, the new European Standard (EN 16372) could help offer assurances to consumers in countries where there are no legal requirements in this area.

The CEN Project Committee on ‘Aesthetic surgery and aesthetic non-surgical medical services’ (CEN/TC 403) is currently developing a separate European Standard in relation to non-surgical medical procedures (pEN 16344). CEN Members will open public enquiries in order to invite comments on this draft standard (these enquiries are due to be launched at the end of February 2015).

For more information on European standardization in relation to services, please see the CEN website:

http://www.cen.eu/work/areas/services/Pages/default.aspx
REPORT FROM THE JOURNAL EDITOR

Henry M. Spinelli, MD – United States
Editor-in-Chief, Aesthetic Plastic Surgery

O n behalf of the staff at Aesthetic Plastic Surgery (the blue journal), I would like to thank its readers, authors and reviewers for their continued support. We are very excited about the current state of the journal, which has grown significantly over the past five years under my leadership as Editor-in-Chief. I am excited about the current state of the journal, which has grown significantly over the past five years under my leadership as Editor-in-Chief. Thanks to the efforts of many people. In partnership with our publisher, Springer, we have greatly altered the journal since my taking over the helm.

Recently, we had an important meeting in New York City attended by the chairman of the Journal Operations Committee, Renato Saltz, and our President, Susumu Takayanagi. Key representatives of Springer explained the intricacies and complexities of operating and publishing an international journal and an interactive, fruitful discussion was engaged in by all of us.

I would like to underscore changes in our journal which have occurred and what we are planning in the future. Many, if not most, of the changes we have undertaken seem to have been unnoticed or, at Springer executives pointed out, have occurred behind the scenes. In that respect, the meeting in New York City was very valuable. Furthermore, it gave both Springer and me an appreciation of the direction of our society. This will enable us to measure if the journal is improving accordingly, within the context of quality peer review and integrity of the content.

Aesthetic Plastic Surgery (APS) is larger and more diverse than ever. One only has to peruse old issues to notice the profound changes.

We have introduced independent double-blinded peer review for the first time. Evidence-based medicine (EBM) has been fully integrated into our journal. In fact, ours is only one of five journals in the Springer family of over 700 journals that utilizes this metric. Our proprietary watch glass icon and numeric scale is larger and more diverse than ever. Our education programs serve to advance our members in the Aesthetic Plastic Surgery society. Our education programs serve to advance our members in the Aesthetic Plastic Surgery society. Our education programs serve to advance our members in the Aesthetic Plastic Surgery society.

The number of submissions has doubled and yet the turn-around time is at a record low. Selectivity has profoundly increased with fully 75-80% submitted papers rejected.

The number of active recognized reviewers who have definitive expertise and interest has easily tripled. These dedicated men and women are from all corners of the world.

Submission downloads of our published articles is fully international and in geographically in keeping with our society’s membership.

Manuscripts are routinely downloaded equally in North and South America, Europe and Asia. We are seeing more African continent participation as well.

APS has generated record revenues for this publication to ISAPS and Springer.

The day-long meeting provided many insights regarding operations governing our journal and also showed in several ways the strength of our major publication and primary member benefit.

Main Retreat Objectives:

- Define the role of APS in relation to ISAPS’ overall strategic plan (multi-specialty meetings and membership)
- Define the role of APS as a benefit of ISAPS membership
- Define the role of APS in the aesthetic plastic surgery community at large
- Synchronize with above APS Aims & Scope, Editorial Board composition

Action Items developed:

- Distribute a Membership Survey (what do our members think about the journal)
- Author Survey (why they submitted to APS and their interest in digital format)
- Author recruitment letter (invite renowned authors to publish in APS)
- Demographics (there is interest in the diversity of authorship and readership of our Journal — create strategy to engage more authors based on that diversity)
- Use the newsletter to “market” APS. (Hank will have a regular column in the newsletter to promote the journal where he will announce top articles coming up in future issues and discuss top articles of previous issues. It will be his “connection” with the membership through our newsletter)
- Rewrite the Aim & Scope of the journal (we currently have a very antiquated statement that does not really represent what the journal does today)
- Editorial Board revamp (recruit new names to help “market the Journal.” Also include multi-specialty names since they will now be speaking at our meetings and soon will become affiliate members)
- Involve ISAPS Course Directors as “journal ambassadors” (recruit authors to publish in APS. Hank will work with Lisa regarding future courses and approach course directors to help with the Journal. Since they are organizing the meeting, they know of any new technology/techniques being presented and will approach the authors in a much more directed way. Therefore, we don’t have to have the editor-in-chief traveling to every single course but will have someone representing him there.)
- Course Directors to collect presentation summaries (bullets of course presentations) and submit to the editor for possible expansion in an article, editorial or topic supplements.

The editor-in-chief was very open to the recommendations made by all participants and appeared to be enthusiastic about the direction we are taking. He was reminded by President Takayanagi that the Board expects to see changes taking place within six months of the meeting in Rome. I believe this Journal Retreat was critical and very instrumental in setting the right path for the Journal, the publisher, and Dr. Spinelli as editor-in-chief. I am hopeful many of these changes will be already in place by the next Board Meeting in Montreal in May.

As the Chair of the Journal Operations Committee, it is my responsibility to ensure that our journal is the best it can be and, along with my committee members, to work to continually review and recommend changes that will improve this publication. I call on all members to help us grow and develop this important asset. Our education programs serve to advance our skills. Our journal serves to represent ISAPS as the leading international aesthetic plastic surgery society in the world. Let us ALL contribute to make Aesthetic Plastic Surgery the highest ranking publication in our field.

REPORT OF THE 2015 JOURNAL RETREAT

Renato Saltz, MD – United States
President-Elect and Chair, Journal Operations Committee

The day-long meeting provided many insights regarding operations governing our journal and also showed in several ways the strength of our major publication and primary member benefit.
The demand for non-invasive cosmetic procedures continues to increase in the United States. According to the American Society of Aesthetic Plastic Surgeons (ASAPS), there was a 13% increase in non-surgical procedures from 2012 to 2013. The appeal is obvious: no incisions, no scars, minimal down-time (if any), and decreased cost. In my own practice, I have gradually shifted away from facelifts and towards minimally invasive and non-invasive procedures of the face and neck. This decision was influenced by two factors: 1) the growing number of patients who request facial rejuvenation without the use of surgery, and 2) the addition of an experienced and aggressive aesthetician to my practice. Unless a patient has significant skin laxity or platysmal banding, I advise them that a number of non-surgical regimens are available. I advise patients that while these treatments can never replace surgery, they are a good starting point, especially if addressed to correct lip defects (cheek, lip, nasolabial folds, and labiomental folds).

