



# ISAPS NEWS

OFFICIAL NEWS OF THE INTERNATIONAL  
SOCIETY OF AESTHETIC PLASTIC SURGERY

Volume 13 | Number 1

## INSIDE ■

New Editor-in-Chief

Global Perspectives  
Facial Rejuvenation

New Column:  
Myths and Facts

# BOARD OF DIRECTORS

---

## **PRESIDENT**

Dirk Richter, MD, PhD  
Wesseling, GERMANY  
[president@isaps.org](mailto:president@isaps.org)

## **PRESIDENT-ELECT**

Nazim Cerkes, MD, PhD  
Istanbul, TURKEY  
[ncerkes@hotmail.com](mailto:ncerkes@hotmail.com)

## **FIRST VICE PRESIDENT**

Lina Triana, MD  
Cali, COLOMBIA  
[linatriana@drlinatriana.com](mailto:linatriana@drlinatriana.com)

## **SECOND VICE PRESIDENT**

Gianluca Campiglio, MD, PhD  
Milan, ITALY  
[info@gianlucacampiglio.it](mailto:info@gianlucacampiglio.it)

## **THIRD VICE PRESIDENT**

Arturo Ramirez-Montanana, MD  
Monterrey, MEXICO  
[docarturo@gmail.com](mailto:docarturo@gmail.com)

## **SECRETARY**

Ivar van Heijningen, MD  
Knokke-Heist, BELGIUM  
[ivanheijningen@duinbergen-clinic.be](mailto:ivanheijningen@duinbergen-clinic.be)

## **TREASURER**

Kai-Uwe Schlaudraff, MD, FEBOPRAS  
Geneva, SWITZERLAND  
[schlaudraff@concept-clinic.ch](mailto:schlaudraff@concept-clinic.ch)

## **HISTORIAN**

Peter Scott, MD  
Johannesburg, SOUTH AFRICA  
[peters@cinet.co.za](mailto:peters@cinet.co.za)

## **PARLIAMENTARIAN**

Tim Papadopoulos, MD  
Sydney, AUSTRALIA  
[drtim@drtim.com.au](mailto:drtim@drtim.com.au)

## **EDUCATION COUNCIL CHAIR**

Vakis Kontoes, MD, PhD  
Athens, GREECE  
[vakiskont@gmail.com](mailto:vakiskont@gmail.com)

## **EDUCATION COUNCIL VICE CHAIR**

Ozan Sozer, MD  
El Paso, Texas, US  
[doctor@elpasoplasticsurgery.com](mailto:doctor@elpasoplasticsurgery.com)

## **NATIONAL SECRETARIES CHAIR**

Michel Rouif, MD  
Tours, FRANCE  
[michel.rouif@wanadoo.fr](mailto:michel.rouif@wanadoo.fr)

## **PAST PRESIDENT**

Renato Saltz MD, FACS  
Salt Lake City, Utah, US  
[rsaltz@saltzplasticsurgery.com](mailto:rsaltz@saltzplasticsurgery.com)

## **TRUSTEES**

Fabian Cortinas MD  
Buenos Aires, ARGENTINA  
[fabiancortinas@gmail.com](mailto:fabiancortinas@gmail.com)

W. Grant Stevens, MD, FACS  
Marina del Rey, California, US  
[drstevens@hotmail.com](mailto:drstevens@hotmail.com)

## **EXECUTIVE DIRECTOR**

Catherine Foss  
Hanover, New Hampshire, US  
[isaps@isaps.org](mailto:isaps@isaps.org)

**01**  
VOLUME 13

---

# CONTENTS

Message from the Editors	3
Message from the President	4
Global Alliance	7
Guess What	11
Education Council Update	12
Symposium: Cordoba	15
EC Course: Kolkata	16
WAPSCD 6th Congress: Taiwan	18
Symposium: Pakistan	20
Visiting Professor Program	21
ISAPSexpert	26
Myths & Facts	27
Feature: ANSM	28
Patient Safety	30
Humanitarian	34
Committee Report	36
Journal Update	38
Marketing	39
Members Write	41
Global Perspectives	42
Surgical Marking	58
History	64
In Memoriam	68
New Members	70
Meetings Calendar	72

# MESSAGE FROM the Editors

Dear Colleagues,

It has been a true privilege to serve as Editor of *ISAPS News* since 2008. Now that my term has come to an end, I want to take this opportunity to express my gratitude to the members and leadership of our society for the opportunity to serve ISAPS in this role. *ISAPS News* helps to connect us and rally around our mission by reporting the impactful educational, humanitarian, and leadership activities conducted by ISAPS members. While our members are distributed around the globe, our newsletter brings us closer together. It highlights the innovation, integrity, dedication to patient safety, and camaraderie of our global plastic surgery community.

I am pleased to introduce the new Editor, Nina Naidu, MD, from New York. She brings vibrant energy and great enthusiasm to this post, and will serve ISAPS with dedication. I wish to thank our members for your tremendous support of *ISAPS News* during my tenure as Editor. I humbly ask that you please keep your exciting contributions to this publication flowing. You, our members, are the heart and soul of *ISAPS News*.

Special thanks go to Catherine Foss, Executive Director of ISAPS and Managing Editor of *ISAPS News*. She has a staunch commitment to excellence and passion for ISAPS, and has been a pleasure to work with. I also give thanks to the ISAPS presidents under whom I have been honored to serve: Foad Nahai, Jan Poell, Carlos Uebel, Susumu Takayanagi, Renato Saltz, and Dirk Richter. You have all brought great vision and passion to ISAPS. I wish hearty congratulations to Dirk Richter on his new presidency, and look forward to his leadership over the next two years.

Warm Regards,



**J. Peter Rubin, MD**



Dear Readers,

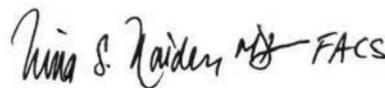
It is an honor to take over from Dr. Peter Rubin as the new Editor-In-Chief of *ISAPS News*. We are very grateful to Dr. Rubin for his hard work and dedication over the past ten years.

*ISAPS News* has a long history and a wide readership. It is sent quarterly to more than 27,000 subscribers. This is your newsletter, and I am eager to receive any constructive comments you may have about the publication. Several new columns have been added, including a Marking section that has been met with great enthusiasm, as well as a Myths column in which common misconceptions about plastic surgery are dispelled with the presentation of scientific data that we can present to our patients.

The popular Global Perspectives section highlights facial rejuvenation in this issue and will be more focused going forward, including topics on mastopexy, periorbital rejuvenation and non-invasive fat reduction. You will also note a few policy changes, including a general requirement of ISAPS membership for article submission, and a request for finalization of all articles at the time of submission to limit the need for multiple revisions.

Above all else, we are advocates for our patients' rights and safety. Thus, I would especially like to draw your attention to key articles in this edition including Dr. Mark Jewell's feature on the recent actions of the Agence Nationale de Sécurité du Médicament in France regarding the use of textured breast implants, and Dr. Claude Oppikofer's piece on the critical role we play in safeguarding our patients' wellbeing.

Thank you for your continued support of ISAPS and all that we do.



**Nina S. Naidu, MD FACS**  
**Editor-In-Chief**





OUR MEMBERSHIP PACKAGES HAVE DONE GREAT SO FAR AND MANY OF OUR MEMBERS ARE RECOGNIZING THE COST-EFFECTIVENESS OF UPGRADING TO THE BUSINESS OR FIRST LEVELS.



## MESSAGE FROM the President

---

Dear Friends and Colleagues,

### New ISAPS News Editor-in-Chief – Welcome Nina Naidu

Have you noticed all the recent changes? *ISAPS News* has not only gotten a great facelift, but also a new Editor-in-Chief: Nina Naidu. We are more than grateful to have found a highly qualified and committed editor to succeed Peter Rubin, who has chosen to pursue other professional duties after ten years of very successful work. 1000 thanks, Peter, and welcome, Nina. Congratulations on your new position!

### New Marketing Team at Full Speed

I would especially like to thank our new marketing team from boeld communication in Munich, Germany for more than just design changes. Since January, they have been working for ISAPS at enormous speed and meet my exact taste and style. I hope they meet yours as well.

### New Membership Packages Proving Successful

Our membership packages have done great so far and many of our members are recognizing the cost-effectiveness of upgrading to the business or first levels. Take a look at our membership website before renewing your membership and paying your dues: [www.isapsmembership.org](http://www.isapsmembership.org)

I would also like to strongly endorse ISAPSMedOne Aesthetics, our all-new e-learning platform with over 1000 videos and 60 books with a special focus on aesthetic surgery and its conservative alternatives. I use it almost every day, and learn so much from it.

### World Premiere in Moscow

Learning was a top priority in the past months as we celebrated our world premiere of the FAST program in Moscow in February. The Fundamental Training in Aesthetic Surgery (FAST) program focused especially on the needs of our young residents and fellows, and featured sound presentations from experts in the field. The feedback about this course in Moscow was incredibly motivating. Many thanks to the participants and the international and Russian top-class faculty.

### BIA-ALCL Update

BIA-ALCL remains an issue. At the end of the day, the hearing in France brought nothing new. All textured implants except Allergan BioCell remain unchanged on the market and there is no general recommendation to remove implants as a precaution. Nina Naidu will represent ISAPS at the FDA hearing in Washington, DC in March and will report to us promptly on the latest news in the American sector. We would like to take this opportunity to thank our Chairman, Mark Jewell, for his detailed reporting on this issue, and Nina Naidu for representing ISAPS in Washington, DC.

# PLASTIC SURGERY

## New Start on ISAPS Social Media

Our social media presence has been completely reworked and has now picked up great drive. We are happy about every contribution from you and every comment. We want to use these channels more and more to inform you and to reduce the flood of daily e-mails. Follow us on Instagram, Facebook, LinkedIn and YouTube, so you don't miss a thing! Click on the buttons at the end of any email to see ISAPS on social media.

## Annual Statistics Survey – Get Your Seal!

Finally, I would like to ask you for a favor. Our annual statistics survey is coming up, and we want more participation this

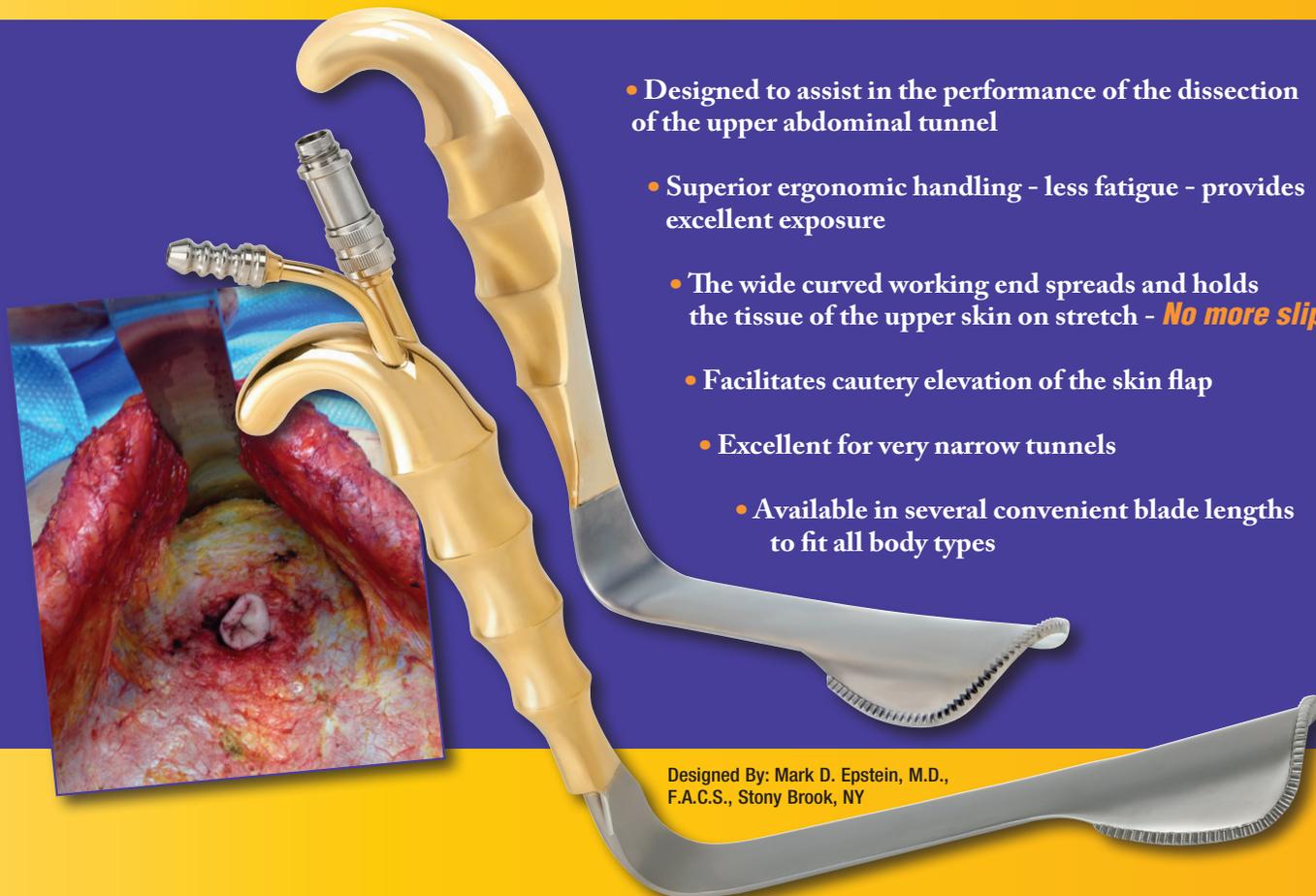
year than ever before! As a thank you for joining us in completing this important survey, we have designed a seal of participation for members and non-members alike, which you will receive after completing the questionnaire as a thank you, and which you can advertise freely. I think your patients will really appreciate your involvement in quality assurance.

Best regards,



**Dirk Richter MD, PhD, ISAPS President**

# EPSTEIN ABDOMINOPLASTY RETRACTOR



- Designed to assist in the performance of the dissection of the upper abdominal tunnel
- Superior ergonomic handling - less fatigue - provides excellent exposure
- The wide curved working end spreads and holds the tissue of the upper skin on stretch - **No more slippage!**
- Facilitates cautery elevation of the skin flap
- Excellent for very narrow tunnels
- Available in several convenient blade lengths to fit all body types

Designed By: Mark D. Epstein, M.D.,  
F.A.C.S., Stony Brook, NY

**ASSI.ABR31726**

**80 x 27mm** blade with 60mm wide working end with teeth and ergonomic handle

**ASSI.ABR31826**

**110 x 27mm** blade with 60mm wide working end with teeth and ergonomic handle

**ASSI.ABR32026**

**140 x 27mm** blade with 60mm wide working end with teeth and ergonomic handle

**ASSI.ABR31926**

**160 x 27mm** blade with 60mm wide working end with teeth and ergonomic handle

**ASSI.ABR32226**

**240 x 27mm** blade with 60mm wide working end with teeth and ergonomic handle

**ASSI.ABR41726**

**80 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and ergonomic handle

**ASSI.ABR41826**

**110 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and ergonomic handle

**ASSI.ABR41926**

**160 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and ergonomic handle

**ASSI.ABR42126**

**140 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and ergonomic handle

**ASSI.ABR42226**

**240 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and ergonomic handle

**ASSI.ABR51726**

**80 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and **suction** with ergonomic handle

**ASSI.ABR51826**

**110 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and **suction** with ergonomic handle

**ASSI.ABR51926**

**140 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and **suction** with ergonomic handle

**ASSI.ABR52126**

**160 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and **suction** with ergonomic handle

**ASSI.ABR52226**

**240 x 27mm** blade with 60mm wide working end with teeth, **fiber optic** and **suction** with ergonomic handle



**accurate surgical & scientific instruments corporation**  
800.645.3569 516.333.2570 fax: 516.997.4948 west coast: 800.255.9378  
Info: [assi@accuratesurgical.com](mailto:assi@accuratesurgical.com) • Orders: [orders@accuratesurgical.com](mailto:orders@accuratesurgical.com)  
[www.accuratesurgical.com](http://www.accuratesurgical.com)

Not all ASSI products shown in our literature or on our website are available for sale in Canada



# ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

## ARGENTINA

Sociedad Argentina de Cirugía Plástica Estética y Reparadora (SACPER)

## AUSTRALIA

Australasian Society of Aesthetic Plastic Surgeons (ASAPS)

## AUSTRIA

Österreichische Gesellschaft für Plastische, Ästhetische und Rekonstruktive Chirurgie (ÖGPÄRC)

## AZERBAIJAN

Society of Plastic Surgery Azerbaijan (SPSA)

## BELGIUM

Royal Belgian Society for Plastic Surgery (RBSPS)

## BOLIVIA

Sociedad Boliviana de Cirugía Plástica Estética y Reparadora (SBCPER)

## BRAZIL

Sociedade Brasileira de Cirurgia Plástica (SBCP)

## CANADA

Canadian Society for Aesthetic Plastic Surgery (CSAPS)

## CHILE

Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)

## CHINA

Chinese Society of Plastic Surgery (CSPS)

## CHINESE TAIPEI

Taiwan Society of Plastic Surgery (TSPS)

## COLOMBIA

Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)

## CYPRUS

Cyprus Society of Plastic, Reconstructive and Aesthetic Surgery (CySPRAS)

## CZECH REPUBLIC

Czech Society of Aesthetic Surgery (CSAS)

## CZECH REPUBLIC

Czech Society of Plastic Surgery (CSPS)

## DENMARK

Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)

## DOMINICAN REPUBLIC

Sociedad Dominicana de Cirugía Plástica Reconstructiva y Estética (SODOCIPRE)

## EASAPS

European Association of Societies of Aesthetic Plastic Surgery (EASAPS)

## ECUADOR

Sociedad Ecuatoriana de Cirugía Plástica, Reconstructiva y Estética (SECPRE)

## EGYPT

Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)

## FINLAND

Suomen Esteettiset Plastikkirurgit ry. (SEP)

## FRANCE

Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)

## GERMANY

Vereinigung der Deutschen Ästhetisch Plastischen Chirurgen (VDÄPC)

## GREECE

Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)

## INDIA

Indian Association of Aesthetic Plastic Surgeons (IAAPS)

## INDONESIA

Indonesian Association of Plastic Reconstructive and Aesthetic Surgeons (InaPRAS)

## IRAN

Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)

## IRELAND

Irish Association of Plastic Surgeons (IAPS)

## ISAPS

International Society of Aesthetic Plastic Surgery (ISAPS)

## ITALY

Associazione Italiana di Chirurgia Plastica Estetica (AICPE)

## ITALY

Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)

## JAPAN

Japan Society of Aesthetic Plastic Surgery (JSAPS)

## KUWAIT

Kuwait Society of Plastic Surgeons (KSPS)

## LEBANON

Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)

## MALAYSIA

Malaysian Association of Plastic, Aesthetic and Craniomaxillofacial Surgeons (MAPACS)

## MEXICO

Asociación Mexicana de Cirugía Plástica Estética y Reconstructiva (AMCPER)

## MOROCCO

Société Marocaine de Chirurgie Plastique Esthétique Plasticiens (SOMCEP)

## NETHERLANDS

Nederlandse Vereniging voor Esthetische Plastische Chirurgie (NVEPC)

## NORWAY

Norwegian Society of Aesthetic Plastic Surgery (NSAP)

## OSAPS

Oriental Society of Aesthetic Plastic Surgery (OSAPS)

## PAKISTAN

Pakistan Association of Plastic Surgeons (PAPS)

## PANAMA

Asociación Panameña de Cirugía Plástica, Estética y Reconstructiva (APCPER)

## PERU

Sociedad Peruana de Cirugía Plástica (SPCP)

## PHILIPPINES

Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)

## PORTUGAL

Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPRE)

## ROMANIA

Romanian Aesthetic Surgery Society (RASS)

## RUSSIA

Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS)

## RUSSIA

Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS)

## SAUDI ARABIA

Saudi Plastic Surgery Care Society (SPSCS)

## SERBIA

Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)

## SERBIA

Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)

## SINGAPORE

Singapore Association of Plastic Surgeons (SAPS)

## SOUTH AFRICA

Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)

## SOUTH KOREA

Korean Society of Aesthetic Plastic Surgery (KSAPS)

## SPAIN

Asociación Española de Cirugía Estética Plástica (AECEP)

## SPAIN

Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)

## SWEDEN

Svensk Förening för Estetisk Plastikkirurgi (SFEF)

## SWITZERLAND

Schweizerische Gesellschaft für Ästhetische Chirurgie (SGAC)

## SWITZERLAND

Swiss Society of Plastic, Reconstructive and Aesthetic Surgery (SSPRAS)

## THAILAND

Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)

## TURKEY

Turkish Society of Aesthetic Plastic Surgery (TSAPS)

## UNITED ARAB EMIRATES

Emirates Plastic Surgery Society (EPSS)

## UNITED KINGDOM

British Association of Aesthetic Plastic Surgeons (BAAPS)

## UNITED KINGDOM

United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)

## UNITED STATES

American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)

## VENEZUELA

Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)

## VIETNAM

Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)

# GLOBAL ALLIANCE SPOTLIGHT



الجمعية الكويتية لجراحي التجميل  
KUWAIT SOCIETY OF PLASTIC SURGEONS

## KUWAIT SOCIETY FOR PLASTIC SURGEONS



HISHAM BUREZQ, MD - KUWAIT  
President

The Kuwait Society for Plastic Surgeons (KSPS) is a non-profit plastic surgery specialty organization. Our main role is to protect the integrity of plastic surgery as a specialty by supporting all society members in their effort to provide the highest quality of patient care. The society comprises nearly ninety plastic surgeons and is focused on sharing knowledge and expertise, improving quality of care, and advancing the practice of plastic surgery in Kuwait. KSPS is committed to raise and maintain the standards of medical practice of plastic surgery in Kuwait for the benefit of patients and member surgeons.

Founded in 1993 under the umbrella of the Kuwait Medical Association, the society represents all plastic surgeons in Kuwait, making KSPS the only leading authority for aesthetic, burn and reconstructive plastic surgeries in Kuwait.

The mission of KSPS is to ensure that its member surgeons have the highest standard of training, ethics, clinical practice and research in plastic and reconstructive surgery. We are trying to maintain the highest quality of care for plastic surgery patients among member surgeons by producing scientific conferences, workshops and courses. KSPS keeps all members informed about scientific updates related to the field. KSPS promotes public education programs about burns, reconstructive and cosmetic plastic surgery procedures in the form of public

awareness days, brochures, TV shows, newspaper reports and social media posts. KSPS teaches the public when to approach a plastic and reconstructive surgeon, the risks of plastic surgery medical tourism and the importance of choosing a board-certified plastic surgeon.

KSPS membership remains an exclusive privilege for plastic and reconstructive surgeons who possess the necessary qualifications. All KSPS members are certified by the Kuwait institution of Medical Specialties and the Kuwait Licensing Authority. Physicians who have been trained in specialties other than plastic surgery are not eligible for KSPS membership. Most KSPS members are also members of other well-known international plastic surgery societies such as the American Society of Plastic Surgeons, the Canadian Society of Plastic Surgeons or the International Society of Aesthetic Plastic Surgery.

*WE HELP WRITE PLASTIC SURGERY GUIDELINES,  
CONSENT FORMS AND ROLES TO ENSURE THE  
BEST QUALITY OF PATIENT CARE.*

KSPS contributed to the establishment of legal regulations in our field by collaborating with the state institutions that control issues related to our field such as the Ministry of Health, Kuwait Institution of Medical Specialties

and Kuwait Medical Association. KSPS follows closely and reports any malpractice noticed in the private sector especially by surgeons outside the field of plastic surgery. We help write plastic surgery guidelines, consent forms and roles to ensure the best quality of patient care. We actively participate in all investigative committees for any morbidity or mortality related to plastic surgery patients in the state. This is to ensure fair non-biased investigation, thorough fact collection and proper case analysis.

KSPS has been an active and influential member of the Arab Society of Plastic and Reconstructive Surgery, the Gulf Society of Plastic and Reconstructive surgery and the Gulf Society of Burn Surgery.

