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ISAPS NEWS

Official Newsletter of the International Society of Aesthetic Plastic Surgery

ISAPS 2014 RIO CONGRESS – A GREAT MEETING

Our 22nd Congress in Rio was really a successful meeting. More than 1800 plastic surgeons, their families, exhibitors and congress staff from 78 countries arrived in Rio de Janeiro in September to discuss and to present the most recent advances of our specialty. It was a good time to share friendship, to see many colleagues from around the world and of course, to enjoy the wonderful atmosphere of Rio and other nice places in Brazil.

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MESSAGE FROM THE EDITOR

Welcome to this issue of *ISAPS News*. We celebrate the incredibly successful 22nd Congress of ISAPS in Rio de Janeiro, Brazil. How wonderful to gather so many plastic surgeons from 78 countries representing the highest standards of skill, integrity, and commitment to excellence in clinical care. I hope you enjoy the feature story about the Congress and the wonderful photos.

It is also a pleasure to congratulate our new president, Dr. Susumu Takayanagi. His commitment to patient safety, education, and service will build upon that great momentum of ISAPS and propel the mission of the society forward.

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Our Global Perspectives series this time focuses on rhinoplasty. We have a wonderful collection of articles by renowned experts from around the world. It is so very interesting to compare and contrast clinical practice patterns, trends, and observations among different regions.

In this issue, we also have a great piece on the psychology of plastic surgery by Dr. David Sarwer. He discusses the topic of extreme body modification. Dr. Ricardo Mazzola shares his great expertise in the history of surgery, writing about Pietro Sabattini and the Lip Switch Flap.

All these great features and much, much more are in this informative issue of our newsletter.

I encourage you to send us articles of interest for the next issue to be published in March. The theme of the next "Global Perspectives" series is Non-Invasive Aesthetic Treatments.

Warmest regards,

J. Peter Rubin, MD, FACS
ISAPS News Editor

MESSAGE FROM THE PRESIDENT

It is my great honor to become President of ISAPS following Dr. Carlos Uebel, who has done tremendous and excellent work. I will devote all of my energy for the next two years to live up to this great responsibility.

Have you ever seen the film, *The Last Samurai?* It depicts samurai, as members of the warrior class in Japan were known until approximately 150 years ago, dying for the spirit of the samurai against modern utilitarianism and efficiency. I love this movie. What is deeply fulfilling in our lives is the mission we are given and the cooperation we have with colleagues who understand, believe in, and share this mission. That is why the last words of the samurai in the film, "Everything was perfect," touches our hearts. It would be wonderful if I could say "Everything was perfect" when I finally stop being a plastic surgeon. To be able to conclude my working life with these words, it is surely essential to be faithful to the mission of a plastic surgeon and to work with colleagues who believe in and share the same mission.

We must define our mission in a way that transcends the times. The mission is to ensure our patients' safety. This duty will never change for either for our members or for ISAPS. In order to fulfill this mission, we need to manage ISAPS in the following manner.

First, ISAPS will open our doors wider. We have long adhered to a system where plastic surgeons were assigned as lecturers at the biennial congress, ISAPS courses and ISAPS symposia, to impart their skills and knowledge. Only plastic surgeons were allowed to enter these venues. From now on, however, we will open our doors of new faculty members and to quality non-plastic surgeons. Non-surgical treatment has widely been accepted by patients who require cosmetic medicine and the number of treatment methods is increasing. When the safety of patients and the benefits to them are our priority, it is preferable to have methods other than surgical interventions among our options. Therefore, we should have the most precise and the latest knowledge related to non-surgical treatment. It is important to learn from doctors other than plastic surgeons who have achieved excellent therapeutic effects from laser or filler therapy, toxins and hair transplantation, for example. If you find a presentation on an amazing therapy in your country or region, please recommend it for submission to our journal. And please give the name of the doctor and the content of the therapy to Dr. Lina Triana, the Chair of the Education Council, to Education Council members, or to Board Members. We would like to invite quality physicians as faculty for future meetings of ISAPS. We will also continue to evaluate every faculty member so that highly-rated faculty members will continue to be invited to join the faculty in the future.