In my practice, I currently offer professional facials, chemical peels, microdermabrasion, dermabrasion, microneedling, Pelleve® and Ultherapy®. Facial, chemical peels, and microdermabrasion have the benefit of gently introducing patients to what can be achieved non-invasively. In addition, they allow the patient to begin a maintenance regimen for healthy skin which can offer aesthetic procedures ONLY as a part of dentists’ armamentarium. This conduct raised a legal issue between core specialists (plastic surgeons and dermatologists) and odontologists which has been recently cleared by official advice of the Italian Health Minister. According to this document, odontologists can offer aesthetic procedures ONLY as a completion of a program of oral care and not with a pure cosmetic purpose, only if addressed to correct lip defects (cheek, nasolabial folds, and labiomental folds) are therefore excluded, and only using products in an on-label way (botox injections are excluded as they are currently considered off-label in the perioral area). The debate is still open as odontologists rejected this advice and their lawyers are considering an appeal against the health authorities. Injection of fillers or botox requires proper training and in-depth clinical experience especially where it concerns the prevention and treatment of potential complications. Companies and private schools are currently offering odontologists short and intensive courses which cannot be considered appropriate for these purposes. Secondly, the present insurance for odontologists does not cover any “aesthetic” risk so the patients (as well as the professionals) would not be properly protected in case of litigation.

The two more “aggressive” (and expensive) technologies which I offer include Pelleve® and Ultherapy®. Pelleve® is a radio-frequency-based treatment that delivers energy to the dermal tissue. The heat emitted induces collagen denaturation and subsequent contraction, which creates skin tightening. There is a reasonable amount of literature supporting its safety and effectiveness for the treatment of fine wrinkles. Patients do see an immediate result, which is typically sustained following three treatments spaced one month apart. It takes 30 minutes to perform, is painless, and can be done in conjunction with other non-invasive procedures. I have been generally pleased with the results of Pelleve® treatments, although both the machine and disposables are expensive. Ultherapy® uses intense, focused ultrasound energy to create thermal injury zones deep to the epidermis for non-invasive lifting of the neck, brow, and submental regions. Unfortunately, I have been relatively unimpressed by Ultherapy®. The treatment is painful, and somewhat costly for the patient ($2,000-3,500 USD). Although results are seen, they are not, in my opinion, dramatic enough to justify the very high cost of the machine and its disposables. I have avoided lasers and fat dissolusion machines in my office, as they are both expensive and readily available in almost every spa in New York City. Having an experienced aesthetician in the office is very helpful in both promoting and performing these treatments. Although I perform dermabrasion myself, my aesthetician is trained in all of the other modalities. Without her, I frankly wouldn’t have the time or patience to perform these procedures.

Despite our desire as surgeons to be in the operating room delivering immediate, dramatic results, we need to acknowledge the growing demand for and role of non-invasive procedures. If we don’t add these techniques to our arsenal, we will quickly lose patients to our non-surgical colleagues and the growing number of medi-spas. The author has no financial relationship with the manufacturers of any products mentioned.
GLOBAL PERSPECTIVES: Non-invasive Procedures

EUROPE: UNITED KINGDOM

Nigel Mercer, MD – United Kingdom
Past President, BAAPS and BAPRAS

At Bristol Plastic Surgery, our plastic surgeons work closely with two cosmetic doctors, Dr. Rita Rakus (The London Lip Queen), her young associate Dr. Sherina Balaratnam and a nurse injector in delivering state-of-the-art injectables and skin rejuvenation. Before any facial rejuvenation surgery, the patient will have an assessment of their individual needs to get their skin in as good condition as possible. This usually takes the part of Hydrafacial to start with for cleaning the skin and preparing it for topical skin products. Depending on the skin damage and laxity we may also recommend the use of RF (Thermage) and occasionally peels, which are usually TCA based. We found the side effects after phenol and croton oil were such that patients, whilst liking the effect on lines and skin tone, really did not like the need to stay away from the sun afterwards.

We use only FDA approved injectables for their safety profile and we believe in running a very safe practice. Any single patient who has a bad experience will put five others off coming to you. As a result, the deeper fillers are done by our cosmetic medical colleagues and the surgeons do the surgery. Having the broad breadth of experts means that the patients can choose who looks after them in the knowledge that the treatment (simple BONTA and fillers) will be delivered in exactly the same way. We are not great fans of putting a lot of fat into faces. We always ask to see pictures of the patient in their 20s or 30s to allow us to assess what has happened to their facial volume. NONE of our patients want the risk of ‘pillow face’ or of fat from another anatomical site gaining weight as they age.

We believe strongly that it is always better to treat a patient and top up if necessary. The author has no financial relationship with the manufacturer of any products mentioned.

EUROPE: BELGIUM

Ivar van Heijningen, MD
ISAPS National Secretary for Belgium and Membership Committee Chair

Fortunately, in Belgium the majority of procedures are done by registered specialists mainly dermatologists and plastic surgeons. But the group of non-core doctors have worked hard to obtain a better position. This resulted in a law stating that “specialist in non-surgical aesthetic medicine” will be added to the list of specialties. However, where and how this speciality will be trained remains unclear.

The term “non-invasive medical treatments” is suggestive that these procedures are light, but a deep TCA peel or ablative laser treatment is more invasive to the patient than a simple upper blepharoplasty. The more important that proper training for these procedures is ensured, since they are definitely invasive.

These procedures have become a valuable source of income as non-surgical treatments have been gaining popularity in recent years. The same trend applies in Finland. Considering the phenomenon known as the 7-47 effect, we as plastic surgeons cannot afford to lose this rapidly growing market. In Hospital Silisetti, we are among the top three private clinics using lasers in Finland.

We have used CO2 laser for years for cutting purposes in the operating room. For peeling and resurfacing, we shifted from CO2 and Erbium to 2790-nm erbium:yttrium-scandium-gallium-garnet (Er:YSGG), but occasionally still also use CO2 laser. We use 1064-nm Nd:YAG (neodymium-doped yttrium aluminium garnet; Nd:Y3Al5O12) for vascular lesions, hair removal and to treat facial redness (Cutexa Cool Glide, Lasergenesis).

We use RF with 810nm diode laser or RF with 915nm infrared therapy for hair removal and skin tightening (Syneron E-max DSL, Matrix IR). Also 1100-1600nm infrared device (Cutexa Titan) is used for skin tightening. IPL is used mainly for vascular or pigmented lesions (Cutexa LimeLight 520-1100nm, Acutip 500-650nm) and hair removal (Cutexa Prowave 770-1100nm).

The devices for hair removal are operated by our beauticians. As an alternative for laser resurfacing, we also use chemical peels, such as TCA. These therapies usually consist of three to five consecutive treatments performed by our nurses.

Laser skin resurfacing — being performed in the operating theater — is often combined with face lifting procedures or fat grafting under general anesthesia. When performed as a solo procedure, local anesthetic and/or anesthetic cream can be used. The periodical skin tightening therapy and repetitive fat grafting sessions are also great options to be able to offer your patients to maintain the facelift result.

For fat dissolution we currently use Ultrashape 3, which is a combination of external mechanical suction, RF and ultrasound. This device is a perfect alternative for some patients, but most of all it also brings customers requiring liposuction to our clinic. Depending on the accumulating scientific data, we may consider a fat-freezing device in future.

We use IR (infrared), bi-polar RF (radiofrequency) and vacuum device (Vela Shape 3) for cellulite treatment and post liposuction therapy. The most popular non-invasive therapies are injections (botulinum toxin and fillers) whose popularity has sky rocketed in the past ten years in Finland. The general trend also indicates these therapies being gradually shifted away from plastic surgeons to non-core practitioners and non-physicians. The industry-driven marketing together with still lacking legislation is causing serious safety concerns all over Europe. The ultimate goal for the manufacturers for maximal distribution would undoubtedly be an “inject yourself” home kit.