# GLOBAL ALLIANCE SPOTLIGHT: SAUDI ARABIA



JAMAL JOMAH, FRCSC, FRCSED, ABHRS, FACS - SAUDI ARABIA  
President, Saudi Plastic Surgery Care Society



جمعية الرعاية الجراحية  
SURGICAL CARE SOCIETY



*The Laws and Regulations of Investigation and Trails in Saudi Health System (14 Dec. 2018)*



*Breast Reconstruction Awareness Campaign (22-23 November 2018)*



*J-Plasma Workshop (5 Dec. 018)*



*Treatment of the Ptotic Breast Seminar (13 Nov. 2018)*

Saudi Arabia, officially the Kingdom of Saudi Arabia, is the largest sovereign state in the Middle East, geographically the fifth largest in Asia, second largest in the Arab world after Algeria and 12th largest in the world. The Saudi Plastic Surgery Care Society was first conceptualized in early 2016 with the aim of promoting and establishing safe, successful, high standard plastic surgery service in the Kingdom of Saudi Arabia. The success of the 1st Saudi Plastic Surgery Congress and ISAPS Symposium last April 2018 has eventually led to creating a professional society named the SAUDI PLASTIC SURGERY CARE SOCIETY in the kingdom to promote the specialty and to facilitate the exchange of knowledge and experiences locally and internationally. The word "Care" was added because the society will reach out to caring and educating the public and non-physician professionals.

The society was established and formally registered on August 8, 2018. As President, together with the twelve Board Members, I presided over the society's first General Assembly meeting in October 2018. The SPSCS Board Members are: Dr. Fuad Hashem, Dr. Mohamed Amir Mrad, Dr. Adnan Gelidan, Dr. Abdulaziz Jarman, Dr. Manaf Alazawi, Dr. Abdullah Alnamlah, Dr. Saud Alshlash, Dr. Tawfeik Alyafi, Dr. Abdullah Althunayan, Dr. Badr Abdulraouf, Dr. Bisher Alshanawani, and Dr. Mohamed Qattan.

The Society's mission and vision is to have a high level of scientific and professional performance of doctors and allied health professions by holding symposia, seminars, and workshops, and by organizing awareness campaigns and public educational activities. The society also has the privilege of establishing clinical centers to provide non-profit medical care in the field of Plastic Surgery.

Continued on page 10



## JOMAH CONTINUED

We are a society starting its first year, but we have proudly achieved a lot in short time by providing up-to-date education for our members through local scientific activities and workshops where eminent plastic surgeons, Dr. Paul G. Ruff and Dr. Dennis Clyde Hammond, have been invited.

	Date	Activity Name	Location	City
1	02/01/2019	Breast Reconstruction Awareness Campaign	King Saud Medical City	Riyadh
2	14/12/2018	The Laws and Regulations of Investigation and Trails in Saudi Health System	Crowne Plaza Hotel RDC Hotel	Riyadh
3	05/12/2018	J-Plasma Workshop	Crowne Plaza Hotel RDC Hotel	Riyadh
4	22/11/2018	Breast Reconstruction Awareness Campaign	King Khalid Hospital - King Saud University	Riyadh
5	23/11/2018	Breast Reconstruction Awareness Campaign	Panorama Mall	Riyadh
6	13/11/2018	Treatment of the Ptotic Breast	Crowne Plaza Hotel RDC Hotel	Riyadh
7	12/10/2018	The First Board Meeting	Movenpick Hotel	Riyadh

Upcoming activities include a Burn Awareness Campaign, a Flap Dissection Course, a program on Plastic Surgery and Social Media and our Annual Congress in November.

We work hard to disseminate accurate and current information to the public and the media and to promote safe plastic surgery nationwide. Currently, we have approximately 230 members.

The addition of SPSCS to the ISAPS Global Alliance is a rational growth in the direction to promote international collaboration and cooperation in the field of aesthetic surgery. We are so proud and honored to be affiliated with this prestigious and renowned body and we look forward to a fruitful relationship.

# GUESS WHAT

---



CAN YOU IDENTIFY THESE TWO IMAGES?  
ANSWER ON PAGE 67.

ISAPS WOULD LIKE TO  
OFFICIALLY THANK  
AND ACKNOWLEDGE  
THE GENEROUS  
SUPPORT OF OUR  
GLOBAL SPONSORS

ISAPS Premier  
Global Sponsor  
Program



POLYTECH





VAKIS KONTOES, MD, PHD - GREECE  
Chair, ISAPS Education Council

# EDUCATION COUNCIL UPDATE

---

The Education Council (EC) is steadily moving forward in achieving the targets and realizing the vision established during the Miami Biennial Congress of ISAPS. The new EC committee is working closely and as a strong team and step-by-step the structured plan is progressing.

The following have been achieved during the last three months:

## ISAPS Course – Ho Chi Minh City, Vietnam

This Course, including live surgery demonstrations, took place 7-9 December 2018 in Ho Chi Minh City with great success and a high-class faculty. It could not be better described than by the words of the local organizer and President of the newly formed Vietnamese Society of Aesthetic Plastic

Surgery (VSAPS), Dr. Le Hanh. This society also became an ISAPS Global Alliance member during this inaugural educational event in Vietnam.

*The echo of the ISAPS Course is still resounding in the hearts of Vietnamese doctors deeply. The magisterial lectures, the excellent surgical demonstrations as well as the liberal, worldly-wise communication partly proved the qualifications of the faculties. In life, there are many ways to do charity, but with the principle of ISAPS, hereby the impartation of standard knowledge to the plastic surgery doctors around the world, that is a wonderful way to do charity with numberless efficiency! The skill and knowledge that the doctors learned from ISAPS courses can help them prevent many complications*



*THE NEW EC COMMITTEE IS WORKING CLOSELY AND AS A STRONG TEAM AND STEP-BY-STEP THE STRUCTURED PLAN IS PROGRESSING.*

*and have good results. Then, the doctors have brought happiness, self-confidence and a better life for the females as well as the males.*

*Being joined with ISAPS, we have not only raised the scientific position and the politics over the world, but also got nearby the clear examples in studying and the wide heart for imparting our knowledge voluntarily. We would like to promise that we will positively comply with the guidelines of ISAPS and will contribute with all our best to build up everything for ISAPS and its mission.*

*Thank you so much for everything and wishing to see again Dr. Saltz, Dr. Kontoes, Dr. Takayanagi, Dr. Kunaporn, Dr. Lucero, Dr. Wu, Dr. Dinyossypoulos and other ISAPS faculty in the ISAPS course in HaNoi in June, 2020.*

We at the Education Council are thankful to the Vietnamese Society and would like to express our support to the Aesthetic Surgery education projects in Vietnam.

### **ISAPS Aesthetic Dissection Course - Liege, Belgium**

This landmark ISAPS Course took place for the 5<sup>th</sup> consecutive year in Liege from the 17<sup>th</sup> to the 19<sup>th</sup> of January in collaboration

with the University of Liege Plastic Surgery and Anatomy Department. The average rating by the participants was 4.9 out of 5 for the Program and the Faculty's performance.

For this jubilee edition, we decided to change our goals and focus more on aesthetic procedures - and less on applied anatomy. From the feedback of the previous courses, we learned that our team of instructors was appreciated the most. The instructors team included: Drs. Alex Verpaele, Gianluca Campiglio, Serge de Fontaine, Olivier Gerbault, Pascal Castus, Jan Fabré, Bahram Dezfoulian, Jean-Luc Nizet,

Ivar van Heijningen and me. Thus, we decided to use this asset even more and assign them to two dissection tables with four attendees each and rotate them so that all instructors would teach all attendees. Our invited

faculty, Drs. Dirk Richter, Mario Pelle Ceravolo and Peter Palhazi had a free role and stepped in where needed.

This Course is really taking a very high position in the ranking of yearly ISAPS educational events.

### **ISAPS Course - Kolkata, India**

This ISAPS educational event took place in Kolkata, India from the 24<sup>th</sup> to 27<sup>th</sup> of January under the organization of the local ISAPS leadership, Drs. Manoj Khanna, ISAPS National Secretary, Rakesh Kalra, ISAPS Assistant National Secretary, and Ashish Davalbhakta, EC Representative for India.

With an enriched Faculty of members from different parts of the world, the meeting opened with a live operative workshop on the 24<sup>th</sup> of January at BNR Hospital in Kolkata where a record twelve procedures were done in nine hours. Some procedures were livestreamed all over the world in an ISAPS webinar lasting over nine hours.

Master classes and lectures followed the operative workshop from the 25<sup>th</sup> to the 27<sup>th</sup> of January covering the entire spectrum of aesthetic surgery. The course had around 300 delegates. More information can be found in the report of the National Secretary in this issue of *ISAPS News*.

Continued on page 14

### ISAPS F.A.S.T. Program - Moscow, Russia

In a world premiere on the 8<sup>th</sup> and 9<sup>th</sup> of February in Moscow, we inaugurated the first module on Face and Rhinoplasty as part of the Fundamental Aesthetic Surgery Training (F.A.S.T.) program. This new ISAPS EC program consists of three modules, face, breast and body, and includes intensive training for young plastic surgeons who are still in training or in the first years of practice. It includes very basic information. The individual in-depth lectures last 60 minutes and cover from A-Z on the selected topics. We had as international faculty our President, Dirk Richter, our President-Elect, Nazim Cerkes, Dr. Kai Kaye, Dr. Maria Wiedner and me, as well as renowned colleagues from Russia. The feedback was extremely positive and very motivating and there was enough time to have detailed discussions. The simultaneous translation was perfect and very helpful.

The next module on breast aesthetic surgery will take place in Moscow on the 24<sup>th</sup> and 25<sup>th</sup> of May. The body contouring module will follow in November this year. We are convinced that this concept will continue to be successful, especially with the focus on further training for younger colleagues, and will make the circle worldwide. Many thanks to our Immediate Past President, current President and all Board members for supporting this new initiative of the Education Council.

For the next two months, we have eight ISAPS endorsed meetings scheduled. More information can be found on the calendar of events at the end of this issue and on our website.

The strong brand of ISAPS in education is the reason of the increase in demand for meeting endorsement. The Education Council is very happy about this and we want to express our thanks to the organizers who respect and support our main mission of *Aesthetic Education Worldwide*®.

In the months of May and June, we also have very interesting educational events about which we will report in our next issue.

The EC is also proud to report one more “first” educational event, an ISAPS Symposium that took place in Karachi, Pakistan on the 24<sup>th</sup> of February, in cooperation with the National Secretary for Pakistan, Dr. Moazzam Tarar and the local plastic surgery society.

On April 15-16, a Visiting Professor Program (VPP) is confirmed with the University of **Alexandria, Egypt**, to be followed by the **ISAPS Course - Egypt** to be held in **Cairo on the 18<sup>th</sup> and 19<sup>th</sup> of April**.

In closing, the EC would like to express its gratitude, for the excellent cooperation with our President-Elect, Dr. Nazim Cerkes, in the organization of **monthly ISAPS Webinars** this year. You will receive information about these programs, including a link to register. They are listed on our website calendar, have a low fee for non-members, and will also enrich the ISAPS Video Library.

Moreover, our President’s efforts in supporting the education mission have immensely contributed to these new educational products by communicating EC activities through our marketing office and the new membership structure of different levels, which are already available to members. The free three months’ trial for the MedOne video library available to all members on our website is also a new step ahead to strengthen our educational mission. This regularly updating video library will be available after the free trial to members at certain membership levels. More details are available in the membership link on our website

Our sincere thanks to all of you for supporting our ISAPS Education Mission from any position in the ISAPS family. We urge you to keep in close contact with us and do not hesitate to contact the EC directly for any matter regarding educational issues in aesthetic surgery. We will be very happy to support and help your initiatives.

# ISAPS SYMPOSIUM

## CORDOBA 2019: BODY CONTOURING SURGERY



**FABIAN CORTIÑAS, MD - ARGENTINA**  
ISAPS National Secretary for Argentina  
and ISAPS Trustee



**GUSTAVO ABRILE, MD - ARGENTINA**  
ISAPS Assistant National Secretary for  
Argentina



*Dr. Fabian Cortiñas, ISAPS National Secretary for Argentina and Symposium Co-Director on the left with the Faculty, Dr. Antonio Graziosi (Brazil), Dra. Ruth Graf (Brazil), Dr. Peter Rubin (USA), Dr. Carlos Malzoni (Argentina) and Dr. Gustavo Abrile ISAPS Assistant National Secretary for Argentina.*



*Dr. Rubin and Dr. Cortiñas discussing patient drawings during live marking demonstration session.*



*Dr. Antonio Graziosi, breast implant selection.*



*Dr. Carlos Malzoni, lower body lift.*



*Dra. Ruth Graf, subfascial breast augmentation.*

**B**ody contouring surgery is growing among post bariatric patients and plastic surgeons must be updated about the latest trends and surgical options. One of the critical parts of the operation, and the key to a smooth procedure, is marking. That was the opening of our Symposium, held in Cordoba, Argentina, on November 23-24. Dr. Peter Rubin and Dr. Carlos Malzoni showed in detail the preoperative marking in live demonstration. After 90 minutes of detailed explanation, the speakers presented different techniques in upper and lower body lift, liposuction, breast surgery, prevention and treatment of complications.

Breast surgery is also a challenge in post bariatric patients and two of the pillars of our practice of body contouring, Dra. Ruth Graf and Dr. Antonio Graziosi from Brazil, were also part of the faculty to teach from their extensive experience in breast augmentation, reduction and breast lifting techniques.

Thanks to the strong support of Dr. Esteban Elena, President of our National Society (SACPER) and Dr. Nicolas Fagalde, the local host (SCPC), the meeting was a success with more than 200 attendees and outstanding social activities.

# ISAPS COURSE AND WEBINAR

## KOLKATA



**MANOJ KHANNA, MD - INDIA**  
ISAPS National Secretary for India



**RAKESH KALRA, MD - INDIA**  
ISAPS Assistant National Secretary for India

The ISAPS Course held in Kolkata, India from the 24<sup>th</sup> to the 27<sup>th</sup> of January had an enriched faculty of members from around the globe, headed by the Educational Council Chairman, Vakis Kontoes (Greece), along with Gianluca Campiglio (Italy), Gerald O' Daniel (US), Carlos Roxo (Brazil), Cemal Senyuva (Turkey), Kai Kaye (Spain) and Nimrod Friedman (Israel).

The meeting opened with a live operative workshop on January 24<sup>th</sup> at BNR Hospital in Kolkata where a record number of twelve procedures were done in nine hours. Some of the procedures were webcast by ISAPS all over the world in a webinar lasting more than nine hours that included facelift and neck lift by Gerald O'Daniel, blepharoplasty by Vakis Kontoes, and breast reduction and liposuction using vaser and abdominoplasty by Cemal Senyuva. Other operative procedures demonstrated were breast lift by Carlos Roxo, lipoabdominoplasty by Kai Kaye, browpey by Gianluca Campaglio, along with breast augmentation

*REGISTERED DELEGATES CAME FROM ALL OVER INDIA, AND ALSO FROM NEIGHBORING COUNTRIES INCLUDING BANGLADESH, UAE, UK, RUSSIA AND THE UNITED STATES.*



Figure 1- Faculty members Drs. Kontoes, Friedman, Kaye, Davalbhakta, Khanna, Kalra, Roxo and Campiglio.

by Marcos Sforza (UAE), vaginal rejuvenation by Rakesh Kalra and Threadlift by Viraj Tambwekar (India).

The operative workshop was followed by master classes and lectures covering the entire spectrum of aesthetic surgery. The 300 delegates represented the highest attendance at any aesthetic surgery meeting in India to date. The entire auditorium was jam packed on all days of the meeting. Registered delegates came from all over India, and also from neighboring countries including Bangladesh, UAE, UK, Russia and the United States.

The conference was inaugurated by the Indian cricket superstar Sourav Ganguly, along with Arun Lal and Member of Parliament, Derek O'Brien, the morning of January 25<sup>th</sup>. The

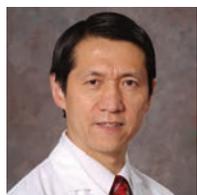
program also included festive dinners with plenty of music and dance where there was lively interaction among the foreign faculty and the delegates attending the meeting.

The feedback from attendees was very positive and everyone felt they had plenty of learning to take home and would love to have such meetings on a regular basis in India in the future. We promised to hold an ISAPS Course every alternate year in India to satisfy the demands of the eager-to-learn aesthetic surgeons of the country.



# THE 6TH CONGRESS

## WORLD ASSOCIATION FOR PLASTIC SURGEONS OF CHINESE DESCENT



**LEE L.Q. PU, MD, PHD, FACS - UNITED STATES**

ISAPS Educational Council, Regional Chair for China  
Associate Editor, *Aesthetic Plastic Surgery*

The 6<sup>th</sup> Congress of the World Association for Plastic Surgeons of Chinese Descent (WAPSCD) was held in Taipei, Taiwan from November 29 to December 1, 2018. It follows the previous five successful world congresses held in Beijing (2008), Taipei (2010), Xian (2012), Hong Kong (2014), and Wuhan (2016). This time the congress was combined with the 2018 Asian Pacific Plastic and Reconstructive Surgery Forum and the 2018 annual meeting of the Taiwan Society of Plastic Surgery. The congress attracted about 1,000 attendees from many countries. Dr. Chien-Tzung Chen served as the Congress Chairman and I served as Co-Chairman. Dr. Hao-Chih Thai was the Executive Chair. The congress was organized by the Chang Gung Memorial Hospital and the National Taiwan University Hospital in Taipei, Taiwan. Dr. Fu-Chan Wei, Dr. Yilin Cao, Dr. David T. W. Chiu, and Dr. Yu-Ray Chen served as the honorary chairmen of the congress.

The congress began with a nice faculty dinner on the night of November 28<sup>th</sup> - a wonderful event for all invited faculty

who enjoyed their time together and shared their friendship and companionship. **(Figure 1)** During the faculty dinner, the congress chairmen and honorary chairmen each gave brief welcoming remarks to all invited faculty who were so happy to be there.

The congress included a two-and-a-half-day scientific program followed by a half-day city tour. The scientific program covered the entire spectrum of plastic surgery including minimal invasive facial cosmetic surgery, mammoplasty, facial contouring, flap reconstruction, body contouring, blepharoplasty, rhinoplasty, mammoplasty, craniofacial reconstruction, face lift, vascular abnormalities, microsurgery, and innovation and management of scars. There was a total of 23 panels in both cosmetic and reconstructive plastic surgery delivered by 58 international invited speakers and 44 local invited speakers. **(Figure 2)**

The first day started with five panel presentations in the morning followed by an opening ceremony. **(Figure 3)**



Figure 1 - A group photo during the faculty dinner



Figure 2 - The entire group photo in the meeting place

During the opening ceremony, I gave a presentation to highlight all the previous congresses (**Figure 4**) and Dr. David Chiu made a presentation on the mission of the society. This was followed by a very impressive presidential speech by Dr. Chien-Tzung Chen and two keynote lectures by Dr. David Chiu and Dr. Yilin Cao. Ten panel presentations were conducted in the afternoon. The welcome reception was held in the first night in the convention center. There was live music and all congress participants and invited speakers were able to socialize with each other in a more relaxed environment.

During the second day there were five panels and three keynote lectures presented by Dr. Yu-Ray Chen, Dr. Andrew Lee, and Dr. William Lineaweaver in the morning followed by a city tour in the afternoon. All the invited speakers were able to enjoy a visit to the most famous Shisanhang Museum of Archaeology and Fort San Domingo with very nice surroundings. That night, there was a gala dinner at Fisherman's Wharf. (**Figure 5** and **Figure 6**)

On the third day, the morning started with keynote lectures presented by renowned plastic surgeons from the US and Taiwan including Dr. Kevin C. Chung, Dr. James Chang, Dr. Paul S. Cederna, Dr. Fu-Chan Wei and me. In combination of the annual Taiwan Society of Plastic Surgery meeting, the Noordhoff Lecture was delivered by Dr. Renato Saltz. He gave a remarkable lecture on the combination of invasive and non-invasive approaches for facial, breast, and body rejuvenation. (**Figure 7**) Once again, this meeting had ten invited keynote lectures that were delivered by world renowned plastic surgeons on various topics including academic plastic surgery, fat grafting, nerve regeneration, hand surgery, microsurgery, burn reconstruction, craniofacial surgery, and head and neck reconstruction. In the afternoon, there were three more panel presentations followed by five free paper sessions.

The 6<sup>th</sup> Congress of the WAPSCD was indeed another great success. It was the largest gathering of Plastic Surgeons of Chinese Descent worldwide and the congress itself covered both cosmetic and reconstructive plastic surgery. The scientific program was world class with participation by many internationally renowned plastic surgeons. As a group that also included our colleagues from the US and other Asian countries, we enjoyed our friendship and companionship in addition to the scientific exchange. The 7<sup>th</sup> Congress of WAPSCD will be held in Hangzhou, China in October of 2019 and again we all look forward to another great meeting in the year to come.



Figure 3 - Invited faculty group photo after the first panel presentation on minimally invasive facial rejuvenation.



Figure 4 - Review of previous congresses by Dr. Pu during the opening ceremony.



Figure 5 - The Congress Chairman, Dr. CT Chen with the Congress Co-Chairman, Dr. Lee Pu.



Figure 6 - The performance before the gala dinner.



Figure 7 - Dr. CT Chen and Dr. Yu-Ray Chen present a certificate to Dr. Renato Saltz for his Noordhoff Lecture presentation.



# SYMPOSIUM REPORT - PAKISTAN

**MOAZZAM TARAR, MBBS, FRCS, FCPS(Plast) - PAKISTAN**  
Course Director and ISAPS National Secretary for Pakistan

The 24th of February was an historic day for the plastic surgery community in Pakistan. The first ISAPS Symposium was held at the end of the Pakistan Association of Plastic Surgeons' (PAPS) silver jubilee annual conference at Aga Khan University in Karachi with over 200 young and senior plastic surgeons in attendance. I was assisted in organizing this event by Dr. Hussein Abulhassan, a member of the ISAPS Education Council and the National Secretary for Egypt, and Dr. Zia ul Islam, organizer of PAPSCON.



Figure 1 - Dr. Hussein Abulhassan addresses the audience.

Speakers were Drs. Al Aly of the Cleveland Clinic in Abu Dhabi; Hussein Abulhassan from Egypt; Michelle Pallazzo from Louisville, Kentucky; Taimur Shoaib from Glasgow, UK; Sameera Ajmal from Riyadh, Saudi Arabia; Mabroor Bhatti from Birmingham, UK; and me.

The topics included facial and peri-orbital rejuvenation, rhinoplasty, aesthetic breast surgery and body contouring. Lectures were of very high quality and were followed by lively discussion sessions. Professor Abulhassan also gave a presentation about ISAPS' work and encouraged the

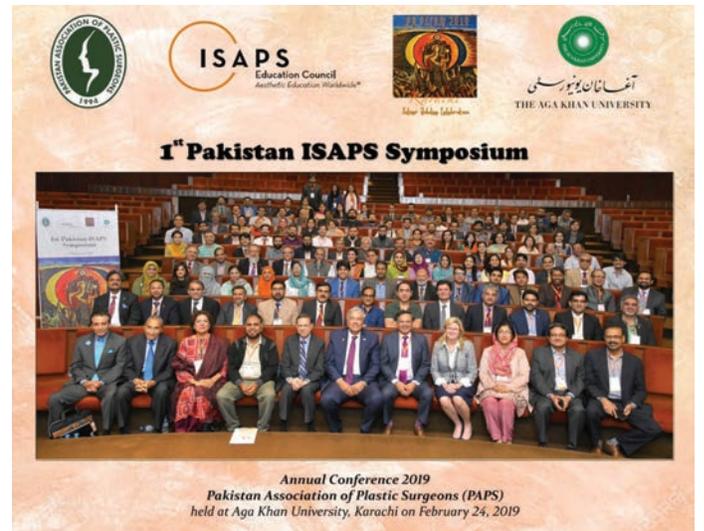
participants to join ISAPS highlighting the many benefits of membership.

The gala dinner held the night before was attended by all of the speakers who were presented with local traditional costumes. They also took part in a folk-dance melee by enthusiastic delegates.



Figure 2 - Gala dinner participants Drs. Al Aly, Zia ul Islam, Abulhassan and Tarar.

The symposium was hailed a great success by both the delegates and the speakers and will pave the way for future ISAPS activities in Pakistan and will certainly help to improve our membership numbers.



# ISAPS VISITING PROFESSOR PROGRAM

## UNITED STATES



**RENATO SALTZ, MD - UNITED STATES**  
ISAPS Immediate Past President

It is a distinct honor to be an ISAPS Visiting Professor!

Last week, I spent three days visiting the Division of Plastic and Reconstructive Surgery at the University of Southern California (USC) in Los Angeles at the invitation of Drs. Grant Stevens and Luis Macias, both in charge of Aesthetic Surgery Education at USC.

I arrived at the LA airport on Wednesday afternoon, February 27, and was welcomed by none other than Dr. Grant Stevens, Director of the Aesthetic Surgery Fellowship at USC and current ASAPS President. That evening, I had my first encounter with the USC Residents, Fellows and Faculty. I gave two presentations, one on Body Contouring Surgery and one on Aesthetic Surgery and Cosmetic Medicine. The meeting lasted over two



Figure 1 - Visiting Marina Plastic Surgery with Dr. Grant Stevens, Director of USC Aesthetic Surgery Fellowship and Current ASAPS President.

hours. Afterward, we had an intimate dinner with Dr. Stevens and his Aesthetic Surgery Fellows.