Next, ISAPS values people who truly serve our society. Doctors who assume important positions in ISAPS, including Board Members, Committee Chairs and National Secretaries in each of our member countries are required to maintain satisfactory results when serving ISAPS. Once they assume important positions, they are required to make an additional contribution to the mission of ISAPS—as a servant of ISAPS. I would like to improve the method of electing Board Members so that the people who satisfy this policy can be elected as leaders of ISAPS at the biennial congress to be held in Kyoto in 2016.

In closing, I would like to see the number of ISAPS members increase globally and I look forward to the time where representatives of each region share equal time as leaders of ISAPS. Being from Asia, I will serve as President for two years this term. In the future, I hope we will have Presidents also from Africa, the Middle East and other regions. When the time comes, one of the goals of ISAPS, Aesthetic Education Worldwide, will then be achieved and become successful. The mission of ISAPS members is shared throughout the world, regardless of race, tribe, politics or religion. It is the wish of ISAPS that patient safety around the world will be ensured by ISAPS members with excellent knowledge and skills and that these patients will show us their smiles. Looking forward to the day when our wish comes true, I would like

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A LETTER TO THE ISAPS FACULTY

Mario Pelle Ceravolo – Italy

Dear ISAPS Colleagues,

All of us are ISAPS members for several years and believe in the importance of this institution, which is the only one that seriously represents aesthetic plastic surgery all over the world. Many of us have participated on the faculty in ISAPS congresses, courses and symposia especially in the last four years during Nazim Cerkes' Education Council chairmanship.

As we all personally organize meetings, and thus know very well the local medical and geographic environment, we are definitely aware of how many difficulties are encountered in the organization of courses from a scientific, political and practical viewpoint. The aim of this letter is to let you know how hard Dr. Cerkes has worked for ISAPS and the excellence of the results he has obtained through a strong personal involvement in the organization of courses and meetings in these difficult areas.

Dr. Cerkes has succeeded in obtaining the best possible quality in organizing a series of events in places where it was hard to imagine producing such meetings. The quality of the faculty, the local organizers, the scientific level, and the enjoyable hospitality which he and his committees in each location were able to provide were almost always outstanding. This was the result not only of his professional qualities, but also of his human disposition. His eclectic personality joins knowledge, humanity, sympathy, kindness, tolerance and humbleness in a way that is rarely be found in any human being and especially in a plastic surgeon! We know very well how much each of us feels like a "prima donna" and how hard it may be to put together several "prime donne" and have them work together with great scientific communicating power.

We know that his chairmanship terminated in September and that we will miss him a lot as an unbelievable and terrific organizer.

Whoever will come next will have to stand a very difficult task to be able to match up with what he did. We wish his successor our good wishes to keep up with the success of ISAPS.

Mario Pelle Ceravolo – Italy
May 2014

BCRF AWARDS 2014

The Body Contouring Research Foundation (BCRF) Awards were presented at the 22nd Biennial Congress of ISAPS in Rio de Janeiro, Brazil in September, 2014. There were two categories: the Young Presenter's Award and the Young Researcher's Award with prizes for 1st and 2nd place in each category.

We are pleased to announce the 2014 winners:

Clinical Awards –

1st place ***Natale FERREIRA GONTIJO DE AMORIM, MD***
Rio de Janeiro, Brazil $4,000

2nd place ***Yoram WOLF, MD***, Tel Aviv, Israel $2,000

Research Awards –

1st place ***Alexandra CONDE GREEN, MD, FACS***
Newark, New Jersey, USA
(Rutgers Medical School) $4,000

2nd place ***Joseph Williams, MD***
Atlanta, Georgia, USA $2,000

The awards committee this year was composed of Luiz Toledo (UAE) as Chair, with judges including former winners Wilson Matos, Jr. (Brazil) and Antonio Costa Ferreira (Brazil) and a third judge, Manuel Athayde (Iran).

The Body Contouring Research Foundation biennial awards given by ISAPS are funded by monies derived from the proceeds of the Lipoplasty Society of North America (LSNA) founded in 1982 and subsequently dissolved. ISAPS is indebted to long-time ISAPS member Dr. Gregory Hetter for his stewardship of the funds that make these awards possible to help our young people.

The winner of the
IDEAS AND INNOVATIONS AWARD
at the ISAPS Congress in Rio de Janeiro, Brazil
was **Dr. Patrick Tonnard** (Belgium)
for his presentation on
Nanofat Grafting.