From a physician’s or clinic’s point of view, these non-invasive procedures have become a valuable source of income as the devices can be operated (under a physician’s supervision) by nurses and staff members, thus increasing their productivity while away from the operating theater. The remaining challenge is to find the right tools from the marketing jungle as only a few of the devices survive through serious peer-reviewed studies. A new device also needs to pay for itself before competitors arrive with even newer models. The author has no financial relationship with the manufacturer of any products mentioned in this article.

EUROPE: FINLAND

Timo Pakkanen, MD, PhD
ISAPS National Secretary

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A: Botulax, Neuronox and Nabota. Hyaluroidase is frequently used for filler dissolution. Even if lipoplasty remains the most performed procedure in western countries, periocular rejuvenation is the most common procedure in Asia and specifically in Korea. Asian periocular rejuvenation includes the use of all non-surgical and surgical technologies. Non-invasive periocular rejuvenation is increasing rapidly in the Asian region. Botulinum Toxin Type A and fillers are most common non-surgical procedures for periocular rejuvenation. Korean doctors use three Korean-made Botulinum Toxin Type A: Botulax, Neuronox and Nabota. Hyaluroidase is frequently used for filler dissolution. The author has no financial relationship with the manufacturers of any products mentioned.

ASIA: SOUTH KOREA
David Daehwan Park, MD
ISAPS Assistant Chair of National Secretaries

Currently, I use two primary ways to resurface the skin of the periorbital area: fractionated carbon dioxide and IPL (Intensive Pulse Light). I don’t use RF treatments or chemical peels. A combination of invasive and non-invasive technologies is also increasing abruptly. Anatomical classification and staging is a powerful tool for the selection or combination of proper non-operative and operative procedures. Proper analysis and slow technique is needed in non-invasive procedures.

The new machines with CE certification come with three different arms, with two different sized curved applicators for different areas, such as abdomen, flanks and back, and with one flat applicator which can be used for thighs and other areas. We can use two applicators simultaneously. I am now treating up to six areas per session.

The cryolipolysis machine is a skin cooling device, which mainly works for resolving the stubborn fat and reshaping upper arms, back, abdomen and flanks. According to the thickness of the fat, the system has three different size arms and five modes with five different temperatures and treatment times. The only disposable is the gel pad, which costs around four dollars each. I already bought my second machine. It keeps the office busy and patients who come for the procedure usually end up undergoing other aesthetic treatments while they are there, such as Botox and fillers. One of the advantages of Coolplas is that it targets fat cells alone, eliminating them in an easy, non-invasive manner that exercise and diet can’t achieve as quickly or as effectively. The treatment is not painful. At the beginning one feels pressure and intense cold. It soon disappears in a few minutes. Sessions last from forty-five minutes to one hour. Patients read, watch TV, play with their phones, or even take a nap during the treatment. They can return to normal activities right after the treatment, since it is non-surgical. Some patients experience redness, minor bruising, tingling, numbness or discomfort in the treated area, but this is temporary and will resolve completely. The only disposable is the gel pad, which costs around four dollars each. I already bought my second machine. It keeps the office busy and patients who come for the procedure usually end up undergoing other aesthetic treatments while they are there, such as Botox and fillers. Some patients decide to have other surgical procedures. I photograph, measure and weigh patients during every visit to help document a noticeable reduction of fat in the treated area. After the initial treatment is complete, it is possible to have further reductions with additional treatments, resulting in even more fat loss, after one or two months. Some patients find that just one treatment fully addresses their goals. As long as the patient maintains a normal diet and exercise, the result should be permanent. In the beginning, I was skeptical of the treatment, but seeing my results made me change my attitude. Patients start seeing results after one month, but final results are seen two months after the application. Patients are happy. They keep coming for more and referring friends.

Contraindications: Treatment with Coolplas is not indicated for patients who present any of the following conditions: hernia, abdominal bleeding time, during pregnancy or lactation period, Raynaud’s disease, patients with pacemaker or who have recently undergone abdominal surgery. Other contraindications are the presence of infected wounds, eczema, dermatitis, or other skin problems.

The author has no financial relationship with Sincoheren, the manufacturer of the Coolplas system.
GLOBAL PERSPECTIVES: Non-invasive Procedures

SOUTH AFRICA
My experience with minimally invasive and non-ablative surgical procedures: Thermage
Ewa A. Siolo, MD (Warsaw), MBChB (Natal), FCS Plast (SA) ISAPS Assistant National Secretary

I am observing are on a younger group of patients (15-45) with thicker and less wrinkled skin. Males are also responding to treatment with better final results. This is due to thicker and better vascularized dermis in male patients.

The level of discomfort that patients may experience during the treatment depends on the level of energy applied. In some areas, this may be more easily tolerated that in other areas such as bony prominences or nerve exits from the facial skeleton that may cause greater discomfort and pain. The physician doing the procedure should pay attention to the patient’s reactions to maintain strict and proper application of the tip’s surface area to the skin. Because there is a risk of causing superficial burns, I strongly recommend this procedure be done by the physician him or herself.

Although Thermage is a non-surgical and non-invasive procedure, complications can be expected. These include immediate superficial burns, prolonged erythema, or transient neuropraxia. Later, soft tissue depressions and nodules can appear, or there can be a lack of expected results.

Thermage as a non-surgical treatment for sagging skin and cellulite is a popular procedure in North America and Europe. It is a “lunch time” procedure providing the patient with improved skin elasticity with minimal downtime. Remodeling of collagen leads to clinically visible improvement in aging skin in its quality and elasticity. Remodeling of deep collagen in fibrous septae connecting dermis and fascia of the muscle allows improvement in contour and cellulite appearance. The effects can vary from patient to patient and generally is assessed as 15-20% improvement in skin elasticity. Unfortunately that cannot be guaranteed as patient expectation must match the occasional unpredictability of the result.

The benefit of this procedure is that patients are usually complimented as less tired looking or questioned if they returned from holiday because results are obvious but subtle. That gives patients a lot of confidence as looking youthful without being accused of vanity or fighting the ageing process.

Thermage addresses only elasticity of the skin. Recent trends in facial rejuvenation emphasize replacement of volume which cannot be addressed with tightening sagging skin. So the next step in getting optimal results is a combination of volume replacement and skin tightening. Modes of treatment of volume depletion are fillers and autologous fat transfer. A few studies have already investigated tissue interactions of monopolar RF heating with commonly used fillers. It is apparent that there is no increased risk of local burns or observable effect on filler being persistent in the tissue. RF also does not cause any structural changes in fillers.

In my practice, I like a combination of Thermage and autologous fat transfers, usually about three weeks post-Thermage when any possible inflammatory reaction to Thermage wears off. Due to the content of adipose derived stem cells, vascularity of soft tissue improves and the quality of skin improves dramatically due to formulation of new collagen.

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Thermage has proven to be useful for a specific group of patients who want subtle results with no downtime. I find it very satisfying in combination with minimally invasive surgical techniques which provide volume restoration like fat transfers.

Patient satisfaction with treatment is high as long as they are properly counselled about expected results. Thermage is a very good adjunct to cosmetic practice. I enjoy doing the procedure as I can see immediate response of treated areas and long term follow up will give me even more satisfaction.