On Thursday morning, I visited Marina Plastic Surgery, Grant's busy office. I had the pleasure of spending time at Marina Man Land and learned why his cosmetic practice

is so successful. I also had the opportunity to spend time with his two fellows, the USC Chief Residents, and learn what great training in aesthetic surgery they are having as part of the USC Aesthetic Fellowship.

In the early afternoon, we drove to the old LA County Hospital for an anatomy lab. The old hospital is an



Figure 2 - Old LA County Hospital.

amazing concrete structure built in 1928 and only replaced by a more modern hospital in 2006. The paintings, photographs and inscription at the grand entrance document times when things were quite different and the focus was primarily on the patients. Everyone, young and old, should read these sayings at the beautiful entrance arches that remind us why we went into medicine.



Figure 3 - Entrance Arches at Old LA County Hospital.

Continued on page 22

## SALTZ CONTINUED

We spent the afternoon in the anatomy lab doing many dissections using endoscopic techniques for brow and mid-face rejuvenation surgery. The facilities and fresh cadavers were quite excellent and the help provided by Mike and his team was outstanding.

That evening, we had a faculty dinner at the prestigious Jonathan Club in downtown Los Angeles. In addition to a superb full-time faculty, USC has an active volunteer faculty of over 50 plastic surgeons in the LA area and the residents spend time in ten different hospitals. Also unique is their exposure to burn reconstruction since full time plastic surgeons still run the burn unit in the USC program. There is an active research group that includes faculty and residents led by Dr. Alex Wong.

On Friday morning, I presented Grand Rounds on Modern Facial Rejuvenation including endoscopic techniques followed by cases presented by the residents and received a beautiful Trojan sculpture. Afterwards, I visited the Keck Hospital and USC Campus with Dr. Wong and finished the day meeting with Dr. Mark Urata, Chief of the Division of Plastic and Reconstructive Surgery at USC.

I congratulate Dr. Urata and his entire faculty for the amazing residency program they put together in Los Angeles. I witnessed first-hand the volume, the exposure and the experience the residents and fellows get in the USC Program - quite amazing! - a residency program where aesthetic surgery education is taken very seriously and at the same level of all other subspecialties in plastic surgery like Microsurgery, Craniofacial, Burns, and Trauma. This certainly makes the USC program quite unique among other training programs I have visited in the US and Abroad.



Figure 4 - Anatomy Lab at LA County Hospital.



Figure 5 - Faculty Dinner at the Jonathan Club in Downtown LA.



Figure 6 - Drs. Stevens, Urata and Macias honored me with the Trojan Sculpture Club in Downtown LA.



Figure 7 - The Trojan Sculpture



Figure 8 - Group Photo at USC Campus and Keck Hospital

# ISAPS VISITING PROFESSOR PROGRAM

## ARGENTINA



**FABIAN CORTIÑAS, MD - ARGENTINA**  
ISAPS National Secretary for Argentina  
and ISAPS Trustee



**GUSTAVO ABRILE, MD - ARGENTINA**  
ISAPS Assistant National Secretary for  
Argentina

In October, we had the pleasure to receive Dr. Peter Rubin in Buenos Aires as an ISAPS Visiting Professor. The Catholic University was the venue thanks to the generous support of the Chairman of the Department of Plastic Surgery, Dr. Francisco Errea, a great host.

Dr. Rubin presented lectures and edited videos about specific techniques in Body Contouring Surgery for a group of 107 residents from all over Buenos Aires City (Figure 1). Enthusiastic young surgeons from different hospitals took part bringing their energy and curiosity about all topics.

At the end of the day, Dr. Rubin gave an update about Stem Cells enlightening the audience about this controversial and commercial field of our specialty (Figure 2).

Thank you very much Dr. Rubin. It was a spectacular experience.



Figure 2 - Dr. Rubin during his presentation about Stem Cells.



Figure 1 - Dr. Rubin with Dr. Errea, Dr. Cortiñas and a group of residents at the end of the day.

# ISAPS VISITING PROFESSOR PROGRAM

## TAIWAN



**RENATO SALTZ, MD - UNITED STATES**  
ISAPS Immediate Past President

The last official trip that was organized while I was the ISAPS 2016-2018 President took my wife Flavia and me to Asia where I spent nine days delivering many lectures, performing two live surgeries and meeting amazing people in the cities of Taipei (Taiwan), Hong Kong and Ho Chi Min (Vietnam).

This report is about the unforgettable (and busy) week I spent in Taipei, Taiwan as the ISAPS Visiting Professor in December 2018. I was invited by Dr. Chien-Tzung Chen and his team at the Department of Plastic and Reconstructive Surgery at Chang Gung Memorial Hospital and spent three days with his more than 100 Residents, Fellows and Faculty during which I presented three lectures and did one live

surgery – a forehead lift. They all also attended the national meeting.

From the moment of our arrival, we were met by amazingly warm people who took great care of us during our entire visit. During the short time in Taiwan, we met world renowned plastic surgeons and young colleagues who attended my lectures, live surgery and participated in the 6th WAPSCD and 2018 APPRS and the Annual Meeting of the TSPS.

I started by delivering Grand Rounds at the famous Department of Plastic Surgery at Chang Gung Memorial Hospital chaired by Prof. Han-Tsung Liao. There I had the opportunity to meet dear friends Prof. Yu-Ray Chen and Prof. Fu-Chan Wei, whose world-renowned microsurgery unit I visited, and spent time with his current Fellows. He has trained so many Fellows who have become the best microsurgeons in the world.

The highlight of my visit to Taiwan was to deliver the prestigious Noordhoff Lecture in Plastic Surgery. I was humbled to accept this honor that has been previously bestowed on distinguished colleagues. Dr. Noordhoff came to Taiwan in 1959



Figure 1 - Ground rounds with the full Department of Plastic & Reconstructive Surgery at Chang Gung Memorial Hospital faculty, fellows and residents.



Figure 2 - Drs. Han Tsung Liao, Chien-Tzung Chen, Yu-Ray Chen, Renato Saltz and Fu-Chan Wei.



Figure 3- Taiwan National Palace Museum

as a medical missionary and spent his entire surgical career in Taipei. He saw the need for plastic surgery, became board certified in the specialty, and devoted his medical career to the development of plastic surgery in Taiwan. He retired in 1999 as Superintendent Emeritus and Chief of Plastic Surgery, Chang Gung Memorial Hospital and Professor of Surgery at Chang Gung University and College of Medicine. He established the Noordhoff Craniofacial Foundation to help people with craniofacial deformities receive holistic care, sponsor research to advance the quality of medical care and improve public awareness and social acceptance of those patients. Sadly, Dr. Noordhoff passed away at his home in the United States just a few days after I gave my lecture in Taipei.

During the busy week in Taipei we had the opportunity to visit several sites including the incredible Taiwan National Palace Museum where we learned the history, art and traditions of Taiwan.

I thank my hosts and colleagues of Taiwan for the honor and privilege to visit their country and the Department of Plastic and Reconstructive Surgery at the Chang Gung Memorial Hospital.

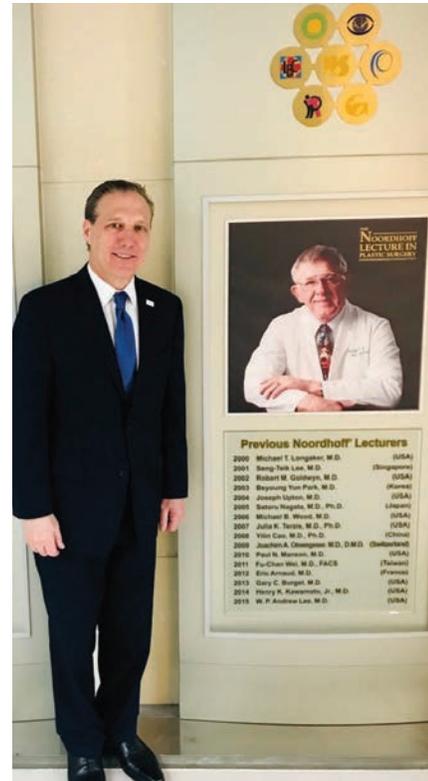


Figure 4 - Dr. Saltz receives the Noordhoff Certificate after the Noordhoff Lecture from the two senior members of the Department of Plastic and Reconstructive Surgery at Chang Gung Memorial Hospital (Chen & Chen).



Figure 5 - The senior and junior faculty of the Department including 3 new stars (left)



# VISIT AN ISAPSexpert

---

**A**s an ISAPS Resident/Fellow member, the “Visit an ISAPS Expert Program” has been an invaluable opportunity to continue my growth as a plastic surgeon.

I was able to visit Dr. Gianluca Campiglio (Milan, Italy) for a two-week period in early December. It was an enriching experience that allowed me to learn about the surgical techniques applied by the expert, as well as fundamentals of the practice business model used in the European region.

I am deeply grateful to Dr. Campiglio for having me as a fellow and being so welcoming, and to ISAPS for developing and maintaining such a program.

Yours truly,  
Henry Rodríguez, MD – El Salvador

Information about the **Visit an ISAPSexpert** and **ISAPSmentoring** programs for our Resident and Fellow members is available on our website at <https://www.isaps.org/medical-professionals/residents-fellows/>



Figure 1 - Dr. Campiglio welcomes his visiting Resident from El Salvador.

# DO MAMMARY PROSTHESES EVER EXPLODE?

---

## MYTHS AND FACTS



**GIANLUCA CAMPIGLIO, MD, PHD - ITALY**  
ISAPS 2nd Vice President

*In this issue, we introduce a new section on dispelling surgical misconceptions. We welcome future articles that discuss this aspect of aesthetic plastic surgery.*

For women, breast augmentation is the most desired surgical procedure, but also one of those about which rumors and incorrect information circulate. The “false myths” affecting breast implants are the most disparate and range from their rupture while in flight to the insecurity of the materials used. Let’s look at two of the main misconceptions: the possibility that they explode on airplanes or while the patient is scuba diving and try to understand what is true and what is false.

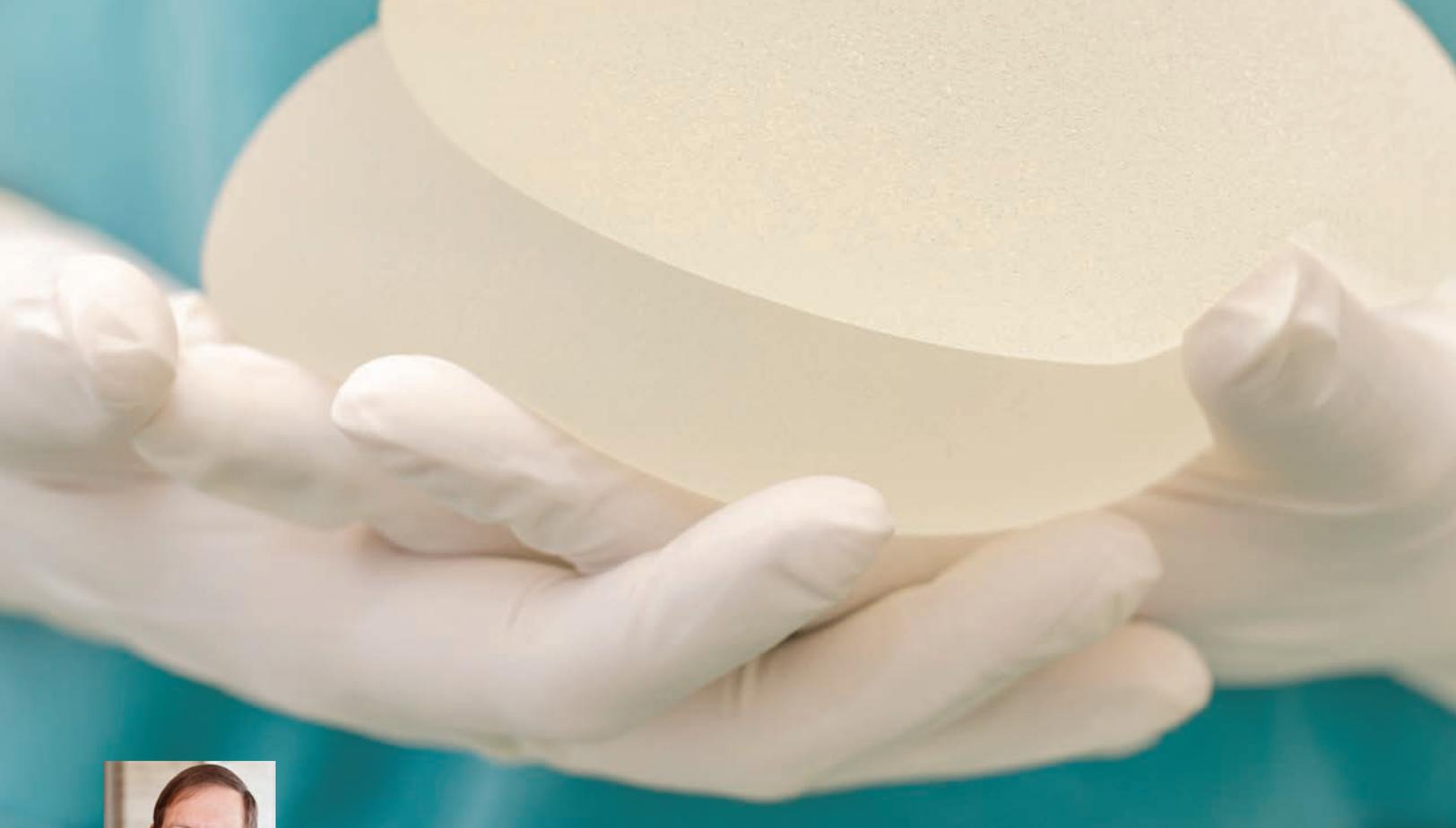
Many patients ask me if they can fly with breast implants. The answer is simple: there is no possibility that the prostheses will break open during the flight because the cabin is pressurized, and the pressure inside is equal to that in the high mountains. Many serious scientific studies, such as those of Vann of 1988 and Lovich of 1990, have shown that breast implants filled with silicone gel, like those used in the vast majority of cases, do not run any risk when implanted in women who fly on commercial airlines. Some American media have even reported the news of an astronaut who participated in a space flight with a breast augmentation. She left, flew and returned to earth without any problem.

Probably this “false myth” originated in the 70s and 80s, when there was talk of a “hostess syndrome.” In those years, the implants filled with water (saline solution) and those with double lumen (a pre-filled chamber of silicone and one of saline)

were popular. During the implantation of these two types of prosthesis, it may happen that during the phase of their filling with sterile water, one can inadvertently also introduce air which, during a flight, due to the decompression in the cabin, could expand according to one of the laws of physics known as Boyle’s law. It has been calculated that 20 cc of air at 3,000 meters, which corresponds to an atmospheric pressure equal to that normally present in the cabin of an airliner, expands to 7 cc (135%) while at 6,000 meters the increase of volume is 20 cc (200%). This phenomenon could explain the so-called “hostess syndrome” - that strange feeling of tension in the chest, absolutely harmless, reported in the past by some hostesses during flights. However, no patient has ever experienced a rupture of a prosthesis during or after an air flight because the reabsorption of air occurs spontaneously within a few weeks because its casing is permeable to gases.

Regarding the risk during scuba diving, several studies have been done to verify the safety of breast implants in extreme situations. These studies have shown that breast implants are not damaged at all even when subjected to pressures far greater than those which the most experienced diver experiences. As in any other human tissue, the inhalation of a mixture of nitrogen and oxygen (such as air) causes the diffusion of nitrogen also in breast implants with the formation of small gas bubbles. These studies have shown that gas bubbles are formed more frequently in silicone filled implants than those filled with saline, probably because the solubility of nitrogen in water is lower than in silicone gel. The bubbles inside the prostheses disappear spontaneously in a short time.

However it could be a problem, even if only theoretical given this unlikely situation: in a deep dive followed immediately by a plane flight that is not pressurized over 10,000 meters, the disappearance of the bubbles could slow down, bringing the worst case scenario of an increase in the size of the prosthesis and to its rupture. But it’s just science fiction!



**MARK JEWELL, MD - UNITED STATES**  
Chair, ISAPS Breast Implant Taskforce

# TEXTURED BREAST IMPLANTS AND ANSM

---

(AGENCE NATIONALE DE SÉCURITÉ DU MÉDICAMENT, FRANCE)  
DECEMBER 2018 ANSM ANNOUNCEMENT ON TEXTURED BREAST  
IMPLANTS

In December 2018, ISAPS received an announcement from the ANSM agency (Agence Nationale de Sécurité du Médicament, France) indicating that Allergan Microcell and Biocell breast implants and tissue expanders no longer have the CE Mark and cannot be sold within the European Union.

The ANSM's November 21 recall recommended that health professionals use breast implants with a smooth envelope, pending the opinion of a committee of experts on the use of implants, in particular those with textured envelopes, in

cosmetic and reconstructive surgery. Iceland, Liechtenstein, Norway and Switzerland had additionally prohibited the use of Allergan textured surface implants.

ISAPS believes that the ANSM announcement relates to an association between textured implant surfaces and the late-term development of breast implant associated anaplastic large cell lymphoma (BIA-ALCL). In the case of Allergan, ANSM made this announcement because the renewal time for the CE Mark was under review. BIA-ALCL has been associated with various types of textured implants



Dr. Michel Rouif, the ISAPS Chair of National Secretaries. ISAPS will update members when the panel of experts at ANSM has reached a decision.

*ABOUT 615 CASES OF BIA-ALCL ARE KNOWN AND DOCUMENTED SINCE 1997 WORLDWIDE.*

### ISAPS Patient Advisory Information Regarding Textured Implants

If patients have a textured implant of any kind and have no symptoms, there is no reason for concern according to the current state of knowledge.

BIA-ALCL Symptoms include:

- Acute, painful swelling on one side from a fluid collection around the implant that occurs years after implant surgery.
- Fluid accumulation can occur for a variety of reasons, including BIA-ALCL
- Laboratory testing of the fluid will determine if the rare BIA-ALCL is present
- This Breast Lymphoma is not classified as breast cancer, but as a cancer of the lymphatic system located at the breast with very good treatment options.
- Surgery to remove implant and capsule is the best treatment for BIA-ALCL

from different manufacturers and is not thought to occur with smooth-surface implants. There is no new scientific evidence regarding the safety profile of textured-surface implants that changes the risk/benefit of these devices. At this stage, the ANSM has not identified any immediate risk for the health of women carrying the implants concerned. ANSM reminds that women with breast implants should be monitored annually.

### ANSM Hearing February

A public hearing of the ANSM was held on February 7-8, 2019 to review the safety of textured breast implants. Prior to the hearing, ISAPS President, Dirk Richter communicated with the membership to ask for comments to be sent to the Agency. ISAPS was represented by two board members at the hearing: Dr. Kai-Uwe Schlaudraff, the ISAPS Treasurer and

About 615 cases of BIA-ALCL are known and documented since 1997 worldwide. There are about 11 million implant patients in the world. Even the most unfavorable statistics show a BIA-ALCL mortality risk that corresponds to the risk of a day's visit to New York City. However, it is important to better understand and study this rare form of breast lymphoma. Thus, studies are already underway by experts globally.

There is no reason to panic and no reason to have implants removed as a precaution. Patients should continue with their personal breast care, including monthly breast self-examination, mammograms as recommended and an annual visit to their plastic surgeon. If a patient experiences sudden swelling and pain years after implantation, they should immediately contact their board-certified plastic surgeon for evaluation.

# PATIENT SAFETY

---

## PATIENT SAFETY IS THREATENED WHENEVER WE TAKE IT FOR GRANTED



CLAUDE OPPIKOFER, MD - SWITZERLAND  
Member, ISAPS Patient Safety Committee

**A**rticle based on the Master Class *Improved efficiency and patient safety through better knowledge of human factors*, presented at the biennial ISAPS Congress in Miami Beach, November 2018.

A former president of the United States considered that democracy was threatened whenever we take it for granted.<sup>1</sup> The same threat is true for patient safety. Much too often in medicine we are sure we have everything under control, especially the human factors that contribute to safety.

The aviation industry has recognized the paramount importance of human factors for the safety of air transportation early in their history – and thus the success of the industry! They designed tools like Crew Resource Management (CRM) intended to maximize effectiveness and safety by optimal utilization of all resources of a team, especially the human factor. If *chances of dying from avoidable human error are 10,000 times greater in a hospital than in an airplane*,<sup>2</sup> this is mainly due to a better understanding of these aspects. Yet, in healthcare it is only twenty-five years since someone first published a call to action and stated that *systems that rely on error-free performance are doomed to fail*.<sup>3</sup>

While it may be assumed that ISAPS members master technical knowledge and skills, there is certainly a potential for improvement in the field of non-technical skills (team work, leadership, situational awareness, decision taking, task management, and communication).

Acknowledging that *to err is human*<sup>4</sup>, major improvements in avoiding serious complications and adverse events can be made if all members of a surgical team are constantly encouraged to **speak up**. Statistical data shows that up to 50% of caregivers will not speak up to a surgeon and that in more than 90% of incidents someone knew beforehand that an error would happen<sup>5</sup>. Thus, a systematic effort to improve these numbers will be tremendously beneficial for the safety of our patients. The repeated encouragement from us as medical leaders to all members of our team will get them *on board* with safety efforts and is the key to success.

Also, let us not forget to consider the patients as integral to the team and include them in our encouragement to speak up if they have a feeling that something is not normal. In our specialty, where many operations are done under local anesthesia, the patient's input before and during surgery will greatly contribute to quality and safety.

While encouragement to speaking-up can be considered a measure that immediately leads to improvement of safety and better outcomes, it would be dangerous to think that all safety efforts will have such rapid effects. Speaking-up is an important element of safety culture. But further cultural changes need an ongoing effort and resources.

A typical example of a misleading feeling of safety is the introduction of a surgical checklist without team training<sup>6</sup>.

The implementation of a surgery checklist cannot be a top-down enforcement but will need customization and also participation of the users in the design. Only then will teams see the real benefit of the checklist and the added value for safety. Reported failures of checklists were always due to the expectations of immediate measurable results following their introduction, when in reality, the process represents a gradual, step-by-step improvement plan.<sup>7</sup>

Today, a requirement for hospitals as well as for surgical offices is the implementation of a Safety Management System (SMS), a systematic approach to managing safety, including the necessary organizational structures, accountabilities, policies and procedures.<sup>8</sup> Such a system must be customized to the needs of each organization, but a major element must always be the assessment of the risks of every activity. A simple table like in Figure 1 will generate a rapid overview of which risks are present. Figure 2 shows examples of risks and measure to be taken.

Safety measures require effort and resources, time and money. It is an ongoing process, but it may well be the best investment for hospitals as well as for surgical practices. Programs and tools are available. Surgeons' leadership is required to promote them, especially in times where *hospital managers and even medical staff appear more preoccupied with survival in the marketplace than with survival of their patients.*<sup>9</sup> Or, as it is often mentioned in aviation:

If you think safety is expensive – try an accident!

References:

1. <https://www.youtube.com/watch?v=h5RemSVCr34>, accessed February 12, 2019
2. Weinstein KW The Sisyphus Dilemma in Health Care: Why Safety and Quality Matter. Pittsburgh Regional Healthcare Initiative, 2001
3. Leape LL. Error in medicine, JAMA. 1994;272(23):1851-1857
4. Lucius Annaeus Seneca, 1st century AC
5. Data with special thanks to Dr. Michael Leonard, Pascal Metrics
6. Borchard A, Schwappach DL, Barbir A, Bezzola P. A systematic review of the effectiveness, compliance, and critical factors for implementation of safety checklists in surgery. Ann Surg. 2012;256:925-933.
7. Oppikofer C, Schwappach D, Plast Reconstr Surg. 2017 Dec;140(6):812e-817e
8. International Civil Aviation Organization (ICAO) definition
9. Schiff GD. Fatal distraction: finance versus vigilance in U.S.hospitals. Int J Health Serv. 2000;30:739-43.