The author has no financial relationship with the manufacturer of any product or device mentioned in this article.

Skin Care Specialists: An Integral Part of Your Plastic Surgery Practice

Renato Saltz, MD – United States
ISAPS President-Elect

Twenty-two years ago, a group of aesthetic plastic surgeons recognized the need to provide an educational forum for the emerging specialty of plastic surgical skin care. It was their belief that a team approach can enhance and deliver better patient care, collaborating and forming a unified organization for the ancillary staff that supports the aesthetic surgeon’s practice.

Today, the Society of Plastic Surgical Skin Care Specialists (SPSSCS) plays a seminal role in the education, training and service improvement of plastic surgery practices throughout the United States.

The skin care business within plastic surgery has become a necessary, revenue-generating adjunct to the aesthetic surgeons’ patient portfolio, complementing and supporting their cosmetic surgical practices. Surgeons who have implemented these services know that many surgical and non-invasive procedures began in the aesthetician’s suite.

The aesthetician’s position on the practice team isn’t limited to the introduction and uses of a skin care product. Today, skincare professionals integrate and coordinate the use of adjunct technologies such as lasers, permanent makeup, tattooing, injectables and peels to produce the best results for their clientele. Success in disseminating the technical knowledge and expertise, as well as the business savvy in packaging and marketing skin care services has led to recognition of their innovative thinking, and greater respect for their skills and expertise.

Today, the Society of Plastic Surgical Skin Care Specialists is an elite group, known internationally for its drive for knowledge, science and professionalism.

As the SPSSCS moves forward, the focus will remain on education and the advancement of the science and art of skin care and skin health. The members of the SPSSCS will continue to work alongside their surgeons to aid in safe and effective care for their patients. Just think: if every plastic surgeon were aware of the SPSSCS, and made a commitment to having their skin care specialists become a part of this elite organizational — how successful the outcome would be.

My nurse and three master aestheticians have attended the Skin Care Society Annual Meetings. They benefit from it in so many ways, but especially they learn from doctors, nurses, and other aestheticians what works and what does not for skin care, treating pigmentation and other skin conditions. They enjoy the wide variety of panel speakers, the multidisciplinary approach to education and find the meetings very informative.

The SPSSCS 21st Annual Meeting is on May 12-15 in Montréal, Québec, Canada. For more information please visit www.spsscs.org/meeting/2015.
Greetings from Emel Hospital in Reyhanli, Turkey where, together with members of the Syrian American Medical Society (SAMS), ISAPS-LEAP Surgical Relief Team® has just completed a productive and very successful site assessment visit and surgical mission. Over the course of the last eleven days, ISAPS-LEAP Surgical Relief Team® volunteer Dr. Burt Faibisoff performed 82 clinical evaluations, subsequently electing 40 patients for surgery and one steroid injection. A thorough inspection of the facilities at Emel Hospital reveals a surgical center with notable subspecialty equipment and supply deficiencies, but boasts a significant increase in access to wounded patients in need of chronic wound care for injuries sustained in northern Syria. More than that, what makes Emel Hospital a particularly inviting location for future surgical teams is the warm collaborative spirit of the hospital administration and staff. Added to all of these factors, the promise of future collaboration with SAMS would further bolster the ISAPS-LEAP program with regard to logistical considerations and importation of large scale supply donations. All in all, Emel Hospital appears to be very inviting and worthy of future consideration.

As we look forward to future ISAPS-LEAP Surgical Relief Team® missions in 2015, we also look back to the huge success of the program in 2014. Participating in surgical missions to Jordan and Lebanon, an international collective of 27 plastic reconstructive and aesthetic surgeons and 6 surgical assistants representing 14 countries evaluated more than 419 patients and treated 258 for all manner of war-related injuries, both acute and chronic.

Invited as consultant surgeons to work alongside organizations including the Treating the Wounded Syrian Program, the Syrian Medical Relief Office, and the Syrian American Medical Society, our volunteers significantly increased the surgical capacity of these host programs.

In the case of acute and traumatic wounds, ISAPS-LEAP surgeons provided expert level care in consultation with hosting general, orthopedic and burn surgeons. While the absence of key equipment and instrumentation have thus far prevented the use of free flaps, teams routinely performed a variety of local flaps, which incidentally provided unique educational opportunities for our hosts. As for chronic injuries and wound management, the focus of ISAPS-LEAP surgeons was primarily placed on the return of as much mobility and functionality to the patient as possible. To keep expectations low, our teams sought to give their best working with patients who had often received less than adequate care for injuries sustained, in some cases more than two years prior. Particular attention was given to instruct and assist with proper wound debridement, dressing including, when available and appropriate, the proper use of negative pressure dressing therapies, and delayed primary or secondary closures.

While ISAPS-LEAP Surgical Relief Team® was not initially established to provide surgical services in the midst of man-made civil conflicts, we felt that the need to assist a population of war-wounded persons represented a unique opportunity to offer disaster relief services particular to our international community of surgical specialists. In so doing, this innovation to the ISAPS-LEAP program has enabled us to help a population of people far more numerous than those our volunteers directly treated. We must also consider the lives of patients’ family members who have likewise benefited from our charitable surgical services. As our teams have witnessed first-hand, the return of health, functionality and a semblance of the normalcy that was present prior to the Syrian war is a gift enjoyed by whole families. This would not have been possible without the dedication and generosity shown by our volunteer surgeons and assisting medical professionals who graciously gave of their time and talents to participate in these surgical missions. Our success to date demonstrates the strength of this valuable partnership between the LEAP Foundation and ISAPS. We celebrate the international diversity of surgeons who have thus far brought tremendous skill and resources to the program. We also wish to thank again each of the aforementioned humanitarian partners and their hosting hospitals. To have worked with such professional and compassionate medical establishments has been an honor. We can only hope that each of these organizations have been blessed with an equally positive experience of our surgical team members. As prospective avenues for future surgical missions develop, we anticipate expanding our work around the world where it is needed most. At such time when opportunities arise, we eagerly await coordinating new and returning volunteers. Should you have questions regarding the upcoming mission calendar and/or how you can support those ISAPS member surgeons currently scheduled to participate, we look forward to hearing from you. For information, contact me at: Ryansnyderthompson@leap-foundation.org

HUMANITARIAN

ISAPS-LEAP DONATIONS

We gratefully acknowledge the generous donation provided by Dr. Giovanni Botti (Italy) of $40,000 in support of the ISAPS-LEAP Surgical Relief Team® efforts that are highlighted in this issue of ISAPS News. The funds are held in an income generating account with our investment advisors at Morgan Stanley.

We have created a link on our website home page to make donations easily through ISAPS. Each donor will be sent a receipt for tax purposes. Donations are tax deductible, but we recommend that you check with your own financial advisor on this point.

Each donation is matched at twice its value by our partners at Marina Medical who provide surgical instruments to our mission teams. We appreciate your donation of money, time, supplies, and even frequent flyer miles to help our volunteers reach our mission destinations.

Donations can also be made through the LEAP Foundation.

HUMANITARIAN
AICPEonlus RECOGNIZED BY THE PRESIDENT OF THE ITALIAN REPUBLIC
Claudio Bernardi, MD – Italy
President of AICPEonlus, ISAPS member

AICPEonlus, the non-profit association of the Italian Association of Aesthetic Plastic Surgery, received a donation from the president of the Italian Republic.