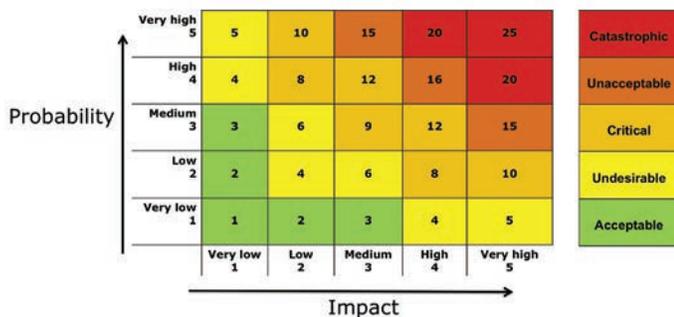


Figure 1 - Risk Analysis: Probability and Impact

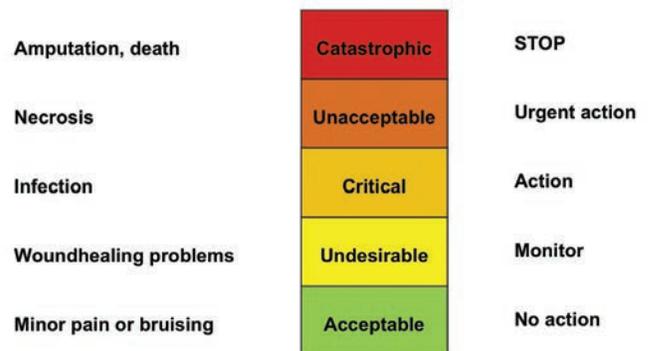


Figure 2 - Risk Analysis: Measures

# PATIENT SAFETY

## THE USE OF TRANEXAMIC ACID FOR PATIENT SAFETY



**JAMES FERNAU, MD - UNITED STATES**  
ISAPS Patient Safety Committee

**T**ranexamic acid is widely accepted in the fields of orthopedic, cardiac and trauma surgery as a means to minimize blood loss. More specifically, in plastic surgery, wide use of tranexamic acid has been limited to craniomaxillofacial and orthognathic surgery. Last year, Rohrich and Cho cited the safety and efficacy of tranexamic acid in rhinoplasty, facelift and breast surgery and Rohrich described his early experience in facelifts, blepharoplasty, rhinoplasty, abdominoplasty and breast augmentation. He observed reduced bleeding, bruising and swelling in over 150 patients. (1) Similarly, Brown et al. cited decreased blood loss in facelifts, rhinoplasty, liposuction and breast reduction. In rhinoplasty, Brown et al specifically cited the positive effects of decreased intraoperative bleeding, improved visibility of the operative field and decreased periorbital edema and ecchymosis. (2) Tranexamic acid is an anti-fibrinolytic agent. It is a synthetic lysine analog that competitively inhibits the activation of plasminogen to plasmin, thus temporarily avoiding degradation of fibrin clots by plasmin. The characteristics of tranexamic acid are listed in figure 1.

Tranexamic Acid	
Mechanism of action	Competitive inhibition of plasminogen activation; antiplasmin activity
Bioavailability, %	34
Terminal half-life, hr	3.1
Elimination	95% renal excretion as unchanged drug
Administration	By mouth or injection
Clinical indications	Treat or prevent excessive blood loss from major trauma, postpartum bleeding, surgery, tooth removal, nosebleeds, and heavy menses
Drug interactions	No studies of interactions between tranexamic acid and other drugs have been conducted
Contraindications	Acquired defective color vision, subarachnoid hemorrhage, active intravascular clotting, hypersensitivity to tranexamic acid
Main adverse effects	Headaches, back pain, nasal sinus problem, abdominal pain, diarrhea, fatigue, anemia
<b>Recommended dosages</b>	
Normal renal function	10 mg/kg 3-4- times daily
Cr 1.36 to 2.83 mg/dl	10 mg/kg twice daily
Cr 2.83 to 5.66 mg/dl	10mg/kg once daily, or 10 mg/kg every 48 hr
Cr >5.66 mg/dl	5 mg/kg every 24 hr

It can be given orally, intravenously and/or topically. In fact, it has been mixed and used as tumescent fluid in facelift and liposuction surgery. The oral dose of tranexamic acid has been described as 1 g three times a day, five days before surgery. Intravenous dosing includes an initial bolus of 10

mg/kg followed by a constant infusion of 1-5 mg/kg/hour during surgery or two boluses, one bolus preoperatively (10-15mg/kg or simply one gram) and the second bolus postoperatively (10-15 mg/kg or simply one gram). Intravenous infusion should be performed slowly over 30 minutes to avoid hypotension. Topical dosing includes a 3% solution which is 3 grams of tranexamic acid in 100 ml normal saline. It is either irrigated or placed on surgical gauze. Recently, topical tranexamic acid has been showing at least as effective as intravenous dosing yet with a safer profile.

Tranexamic acid has been found to significantly decrease blood loss, during the following surgeries: cardiac, orthopedic, spinal, cranial facial, sinus, obstetric, thoracic, orthognathic, neurologic, and trauma surgery. In the United States, the approved indication for tranexamic acid is extremely limited and therefore all use of tranexamic acid is off label. Higher doses of tranexamic acid 50mg/kg – 100 mg/kg have been associated with seizures, but not thromboembolic events. Tranexamic acid has been shown effective in cosmetic surgical procedures including rhinoplasty, rhytidectomy, liposuction and reduction mammoplasty.

A Brazilian study of liposuction patients who used tranexamic acid showed 37% less bleeding during surgery. (3) The study was a clinical, prospective, double blind, non-randomized study of 20 patients who received tranexamic acid compared to 20 patients who received saline. In another liposuction study in which tranexamic acid was given intravenously, the volume of blood loss for every liter of lipoaspirate was 56.2% less in the tranexamic group compared with the control group. (4)

Tranexamic acid can be taken orally, given intravenously, or used topically and some surgeons are even placing it in their local infiltration. It has been used in a 1% concentration in local anesthesia during rhinoplasty. It has been used in tumescent anesthetic solution at a concentration of 0.075% for cosmetic facial surgery. (5) They observed significant decrease in intraoperative bleeding and postoperative bruising. Others have found decreased postoperative edema and ecchymosis after rhinoplasty. (6)

The primary use of tranexamic acid in major surgical procedures such as orthopedic and cardiac procedures is to reduce blood loss and subsequent blood transfusion. The use of tranexamic acid in aesthetic procedures is different.

The primary benefit of using tranexamic acid in aesthetic procedures is to reduce swelling and bruising by inhibiting the formation of plasmin which stimulates the production of cytokines and facilitates the inflammatory cascade. When

tranexamic acid blocks the formation of plasminogen into plasmin, it becomes a very important anti-inflammatory agent which decreases swelling. Tranexamic acid was shown to decrease periorbital swelling after rhinoplasty. Furthermore, tranexamic acid also inhibits neovascularization induced by basic fibroblast growth factor, leading to decreased erythema. Plasmin plays the key role in this process. The effects of plasmin are as follows:

1. Degrades fibrin clots allowing them to be dissolved (fibrinolysis)
2. Stimulates cytokines, inducing inflammation
3. Stimulates fibroblast growth factor inducing neovascularization.

A summary of the benefits of tranexamic acid in aesthetic surgery are as follows:

1. Reduce bleeding, bruising and swelling
2. Anti-inflammatory reduction of swelling
3. Inhibition of neovascularization reduces erythema
4. Clearer surgical field

Tranexamic acid has been shown effective in major cardiothoracic and orthopedic surgery. Its recent use in plastic surgery is encouraging. It should be considered as another means to enhance patient safety.

#### REFERENCES:

1. Rohrich RJ, Cho MJ. The Role of *Tranexamic Acid* in Plastic Surgery: Review and Technical Considerations. *Plast Reconstr Surg.* 2018 Feb;141(2):507-515.
2. Brown S, Yao A, Taub, PJ. Antifibrinolytic Agents in Plastic Surgery: Current Practices and Future Directions. *Plast Reconstr Surg.* 2018 Jun;141(6):937c-949c.
3. Cansancao A, Consancao A, Cansancao B, Vidigal RA. Effect of *Tranexamic Acid* in Bleeding Control in Liposuction. *Plast Reconstr Surg.* 2015 Oct;136(4S):80.
4. Cansancao AL, Conde-Green A, David JA, Cansancao B, Vidigal RA. Use of *Tranexamic Acid* to Reduce Blood Loss in Liposuction. *Plast Reconstr Surg.* 2018 May;141(5):1132-1135.
5. Nayak LM, Linkov G. The Role of *Tranexamic Acid* in Plastic Surgery: Review and Technical Considerations. *Plast Reconstr Surg.* 2018 Sept;142(3):423e.
6. Ong AA, Farhood Z, Kyle AR, Patel KG. Interventions to Decrease Postoperative Edema and Ecchymosis after Rhinoplasty: A Systematic Review of the Literature. *Plast Reconstr Surg.* 2016 May;137(5):1448-1462.



# HUMANITARIAN MISSIONS OF ONLUS

MARCO STABILE, MD - ITALY  
President AICPE Onlus



Figure 1 - Drs. Bernardi and Stabile with a young patient during the first mission in Benin.



Figure 2 - Dr. Stabile and the Health Minister of Benin.

The AICPE Onlus missions continue on the African continent including this year three missions in Togo and one in Benin.

The development of the missions in Togo is thanks to the coordination of Claudio Bernardi while I serve as Project Manager for missions in Benin.

The third will be carried out in July with Dr. Yuri Macrino and Antonella Gallodoro to complete our missions to Togo.

The humanitarian action scheduled for the end of June in Benin this year will be enriched by training the local health workers in the field under their supervision of Claudio Bernardi and me. The intervention will therefore be twofold: theoretical and practical.

Always trusting in greater availability of doctors and donations to AICPE Onlus, I sincerely thank the volunteers for their efforts.

*ALWAYS TRUSTING IN GREATER AVAILABILITY OF DOCTORS AND DONATIONS TO AICPE ONLUS, I SINCERELY THANK THE VOLUNTEERS FOR THEIR EFFORTS.*

With the constant help of Italian doctors, it has been possible to give continuity to the project started in Togo at the Afagnan Hospital for six years. The first mission was completed

in January with Drs. Bernardi, Paola Emiliozzi, and Antonio Montone, followed by the second scheduled in March with Adriana Pozzi, ISAPS National Secretary for Italy and Francesco Bellezza.

**P  
A  
S  
M  
2019**

# Plastic Aesthetic Surgery Meeting 2019

18-19 October 2019

Academia @ Singapore General Hospital

*Fat graft, Face lift, Fillers*

We are pleased to invite you to the 4th Plastic Aesthetic Surgery Meeting that is held annually in Singapore. This year our theme will be facial aesthetics with our main focus on **F**at graft, **F**acelift and **F**illers.

## Speakers include:



**Dr Patrick Tonnard, Plastic Surgeon**  
Aesthetic Medical Centre 2 (E : MC<sup>2</sup>), St-Martens  
Latem, Belgium  
Coupure Centre for Plastic Surgery, Gent, Belgium



**Dr Min Hee Ryu, Plastic Surgeon**  
Affiliated Friendship Plastic Surgery Hospital of  
Nanjing Medical University, Beijing, China



**Dr Xiaoxi Lin, Plastic Surgeon**  
Shanghai Ninth People's Hospital, Shanghai, China



Register at [www.pasm2019.com](http://www.pasm2019.com)

*Early bird ends on 31st July 2019*

# COMMITTEE REPORT

---

## HUMANITARIAN PROGRAMS



**NINA NAIDU, MD, FACS - UNITED STATES**  
ISAPS National Secretary for the US  
Co-Chair, Humanitarian Committee

The ISAPS Humanitarian Committee would like to thank all members who have donated their time and skills in numerous missions around the world. As you know, we are currently refocusing our efforts on established programs in which our members can participate for 1-2 weeks. Our goal is to connect qualified and available ISAPS members to these missions on an ongoing basis.

We are grateful to those members and organizations who have already contacted us with information about their programs. If you are leading or participating in a reconstructive surgery program in which ISAPS members could participate, and have not yet added your program to our list, please email me at [drnaidu@naiduplasticsurgery.com](mailto:drnaidu@naiduplasticsurgery.com). We need the following information for each program:

1. name of organization
2. contact person and email
3. location and dates
4. specific surgical need (cleft lip/palate, hand, burn reconstruction, etc.)
5. how many surgeons needed

We appreciate the many members who have indicated that they would like to join a mission. At this time, we are not collecting the names of potential volunteers. Instead, we will be collating a list of available programs and posting updates on the ISAPS website regularly. An initial list of programs recruiting surgeons is listed below. Because of the variable nature of each program's needs, location, and timing, we feel that it is more efficient for interested members to contact the organizers of the individual programs directly.

Thank you for your assistance with this important mission of ISAPS.

### RECONSTRUCTIVE SURGERY MISSIONS OPEN TO ISAPS MEMBERS:

**Department of CranioMaxilloFacial and Plastic Reconstructive Aesthetic Surgery at Viet Duc University hospital of Hanoi, Vietnam**

Contact: Dr Nguyen Hong Ha [nhadr4@gmail.com](mailto:nhadr4@gmail.com)

Location and dates: Vietnam, all year

Specific surgical need: Craniofacial Maxillofacial, Maxillofacial Trauma, Vascular Malformations,

Hand, Reconstructive & Aesthetic Surgery

Number of surgeons needed: 2 - 10

**Programa Nuevo Amanecer de GUANAJUATO (New Sun Rising program of GUANAJUATO), Mexico**

Contact: Dr. Abel De la Peña [docabel@icloud.com](mailto:docabel@icloud.com)

Location and dates: Guanajuato, Mexico; May 2-5, 2019, November 2019

Specific surgical need: cleft lip/palate

Number of surgeons needed: 5 board-certified plastic surgeons and 8 plastic surgery residents

### **Palestine Children's Relief Fund**

Contact: Suhail Flaifl [suhail@pcrf.net](mailto:suhail@pcrf.net)  
Location and dates: Palestine, open dates  
Specific surgical need: none specified  
Number of surgeons needed: as many as possible

### **AICPE Onlus, ITALY**

Contact: Marco Stabile, MD [marcostabile@gmail.com](mailto:marcostabile@gmail.com)  
Location and dates: Togo, Paraguay, Guatemala, Benin; please email for dates  
Specific surgical need: malformation repair, flaps, skin grafts, and wound debridement  
Number of surgeons needed: 2+ board-certified surgeons

### **Smile Network International** ([www.smilenetwork.org](http://www.smilenetwork.org))

Contact: Maureen Cahill, Executive Director. [maureen@smilenetwork.org](mailto:maureen@smilenetwork.org)  
Locations and dates: Haiti, Guatemala, India; 8-10 missions per year  
Specific surgical need: cleft lip/palate  
Number of surgeons needed: 2 surgeons/mission, up to 16 surgeons/year  
Interested surgeons should apply at:  
<http://www.smilenetwork.org/participate/volunteer-for-a-mission/>

### **Mision Caritas Felices, Peru**

Contact: Lissel Kruger [mcf@misioncaritatisfelices.org](mailto:mcf@misioncaritatisfelices.org)  
Locations and dates: Lima, Perú; 5 missions per year, please contact for specific dates.  
Specific surgical need: cleft lip/palate  
Number of surgeons needed: they usually work with only local surgeons, but visitors are welcome.

### **Operation Smile, International**

Contact: Sarah Yatsko  
Locations and dates: <https://www.operationssmile.org/content/mission-schedule>  
Specific surgical needs: cleft lip/palate  
Number of surgeons needed: 1 plastic surgeon per mission  
Apply online at: <https://www.operationssmile.org/medical-volunteer>

## **GLOBAL PERSPECTIVES: FUTURE THEMES**

**June 2019: Mastopexy**

**Deadline: April 15**

**September 2019: Periorbital Rejuvenation**

**Deadline: July 15**

To contribute an article of 500-750 words, please forward it to [ISAPS@isaps.org](mailto:ISAPS@isaps.org) with the subject line: ISAPS NL Series. This should be a non-referenced opinion piece of several paragraphs giving your observations and perspectives on the topic. What do you do in your practice? What unique approaches do you use? What do you see your colleagues doing in your country or region? Photos are welcome, but must be high resolution JPG files attached, not embedded in your article. Please include photo captions.

Articles must be submitted as WORD documents.

# ISAPS JOURNAL

## MESSAGE FROM THE EDITOR-IN-CHIEF



BAHMAN GUYURON, MD - UNITED STATES

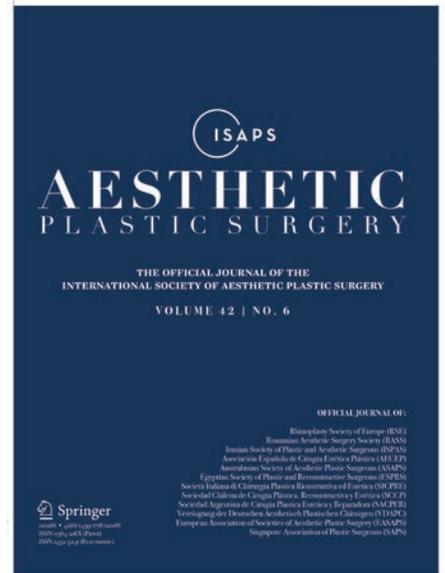
I would like to extend my warmest welcome to our new Editorial, Associate Editorial and Resident Board members from around the world including, justifiably, a proper number of members from Asia, especially from China and Japan.

Even though we have been very selective in processing the articles that are clearly aesthetic in nature, unlike the past, our submissions have been steady and increasing. Because of these sustained and even increased submissions, we have been able to raise the bar, accept the higher quality articles and with better illustrations and images. Standardized images are now a prerequisite for certain anatomical areas such as the nose before the article is submitted for a review or are identified as a requirement during the review process. To facilitate the review process, it is empirical to include standard pictures with the articles. This way the authors reduce one element that would likely be a reason for a revision.

Due to the arduous efforts of Dr. Lisa Gfrerer, one of our Resident Board members, and with contributions from Drs. Steve Cohen and Ash Ghavami, we are about to launch our social media presence. One of the goals is going to be highlighting articles of interest to the public. I am particularly

grateful to these individuals who have taken this responsibility on in spite their many obligations.

Your journal, thus the articles that you publish in it, is circulated to over 4,200 ISAPS members internationally, the largest aesthetic plastic surgery organization in the world. With the rising impact factor, the journal is gaining the attention that it deserves. We owe this progress to all of you who submit your scientifically strong articles to your journal.



Use #ISAPSbluejournal when posting about the Aesthetic Plastic Surgery journal online and on social media!



We invite you to submit a paper to our journal.

For information go to:

<https://www.isaps.org/medical-professionals/isaps-journal/>

# MARKETING

## DEVELOPING A PATIENT FOR LIFE



CHERYL TAYLOR - AUSTRALIA

Several years ago, we received a one-star rating and it was gutting! I asked myself what motivated a patient to award a one-star rating and after surveying our patients, we gained an understanding of what was important to them and developed a program we call “The Patient for Life.”

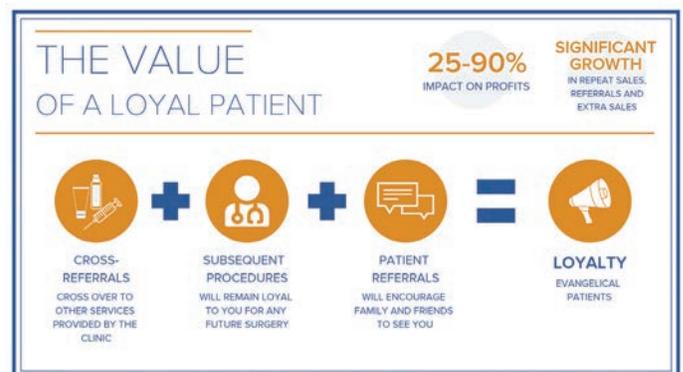
‘Patient for Life’ is a template for patient interaction within our practice. It’s not about conversion and chasing surgery dollars, but an understanding that patients who have their expectations met as a commercial transaction are merely satisfied, but not impressed. We learnt this experience equates to a three-star rating. Patients who are very happy and rate you above average, with their expectations exceeded, are rating four stars. A five-star rating comes from an extraordinary interaction where the patient feels connected with you and all the services you provide. These patients are evangelical about the difference you have made in their lives and look for ways to stay in the practice. They trust you and are loyal. In this patient, you have succeeded in achieving a ‘Patient for Life’.

‘Patients for Life’ are the most valuable patients you can have in your practice, they become your advocates, undertake additional surgery with you, encouraging their family and friends to have surgery and happily move to your non-surgical services because they trust you. More importantly they



become vocal in your community about your practice and its services. The value this patient brings to your practice cannot be underestimated.

The challenge for us was not to convert a one- or two-star patient (they are not the patients you want or need in your practice) but work with our three- and four-star patients to move them up to five-star ratings. We started by assessing the ‘Patient Touch Points’, analyzing every point where the patient interacts with the practice, and looked at ways we could enhance the patient’s experience.



Continued on page 40

The Touch Points provide you with an opportunity to develop a *relationship* with your patients. If successful, the patient won't feel you have treated them like a number. They feel a connection to your practice and most importantly, they develop trust in you.

Below is the strategy we employ and how we manage it, but every practice is different. I encourage you to look at the opportunities of your practice and showcase *your* points of difference. The touchpoints listed below are what we do to cultivate a 'Patient for Life'.

**Branding:** Branding is not just your logo. It is your website, social media, advertising, and promotional material; it extends to the presentation of your rooms and your team; right down to the way your receptionist and Patient Coordinator represent you on the phone and in the clinic.

**Welcome:** Once a patient makes an appointment with you, keep them close. Ensure that your Patient Coordinator contacts them by phone. This is a great way to learn the motivation of the patient. Are they just shopping around? Have they been referred by another patient? What is their time frame for surgery? Send a warm welcome email (using a soft picture of the surgeon consulting – not a mug shot) with details of the clinic, parking directions, what to bring and cancellation terms and conditions.

**Consultation:** Be ready! Ensure that the clinic looks professional and clean. Have the welcome pack and file ready, your team welcoming and inviting. Make the cross-marketing material easily accessible to read or shown (via a looping video or PowerPoint in your reception area) and most importantly, don't overbook. Nothing says unprofessional more than a patient waiting over an hour to see you.

**Surgeon's Consultation:** Number one rule: manage expectations. Listen and be honest. Schedule enough time to provide assessment, education, and an honest discussion about what can and cannot be achieved through the surgery. NEVER talk fees.

**Conversion:** This is the role of the Patient Coordinator. In our practice, the surgeon manages the clinical aspect of the surgery and it is the Patient Coordinator's role to provide practical and relationship support. Our Patient

Coordinator is the 'problem solver'. They talk fees and recovery expectations, and the offer solutions to the barriers patients often have before they book surgery.

**Follow-Up:** This is an essential step in developing the connection between the patient and the practice. It can be done by phone, but we find the best method is a stylized email, again answering questions that may have been raised during the consult and offering solutions.

**Booking Surgery:** Once a patient books – love them all the way to surgery. We do that in a series of emails. This allows you to keep your patients close and demonstrate care without being invasive.

The 'Booking Surgery' email confirms the surgery date and pre-surgery consultation appointment. We have our own hospital, so our nurses see every patient prior to the surgery. It details what to bring to the appointment and provides banking details for deposits.

The 'Four Weeks' and 'Two Weeks' emails detail helpful information for patients to get fit, eat well and prepare their home for their recovery.

A 'Week of Surgery' email details admission and fasting time, what to bring, and visitor information.

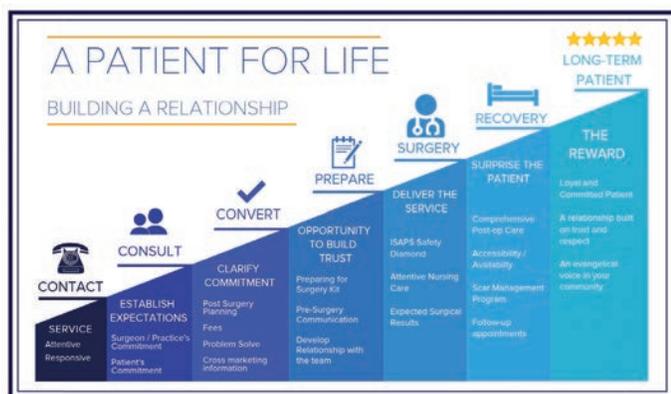
**Pre-surgery Consultation:** Performed by our nurses. We use this time for the nursing team to begin their relationship with the patient. We complete documentation, provide pre-surgery information and answer any remaining questions the patient may have. Patients are also given pre-surgery vitamins that are included in the surgery fee.

**The Surgery:** Having our own hospital allows us the luxury of controlling every aspect of the patient's surgical experience. Most importantly, patients feel safe, not judged, and their fears or concerns are taken seriously.

**Recovery:** It is at this point that you can really surprise the patient and secure their trust. Most patients have a very low expectation of your involvement in the recovery. Most surgeons focus on the surgery, not the recovery, and only provide the necessary care. If you can demonstrate at this point your attentiveness and compassion, patients will love you forever.

**Post-op:** Provide a minimum of three post-operative consults included in your fees. This allows you and your team to share the results with the patients and demonstrates that you really do care about their outcome. It is also the opportunity to introduce non-surgical services offered by the practice.

Your point of difference might be your exceptional team, the extra services you provide, or your speciality in a certain surgery. Whatever it is, work with your team to begin to formalise your patient's journey and treat every touchpoint as an opportunity to build the relationship. This program may require an investment of time and money to establish, but once implemented with training and buy-in from your team, I promise you, you and your practice will reap the rewards.



*Ms. Taylor is the CEO and Co-Owner of The Canberra Aesthetic Plastic Surgery Clinic (The CAPS Clinic) in Canberra, Australia. The clinic is a multi-faceted medical facility incorporating plastic surgery, a specialist skin cancer center, a hospital and a non-surgical rejuvenation clinic.*



## ISAPS MEMBERS WRITE

CRESCENZO D'ONOFRIO, MD - UAE

The official reason for Adan's travels is his activity as a surgeon, an expert in the reconstruction of faces and bodies, marked and deformed by human barbarism. A sort of cover to his restlessness, but also a way to penetrate more deeply into the human soul. A mission in Mozambique, a chaotic Asian city, the Sierra Leone of child soldiers, the spirituality of the Himalayas, the majestic nature of Kenya.

The rhythm of the journey, physical or mental, puts us in resonance with the joy and suffering of the world.

© 2019 - Il Seme Bianco

ISBN 9788833611266

Available on Amazon in Italian.





KAI O. KAYE, MD - SPAIN

# GLOBAL PERSPECTIVES

---

## PANFACIAL FAT GRAFTING

Volume loss of both bony and soft tissues results in loss of projection and subsequent skin ptosis, leading towards a concave facial contour with deepened nasolabial folds and mid-cheek grooves, resulting in changes in the double ogee shape of a youthful facial contour towards an aged and exhausted appearance.

Facial recontouring with autologous fat grafting has become widely accepted for facial rejuvenation either as a stand-alone procedure or in combination with surgical lifting techniques since its introduction by Coleman. Since then, multiple techniques to optimize fat grafting have been suggested,

such as structural fat grafting (Coleman technique), the 3M3L technique, and nanofat grafting.

Facial fat is highly compartmented consisting of multiple layers of fat compartments, including both superficial and deep fat compartments. The facial contour is defined by these fat compartments which change in a different way during aging, and therefore a compartment-related augmentation technique taking into account the real physiologic changes should be developed to avoid a universally augmented look after facial fat grafting.

# ACIAL ATION

## Area 1 Temples:

Main Goal – The temples are one of the first areas to age and their deflation, due to loss of fat compartment volume, leads to not only a descent of the brow and the lateral area of the face, but also to severe hollow temple in patients, to a skeletonized look and loss of contour in anterior temples. Our goal is not only to restore volume into the deep fat compartments to recontour the area, but also to augment projection and therefore provide support for lateral eyebrow and lateral cheek. Nanofat is used in the area overlying the venous plexus to achieve dermal rejuvenation by SVF effect.

Type of fat: microfat and nanofat

Layer injected: posterior temple (behind hairline) deep layer microfat/anterior temple microfat deep compartments and intramuscular and nanofat superficial compartments.

Aesthetic effect: lifting and revolumizing of lateral brow, lifting of lower lateral temple/lateral orbital region.

## Area 2 Midface/malar:

Main Goal – Deflation of the midface/malar areas occurs quite early during the ageing process. As the volume loss in combination with the progressive loss of bony support by the inferior orbital rim lead quickly to a lack of support of the lower eyelid, even young patients often complain about having a tired look. Re-volumizing the SOOF and restoring support for lower eyelids is one of the main goals, as well as recontouring of the zygomatic bone to augment projection and to achieve lift of the lateral face.

*FACIAL FAT IS HIGHLY COMPARTMENTED CONSISTING OF MULTIPLE LAYERS OF FAT COMPARTMENTS, INCLUDING BOTH SUPERFICIAL AND DEEP FAT COMPARTMENTS.*

Type of fat: microfat

Layer injected: Deep compartments anterior and lateral cheek, SOOF

Aesthetic effect: Better contour of the cheek/malar and smooth transition into the lower

face, less sunken and deflated lower eyelid with short and re-volumized lid-cheek junction and a more rested look.

## Area 3 Mandibula/Gonian Angle:

Main Goal – The mandibles not only define the framework of a masculine look in men, but also provide a strut-like tension support for the overlying facial skin in both sexes. An under-projecting mandible does not provide this strut-like support anymore and leads to premature formation of jowls. According to Shaw, et al, the gonian angle and the mental protuberance of the body start losing projection from 25 years onwards; therefore, restoration of volume and reconstitution of the angle should be considered early in both sexes as an approach to delay the ageing related changes described above.

Type of fat: microfat

### Layer injected: Deep to SMAS/Periosteal

Aesthetic effect: Better contour and definition of jaw. Better posterior projection of the gonian angle and anterior projection of chin/mental protuberance to augment projection of the mandibula, to enhance the cervico-mental angle and to provide a lifting effect for the anterior neck.

Continued on page 44

#### Area 4 Periorbital/Brow:

Main Goal - In the author's opinion, the brow and periorbital area form an aesthetic unit which should be addressed conjunctively, as their visual connection defines the eye-frame of any beautiful eye. Progressive descent of the brow caused by laxity of the forehead skin in combination with deflation of the ROOF during the aging process leads to a heavy upper eyelid and patients often complain about looking sad. Atrophy of the superficial portion of the ROOF underlying the lid crease leads to an augmentation of visible upper eyelid height (doll eye effect). Ageing related atrophy of the SOOF augments the visible lower lid length and deepens the lid-cheek junction and subsequent exposure of the underlying structures like fat compartments and canthal ligaments results in skeletization of the infraorbital area.

Revoluminization of lateral eyebrow fullness and reprojection of eyebrow shape is one of the goals for this area, as well as reduction of upper lid height, correction of lower lid skeletization and treatment of dark circles

Type of fat: microfat and nanofat

Layer injected: Brow and forehead deep layers microfat on the periosteum, upper eyelid microfat in ROOF and nanofat superficial in the upper eyelid crease, lower eyelid microfat under the orbicularis oculi muscle and nanofat over the orbicularis oculi to achieve dermal rejuvenation by SVF effect.

Aesthetic effect: Better contour of the brow, restoration of lateral fullness with brow elevation, correction of skeletization effect, correction of eyelid height and lid/cheek junction.

#### Area 5 Perioral/Lips:

Main Goal - The same way as the periorbital area should not be addressed separate from the brow, the perioral area forms an equally strong aesthetic unit with the lips. Structures like the philtrum, the white roll and the vermilion support the lip and define its youthful shape. From the mid-twenties onward, the maxillary bone starts to lose projection and with further advance of the ageing process, the deep submuscular fat compartments lose volume resulting in a loss of support for the anatomic structures mentioned

above. The lip becomes straight, loses the cupid bow shape and becomes inverted. In cases with severe deflation and loss of volume in the subcutaneous layer, the patient often complains about the bar code appearance of the upper lip. Restoration of support and recreation of a youthful shape reflecting the different distribution of volume and projection in different parts of the lip is one principal goal in this area, as well as conservative volume restoration and correction of dermal wrinkles.

Type of fat: microfat and nanofat

Layer injected: perioral deep compartments microfat, lips intramuscular microfat/white roll nanofat, superficial subdermal layers upper lip nanofat

Aesthetic effect: Better contour of the lip and proportions, lip eversion, smoother skin and wrinkles around mouth.

#### Area 6 Fossa Piriformis/Nasolabial/Deep Cheeks:

Main Goal - The nasolabial fold was the first area to be addressed many years ago with volume restoration. Back then, we did not understand so well that the line called "nasolabial fold" has to be treated in its total unit and not only its line. The piriform fossa is the triangular area of the upper part of the lip that extends to the cheek on both sides of the ala of the nose. It gives support not only to the perioral area, but also the base of the nose. When it is deflated, it gives a sad and aged look and the goal of its restoration is to smoothly create a transition in between the cheek and the perioral area.

Type of fat: microfat

Layer injected: Piriform fossa and deep cheeks deep layers microfat

Clinical Effect Expected: Better transition of the lip and cheek, eversion of the lip, project base of the nose and smooth some kinds of gummy smile.

The overall goal of the combination of micro and nanofat injection in a holistic approach is not only to give the patient a youthful look, but also to create beauty through proportions and to restore a part of the natural glow that characterizes young skin - a true 3D regeneration concept.



# BASEL CELL CARCINOMA

MOKHTAR ASAADI, MD - UNITED STATES

The patient is a 63-year-old male with ulcerated lesions of the left temporal and zygomatic areas for more than seven years. The patient had a biopsy done by a dermatologist previously, which showed Basal Cell Carcinoma and was concerned about the cosmetic appearance after surgery. The possibility of facial nerve damage during surgery and at the time of reconstruction was discussed pre-operatively.

On physical examination, he had three ulcerated lesions of the left zygomatic and temporal areas measuring about 5cm in diameter. There were no palpable cervical lymph nodes. X-Rays of the underlying bones were normal.

Under general anesthesia excision of the Basal Cell Carcinoma of the left temporal and zygomatic area were done. The defect measured about 7cm by 4 · cm in size. Immediate frozen section was done from the margins and also from the deepest portion of the specimen. All margins were negative. Diagnosis was Basal Cell Carcinoma. Reconstruction was done using a left temporal flap based on the superficial temporal artery and a V-Y Island advancement from the left side of the face and primary closure of the donor site.

The post-operative course was smooth. In subsequent office visits and follow-up there was no evidence of facial weakness. The scars are healing well and are gradually fading. The patient is pleased with the results of surgery.

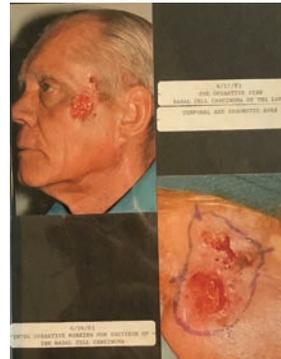


Figure 1 - Left - Pre-operative view Basal Cell Carcinoma of the left Temporal and Zygomatic area; Right - Intra Operative marking for excision of the Basal Cell Carcinoma area.

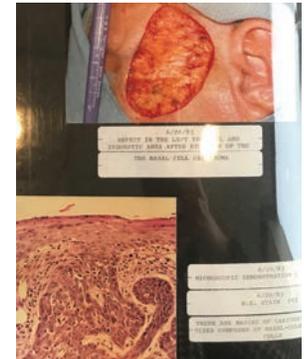


Figure 2 - Left - Defect in the left Temporal and Zygomatic area after excision of the Basal Cell Carcinoma; Right - Microscopic demonstration of the tumor. H.E stain 25X. There are masses of various shapes and sizes composed of Basal Cell Epithelioma Cells



Figure 3 - Intra Operative picture demonstrating V-Y Island Advancement from the left side of the face and left temporal flap.



Figure 4 - Left - Intra operative picture after completion of the surgery and closure of the defects; Right - Post-operative view.



Figure 5 - Post-operative view comparing the operated side vs non-operated side.

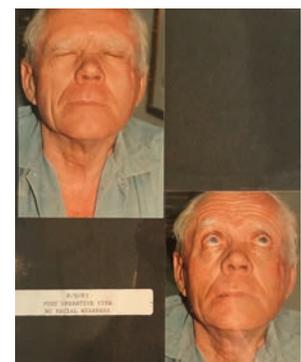


Figure 6 - Post-operative view. No facial weakness

# FACELIFT

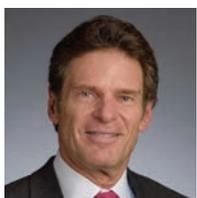
## SURGICAL REJUVENATION OF THE AGED FACE



ANSON NGUYEN, MD - UNITED STATES



OBAID CHAUDHRY, MD - UNITED STATES



ALAN MATARASSO, MD - UNITED STATES

### Patient History and Physical Findings

A number of components factor into the aging of the face including skin and ligament laxity/redundancy, soft tissue descent, and fat atrophy. These manifest as common findings such as loss of volume, deep nasolabial folds, loss of malar prominence, marionette lines, and jowls. The aged face typically presents as a more rectangular shape with radial expansion inferiorly in contrast to the youthful face which has the tapered appearance, commonly referred to as an “Ogee” curve.

During the consultation, it is important to discuss the patient’s goals and expectations and align them with the appropriate procedures. Subsequently, the surgical plan, along with any ancillary procedures such as laser skin resurfacing, buccal fat removal, and fat grafting can be discussed. Comprehensive facelift surgery addresses the area from the lateral canthus to the clavicle. It generally involves elevation and wide undermining of skin, manipulation of deep tissue (SMAS) (through plication, flap elevation, or resection), appropriate excess skin excision and wound closure. Incision patterns (Figure 1) may vary based on goals of the surgery and range

Facial aging is a common patient concern. Patients begin to notice aging as early as their mid-thirties. Consequently, at that point they may begin to consider minimally invasive procedures and innovations such as microneedling, energy-based devices, injectables, neurotoxins, or resurfacing. Depending on their anatomy and goals, these can target specific areas and offer improvement. However, for the patients with more advanced aging, the gold standard for facial rejuvenation remains a surgical facelift.

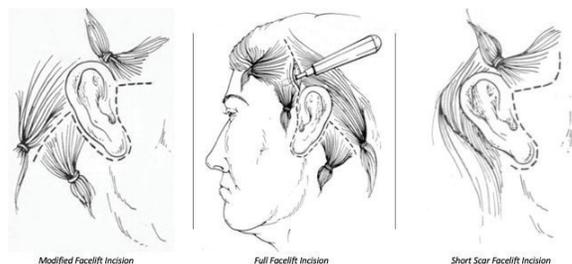


Figure 1 - Facelift Incision Patterns

from short scar to modified or full facelift incisions. The mastoid incision can be adjusted to be in or along the hairline depending on hairstyle, density, and patient preference. The neck, which can be treated independently, is also a routine component of a facelift. Focused techniques for the neck can range from a submental incision with midline modification of platysmal bands and/or lateral platysmal fixation to the mastoid fascia with or without backcuts which aids in jawline definition. The submental incision can be utilized for other maneuvers as necessary including digastric muscle shaving or submandibular gland pexy or resection. The majority of patients will benefit from suction assisted lipectomy of the neck.

### Surgical Management

Facelift surgery is performed under systemic anesthesia administered by an anesthesiologist. Pre-operative antibiotics and corticosteroids are administered as well as TED stockings and sequential compression devices. Betadine soaked cotton is placed into the ear canals.

### Techniques

After anesthesia is induced, dilute local anesthetic (100cc of 1% lidocaine with 300cc of normal saline with 1 cc of epinephrine) is instilled to provide vasoconstriction and facilitate skin undermining. Liposuction and autologous fat transfer are performed as indicated. The facelift incision is then made and wide skin undermining is performed. A double-armed barbed 3-0 monoderm suture is then started at the angle of the zygoma, grasping redundant SMAS. One arm of the suture is used to plicate SMAS horizontally along the inferior border of the arch (Figure 2). The other arm of the suture is run inferiorly to resuspend platysma to the sternocleidomastoid fascia. Hemostasis is then performed. Redundant skin is elevated, re-draped, and trimmed. Closure is performed with a single layer of 5-0 nylon suture for the pre-



Figure 2 - SMAS plication with barbed suture. Arrows indicate direction of suture.

auricular incision. The post-auricular incision is closed over a Jackson Pratt drain with a 4-0 nylon and surgical staples are placed in the hair-bearing portion of the wound.

Antibiotic ointment is applied to the incisions and drain site followed by three-layers of 4x8 gauze and then a tubular elastic net dressing.

### Postoperative Care

Post-operatively, it is paramount to monitor and control the blood pressure (generally below 120-130mm Hg) to reduce likelihood of bleeding. The patient is asked to keep his or her head elevated in a semi sniffing position to decrease vascular compromise. Dressings and drains are typically removed within 48 hours. Staples and sutures are removed subsequently over the ensuing 7-10 days. Gradual return to normal activity resumes over the ensuing 2-6 weeks.

### Outcomes

Optimal outcomes are achieved by reconciling patient expectations with appropriate surgical treatment based on anatomic findings (Figure 3). Ancillary procedures such as peri-oral or peri-ocular resurfacing and fat grafting may also enhance results and should be discussed for select cases.



Figure 3 - Short scar facelift with peri-ocular laser resurfacing.

### Complications

Complications of facelift surgery have been well documented. Untoward sequelae such as tissue irregularities, small fluid collections, firmness, or scar immaturity should be managed to facilitate the postoperative period and enhance the patient's experience.

### Conclusion

Progress has been made in the way of less invasive modalities for treatment of the aging face. Procedures such as microneedling, radiofrequency treatment, and coned suture "thread lifts" have gained some traction and can certainly offer some improvement in the appropriate situations. However, in many patients who present with the multifactorial aged face, a surgical facelift still offers the most comprehensive and sustained outcome.

# FACIAL REJUVENATION

---

## PERIORBITAL REJUVENATION BY BLEPHAROPLASTY COMBINED NANOFAT GRAFTING



AHMED ALI HASSAN, MD - EGYPT

The periorbital region is a fundamental aspect in facial aesthetics and it usually determines if a person looks healthy or tired. This area is a major concern among individuals of both sexes who approached the age of forty years and above. The periorbital region includes the upper eyelid and eye brow, the lower eyelid down to the tear trough and nasojugal fold, and the lateral orbital skin. In particular, aging of the lower periorbital region in terms of increased skin laxity of the lower eyelid, volume depletion, hyperpigmentation, together with the formation of skin wrinkles, greatly affects the number of individuals who ask aesthetic surgeons to reverse their aging appearance. Restoration of a youthful appearance by only lower blepharoplasty is not enough in the presence of surface irregularities and wrinkles in the remaining lower periorbital area. Therefore, the lower periorbital area should be treated as one aesthetic unit.

Hyaluronic acid derivatives are used in a wide range as an office-based procedure which almost gives a satisfactory temporary result. However, hyaluronic acid cannot be used in conjunction with lower blepharoplasty and in addition, it is a temporary treatment which usually lasts for a few months and needs to be repeated. Furthermore, hyaluronic acid restores volume depletion, but does not rejuvenate the periorbital skin. In contrast, nanofat grafting is a practical solution when combined with lower blepharoplasty to fill and rejuvenate the lower periorbital area. Recently, we have used nanofat grafting in facial aesthetics aiming at restoring volume depletion and skin rejuvenation. The procedure is very simple and fast. The lipoaspirate was collected in 20 cc syringes. After 15 minutes, excess fluid was discarded leaving a pure fat. Thereafter, emulsification of fat was performed by 30 fast passes of fat between couples of 20 cc syringes connected to each other by luer lock connector. The emulsified fat was then transferred to multiple 1 cc syringes. Following completion of blepharoplasty, nanofat was injected to lower eyelid and tear trough area using a 27-gauge needle. Following nanofat injection, digital pressure was applied over the lower eyelid and nasojugal folds. The mean amount of nanofat was 1.4 ml per each side.

In 2003, Patrick Tonnard and his colleagues introduced nanofat grafting to treat facial superficial wrinkles and dark lower eyelids. Different experimental studies have shown that nanofat is devoid of viable adipocytes. However, cell culture studies have proved that stromal vascular fractions (SVF) are richly present in the nanofat grafts which are capable of proliferation and differentiation into adipocyte-derived

stem cells. Adipocyte-derived stem cells in nanofat are responsible for the regenerative process following grafting. Another theory states that fat graft depleted from viable adipocytes can serve as a soft tissue matrix that attracts viable new adipocytes enhancing and maintaining volumization. Macrofat and microfat grafting, although containing viable adipocytes, are not a practical tool for the delicate periorbital region due to relatively larger fat particles liable to clump leading to surface irregularities.

The use of nanofat grafting in the periorbital area can serve in both volume replacement and rejuvenation which gives a youthful look of long duration. I have performed a series of blepharoplasties combined with periorbital nanofat grafting to the lower periorbital area and lateral orbital skin. The relatively long-term results were excellent in terms of a youthful aesthetic look of the periorbital region together with improved lower eyelid and tear trough contour. Nanofat grafting greatly improved the quality of skin tone and skin hyperpigmentation. I would recommend the combining of nanofat grafting with blepharoplasty as an integral procedure to rejuvenate the periorbital region.



Figure 2 - Close-up view of the rejuvenation effect of nanofat grafting of lower periorbital area.



Figure 3 - Pre- and 3 months results of a 41-year old lady who underwent nanofat grafting to rejuvenate the lower periorbital area.



Figure 1 - Pre- and 6 months post-operative results of 46-year old patient who underwent upper and lower blepharoplasty combined with nanofat grafting of lower periorbital area.



Figure 4 - pre- and 3 months result of 48-year old women underwent upper and lower blepharoplasty combined with nanofat grafting of lower periorbital area.

# ADIPOFILLING: A VOLUMETRIC SUSPENSION

## AND A SUSPENSION OF SINGLE CELLS INJECTED INTRADERMALLY TO REJUVENATE THE SKIN OF THE FACE AND NECK AND ELIMINATE WRINKLES



**SERGIO CAPURRO, MD - ITALY**

### INTRODUCTION

As a reconstructive plastic surgeon and researcher, I have always been interested in innovative techniques. Adipofilling is one of these. Adipofilling was designed several years ago (2007) but only now has it been made available.

### ADIPOFILLING

Adipofilling constitutes an innovation in lipofilling. In a few seconds, the lobular fat aspirated through a 4 mm diameter is transformed by an aspiration vortex into a suspension of small lobular fragments or single living cells.

In the face, intradermal injection is the most powerful technique for regenerating aged or damaged skin and the most powerful anti-wrinkle tool there is. Nor are its applications limited to the esthetic field.

My guiding concept has always been to maintain the integrity of both components of adipose tissue: stromal cells and adipocytes. Withdrawing fat by means of small-caliber cannulas and using filters, steel pellets and centrifugation at 3000 RPM destroys the adipocytes. This is tantamount to grafting the conductor of the orchestra, but with few musicians or even without the orchestra itself.

Local anesthesia is performed with mepivacaine, as lidocaine prevents glucose from entering the adipocytes.

### TECHNIQUE

Adipofilling has been made possible by the Adipopimer, an economical disposable device (Capurro patent). Lipoaspirate is drawn through a 4 mm cannula, washed in an Erlenmeyer flask with a tap and transformed by the Adipopimer into a suspension of small lobular fragments within a few seconds (Fig.1).

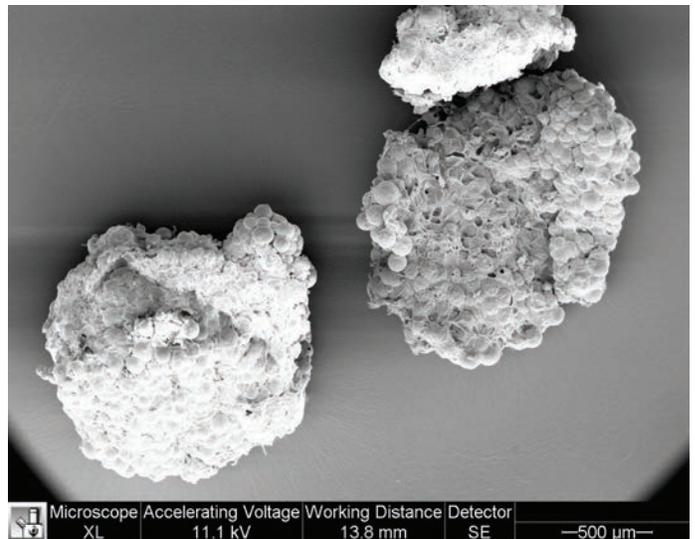


Figure 1 - Adipofilling. Volumetric suspension. Scanning electron microscope.

This suspension can be used to enhance volumes of the scalp, forehead, temporal region, cheeks, mandibular arch, lips, and neck. The small dimensions of the fragments of lobular fat facilitate rooting. The procedure enables the quantity of fat needed to restore the volumes to be grafted in a short time.

Prolonging the action of the Adipopimer for a further 10-20 seconds creates a suspension of single, living adipose and stromal cells. (Fig.2) When centrifuged at 400 RPM for 4 minutes and injected into the dermis, these cells can rejuvenate aged or sun-damaged skin and eliminate wrinkles.

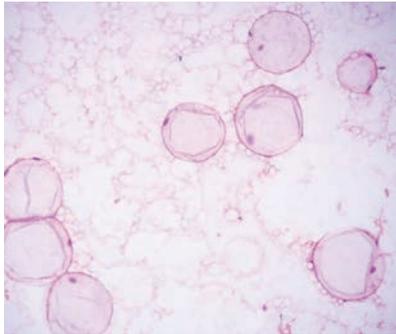


Figure 2 - Adipofilling. Cellular suspension. Smear (hematoxylin eosin)

### CELLULAR INTRADERMAL ADIPOFILLING

This new intradermal application is the most powerful, bio-stimulating, regenerative technique for aged or damaged skin, and the most powerful anti-wrinkle tool there is (Fig.3).