Not only is this an effective economic aid, but also an important sign of recognition of our association and its aims. This is the purpose of the 3,000 contribution that the non-profit association AICPEonlus, a branch of AICPE (the Italian Association of Aesthetic Plastic Surgery), dedicated to humanitarian activities in plastic surgery, has received by the Presidency of the Italian Republic.

Such contribution is also a major incentive for our association to continue to implement our projects.

Following international alarm about the outbreak of the Ebola virus that has affected some countries in West Africa, AICPEonlus had to interrupt a few missions already planned in Togo, but created the new “Ebola Emergency Project,” which provides financial assistance to the hospital of Afagnan, Togo, to set up an insulation area, which is now lacking, in order to isolate possible early cases of infection.

Meanwhile, we have planned two humanitarian missions, one in Paraguay (Marco Stabile, treasurer of AICPEonlus and ISAPS member) and a second in Guatemala (Claudio Bernardi), pending continuation of those already started in Togo which will probably resume in May 2015.

Lastly, there has been a large number of patients from many Asian countries and western countries visiting Korea for rhinoplasty. Thus the Korean plastic surgery market has been focusing on medical tourism because the domestic situation has slowed down and become highly competitive!
JAQUES REVERDIN, THE FIRST SKIN GRAFT?
HISTORY OF A SURGICAL INNOVATION
Denys Montandon, MD – Geneva, Switzerland

Gentlemen! Anyone who has — at any time — studied the process of wound healing will always remain interested in this topic. Therefore, the beautiful invention of Reverdin’s seemed to me an invitation to take up again my earlier researches in the healing process of wounds. — Carl Thiersch, 1874

This acknowledgment of Reverdin’s invention was published five years after the first skin graft presentation by the Swiss surgeon, Jaques-Louis Reverdin, at the Imperial Surgical Society of Paris. During these five years, skin grafting had become a routine procedure all over Europe for treating and accelerating the healing process of granulating wounds.

Who was Jaques-Louis Reverdin?
Born in Geneva in 1842, Jaques Reverdin, like most of his French-Swiss colleagues, studied medicine in Paris because there was no medical faculty in his city at that time. Already “Interne des Hôpitaux” in 1865, he was working at the Hôpital Necker in 1869, under the direction of Félix Guyon, a young chief-surgeon who became in 1876 the first professor of urology at the Faculty of Paris. During the Franco-Prussian war in 1870, Reverdin, although Swiss by nationality, collaborated with the French army, at the head of the “Swiss Ambulance” in Paris, treating many wounded soldiers. Back in Geneva two years later, he became chief-surgeon at the Hôpital Cantonal de Genève and the second professor of surgery in the newly created Faculty of Medicine at the University. He was the first Swiss surgeon to recognize the importance of Lister’s antiseptic method and introduced it in the Geneva hospital. In 1884, he wrote a book on surgical antisepsis and asepsis and in 1910 a book on war surgery. During his 34 years of professorship, he published many papers, mainly on surgery of goiters, in which he had acquired a large experience. He is credited to be the first to have noticed, before Theodor Kocher, another Swiss surgeon from Bern, the symptoms of hypothyroidism after extensive thyroidectomy and gave it the name of myxedema, suspecting an endocrine function of the gland. In 1908, he was invited to present his experience and observations on this subject in a major surgical meeting in Chicago. But in 1909, it was Kocher who received the Nobel prize for his work on thyroid!

For cleft palate surgery, Reverdin created a needle for sutures which bears his name and is still commonly used in Europe. In 1876, he wrote a book on surgical antisepsis and asepsis and in 1910 a book on war surgery. During his 34 years of professorship, he published many papers, mainly on surgery of goiters, in which he had acquired a large experience. He is credited to be the first to have noticed, before Theodor Kocher, another Swiss surgeon from Bern, the symptoms of hypothyroidism after extensive thyroidectomy and gave it the name of myxedema, suspecting an endocrine function of the gland. In 1908, he was invited to present his experience and observations on this subject in a major surgical meeting in Chicago. But in 1909, it was Kocher who received the Nobel prize for his work on thyroid!

Reverdin showing his collection of butterflies to a colleague in 1920

it was never presented and published in a well-known medical academy. On another hand, the interesting experimental studies published by Giuseppe Baronio in 1874 and by Paul Bert in 1875 were performed only on animals. Johann Friedrich Dölling had stimulated the latter to study skin grafting following a visit to Claude Bernard in Paris. The renowned Berlin surgeon had written his doctoral thesis on skin transplantation in 1822, but admitted that he failed to succeed in performing a free graft in humans. In 1869, the young Reverdin apparently had not read these publications. As he explained later on, the idea came to him from another German surgeon: “I had read in the surgical lessons of Billroth that sometimes islets of cicatrisation can develop at a distance from the wound borders in burns or varicose ulcers. The apparition of these islets on spots within the deep dermis layers had been spared. The idea to imitate such a process in my mind briskly one night: I told myself: could we not, by placing small fragments of living epithelium on the surface of a granulating wound, stimulate the creation of islets of cicatrisation? Would these small pieces of epithelium adhere? There was only one means to know: it was to attempt the experiment. I made this attempt the next morning. I detached with a lancet on my own leg two to three fragments of skin as thin as possible and placed them on a granulating wound of one of my patients. I secured it with tape and a dressing and waited for the result with anxiety. After a few days, my previsions had been totally confirmed; not only the small pieces had taken and were solidly adherent, but around them new skin was formed, growing day after day at a distance from the borders of the wound.”

This case report would have remained unnoticed if Félix Guyon, Reverdin’s chief, had not decided that it should be reported as soon as possible to the Imperial Academy of Surgery in order to provide a date (a means of fixing a date). This was done the 8th of December 1869 and published three months later in the Bulletin of the Society with the commentaries of the eminent surgeons who had attended the presentation.

Graffe epidermique—expérience faite dans le service de M. le Docteur Guyon, à l’hôpital Necker.

Gentlemen: The communication, which I have the honor to make to the Society of Sur¬gery, pertains to a very common question of pathology, apparently well understood, but which still presents some obscure and inter¬esting points for elucidation. I refer to the cicatrization of wounds by second intention.

A detailed description of the case report and the result obtained was then produced:

November 24, I tried the following experiment: I removed with the point of a lancet from the right arm of the patient three small slivers of epidermis. I placed my epidermic slivers in the middle of the wound, their deep surface in contact with the granulations and I supported them with some dichalon bandelettes.

December 1, the skin slivers have united and formed a little pale white plaque; there has evidently grown a small epidermic zone around each of them. In the days that followed, this pale border extended more and more to form a little pale and thin islet quite analogous to the epidermic border which has formed along the edges of the wound.

Today, December 8, it is observed, that the islet is notably enlarged and the wound practically healed. The 28-year-old Reverdin then concludes:

Such are the facts that I have the honor to submit to the Society of Surgery. I report them now as a matter of record, but I pledge myself to pursue these researches. I will have to study as closely as possible the histological process: Is it a simple result of contact, of environ¬ment? Is there proliferation of the trans¬planted elements? Here are many ques¬tions, which deserve some researches that I intend to undertake.