Figure 3 - When injected intradermally, the single cells rejuvenate the skin and eliminate wrinkles. After only 20 days, the result can already be seen.

When injected into the dermis, the cellular suspension does not exert a volumetric effect; rather, the effect is exclusively regenerative. As the stromal cells and adipocytes are not subject to inhibition by contact, they are free to abundantly secrete numerous substances. When injected into wrinkles, the suspension spreads amply, eliciting the greatest remedial effect. This great regenerative power of the cellular suspension means that it can also be used in orthopedics and in inflammatory, degenerative and painful conditions. The suspension of single cells can also be injected beneath the dermis, where it exerts a modest volumetric effect. By contrast, the suspension of small fragments of adipose tissue has a chiefly volumetric effect and maintains the cellular ratios that are characteristic of the tissue.

### ADIPOCYTES AS A SECRETORY ORGAN

The adipocytes constitute an organ which secretes substances that exert a powerful local action: cytokines, adipokines, leptin, TNF $\alpha$ -resistin, visfatin, IL-6, IL-8, SP, angiotensinogen, PAI-1, adiponectin, and cathelicidin with an antibacterial action. These substances are essential to the proper functioning of the stem cells and promote the trophism of the tissues and the rooting of lobular fragments.

### ADIPOFILLING SUSPENSIONS DO NOT FREEZE

A very interesting recent observation is that both suspensions used in Adipofilling can be stored for months at low temperatures: from -21°C to -31°C.

In practice, we have a biological, active filler that is able to perfect and maintain our results. (Fig. 4).



Figure 4 - The syringes containing the volumetric (blue caps) and cellular (white caps) suspensions can be conserved for months at a low temperature, without freezing.

### CONCLUSION

The cells of lobular fat are separated in a few seconds in an atraumatic manner by the aspiration vortex created by the Adipopimer. The atraumatic nature of the procedure is confirmed by the fact that only a very thin layer of oil is seen in the supernatant after centrifugation at 400 RPM for 4 minutes. Adipofilling is a section of the [CRPUB.ORG](http://CRPUB.ORG) [Open access Medical Video Journal](http://www.isaps.org)

# FACIAL REJUVENATION

## LASER ASSISTED FACELIFT



J. ABEL DE LA PENA, MD, FACS - MEXICO

Since facelift started in plastic surgery to reduce the aging process caused by gravity and skin laxity, concept changes have occurred. Surgical approaches started by skin resection with little undermining, then more aggressive approaches were used undermining the cheeks and neck. Then a separate treatment, SMAS, (superficial musculo-aponeurotic system) appeared, lifting independently the superficial muscles of the face and neck, but the more interesting concept is that non-specific treatment for skin quality has been done simultaneously.

This is why we introduced the concept of Laser Assisted Face Lift, where energy is used to lift the cutaneous flaps, simultaneously stimulating skin contraction and collagen formation on the face and neck from the temporal region to the clavicles, improving skin quality, with a simple procedure.

Goals for using laser for subcutaneous dissection of the flaps are:

1. Tunneling the flaps from the temporal area to the supra-clavicular area, permitting a wide dissection with multiple vascular connection and do not devascularize the flaps.

2. Laser stimulation of the skin through the laser producing skin contraction and collagen/elastin formation, fat consumption and face definition.
3. Less bleeding during SMAS treatment. Hematomas and ecchymosis are rare.

### Laser treatment

Surgical intervention starts designing the skin incision that is selected according to the surgeon's preference. ND Yag laser (Cellulaze®) from Cynosure® is used passing the fiber in the subcutaneous space approaching from the temporal region, the ear lobe, a pre-tragal and a central submentonian stab incision.

The energy delivered is determined according to the amount of fat to be removed, and the skin quality. The more energy delivered to the skin, the more skin retraction and collagen formation, improving skin quality.

The Cellulaze® laser fiber has two beams, one on the tip 180° and another at 90° that delivers energy to the deep part of the skin through the sub cutaneous space or to the fat turning the beam to the fat in the neck or jowls.

Open surgery starts with selective undermining in the neck, in the retroauricular area, searching just the external border of the platysma, and lifting the platysma from the Sternomastoid muscle enough to free the muscle allowing it to move up to the mandibular angle, fixing it to Lore's fascia. This will bring the skin on top of the platysma muscle that

*THE MORE ENERGY DELIVERED TO THE SKIN,  
THE MORE SKIN RETRACTION AND COLLAGEN  
FORMATION, IMPROVING SKIN QUALITY.*

is connected by the vascular and mesodermal structures in between the tunnels to define the jaw line with no skin devascularization.

If special treatment is required in the midline neck, it is done through the submental incision with conservative midline undermining and treating the medial platysma bands or reducing and suturing the digastric muscles, and if the submaxillary gland has to be partially resected, this is done from the subplatysma dissection.

### Temporal and cheek dissection

As energy is delivered, the facelift continues with great advantage. There is no need to skeletonize the whole face. Selective undermining is done to get access to the SMAS treatment, either a SMAS flap, SMAS-ectomy or plication, that can be done through the undermining at the malar area up to the most projecting point of the malar bone.

Two inches of undermining on the pre-auricular region and on top of the malar bone are enough to work on the SMAS. Incisions can be shorter using just the upper incision in front of the ear, or the complete anterior incision or include the posterior auricular incision if skin is redundant.

Energy for the neck is about 4,000 to 6,000 joules depending on presence of fat or the neck size. Also, the energy in women is usually less than in men's necks. For the cheeks, from the temporal region energy for each side is about 5,000 joules.

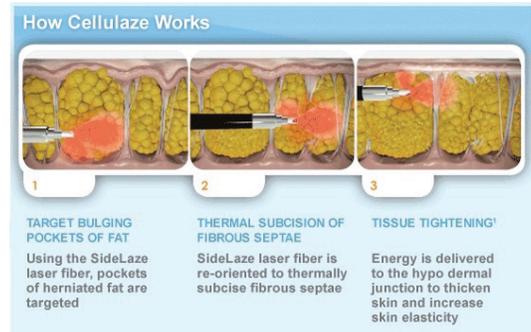
If the neck has fat to be removed, we do the laser first and then the fat aspiration by a closed suction technique. Laser helps in obtaining a uniform flap all over the neck and cheeks.

Cellulaze® has a temperature sensor that allows one to know the skin flap temperature and the setting avoid any possibility of burning.

When working in the cheeks, we deliver the energy and do the tunneling simultaneously. Limits for laser treatment are the orbital margins. Nasolabial folds are trespassed so that the fold is treated with energy, and the lifting effect reaches the upper and lower lip. Recovery is shorter because the presence of hematomas and ecchymosis, as well as neuropraxia, are rare. Great improvement on the quality of skin is noticed all over the face and neck and special areas like the central neck below the hyoid bone.

Technology has reached our procedures, simplifying them and reducing adverse effects.

*The author has no financial relationship with any product or company mentioned in this article.*





# FACE REJUVENATION: BACK TO SURGERY

ANDRÉS FRESCHI, MD - ARGENTINA



Figure 1 - Dissecting through pre-masseter space. Note the buccal branch running protected under the Masseteric fascia. The buccal fat pad can be accessed through the deep plane facelift easily, where it can be removed or plicated.



Figure 2 - 28-year-old man with heavy lower face (Left) corrected by a deep plane facelift 1 year. postop. (Right).



Figure 3 - Preop. picture (Left) 35-year-old woman with subtle signs of aging mainly on the lower face and neck. Postop. (Right) after 1 year.

Cosmetic medicine has had a massive expansion in the last years. It is amazing what a variety of conservative and minimal-invasive procedures we can offer the patient, which was unthinkable twenty years ago.

The treatments with botulinum toxin and fillers have taken over many facial procedures in the last decades, if we look at the number of browlifts, coronal lifts, cheek implants, and chin implants. The number of operations for these procedures have all decreased.

Facelift surgery has always had not the best reputation and with good reason. If we look at the results in the 1980s or 1990s, they were as disharmonious as the overfilled frozen faces of today. We are seeing more deformed faces than ever before due to over indication of fillers. With less popularity, face surgery has evolved significantly, and it is still the gold standard for face rejuvenation.

The level of understanding of the aging process related to face anatomy is well known. Today, we can reconstruct a youthful appearance by doing a true repositioning of the SMAS, addressing the retainment ligaments with no tension on the skin, achieving superior and natural results instead of a distorted, overdone face.

We cannot deny the benefits that cosmetic medicine has brought to our practice, but aren't we going too far? No doubt about the volumetric rejuvenation, but it is one thing is to restore the volume loss and another to overfill to avoid sagging. We all know that sagging, mainly in the lower face, is corrected only by surgery.

With the proper surgical technique, we can rejuvenate a patient in his 30s with unparalleled and lasting results.

We are surgeons. We have to think as surgeons. So, let's go back to surgery.



# FLAP OR PLICATURE?

MARIANO RAMIL, MD - ARGENTINA



Figure 1 - The blepharoplasty incorporates periorbital fat grafting to restore the light reflecting convex surfaces.



Figure 2 - Benefits of lipostructure in the malar and pre-jowl zones when combined with a MACS Lift.

While we are still debating about what to do with the SMAS for long lasting results, facial rejuvenation has moved forward thanks to the incorporation of fat grafting.

As what happened with rhinoplasty, resecting, suturing and relocating have become insufficient to obtain the desired results. Support has become the new goal and lipostructure is the key.

As with grafts for rhinoplasty or implants in mastopexy, lipostructure reduces the amount of skin to be resected and enhances contour lines when performing a facelift or blepharoplasty.

Besides its benefits for skin qualities, fat grafting can be performed all over the face to restore or improve the youthful light reflecting convex zones.

In the upper third of the face, the temples and upper eyelids can be properly addressed now when volume loss is the problem, but what I find enthralling is the merging of the MACS lift technique and lipostructure for dealing with the middle and lower third. There is no better help to restore the ogee line and by grafting the pre-jowl area also, the mandibular line trace can be completed, avoiding the “witch’s chin” look.

As always, debate will carry on. Maybe now regarding whether to graft at the beginning or at the end of surgery. Still, we are now in a great moment for facial

rejuvenation with so many open doors to explore yet. I believe that new devices for skin tightening combined with lipostructure will shake the paradigm again, as botulinum toxin did before.

*THERE IS NO BETTER HELP TO RESTORE THE OGEE LINE AND BY GRAFTING THE PRE-JOWL AREA ALSO, THE MANDIBULAR LINE TRACE CAN BE COMPLETED, AVOIDING THE “WITCH’S CHIN” LOOK.*

# GLOBAL PERSPECTIVES

---

## FACIAL REJUVENATION



**BABIS RAMMOS, MD, FACS - UNITED STATES**



**JOSEPH P. HUNSTAD, MD, FACS - UNITED STATES**



**SARA M. TAEGE, BA - UNITED STATES**

### **Surgical and Minimally Invasive Approaches for the Aging Face**

Facial rejuvenation techniques have evolved from approaches using minimal access to surgical multiplane and deep dissections. The most ideal approach would be the one to offer the longest lasting results with the fewest complications and achieve high patient satisfaction.

#### **Surgical Procedures**

According to the American Society for Aesthetic Plastic Surgery National Data Bank Statistics, facelifts were amongst

the surgical procedures that saw the most significant increases in 2017 (21.9%), with approximately 82,410 procedures performed in the United States.

- **Facelift**

The techniques used in facelift surgery are highly variable with a trend towards a deeper level of dissection recently; however, there is no single technique that has emerged as the procedure of choice. There are two conceptually different approaches, the subcutaneous technique with plication of the Superficial Musculo Aponeurotic System (SMAS), and the SMAS flap dissection. There is no general agreement as to which of these techniques is most effective, and the debate about which one is the best is ongoing, without clear and direct evidence supporting the use of one surgical approach over the other.

- **Fat Grafting of the Face (micro and nano fat grafting)**

Fat grafting of the face may be performed alone or at the same time as a facelift procedure. The areas to be grafted are marked in a topographic manner and are reviewed with the patient. Syringe liposuction is utilized for fat harvest until an appropriate amount is obtained for the fat grafting to the face. The fat is strained for preparation, centrifuged, and placed into syringes. An 18-gauge needle is used to gain access and fat grafting to the face is then performed using blunt tip cannulas, with micro fat grafting to the areas that had been marked. A portion of the fat is emulsified to create nano fat, and this is injected into the perioral areas intradermally with the use of a 27-gauge needle. A clinical result of fat grafting of the face is shown in Figure 1.

## Minimally Invasive Procedures

- **Ablative Laser Skin Resurfacing, Intense Pulsed Light (IPL) and Platelet Rich Plasma (PRP) Injections**

Facial rejuvenation and wrinkle reduction are approached with a combination of fractional Erbium ablative resurfacing (2940 nm), intense pulsed light and platelet rich injections of the face. One pass of the IPL is performed followed by at least 3 passes of the fractional Erbium laser. A very even, thorough, and complete laser skin resurfacing is performed. An appropriate amount of blood is drawn and placed into vacuum tubes which are centrifuged. The platelet rich portion of the plasma is then drawn up into syringes and then injected diffusely into the face.

- **Chemical Peels**

Chemical peels involve the application of a chemical exfoliant to initiate a controlled wound of the epidermis and dermis. Deep peels such as the Phenol peel that penetrates to the deeper dermis, is mostly used by Plastic Surgeons. Pretreatment is critical for preventing complications. Compared to the Laser, it may be more effective in treating deeper rhytides.

- **Botulinum Toxin**

Eyebrow position and forehead rhytides can be improved with Botulinum Toxin products. The muscles commonly targeted are the lateral orbicularis oculi (lateral depressor), the glabellar complex (medial depressors), and the frontalis. These procedures are noninvasive and safe; however, the result is temporary and there is a need for repeated injections. Botulinum Toxin injections have gained popularity in the male population - Figure 2.

- **Soft Tissue Fillers**

Hyaluronic Acid (HA) was approved by the FDA in 2003. HA absorbs water and expands after injection. A choice of the desirable HA is based on degree of cross-linking of the filler product and duration of correction. Largest HA particles should be injected into the deepest layers, while midsize and smallest particles should be injected at the middle dermis. Clinical results of fine HA injection to correct tear trough deformity are shown (Figures 3,4)

In conclusion, there are many well-described surgical and nonsurgical approaches to address facial aesthetics. The ultimate goal is to create beauty and balance while minimizing evidence of intervention.



Figure 1 - Preoperative frontal view of a 59-year-old female with facial atrophy (above). Image obtained at 4 months follow up after pan facial fat grafting (below).



Figure 2 - Pretreatment frontal view of a 32-year-old male with deep forehead rhytides (above). Image obtained at 4 weeks follow up after Botulinum Toxin injection (below).



Figure 3 - Pretreatment frontal view of a 34-year-old female with prominent tear troughs (above). Image obtained at 1 week follow up after fine HA injection (below).



Figure 4 - Pretreatment frontal view of a 40-year-old female with prominent tear troughs (above). Image obtained at 1 week follow up after fine HA injection (below).



# SURG MAR



VAKIS KONTOES, MD, PHD - GREECE  
Chair, ISAPS Education Council

## MARKING IN UPPER BLEPHAROPLASTY

*(from "State of the Art in Blepharoplasty. From Surgery to the Avoidance of Complications." Published by Springer)*

**M**arking is a very important part of the upper blepharoplasty operation. I believe that this step of the procedure, provided it is performed meticulously and correctly, guarantees one half of a high standard final outcome. It always has to be performed with a good and fluid proof marker, as during surgery tissue fluids, local anaesthesia and the surgeon's manipulation can distort the marked lines. Taking into account intraoperative oedema of the tissue, this can result in non-precise dissection and resection. Marking should be done with the patient in the upright position.

In upper blepharoplasty, the key point line is the existing upper eyelid crease which should not be violated and should be rejuvenated and defined post operatively. This crease is located 8-9mm above the ciliary line in women and 7-8mm in men. The upper part of the incision should be located at a point of 10mm below the inferior border of the eyebrow, always bearing in mind that in female patients, in most cases, eyebrow shapes vary for cosmetic reasons (epilation, hair removal, alteration of the eyebrow line, and permanent tattoo). In these cases, the upper part of the incision should be located at a point which will be selected, after requesting the patient to open and close the eye and judging the correct location by evaluating the borders of the

# ICAL KING

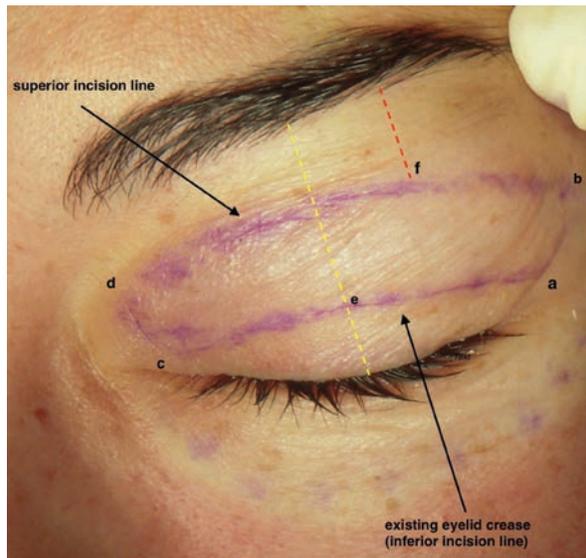


Figure 1

cilia border, but should be approximately 10mm (point f). Points a, b, c and d show the upturning lines location. Point a is the end point of the existing eyelid crease when the eyelid is open, located approximately 6 mm above the ciliary line. Point b is located approximately 6 mm above the lateral canthus. Point c is the medial end of the existing eyelid crease

with the eyelid open. Point d should always be located in the eyelid bearing skin and not in the adjacent nasal skin to avoid medial incision webbing of the epicanthal folds. Point e indicates the eyelid crease at the level of the mid-pupillary line.

The three points to start with in marking of the inferior incision line are a, c, and e and of the superior incision line, point f. (Figures 1 and 2)

orbital rim and the existing skin laxity of the upper eyelid. The fullness of the upper eyelid, related to skin remainder tissue should in general be achieved by preserving a vertical eyelid height of 19-20mm postoperatively. The distance of the eyelid margin to the brow cilia defines the eyelid height.

The upper part of the incision line should extend from the medial to the lateral canthus. To avoid medial webbing, we draw a gentle upturn of the medial incision and laterally we extend the line approximately 5mm above the medial canthus, upturning again.

The connection of the upturning lines of the incision laterally and medially is very important. The lateral upturning line, if marked correctly, will induce an upward lift of the lateral canthal area and the medial one will help in avoiding medial incision webbing of the epicanthal folds, which is very annoying for the patient. (Figure 1)

Figure 1: The inferior (existing eyelid crease) and superior location of the upper eyelid incision is shown. The yellow line indicates the upper eyelid vertical height and the red line shows the distance of the superior incision line to the eyebrow cilia at the level of the lateral limbus of the eyelid. This line may vary depending on the eyebrow shape and



Figure 2 - Key points a, c, and e are marked, as described above, along the eyelid crease.



Figure 3 - Final appearance of upper eyelid marking. Notice the inferior and superior lines located in the existing crease and 10mm below the eyebrow cilia, respectively. The upturn lines ab and cd, as described in Figure 1 are also shown.

The three points of the inferior line are connected to form the eyelid crease corresponding to the inferior incision line. The superior marking is then completed by drawing a gentle line parallel to the inferior one and connecting points b and d. (Figure 2)

**Tip:** When marking, attention should be focused on existing asymmetry between the eyelid folds of the two upper eyelids. In this case, marking should be performed in this manner so that symmetry should be achieved postoperatively, by removing different amounts of skin and/or muscle from each eyelid.

# HOW I MARK MY PATIENTS BEFORE SURGERY

---



**ADRIANA POZZI, MD - ITALY**  
ISAPS National Secretary for Italy

It is said that “the night brings counsel” so, when possible, I prefer to mark my patients the night before surgery, and double check the photos of my markings to verify the symmetry of my design before going to sleep.

I take advantage of that marking time to discuss the procedure and the informed consent together with my patient again, answering any questions or doubts that still beset them, and, finally, taking pictures.

When it is time for marking, patients often arrive early. The earlier they arrive, the more I understand that they may be anxious. They are seated in the waiting room where they are welcomed with relaxing music. When it's their turn, I take them to a small and cozy photo room that has a dark blue wall which serves as a background to the pictures.

Then I walk out of the room and give them time to take off their clothes in complete privacy and, if they are a candidate for body contouring, at the beginning I let them wear a clean gown open at the front.

While marking my patients, I wear disposable gloves. Too many times in the past I have dirtied my hands with the water-resistant marker.

I usually mark my patients while they are standing up, but for abdominoplasty, face lift and blepharoplasty I do it when they are lying down, too. It makes it easier to find important anatomical landmarks.

Every time I mark a patient in a standing position, I ask her/him if they want to pause for a while and sit or, even better, lie down. In the past, I have had cases when a patient has felt faint whilst being marked, after being in a standing position for a long time.

Before marking the skin, I clean the interested area very softly, with cotton wool and alcohol solution, and then I start marking with a permanent marker, usually Edding 3.000-2000C or 400 in three colors: black, when I want to mark the main reference lines, e.g., the medial line or the mid-clavicle and red for anatomical point warnings, e.g., 11° intercostal vessels in augmentation mammoplasty; femoral vessels in Scarpa's triangle for liposuction and inner thigh lift. Red also means a lack of subcutaneous tissue or depressions before lipostructure. Green marks the place where an excess of sub cutaneous tissue is present and there is a chance for me to harvest fat for lipostructure.

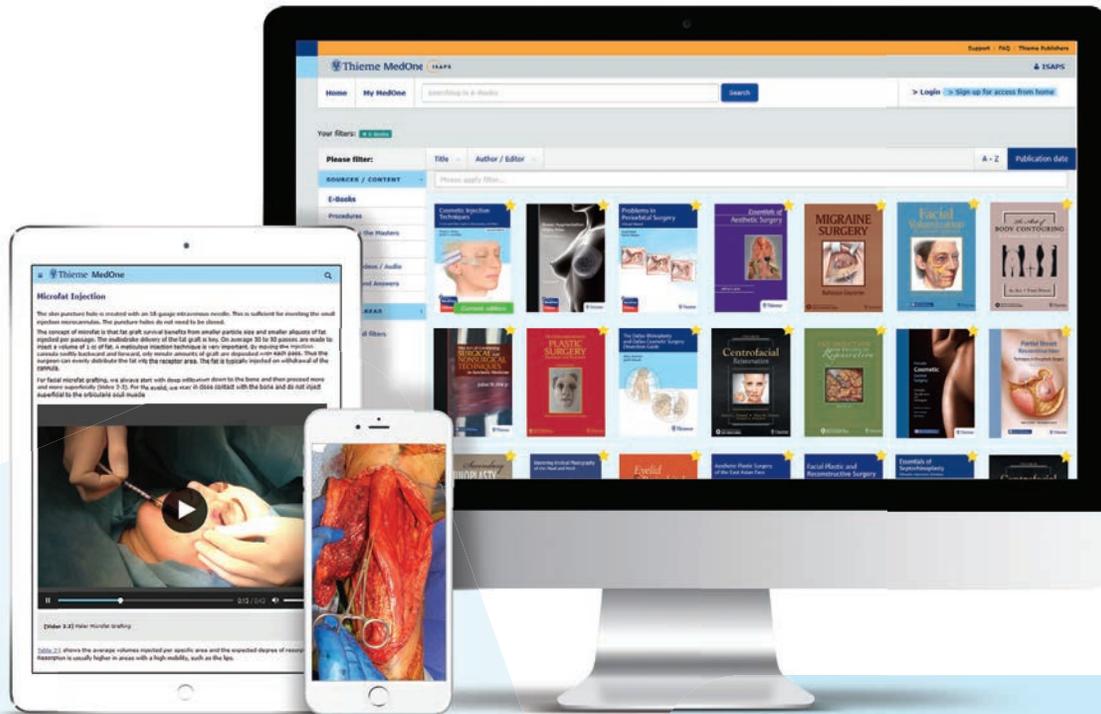
For breasts, I use “homemade” areola patterns made with wire and perform the Aufrich manoeuvre to design my flaps.

On the day of surgery, before starting the procedure, I double check my markings, and I highlight the main reference points by tattooing them with methylene blue. This was one of the first things that I was taught when I was a Resident.

For flap designs, like rhomboid flaps, again I have my “homemade” patterns of various dimensions, made from a plastic sheet.