No wonder, several questions and commentaries were very critical and would have discouraged many young sur¬geons from pursuing further research.

M. Trélat: M. Reverdin believes that epi¬dermic proliferation must be attributed to the graft. In order for this experiment to have a real value, it would be necessary for it to be repeated a great many times, and that it should always succeed. It is necessary, in fact, to exercise on this point a very great amount of reserve.

M. Blot: From the practical point of view the question of the epidermic graft, or that of the Malpighian or mucous layer, appears to me to be of no importance. To remove a piece of dermis from the arm or elsewhere to unite it to the surface of a suppurating wound which is slowly cicatrizing, just to save a little healing time, is to expose the patient, above all in our hospitals, to the danger of erysipelas.

M. Léon le Fort: I share completely the opinion of M. Blot. The recent wounds borne by the patient from which the epi¬dermis had been taken were covered by a reddened crust showing that at least a blood discharge had followed. There¬fore, the epidermis alone had not been

[continued on page 40]
removed; a fragment had been taken comprising capillaries and a door opened for erysipelas. As to the utility of the method, it is used synonymously with invention, although innovation is more precisely defined as something thought up or mentally fabricated. Importantly, no technology or its application is entirely new, as no inventor works within a vacuum. The discoverer has often proceeded by analogy." Reverdin followed the observations of Billroth on the healing of wounds of unequal depths, where islands of epidermis are growing from the remaining skin adnexae. He did not care about theory, he just wanted to improve the healing of his patients. Once it had been published, he realized that his idea could lead much further.

Surgical innovations may be incremental, meaning that it marginally improves upon currently available technology, or enabling, leading to further development of new procedures within a field. Reverdin’s needle is an example of incremental innovation, whereas the idea of skin grafting belongs definitely within the field of enabling innovations, opening not only on the field of the various methods of skin grafting, but also on other tissues and organ transplantations. During his experiments, Reverdin was also particularly concerned with the observations that the transplanted islets of skin were growing and the epithelial cells spreading to cover the wound. “The grafts, once adherent, the islands continue to grow, depending on the general state of the patient and the local status.”

The concept of cell culture was born.

What were the mistakes of Reverdin?

Considering nowadays the publications of Reverdin on skin grafting, one must conclude that he made two mistakes: 1) Even though he called it epidermic graft, he was transplanting pieces of epidermis with some dermis. 2) He pretended that he took skin from his own leg to cover the wound of his patient, and later on claimed successful grafts from Negroes to Whites, from rabbits to men, to cats, from man to sheep and to other species, while we know that these allografts could never have survived.

The first mistake is mainly a matter of language that the surgeon attending his first presentation had immediately noticed. He admitted that he could not harbor only epidermis, “it is almost impossible to do otherwise,” but insisted on the importance of the epidermal cells for the healing of wounds. This wrong assumption gave the opportunity for others to claim new inventions or innovations (Pollock 1870, Lawson 1870, Ollier 1872, Lexer 1872, Thiersch 1874, Wolfe 1875, Krause 1883, and many others). Already in 1884, Emil Bock, an ophthalmologist, had collected more than 200 published articles describing various skin grafts.

The second mistake is more striking. How can we explain that he never realized that long-term all his allografts would fail? “I often took the skin fragments on myself, to graft them on patients who would refuse the operation, thinking that it was painful. In our first grafts, I had taken the tegument on the subject himself, but I became soon assured that the result was the same when transplanting grafts from one subject to another; this fact has been abundantly demonstrated…”

In fact, for decades, almost every surgeon believed that a skin transplant could be harvested on another person or even on animals. The use of cadavers or amputated limbs as donor sites was common and was almost never questioned until the nineteen twenties. Winston Churchill recorded a famous homogram in his memories. To replace a nurse who was fainting when asked to give a piece of her skin for a wounded officer during the battle of Omburmann in 1858, heroic Churchill offered himself. “The doctor then proceeded to cut a piece of skin and some flesh about the size of a shilling from the inside of my forearm. I managed to hold out until he had cut a beautiful piece of skin with a thin layer of flesh attached to it. This precious fragment was then grafted on to my friend’s wound. It remains to this day and did him lasting good in many ways. I for my part keep the scar as a souvenir.”

Even more surprising is the fact that many surgeons, particularly ophthalmologists, claimed to practice successful xenografts, using frog skin for eyelid repairs. Reverdin himself recorded the use of rabbit’s periosteum in a case of partial nasal reconstruction. In the 16th century, Tagliacozzi was already doubtful in this matter: “Un ex alieno corpore, un vero ex proprio tradux eligen- dus fix?”

Offer, the father of bone and periosteal grafts, was in favor of allografts, but against the use of xenografts. One had to wait for Lexer’s publication in 1914 to put serious doubts on the permanent viability of allografts or between different species. But even at that time, Alexis Carrel, Nobel Prize winner in 1912 for his research on organ transplantation, claimed that he had grafted successfully skin from a black dog to a white one!

Why has this so-called “invention” become a landmark in the practice of surgery?

The state of art of our profession is a compendium of surgical methods, which have been selected among thousands of innovations brought throughout the ages. According to Riskin and Longaker, “innovation is a broad term defined as the act of introducing something new or the use of a new idea or method. In some instances, it is used synonymously with invention, although innovation is more precisely defined as something thought up or mentally fabricated. Importantly, no technology or its application is entirely new, as no inventor works within a vacuum. The discoverer has often proceeded by analogy.” Reverdin followed the observations of Billroth on the healing of wounds of unequal depths, where islands of epidermis are growing from the remaining skin adnexae. He did not care about theory, he just wanted to improve the healing of his patients. Once it had been published, he realized that his idea could lead much further.

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The concept of cell culture was born.
Yves-Gerard Illouz was born in 1929 in Oran, Algeria into a modest family. At that time, Jews who had acquired French citizenship in 1870 by the Crémieux Decree wanted one thing: to integrate and become “true French.” For this, it was necessary to study and in this milieu that meant to become a doctor or lawyer. He told me that one of the major traumas of youth was the abolition of the Crémieux Decree from October 7, 1940 until 20 October 1943 by the Vichy Government. At the age of 11, for three years, he lost his French nationality of which he was always proud.

In 1945, he was sixteen years old when he decided to go to France to continue his studies, first in Montpellier, and then the following year in Paris. These years were not easy for him, with no money and without his family. He took courses in philosophy to achieve a diploma at the Sorbonne University—not surprising to those who knew his knowledge in this area.

When I met Y-G in 1980, some said then that he was not a surgeon and therefore his publications could not be trusted. It is true that the first photos, presenting the liposuction technique that he had developed, were not truly of a quality considered as “professional.”

On completing his thesis on acute breast cancers, he graduated and settled quickly into private practice, but, and this was a turning point in his career and settled into private practice, but, and this was a turning point in his career, he had no time to be part of the Seraglio. Yet I was always amazed to see what patience, one can even say how selflessly, he agreed to receive the first colleagues who believed in him, and then secondarily those who had criticized him.

As always, the mysteries of life have shown the character that most know today. In the years 1977-78, an idea was in the air in the field of plastic surgery as for his personal and professional life.

Assuming that it was that tool that created the technique, and not the reverse, we can say that liposuction is not a technique but a tool which allowed a fundamental check, which is only in cosmetic surgery, but also in all areas of reconstructive surgery by a better understanding of the fatty tissue of the cutaneous vasculature and the consequences of subcutaneous dissection.

Y-G was recognized very late by his peers, as he had no time to be recognized as a true “father.” Yet I was always amazed to see what patience, one can even say how selflessly, he agreed to receive the first colleagues who believed in him, and then secondarily those who had criticized him.

For Y-G, surgery was his life, his passion. Ceasing to operate is saying to himself that his whole life was a mistake. The principle of the technique of liposuction is so basic that it could be developed and practiced simply using a cannula, a tube, and a vacuum machine. As for the posterior period, complications are the exception, always related to the technician, never the technique. The technique is so simple that a number of general practitioners have unfortunately pierced the body which sometimes resulted in fatal complications. In France, it was necessary to legislate liposuction to prohibit practitioners who are not surgeons from practicing this procedure.

The first publication of Illouz’s technique of liposuction is dated 1979. The following one is from 1980 in the Revue Francaise de Chirurgie Esthetique and then in PRS in 1985. In 1988, we contributed to the drafting of several chapters of his book, La sculpture chirurgicale (chirurgical sculpture of lost-wax method), followed the same year by the English edition. In 1988, he published in Aesthetic Plastic Surgery the results of injections of fat in about 167 cases carried out from 1983 to 1987.

Yves-Gerard Illouz, MD (1929-2015) – France

As early as 1986, liposuction was the second most common procedure performed in the US and by 1987 it would become the most practiced intervention by the combined specialties. It is common to see some countries or some authors claim to be the first to describe certain techniques or certain diseases. This was never the case for liposuction.

Regarding the evolution of the technique itself, we can say that the only notable changes that have appeared since the original description have been the use of increasingly fine cannulas that allowed the exploration of virtually all parts of the body. So far, all processes invented to improve it did not really prove their superiority.

Since 1980, another adventure began creating his international community. He crossed the globe and traveled around the world, and global recognition both by his peers and by the general public.

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An idea was in the air in the field of plastic surgery as for his personal and professional life.

To achieve a diploma at the Sorbonne University—not surprising to those who knew his knowledge in this area. When I met Y-G in 1980, some said then that he was not a surgeon and therefore his publications could not be trusted. It is true that the first photos, presenting the liposuction technique that he had developed, were not truly of a quality considered as “professional.”

On completing his thesis on acute breast cancers, he graduated and settled quickly into private practice, but, and this was a turning point in his career,

For Y-G, surgery was his life, his passion. Ceasing to operate was saying to himself that his whole life was a mistake. The principle of the technique of liposuction is so basic that it could be developed and practiced simply using a cannula, a tube, and a vacuum machine. As for the posterior period, complications are the exception, always related to the technician, never the technique. The technique is so simple that a number of general practitioners have unfortunately pierced the body which sometimes resulted in fatal complications. In France, it was necessary to legislate liposuction to prohibit practitioners who are not surgeons from practicing this procedure.

The first publication of Illouz’s technique of liposuction is dated 1979. The following one is from 1980 in the Revue Française de Chirurgie Esthetique and then in PRS in 1985. In 1988, we contributed to the drafting of several chapters of his book, La sculpture chirurgicale (chirurgical sculpture of lost-wax method), followed the same year by the English edition. In 1988, he published in Aesthetic Plastic Surgery the results of injections of fat in about 167 cases carried out from 1983 to 1987.

Mario Vahos, MD (1929-2014) – United States

Long-time ISAPS member, Mario Vahos passed away on December 28, 2014. He was a highly respected pioneering plastic surgeon at St. Agnes Hospital and other area hospitals in the Greater Baltimore area. He is survived by his children, Victoria and David and his wife, Alexis.
Sergey Nudelman, MD (1956-2014) – Russian Federation

Dr. Sergey Nudelman passed away on December 7, 2014 in Ekaterinburg, Russia after a long fight with a chronic illness.

Dr. Nudelman founded the Cosmetology and Plastic Surgery Center which is now the largest clinic of aesthetic medicine in Russia. It was to his pursuit of excellence that many Western surgical innovations and pioneering technologies, such as facial endoscopy, were first introduced in his clinic in Russia in the mid-1990s and early-2000s. In October 2014, the clinic celebrated its 25th anniversary.

Sergey Nudelman was the first Russian plastic surgeon who joined the International Society of Aesthetic Plastic Surgery in 2000. Serving as the ISAPS National Secretary (2000-2008), he opened the doors of this prestigious society for his Russian colleagues. Dr. Nudelman was also an international active member of AAPS and a board member of the Russian SPRAS.

In 1996, Dr. Nudelman initiated an educational course in plastic surgery. The knowledge and experience of world-renowned plastic surgeons became available for Russian surgeons including those practicing in remote places in the country. Sergey Nudelman considered this course to be his mission and a matter of professional honor. Over time, this course has become a biannual international meeting and an integral part of the major Beauty Medicine Forum.

Dr. Nudelman earned great respect of his colleagues and trust of his patients for his professional honesty and decency.

In July 2014 Sergey Nudelman was awarded the title of the Honored Doctor of the Russian Federation by a Presidential Decree. In November 2014 he received the “Golden Lancet” National Prize in aesthetic medicine for his contribution to the development of plastic surgery.

Sergey Nudelman loved Ekaterinburg, which was the most beautiful and interesting town for him and he did everything for its prosperity. He participated in various social charity projects. He was known among artists and musicians as a connoisseur and patron of arts. He liked literature, music and fine arts of different genres and supported cultural institutions, artists and labor veterans. Many outstanding musicians, singers and poets, including Nikolay Petros, Boris Berezovsky, Daniel Kramer, Andrey Vorozhesny and George Garanian gave friendly concerts in his clinic. He had a taste for authentic things and a brilliant sense of humor.

However, his top priority was his family and children. His wife Irina was always by his side. His two daughters, Alexandra and Natalya gave him adorable grandchildren. Sergey was a caring son, a loving husband and a wise father. This is a great loss for all his family, friends and colleagues. We will miss this extraordinary man, who changed the lives of so many of us for the better.

Peter Randall, MD (1923-2014) – United States

Peter Randall, 91, was an innovator in the field of cleft palate surgery who brought his skills to patients in Philadelphia and abroad. He died on November 16 at his home in Pennsylvania.

Dr. Randall, a former chairman of the departments of plastic surgery at the Hospital of the University of Pennsylvania and Children’s Hospital of Philadelphia, focused his research on the repair and reconstruction of facial deformities, especially cleft lips and palates.

He helped to develop one of the most robust training programs for plastic surgeons in the United States and founded the Cleft Palate Clinic at Children’s Hospital. In the late 1950s, Dr. Randall battled the Federal Trade Commission against government criticism of board certification.

He was past president of the American Society of Plastic Surgeons, the American Cleft Palate Association and the Robert H. Ivy Society. He was a member of the International Society of Aesthetic Plastic Surgery, the American College of Surgeons and the unique Pithotomy Club. www.pithotomy.com.

Dr. Randall traveled the world to train doctors and nurses to perform reconstructive surgery. In India, he operated on lepers to restore the use of their hands, and during the war in Vietnam he volunteered to teach local surgeons how to perform skin grafts on burn patients.