In the *Principles of Plastic Surgery*, Dr. Millard writes, “An architect would never dare build without a blueprint and that a principle of good practice for surgeons is to use a pattern as a ‘dress rehearsal’ before cutting into flaps.”

# Introducing: ISAPS MedOne Aesthetic Surgery



## What is ISAPS MedOne Aesthetic Surgery?

ISAPS MedOne Aesthetic Surgery from Thieme is a powerful platform, combining expert information with stunning visuals. Easily searchable, it delivers a cutting-edge learning, research, and teaching tool to residents and specialists alike.

Thieme's aesthetic content available on ISAPS MedOne appears before the books are even printed. The content is always growing, with new books, new masters, procedures, videos and images constantly being added.

- 60 aesthetic surgery books
- Over 1,250 surgical videos
- 27 masters of aesthetic surgery showcase their personal techniques in surgical videos
- A library of over 30,000 aesthetic surgery images, fully downloadable to Powerpoint
- Over 1,000 interactive Q+A
- 35 procedures
- Offline/online reading app

## Accessing ISAPS MedOne Aesthetic Surgery

As an ISAPS member, you have access to the ISAPS MedOne Aesthetic Surgery trial from February 15th until May 15th, 2019.

To start your trial, please look for an e-mail from ISAPS.

If you don't receive the ISAPS e-mail, please contact: [MedOne@thieme.com](mailto:MedOne@thieme.com)

# HOW I MARK

## BREAST AUGMENTATION- INFRAMAMMARY APPROACH



**BABIS RAMMOS, MD, FACS - UNITED STATES**



**SARA M. TAEGE, BA - UNITED STATES**

**V**ECTRA 3D imaging and simulation system is used at the time of consultation. The device takes a 3-dimensional photograph that can then be visualized on the monitor, with the addition of breast measurements. Differences between the two breasts, such as breast volume and sternal notch to nipple distance, may be depicted (Figure 1).

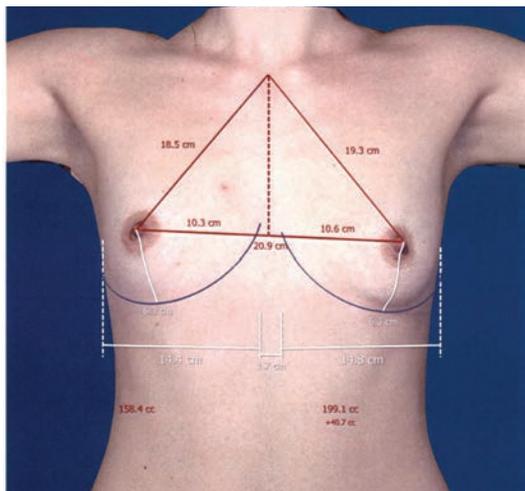


Figure 1 - 3-dimensional photograph of a 26-year-old female using the VECTRA 3D imaging device. Breast measurements are shown.

### Markings

The patient is marked in the upright standing position, and the following markings are made:

- Midline, from sternal notch to xiphoid
- Inframammary Fold
- Superior, medial and lateral borders of the breast. The medial borders are marked 1.5 cm lateral to the midline, so as to prevent synmastia
- Breast meridian
- Marking of the incision. For an inframammary approach, the marking is placed below the inframammary fold, centered at the breast meridian, most often 4 cm in length, 2 cm medial and 2 cm lateral to the meridian (Figure 2).

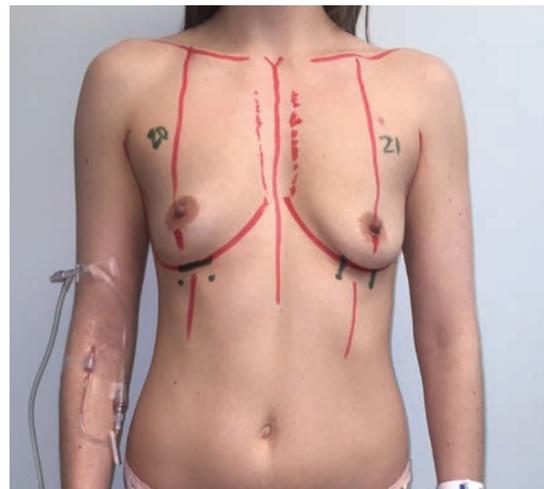


Figure 2 - The markings are made in the preoperative area and reviewed with the patient.

Intraoperative, the inframammary incision is made sharply through the dermis and the superficial layer of the fat until Scarpa's fascia is encountered. A double skin hook is placed followed by an Army Navy retractor and dissection is continued with electrocautery cephalad with care not to violate Scarpa's fascia. The breast tissue is divided and the pectoralis muscle fascia is identified. Submuscular or subfascial dissection is performed with the use of a lighted retractor until the pocket is of appropriate size. The implants are transferred to the Keller Funnel avoiding any contact with the operating table or the surgeon's gloves and they are inserted in a sterile manner using the no-touch technique. The patient is placed in an upright seated position for final appreciation (Figure 3).

Clinical results of breast augmentations are shown (Figures 4a, 4b, 5a, 5b).

*The authors have no financial interest in any product or company mentioned in this article.*



Figure 3 - Patient at the seated upright position with the formal implants in place.



Figure 4a - Preoperative right lateral view of a 26-year-old female with bilateral breast hypoplasia.



Figure 4b - Postoperative right lateral image obtained at 10-month follow up.

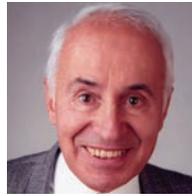


Figure 5a - Preoperative frontal view of a 31-year-old female with bilateral breast hypoplasia.



Figure 5b - Postoperative frontal image obtained at 4-month follow up.

# HISTORY SPOTLIGHT



RICCARDO F. MAZZOLA, MD - ITALY  
Associate Editor, History of Medicine

## THE FIRST TREATISE ON COSMETICS BY GIOVANNI MARINELLO: HIS LEGACY

**D**elecum Marinello's Life - Giovanni Marinello was an Italian humanist, philosopher and physician, whose name is variously rendered as Marinello or Marinelli. Little is known about his life. He was born in Modena in northern Italy, or in the immediate surroundings, in the first half of the sixteenth century and lived at the court of the Este family in Modena. At a young age, he moved to Venice, where he studied medicine, graduated and practiced. The date and location of Marinello's death are unknown; however, due to the concentration of his works between 1560 and 1585, we may assume that he died in Venice about the turn of the sixteenth century.

**Works** - In 1563, he published *Le medicine partenerenti alle infermità delle donne* (*The medicines pertaining to women's diseases*) in three books, where he gives recommendations on obstetrics and gynecology, on women's diseases, but also on weddings, procreation, selection of the ideal couple, suggestions about marriage, how to prevent sexually transmitted disorders, and how to treat male and female impotency.

An entire book deals with pregnancy, delivery and puerperium. The text was composed in the vernacular as he wanted common women to be well informed about their most likely diseases. But Marinello's most important work was *Gli Ornamenti delle donne tratti dalle scritture d'una Reina*

THE TEXT IS DIVIDED INTO FOUR BOOKS AND TRIES TO SOLVE DAILY PROBLEMS THAT COULD IMPACT NEGATIVELY ON WOMEN'S RELATIONSHIPS AND SOCIAL LIFE.

*Greca* (Ladies' Embellishment, drawn from the writings of a Greek Queen), first issued in Venice in 1562 (Figure 1) and dedicated "to Lady Vittoria and Isabella Pallavicino," two Venitian noblewomen.



Figure 1 - Title page of the first edition (1562) of *Gli Ornamenti delle donne* by Giovanni Marinello.

In the foreword, Marinello affirms that the name of a supposedly Greek Queen has been lost, and not traceable anymore. *Gli Ornamenti* is a practical text of about hygiene, beauty and well-being, with the aim of improving female exterior appearance and physical attractiveness. The text is divided into four books and tries to solve daily problems that could impact negatively on women's relationships and social life. It includes numerous recommendations, such as

how to bleach and remove unwanted hair, to maintain teeth white, and to remove unpleasant bodily odors. Renaissance women relied largely on cosmetics and beauty products. Marinello's idea was to gather them in a tract for the first time. The remedies he proposed were a blend of magic and scientific knowledge. On occasion, he used curious mixtures, in vogue in the period, with magic potions of herbs, bowels of animals, and distilling products, whereas sometimes he proposed traditional medications prepared with great dexterity by the druggist.

*Book One* deals with the treatment of diseases of the whole body and of the skin. He gives advice about scented baths, perfumed balms to make the body more appealing with a fragrant and pleasing smell. He proposes diets for gaining or reducing weight. Bloodletting was a potential solution.

*Book Two* takes the hairs of the head into consideration. Haircare played an important role in the concept of beauty of the Renaissance woman. Marinello shows how it is possible to reduce hair loss, to improve growth, to make it curly, or to change the colour to dark, blond, red or white according to the fashion. The manual contains no less than twenty-six recipes for hair dye. Minced licorice, cedar wood, mixed with adiantum and saffron, was considered ideal for blond hair, whereas milk of woman who is nursing a male newborn, blended with sunflower seeds was indicated for white hairs.

*Book Three* describes the face in detail and how to take care of the brow, eyebrows, eyelashes, eyelids, eyes, nose, ears, lips, and teeth for improving their beauty. An ideal nose should be little, not drooping. Teeth have to be fine, small, white, regular - similar to pearls or to ivory. It is essential to keep them healthy. For this, it is important to brush them with wine. An attractive lady, he affirms, has to maintain the hygiene of her mouth to prevent bad breath. The cause should be identified; gums, teeth, or stomach could be responsible for bad breath. He warns that often women were abandoned by their husbands, due to an unpleasant smell from the mouth.

*Book Four* examines the neck, breast, hands, nails, abdomen, flanks, buttocks, and feet. The ideal breast has to be small and firm, neither hypertrophic nor pendulous.

The work, the first one on cosmetics printed in the western world, was a great success, but soon was out of print. It was reissued twelve years later, in 1574, in a revised and enlarged edition, always in Venice by the Valgrisi press.

The title was slightly modified and the phrase *"tratti dalle scritture di una Reina Greca"* (drawn from the writings of a Greek Queen), disappeared. The reason for this change is unknown. The second edition was dedicated to all the *"chaste and young women."*

Marinello's Followers - As often occurs in the history of medicine, Marinello's pioneer work on ladies' embellishment gave rise to numerous publications on the magnification of female beauty and appearance. Marinello's ideas were largely copied, despite the fact that his name was rarely quoted.

The French physician Jean Liébault (1534-1596) translated and adapted the text, with the following title: *"Trois livres de l'embellissement et ornement du corps humain"* (Three books on the embellishment and ornaments of the human body), issued in Paris in 1582 (2) (Figure 2). Marinello is not mentioned.

*"Such is the desire for beauty in every field"* he wrote at the beginning of his work, *"that nothing is considered great, magnificent, excellent, honorable; nothing is judged joyful, pleasant and amusing if it is not accompanied by beauty, especially since beauty is a gift which unveils to the judgement of the mind and of the human eye how great is the perfection of what is nice; therefore suddenly all the senses are delighted and the feelings of each one stimulated to admire, wish, desire, dream, respect and love what is beautiful."*

In *Book One*, devoted to the aesthetics of the body and of the skin, he affirmed that *"male and female face are masterpieces of nature"*.

In *Book Two*, which deals with hair, face, neck and breast, he stated that *"the chest is considered beautiful when it is large enough and has sufficient thickness of skin to*



Figure 2 - Title page of the first edition (1582) of *Trois livres de l'embellissement et ornement du corps humain* by Jean Liébault.

Continued on page 66

*impair the appearance of the underlying bones, and when it accommodates two amazing, round, small, solid apples, not too close to each other, which can fluctuate, as small waves.”*

In *Book Three*, dedicated to the abdomen and limbs, he mentioned the postpartum striae, resulting from an excessive stretching of the abdominal skin during pregnancy. For erasing them, he suggested the use of an ointment made of whale’s sperm, hypericum, almond oil, blueberry oil, and wax.

In 1585, Girolamo Mercuriale (1530-1606), Professor of Practical Medicine at Padua University, published an account on cosmetics in Venice (*De Decoratione*) to demonstrate how it was possible to improve the appearance and the beauty of the body. The text began with the definition of the *Ars Cosmetica* (The art of cosmesis), which incorporates harmony, proportions and embellishment. It was followed by the examination of the different cutaneous imperfections, like spots, corns, and scars. He gave details to treat them properly. He considered nasal wounds to be very unpleasant and anaesthetic. In Chapter 17, he proposed referring these people either to the Calabrian surgeons (i.e., the Vianeos, although not specifically named in the text) or to Gaspare Tagliacozzi from Bologna for improving the aesthetic sequelae. Both of them, particularly expert in nasal repair, could solve the problem in the best possible way. Marinello is not mentioned.

**Marinello’s Name Resurrected** – At the beginning of the twentieth century, after more than three centuries of oblivion, the name of Marinello was resurrected and incorporated in a cosmetics company that a US entrepreneur established in 1904. Ruth D. Maurer (1870-1945), born in Iowa in 1870 as Ruth Johnson, became Maurer in 1898 when she married the physician and surgeon Dr. Albert Maurer.

She became interested in cosmetics while offering beauty hints to Chicago magazines under the name “Emily Lloyd” and later “Mme Michaud.” The use of a French name was a common trick to increase credibility among readers. Before starting the business, Ruth Maurer made numerous market inquiries regarding the demand of creams, lotions, and balms. Having obtained a positive answer, she decided to produce them according to her own formulas.

How Mrs. Maurer came across Marinello’s name, and his contribution to cosmetics, is a bit of a mystery. Anyway, the name for the company was a tribute to Giovanni Marinello,

the author of the first account on cosmetics in the history of medicine. Completely forgotten in his homeland, Marinello was rediscovered in the U.S!

The first list of Marinello’s products, with Ruth Maurer wearing an historical costume (Figure 3), included Creme Celeste (a type of cold cream), Whitening Cream, Antiseptic Lotion, Lettuce Cream (a cleanser), Acne Cream, Tissue Food, Zinc Ointment, Paste Soap, Finishing Cream and Vegetable Powder.

## MARINELLO



Automatic or Water Massage . . . . .	price, complete, \$5.00
Mallets . . . . .	3.00
Comedone Extractor . . . . .	1.25
Antiseptic Lotion . . . . .	1.00
Lettuce Cream . . . . .	.75
Acne Cream . . . . .	.50
Whitening Cream . . . . .	.50
Tissue Food . . . . .	.50
Zinc Ointment . . . . .	.50
Paste Soap . . . . .	.50
Finishing Cream . . . . .	.50
Vegetable Powder . . . . .	.50
Creme Celeste . . . . .	.50

MANUFACTURED BY  
**MARINELLO COMPANY**  
 CHICAGO, ILL. LA CROSSE, WIS.

Figure 3 - List of Marinello’s products published in 1903, with Ruth Maurer wearing an historical costume.

The products immediately had great success and were distributed through more than 5,000 of the largest and most elegant beauty shops (Figure 4) and salons in the country.



Figure 4 - Marinello Beauty shop in Chicago. Postcard, 1910

In addition to cosmetic articles, the company also sold a range of salon appliances including Water Massage and Electrolytic Water Massage units (early vacuum suction devices), Comedone Extractors and Mallets (a sort of Patter) as well as straps and bandalettes.

Following the establishment of the Marinello company, Ruth Maurer, the driving force of the Company, started the Marinello Training School, later known as the Marinello School of Beauty Culture.

The School opened officially in 1905 in Chicago; however, it is possible that classes first began in 1904 (Figure 5). The early Marinello schools used *The Skin. Its Care and Treatment* by Emily Lloyd (alias Ruth Maurer), as a textbook, which



Figure 5 - Marinello Beauty School, 1910. From the left to the right: Red light treatment; Water massage; blue light Acne treatment; Faradic massage (centre); Electrolysis (right).

went through numerous editions. In 1914, it was replaced by *The Marinello Textbook*, remaining the official text for undergraduate classes and went through five editions. The book covered a wide variety of topics including: the anatomy of the skin; the manufacture of skin creams; the use of different cosmetics; the art of massage; the special care of skin, hair, nails, feet, hands, teeth and body; the management of common skin problems such as blackheads, pimples, freckles and wrinkles; electrical treatments; as well as diet, exercise, weight gain and weight loss.

The Marinello schools followed a strict training program similar to medical schools. Students were supposed to have a basic knowledge of anatomy and physiology of the skin, to recognise important skin diseases and conditions,

and to operate in an environment with accepted medical standards of disinfection and sterilisation of the equipment.

In the 1920s, the company moved its operations to New York, where it opened an “Eastern Office” at 366 Fifth Avenue, while the “Western Office” remained in Chicago. In 1925, the company headquarters were moved to 72 Fifth Avenue, New York. The seven story building included offices, a Marinello school and manufacturing facilities. In 1927, Ruth Maurer, aged 57, lost control of Marinello.

With the advent of the Second World War, use of Marinello’s products declined. Some of them disappeared, others were rebranded. Products continued as a part of Zotos International and then of Shiseido Co. Ltd. In the United States. The Marinello Schools remained in operation until 2016, when they finally closed.

Conclusions - In 1562, Giovanni Marinello, a sixteenth century Italian philosopher and physician, wrote “*Gli Ornamenti delle Donne...*”, a practical text on hygiene, beauty and well-being, written with the aim of improving female exterior appearance and physical attractiveness. The work, considered the first treatise on cosmetics printed in the western world, had great success. After more than three centuries of oblivion, the name of Marinello was resurrected and incorporated in a US cosmetics company that Mrs. Ruth Maurer, a US entrepreneur, established in 1904 in Chicago and later headquartered in New York.

#### REFERENCES

1. Marinello G. *Gli Ornamenti delle Donne*, tratti dalle scritture d’una Reina Greca. Venezia, De Francisci, 1562
2. Liébault J. *Trois livres de l’embellissement et ornement du corps humain*. Paris, Du Puys, 1582
3. Mercuriale G. *De Decoratione Liber*. Venezia, Meietto, 1585

### Guest What Answer (from page 11)

Squid on the left, and on the right an osteocartilaginous hump resected during a rhinoplasty - bone on the top, quadrangular excess below and two upper lateral cartilage excess on the sides.

Submitted by Gianluca Campiglio, MD - Italy  
ISAPS 2nd Vice President



# IN MEMORIAM

---

## UNIMAGINABLE SERENDIPITY SEEN BY THE MAGICAL VIEW OF A PLASTIC SURGEON: A PLEA FOR A TRIBUTE TO THE BRAZILIAN PHYSICIAN DR. SEBASTIÃO ELOY



**MIGUEL MARQUES OLIVEIRA, JR, MD - BRAZIL**  
ISAPS Life Member

The passing of my friend and long-time partner, Dr. Sebastião Eloy in June 2018, led me to this plea of homage and gratitude for his services to one of the bastions of the plastic surgery worldwide, of which he was a brilliant assistant and artistic helpmate: John Clarke Mustardé. A casual search comes to reveal the humility of this great Brazilian doctor.

I met Mustardé and Eloy (Figure 1: first to left and last to right respectively) in the middle of my studies of Oculistas Associados at the Red Cross building in Rio de Janeiro 45 years ago, where Prof. Mustardé lectured on his eyelid reconstruction technique. As his widow told me, Dr. Eloy



Figure 1

was an intern from 1966 to 1967 at Ballochmyle Hospital in Mauchline near Ayrshire in Scotland, UK and from then on Prof. Mustardé came to fish in Mato Grosso do Sul, on his pupil's Pantanal farm - repeatedly for at least 10 years. Dr. Eloy was a professor at the Federal University of MS and many doctors were assistants at his famous Eye Clinic in Campo Grande. After I moved from Rio to Campo Grande in 1978, I refreshed my friendship with Dr. Eloy and operated on facial-ocular reconstructive surgeries in his good partnership at the Santa Casa Hospital. In the Collor government crisis, I reformed my Clinic to open it to ENTs, ophthalmologists and vascular surgeons, and Dr. Eloy was a frequent surgeon. In the Clinic, he was aware of an article that I published in the Brazilian Journal of Plastic Surgery and sent me a letter of greeting (Figure 2) which has been filed for many years. Two years ago, I came across this letter and a detail in its signature drew my attention, because it resembles something similar in the Mustardé articles. Reviewing these, I found in *Plast Reconstr Surg* of 1967 (Figure 3) the illustration on page 383, whose Figure 2 is underlined with the same rubric as this letter: SEloy (Sebastião Eloy). By phone contact last year with my friend who was living at home for health reasons, I asked, "Eloy, do

you draw well?" "I drew," he told me. He lived the limited life of a retiree in his residence. Inquiring whether he had made drawings for the Mustardé otoplasty technique, his confirmation led me to see this unimaginable serendipity. Mustardé's scientific importance for Otoplasty worldwide is unanimous in the four corners of the globe, besides being one of the ISAPS founders. I then revealed to my friend this incidental finding during a visit last year, in order to give him an offprint of our study on ear morphology, at the *Aesth Plast Surg*, 41 (2), 2017, for which he was a sponsor friend, reintroducing myself in 2004 to Prof. Mustardé, reviewing text and stimulating our research that resulted in this article. In possession of a notebook and the PDF article

of *Plast Reconstr Surg* of 1967 and opened on page 383, we placed the wheelchair of Dr. Eloy in front of the figures, which led him to speak as soon as he saw the figures: "This drawing I did it!" Warmly reminded fifty two years later! At his 82 years of professional and scientific active life, now with weakened health. It was too touching for me and for his wife, Mrs. Vera Pereira, who watched us. And at that moment I am joking that Prof. Mustardé was egocentric, not quoting his name as a co-author. To which he replied with a friendly smile. Example of great generosity for the plastic surgery of a non-plastic surgeon! Thank you, Prof. Sebastian Eloy, the world of plastic surgery thanks you forever.