Through several tours with Operation Smile, Peter, with his wife, Posey, and multidisciplinary medical teams, traveled to China, Israel, Vietnam and India to work with cleft lip and palate patients. His service and compassion changed the lives of thousands of patients.

“Peter loved his work, and he loved to teach. He was driven by a deep faith and compassion to help his fellow man,” his family said in a tribute. Outside the operating room, Dr. Randall was cheerful and gentle. He was an enthusiastic singer, gardener, birder, and sailor.

Benito Vilar-Sancho Altet, MD (1924-2014) – Spain

Don Benito (as he liked to be called) was born in Valencia 90 years ago into a family with a long tradition of medical practice. His grandfather was a doctor, his father an ENT specialist and one of his uncles a dental surgeon. He graduated with distinction from the Valencia School of Medicine and then moved to Madrid to undertake doctoral studies. In 1950, he saw Sir Archibald McIndoe perform surgery in Madrid, which influenced him so much that he left his budding ear, nose & throat career to engage in plastic surgery at the Queen Victoria Hospital in England, alongside McIndoe and Mr. Percy Jayes.

He returned to England on several occasions to further his studies, visiting Professor Kilner, Mr. Pet and Harold Gillies. From day one, he was fully dedicated to plastic surgery and his doctoral thesis “Surgical treatment of partial-thickness scalp defects” was perhaps one of the first in this specialty.

After the creation of the National Institute of Medicine and Workplace Health and Safety in September 1952, he was appointed Head of Plastic Surgery. From then onwards, he paid particular interest to congenital malformations, publishing a classification of the cleft lip and palate and a procedure for unilateral cleft lip surgery.

In 1956 he founded, along with Doctors Álvaro Lebel, José Sánchez Galindo and José Antonio Soraluce, the Spanish Society of Plastic Surgery (SECPRE). His knowledge of French, German, English and Italian enabled him to travel the world and rub shoulders with leading figures of the time. This also allowed him to organise and chair firstly the European Plastic Surgery Congress, then the World Aesthetic Surgery Congress and finally the World Plastic Surgery Congress, all of which were held in Madrid and thrust Spanish plastic surgery onto the international stage. In 1983, the 7th ISAPS Congress was held in Montreal and he was elected as president of ISAPS, ultimately organising the 8th Congress of ISAPS in Madrid in 1985.

He joined an array of plastic surgery associations, delivered speeches at congresses and symposia, and became chairman of the UEMS, where he approved the name change of our speciality to include the term AESTHETIC. In 1992, he chaired the IPRS World Congress, where he also successfully adopted the word aesthetic into the name of the International Confederation, it being renamed IPRAS.

In 1965, the National Centre for Surgical Specialties was created and he won the official selection process to be named director. From then on, he worked at the former Pavilion Number 8 of the Madrid School of Medicine on all kinds of treatments: post-burn scars, congenital malformations, skin tumours and post-mastectomy reconstruction. He trained numerous resident doctors and worked with a team of highly-experienced plastic surgeons.

It was commonplace for surgeons from both Spain and abroad to come and observe his work. Visits were constant both at Pavilion 8 and at his private consultations, especially to witness rhinoplasty surgery, a technique that he mastered and that his own father, Dr. Rafael Vilar-Sancho imported in 1922 from Germany, after seeing Dr. Joseph Operar.

He performed his last nose operation in 2007, the crowning point of forty years of practice. He retired to his beloved Ibiza, where he would sit in the spacious library of his house in San Antonio Bay, looking out to sea and recalling his other great passions: sailing, spearfishing and diving. He passed away on 21 December 2014 and was buried beside his mother, wife and two of his children.

A man of immense culture, sharp intellect, extreme gentleness and subtle English humour, he has left a profound mark on Spanish medicine and plastic surgery in particular.
Lieutenant Colonel Awni Abu Lail (1970-2014) – Jordan

Contributed by Dr. Samer Haddad

On the 8th of December 2014, the Jordanian Royal Medical Services lost one of its finest plastic and reconstructive surgeons — Lieutenant Colonel Awni Abu Lail.

Dr. Awni died in the operating theater while preparing to operate on a patient. He was 43 years old.

Dr. Awni was born on the 15th of December 1970. He completed his secondary education in Zarqa, Jordan. He attended medical school at the university of science and technology in Irbid, Jordan. After graduating from medical school in 1994, he joined the Jordan Armed Forces Royal Medical Services where he did his residency in general surgery after which he sub-specialized in plastic and reconstructive surgery. During those 20 years he was often deployed as part of a Jordanian medical mission with the United Nations’ peacekeeping force to many war-stricken countries such as Eritrea, Lebanon, Iraq and the Palestinian territories. He did so without ever complaining for them no matter how difficult or time consuming it would turn out to be. He simply did not know how to say no to anyone.

Dr. Awni was a member of many distinguished societies including the International Society of Aesthetic and Plastic Surgery and the Jordanian Society of Plastic and Reconstructive Surgeons among many others. He was well acknowledged and appreciated by many members in those societies who knew him on a personal as well as professional level and who were very saddened by this great loss.

Dr. Awni did not believe in normal working hours. Whenever he was awake he was working. His loyalty to his job and family sometimes came at the expense of his health and his family. He left behind a young wife and two lovely children. For anybody who had the pleasure of knowing him, although gone, he will never be forgotten.

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The impressive opening ceremonies included a Dragon Dance and a warm welcome from Dr. Wing-man Ko, the secretary of food and health, Government of Hong Kong. This large gathering of plastic surgeons of Chinese descent from all over the globe included many of my world-renowned friends and colleagues such as Prof. Yi-Lin Cao, Fu-chan Wei, Yu-Ray Chen, Andy Lee, Lee Pu and David Chiu. I reflected on the significant contributions that these thought leaders and many more of the faculty in attendance have made to our specialty. It was a privilege for me to be amongst them, to listen to their talks, and to share ideas.

I was asked to present a talk on “The Future of Plastic Surgery” which is a challenging topic that I enjoyed preparing and presenting. Following two days of presentations in dual sessions, the meeting concluded with a Gala Dinner on the well known boat restaurant “Jumbo.”

My thanks go to friends and colleagues whom I have already mentioned and to Dr. Daniel Lee for their generous and warm hospitality. Whilst I will soon forget the heavy traffic and the mist that seemed to hang around during my visit, the friendship and kindness will remain with me ’til I next have the fortune of returning to Hong Kong.

Finally, I offer my gratitude to ISAPS for selecting me as a Visiting Professor.
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<td>24 April–26 April 2015</td>
<td>ISAPS Symposium</td>
<td>Guayaquil, ECUADOR</td>
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**Guess Who!**

**Where in the World?**

Answer: National Secretaries  
Chair Peter Scott in Mali. The Dogon culture of the 14th and 15th centuries is animistic and relates to Sirius, the Dog Star, which they say has three parts. This was only confirmed by scientists in 1920. The cliff dwellings are listed as World Heritage Sites and symbolic paintings depict their beliefs. Dr. Scott, an avid amateur archeologist with a major interest in the paleoneuropsychology of rock paintings and engravings, is pointing to a circle of life symbol.

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