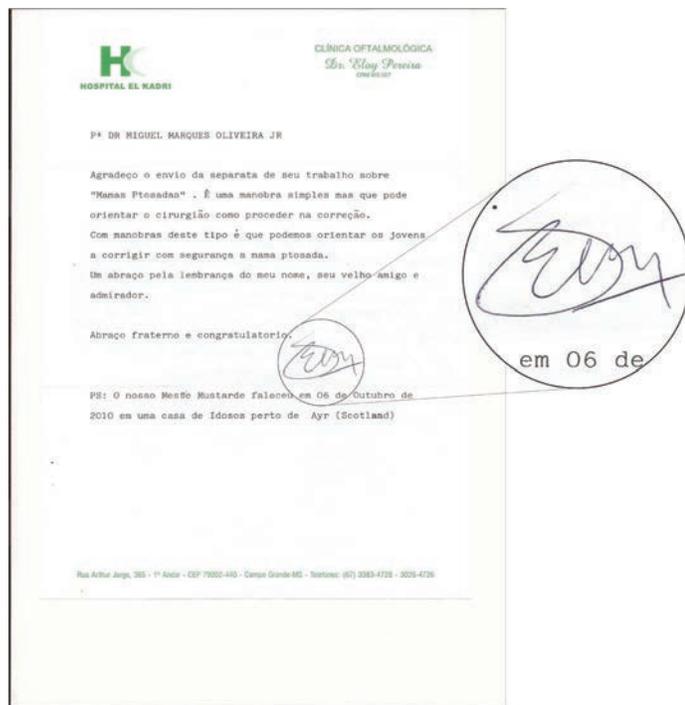


Figure 2

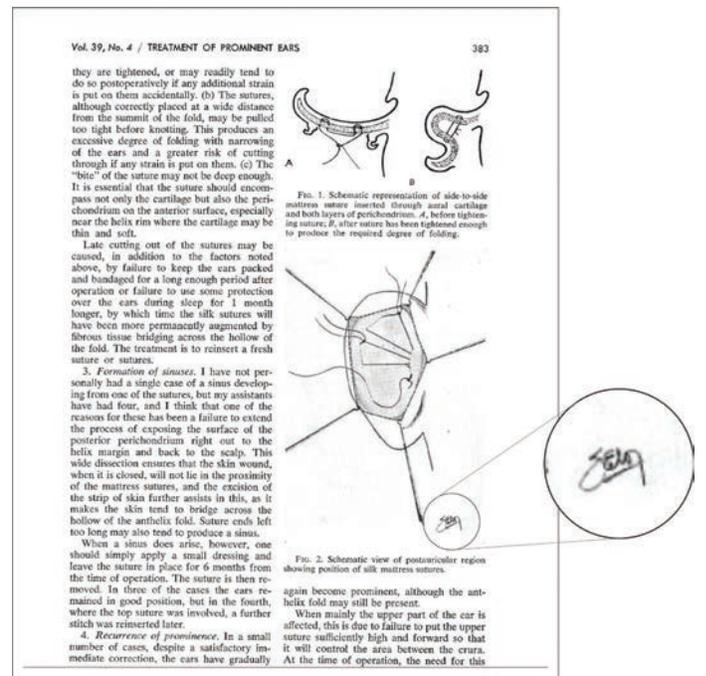


Figure 3

# ISAPS WELCOMES NEW MEMBERS

JANUARY THROUGH FEBRUARY 2019

## BANGLADESH

Tarikul ISLAM, MBBS, FCPS, MS  
Sattar SUMON, MBBS, FCPS

## BOSNIA-HERZEGOVINA

Mufid BURGIC, MD, PhD

## BRAZIL

Vitor PAGOTTO, MD\*\*  
Pedro ROCHA, MD\*\*  
Julio VEDOVATO, MD\*  
Karols VILA CLARO, MD\*\*

## CANADA

Patricia BERBARI, MD

## COLOMBIA

Hernando FLOREZ OSPINO, MD  
Jorge GOMEZ, MD

## DOMINICAN REPUBLIC

Manelic MEJIA, MD

## GERMANY

Iakovos GEORGIU, MD\*\*

## HUNGARY

Béla DEBRECZENI, MD, PhD  
Rudolf ILLESSY, MD\*\*  
Gyula KOLONICS, MD

## INDIA

Arjun HANDA, MBBS, MS  
Rohit KRISHNA, MD  
Vikram RAJA, MBBS, MS, MCh, MRCS  
Lingappan RAMASAMY, MS, DNB, MCh, MRCSEd  
Gunasekar VUPPALAPATI, MBBS, MS, FRCSEd, MCh  
Shabbir WARSII, MBBS, MCh

## JAPAN

Rica TANAKA, MD

## MEXICO

Mauricio BAILEY SPINDEL, MD\*\*  
Jose CHANG CONTRERAS, MD\*\*  
Jorge DIAZ MARTINEZ, MD\*\*  
Claudia ESTRADA CHAVEZ, MD\*\*  
Juan GARCIA NORZAGARAY, MD\*\*  
Israel GAUCIN, MD\*\*

## MEXICO cont.

Diego GONZALEZ CHAPA, MD\*\*  
Arianna IBARRA REYES, MD\*\*  
Jesus LUGO LÓPEZ, MD\*\*  
Sergio MEJIA VALERO, MD\*\*  
Lorena del Pilar MENOSCAL CEVALLOS, MD  
Adrian NIETO ROMERO, MD\*\*  
Oscar PORRAS ESCORCIA, MD\*\*  
Mauro REIGENBORN, MD\*\*  
Gleny SUM GARCIA, MD\*\*

## MONTENEGRO

Duško MARKOVIĆ, MD\*\*

## NETHERLANDS

Emiel HAREN, MD\*\*

## NEW ZEALAND

Katarzyna MACKENZIE, MD, PhD, FRACS\*  
Justin PARR, BSc, MBBS\*\*

## PORTUGAL

João Carlos FERREIRA, MD\*\*  
Rúben NOGUEIRA, MD\*\*

## QATAR

Bulent DEMIR, MD

## RUSSIAN FEDERATION

Dmitry BUZOV, MD  
Samvel PETROSYANTS, MD\*\*

## SAUDI ARABIA

Amr ARKOUBI, MD, FRCS(C)

## SLOVAK REPUBLIC

Ivan ZIKLA, MD

## SOUTH AFRICA

Vivien JANDERA, MBChB (UCT), FCS(SA) Plast

## SOUTH KOREA

Seong Hwan KIM, MD

## SPAIN

Marta DE JUAN MARIN, MD\*\*  
Angela OJEDA, MD\*\*



### SWITZERLAND

Maziar SHAFGIHI, MD, FMH, FEBOPRAS

### THAILAND

Chokchai AMORNSAWADWATTANA, MD  
Vitawat ANGKATAVANICH, MD  
Dulayanat ARANYAPALA, MD, FRCST  
Orawan CHANSANTI, MD  
Thiti CHAOVANALIKIT, MD, FRCST  
Sutin KHOBUNSONGSEEM, MD  
Ronachai KOMTHONG, MD  
Sivat LUANRAKSA, MD  
Virat OSATHALERT, MD  
Suwajo POONPISSAMAI, MD  
Nakarin SALEETHONG, MD  
Asaya SEUBSUK, MD  
Chris SIRIPOON, MD  
Atikom TANADPOJANAMART, MD, FRCST  
Adunchai THAMMASANGSERT, MD, FRCST  
Vitusinee UDEE, MD  
Natthacha VAMVANIJ, MD

### TUNISIA

Anas GHERISSI, MD  
Hichem MAHMOUD, MD

### TURKEY

Sinem CILINGIR, MD\*\*  
Abdullah ETOZ, MD  
Ilke KARAGOZ, MD\*\*  
Mehmet OKYAY, MD\*

### UNITED KINGDOM

Mallappa KOLAR, MBChB\*\*

### UNITED STATES

Uldis BITE, MD, FRCSC  
Rafael GOTTENGER, MD  
Christodoulos KAOUTZANIS, MBBS\*\*  
Matthew LEWIS, MD\*  
Nho TRAN, MD

\* indicates Associate Member

\*\* indicates Associate Resident/Fellow Member

# MEETINGS CALENDAR

## SECONDARY OPTIMIZING AESTHETIC SURGERY SYMPOSIUM (SOS) 2019

DATES: 12 April – 13 April 2019  
LOCATION: Stuttgart, GERMANY  
VENUE: Marienhospital – Bildungszentrum Vinzenz von Paul  
CONTACT: Barbara Boeld  
TEL: +49-89-18-90460  
EMAIL: [congress@bb-mc.com](mailto:congress@bb-mc.com)  
WEBSITE: <http://www.sos2019.eu/>



## ISAPS F.A.S.T. PROGRAM – MOSCOW

DATES: 24 May – 25 May 2019  
LOCATION: Moscow, RUSSIAN FEDERATION  
VENUE: Manturova Institute  
TOPIC: Aesthetic Breast Surgery – Part 2 of 3  
CONTACT: Anna Pimenova  
EMAIL: [orgcom@isapsfast.ru](mailto:orgcom@isapsfast.ru)  
WEBSITE: [www.isapsfast.ru](http://www.isapsfast.ru)



## ISAPS COURSE – EGYPT

DATES: 18 April – 19 April 2019  
LOCATION: Cairo, EGYPT  
VENUE: Marriott Mena House Hotel  
CONTACT: Mourad Elansary  
TEL: 0020 111 8197 093  
EMAIL: [Mourad.Elansary@icomgroup.org](mailto:Mourad.Elansary@icomgroup.org)  
WEBSITE: [www.isaps-egypt.org](http://www.isaps-egypt.org)



## 1ST ABDOMINOPLASTIES, BRACHIOPLASTY AND OTHER BODY CONTOURING TECHNIQUES COURSE

DATES: 29 May – 31 May 2019  
LOCATION: Lyon, FRANCE  
VENUE: Hotel Marriott Lyon  
CONTACT: International Plastic Surgery Advanced Course (IPSAC)  
TEL: 33-04-72837769  
EMAIL: [charles@ipsac.eu](mailto:charles@ipsac.eu)  
WEBSITE: <http://www.ipsac.eu/>



## 32ND ANNUAL CONGRESS OF SOFCEP

DATES: 24 April – 27 April 2019  
LOCATION: Val d'Isère, FRANCE  
VENUE: Val d'Isère Convention Center  
CONTACT: SOFCEP  
TEL: +33(0)53 431 0134  
EMAIL: [sofcep@vous-et-nous.com](mailto:sofcep@vous-et-nous.com)  
WEBSITE: <http://www.chirurgiens-esthetiques-plasticiens.com/congres-sofcep-2/?lang=en>



## BEAUTY THROUGH SCIENCE 2019

DATES: 05 June – 08 June 2019  
LOCATION: Stockholm, SWEDEN  
VENUE: Stockholm Waterfront Congress Center  
CONTACT: All about meetings AB  
TEL: 46 (0) 8 684 27 800  
EMAIL: [bts@allaboutmeetings.se](mailto:bts@allaboutmeetings.se)  
WEBSITE: <https://www.beautythroughscience.com/>



## BARCELONA RHINOPLASTY COURSE 2019

DATES: 01 May – 04 May 2019  
LOCATION: Barcelona, SPAIN  
VENUE: Centro Medico Teknon  
CONTACT: Silvia Vila  
TEL: 34-696-937471  
EMAIL: [svila@vilarovira.com](mailto:svila@vilarovira.com)  
WEBSITE: <https://barcelonarhinoplasty.com/#>



## ISAPS COURSE – RUSSIA

DATES: 13 June – 16 June 2019  
LOCATION: St. Petersburg, RUSSIA  
CONTACT: Igor Bogoroditskiy  
EMAIL: [i.bogoroditski@yahoo.com](mailto:i.bogoroditski@yahoo.com)



## 3RD BUTTOCK SURGERY COURSE

DATES: 02 May – 04 May 2019  
LOCATION: Paris, FRANCE  
VENUE: Intercontinental Paris Avenue Marceau  
CONTACT: International Plastic Surgery Advanced Course (IPSAC)  
TEL: 33-04-72837769  
EMAIL: [charles@ipsac.eu](mailto:charles@ipsac.eu)  
WEBSITE: <http://www.ipsac.eu/>



## BEAULI 2019

DATES: 14 June – 15 June 2019  
LOCATION: Birkenwerder, GERMANY  
VENUE: Asklepios Klinik  
CONTACT: Wibke Bodensiek  
TEL: 49-3303501340000  
EMAIL: [info@pk-bw.de](mailto:info@pk-bw.de)  
WEBSITE: <https://www.beauli.de/>



## THE MASTOPEXY COURSE (ONLINE & ONSITE)

DATE: 05 May 2019  
LOCATION: SAN MARINO  
VENUE: HTA Medica  
CONTACT: Olympos Educational  
EMAIL: [olymposeducational@gmail.com](mailto:olymposeducational@gmail.com)  
WEBSITE: <https://www.olymposeducational.com/events>  
NOTES: Webinar and onsite registration available



## FACELIFT AND OCULOPLASTIC SURGERY

DATES: 15 June – 16 June 2019  
LOCATION: Vienna, AUSTRIA  
VENUE: Medical University Vienna, Anatomy Training Center  
CONTACT: Prof. Dr. Hannes Traxler  
TEL: 43-699-10535714  
EMAIL: [hannes.traxler@meduniwien.ac.at](mailto:hannes.traxler@meduniwien.ac.at)  
WEBSITE: [www.anatomical-surgical-training.com/facelift-and-oculoplastic-surgery.html](http://www.anatomical-surgical-training.com/facelift-and-oculoplastic-surgery.html)



### ISAPS COURSE – TURKEY

DATES: 20 June – 23 June 2019  
LOCATION: Istanbul, TURKEY  
VENUE: Hilton Convention Center  
EMAIL: [yagiz@seveneventcompany.com](mailto:yagiz@seveneventcompany.com)  
WEBSITE: <http://www.eurasian2019.org/>



### ISAPS SYMPOSIUM FOR RESIDENTS AND FELLOWS

*Immediately preceding the EASAPS Biennial Meeting on Facial Rejuvenation*  
DATE: 17 October 2019  
LOCATION: Brugges, BELGIUM  
VENUE: Oud St Jan Convention Center  
EMAIL: [easaps@mzcongressi.com](mailto: easaps@mzcongressi.com)  
WEBSITE: <http://www.easaps.org>



### MIPSS 2019

DATES: 20 June – 22 June 2019  
LOCATION: Marbella, SPAIN  
VENUE: H10 Andalucia Plaza Hotel  
CONTACT: Vanessa Garcia  
TEL: 34-951-775518  
EMAIL: [info@mipss.eu](mailto: info@mipss.eu)  
WEBSITE: <https://www.mipss.eu/>



### ISAPS COURSE – MONACO – LIVE PLASTIC SURGERY (FOCUS: FACE)

DATES: 07 November – 09 November 2019  
LOCATION: MONACO  
VENUE: Grimaldi Forum  
CONTACT: Dr. Henry Delmar & Catherine Decuyper  
EMAILS: [henry@henry-delmar.com](mailto: henry@henry-delmar.com) & [catherine@euromedicom.com](mailto: catherine@euromedicom.com)  
WEBSITE: <https://www.euromedicom.com/lps/en/participants/about-surgery.html>



### THE AESTHETIC CRUISE 2019

DATES: 23 June – 04 July 2019  
LOCATIONS: Italy, Malta, Greece, Montenegro, Croatia, Slovenia  
CHAIR: Dr. Melinda Haws  
CO-CHAIR: Dr. Joseph Hunstad  
ASAPS CONTACT: Debi Toombs  
TEL: 1-562-799-2356  
EMAIL: [debi@surgery.org](mailto: debi@surgery.org)  
CRUISE CONTACT: Bob Newman  
EMAIL: [bnewman.mail@cruisebrothers.com](mailto: bnewman.mail@cruisebrothers.com)  
WEBSITE: [www.surgery.org/cruise2019](http://www.surgery.org/cruise2019)



### ISAPS F.A.S.T. PROGRAM – MOSCOW

DATES: 15 November – 16 November 2019  
LOCATION: Moscow, RUSSIAN FEDERATION  
VENUE: Manturova Institute  
TOPIC: Aesthetic Body Surgery – Part 3 of 3  
CONTACT: Anna Pimenova  
EMAIL: [orgcom@isapsfast.ru](mailto: orgcom@isapsfast.ru)  
WEBSITE: [www.isapsfast.ru](http://www.isapsfast.ru)



### 7TH LIVE SURGERY COURSE MARBELLA

DATES: 27 June – 28 June 2019  
LOCATION: Marbella, SPAIN  
VENUE: Hotel Barcelo Marbella  
CONTACT: Carolina Lerussi  
TEL: 34-952-775346  
EMAIL: [carolina@cirumed.es](mailto: carolina@cirumed.es)  
WEBSITE: <https://livesurgery.cirumed.es/index.html>



### SECONDARY OPTIMIZING AESTHETIC SURGERY SYMPOSIUM (sos) 2020

DATES: 31 August – 01 September 2020  
LOCATION: Vienna, AUSTRIA  
VENUE: Andaz Belvedere Vienna Hotel  
CONTACT: Barbara Boeld  
TEL: +49-89-18-90460  
EMAIL: [congress@bb-mc.com](mailto: congress@bb-mc.com)  
WEBSITE: <http://www.sos2020.eu>



### 13TH BODY LIFT COURSE

DATES: 04 July – 06 July 2019  
LOCATION: Geneva, SWITZERLAND  
VENUE: Hotel President Wilson  
CONTACT: International Plastic Surgery Advanced Course (IPSAC)  
TEL: 33-04-72837769  
EMAIL: [charles@ipsac.eu](mailto: charles@ipsac.eu)  
WEBSITE: <http://www.ipsac.eu/>



### 25TH CONGRESS OF ISAPS

DATES: 02 September – 05 September 2020  
LOCATION: Vienna, AUSTRIA  
VENUE: Austria Center Vienna  
CONTACT: Catherine Foss  
TEL: 1-603-643-2325  
EMAIL: [isaps@isaps.org](mailto: isaps@isaps.org)  
WEBSITE: [www.isapsvienna2020.com](http://www.isapsvienna2020.com)



### ISAPS SYMPOSIUM – POLAND

DATE: 12 October 2019  
LOCATION: Poznan, POLAND  
CONTACT: Dr. Maciej Kuczynski  
EMAIL: [kuczynski@ptchprie.pl](mailto: kuczynski@ptchprie.pl)  
Additional details pending



## ISAPS EXECUTIVE OFFICE STAFF

45 Lyme Road, Suite 304  
Hanover, NH, USA 03755  
Phone: 1-603-643-2325  
Fax: 1-603-643-1444  
Email: [ISAPS@isaps.org](mailto:ISAPS@isaps.org)  
Website: [www.isaps.org](http://www.isaps.org)

### EXECUTIVE DIRECTOR

Catherine Foss  
[ISAPS@isaps.org](mailto:ISAPS@isaps.org)

### GRAPHIC DESIGNER

Jodie LeBrun  
[Abstracts@isaps.org](mailto:Abstracts@isaps.org)

### FINANCE OFFICER

Sally Rice  
[Accounting@isaps.org](mailto:Accounting@isaps.org)

### MEMBERSHIP SERVICES MANAGER

(Ms) Jordan Carney  
[Membership@isaps.org](mailto:Membership@isaps.org)

### EDUCATION EVENTS MANAGER

Michele Nilsson, CMP  
[Registrar@isaps.org](mailto:Registrar@isaps.org)

## ISAPS NEWS MANAGEMENT

### EDITOR-IN-CHIEF

Nina Naidu, MD (United States)

### ASSOCIATE EDITOR, HISTORY OF MEDICINE

Riccardo Mazzola, MD (Italy)

### MANAGING EDITOR

Catherine B. Foss (United States)

### CHAIR, COMMUNICATIONS COMMITTEE

Tim Papadopoulos, MD (Australia)

### EMERITUS EDITOR

J. Peter Rubin, MD, FACS (United States)

## ISAPS BOARD OF DIRECTORS, COMMITTEE CHAIRS & APPOINTMENTS 2018 – 2020

### Board of Directors

President  
President-Elect  
1st Vice President  
2nd Vice President  
3rd Vice President  
Secretary  
Treasurer  
Historian  
Parliamentarian  
National Secretaries Chair  
Education Council (EC) Chair  
EC Vice-Chair  
Past President  
Trustee  
Trustee  
Executive Director

Dirk Richter, Germany  
Nazim Cerkes, Turkey  
Lina Triana, Colombia  
Gianluca Campiglio, Italy  
Arturo Ramirez-Montana, Mexico  
Ivar van Heijningen, Belgium  
Kai Schlaudraff, Switzerland  
Peter Scott, South Africa  
Tim Papadopoulos, Australia  
Michel Rouif, France  
Vakis Kontoes, Greece  
Ozan Sozer, USA  
Renato Saltz, USA  
Grant Stevens, USA  
Fabian Cortinas, Argentina  
Catherine Foss, USA

### Standing Committee Chairs

Executive  
Nominating  
Membership  
By-Laws  
Communications/Branding/Marketing  
Patient Safety  
Journal Operations  
Finance & Investment  
Newsletter  
Residents & Fellows  
Women Plastic Surgeons

Dirk Richter, Germany  
Renato Saltz, USA  
Fabian Cortinas, Argentina  
Tom Davis, USA  
Tim Papadopoulos, Australia  
Foad Nahai, USA  
Nazim Cerkes, Turkey  
Kai Schlaudraff, Switzerland  
Nina Naidu, USA  
Maria Wiedner, Germany  
Teresa de la Cerda, Chile

### Education Council

Vakis Kontoes, Greece – Chair  
Ozan Sozer, USA – Vice Chair

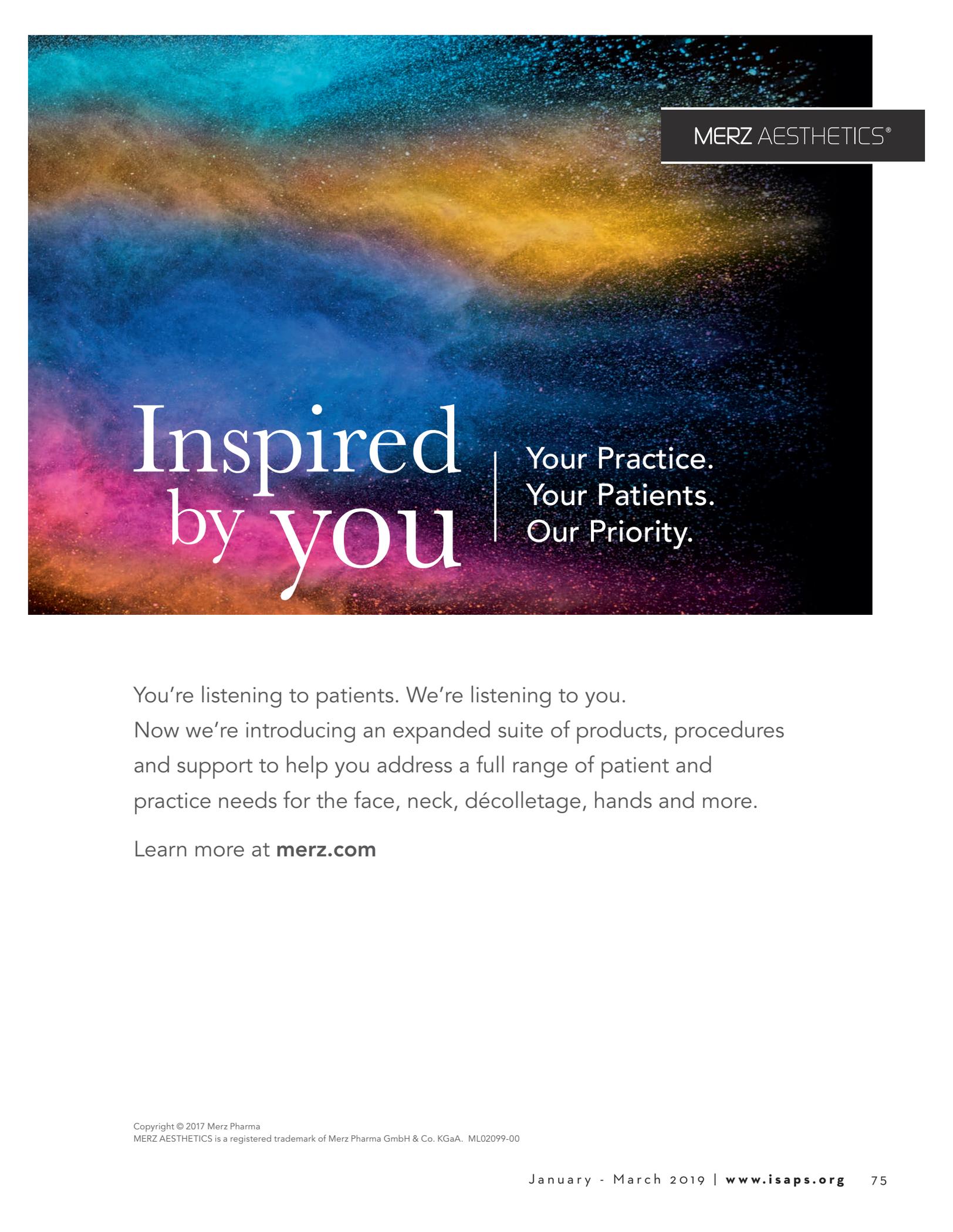
### Ad Hoc Committee Chairs

Humanitarian  
Industry Relations  
Insurance  
Global Survey  
Global Accreditation  
Visiting Professor  
Global Alliance  
Continental Communication  
New Talents  
50th Anniversary  
Patient Education  
Social Media  
Webinar  
E-Learning Development  
Charity  
International Board Examination

Tunc Tiryaki, Turkey & Nina Naidu, USA  
Kai Schlaudraff, Switzerland  
Nigel Mercer, United Kingdom  
Dennis von Heimburg, Germany  
Ozan Sozer, USA & Ivar van Heijningen, Belgium  
Renato Saltz, USA  
Mark Jewell, USA  
Andre Cervantes, Brazil  
Al Aly, UAE  
Joe Hunstad, USA  
Stefano Danilla, Chile  
Simone Hellmann, Germany  
Nazim Cerkes, Turkey  
Gianluca Campiglio, Italy  
Nina Naidu, USA  
Daniel Kalbermatten, Switzerland

### DISCLAIMER:

ISAPS News is not responsible for facts as presented by the authors or advertisers. This newsletter presents current scientific information and opinions pertinent to medical professionals. It does not provide advice concerning specific diagnosis and treatment of individual cases and is not intended for use by the layperson. Readers are strongly advised to confirm that the information complies with the latest legislation and standards of practice. ISAPS, the editors, the authors, and the publisher will not be responsible for any errors or liable for actions taken as a result of information or opinions expressed in this newsletter. Copyright © 2019 by the International Society of Aesthetic Plastic Surgery, Inc. All rights reserved. Contents may not be reproduced in whole or in part without written permission of ISAPS.

The background of the advertisement is a vibrant, multi-colored dust or particle effect. The colors transition from deep blues and purples on the left to bright yellows and oranges on the right, with a dark, almost black, background. The particles are small and scattered, creating a sense of movement and depth.

MERZ AESTHETICS®

# Inspired by you

Your Practice.  
Your Patients.  
Our Priority.

You're listening to patients. We're listening to you.

Now we're introducing an expanded suite of products, procedures and support to help you address a full range of patient and practice needs for the face, neck, décolletage, hands and more.

Learn more at [merz.com](http://merz.com)

Quality you can feel



POLYTECH