ISAPS ACHIEVEMENTS: 2012-2014

Catherine Foss – United States

ISAPS Executive Director

As the largest international society of aesthetic plastic surgeons in the world, ISAPS continues to improve the many programs and benefits we offer our 2800 members in 96 countries. Our goal is to reach 3000 qualified members by year end. This will allow us to improve and expand these programs not only for the benefit of our members, but ultimately for the benefit of their patients whose needs are best served by well-trained and informed surgeons.

ISAPS Structure, Organization and Information

- ***International Survey*** – ISAPS is the only organization in the world that collects data on the number and types of aesthetic surgery procedures performed. The most recent results were released on July 24th and can be found on our website in the News section.
- ***Public Relations*** – our ISAPS public relations office in New York manages information distributed to the global media that is of interest to the public. Continually improving ISAPS' visibility through social media and the press is important as patients seek surgeons for their procedures. This is a high priority in our efforts to improve patient safety.
- ***National Secretaries*** – our 82 National Secretaries are a family within the ISAPS structure that works together to manage our operations in their respective countries. They organize our courses, generate interest in membership, distribute information, and work together on issues of importance to the organization, our members and their patients. They are the backbone of ISAPS and they are both critical to our organization and appreciated for their enthusiasm and quiet hard work.
- ***ISAPS.ORG*** – a significant recent achievement, the revision of our website, including patient information in ten languages, has enhanced our image while making navigation more logical and information contained on the site much more comprehensive. We are constantly improving and updating information and infrastructure through our new website design team partners at Etna Interactive.
- ***Membership Application Process*** – with the help of the Membership Committee and National Secretaries, we have significantly improved and simplified the on-line application to make it less time consuming for new members to join ISAPS. This has required substantial reprogramming of this area of our website. The result has been the addition of, on average, 40 new members per month—on a monthly basis.

Education Programs

- ***Congresses*** – these expanded educational and social experiences held every two years are attended by surgeons from over 75 countries and are always applauded for their excellence. The most recent Congress in Rio de Janeiro was applauded as our best one yet by many who attended.
- ***ISAPS Courses and Symposia*** – organized locally and taught by world class faculty, ISAPS education programs are intended to offer education in smaller countries whose members may not be able to travel to our larger meetings. Twenty-eight programs in this category were produced in the last two years.
- ***Visiting Professor Program*** – Thirty-four members constitute our Visiting Professor group. They provide intimate, short-term training programs for residents and students around the world. This program is available through any National Secretary.
- ***Endorsed programs*** – ISAPS offers our endorsement to educational programs organized by national societies, with our local National Secretary's approval, provided that they meet our strict criteria for educational excellence.
- ***Fellowship endorsement*** – formal fellowship training programs can be endorsed by ISAPS. A list of these endorsed programs along with more informal fellowships offered by ISAPS members in their practice or clinic is on the ISAPS website at www.isaps.org/medical-professionals/fellowship-programs Contact the Executive Office to add a fellowship to this list or to request an endorsement application.

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Achievements, *continued from page 5*

Publications

- ***Journal*** – our 44-year-old, indexed journal, *Aesthetic Plastic Surgery,* is receiving more submissions than ever before. Our Editor-in-Chief has expanded the scope and reach of this important publication. We encourage members to submit manuscripts.
- ***Journal app*** – ajax is our newest member benefit providing easy access to our journal and newsletter on an iPad, iPhone, Android or Desktop.
- ***Newsletter*** – our more informal publication, *ISAPS News,* is growing in popularity and is available for anyone to read on our website. The "Global Perspectives" series featured in each issue offers members an opportunity to write a short, non-academic article about trends and procedures on a specific topic in each issue. All members are encouraged to submit material for the newsletter. Access the on-line version including previous issues at www.isaps.org/medical-professionals/newsletter

Relationships with Other Organizations

- ***ISAPS-LEAP Surgical Relief Teams©*** – our humanitarian program, managed in collaboration with The LEAP Foundation, is intended to send members and others to help in the aftermath of major natural disasters. Currently, an intensive program is underway to help seriously injured Syrian refugees in Jordan. The response by volunteers and donors who want to help has been outstanding. Updates on the progress of this program are published in every issue of I*SAPS News.* For more information, to volunteer, or to donate funds, materials, equipment, or even frequent flyer miles, contact ryansnyderthompson@leap-foundation.org
- ***American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASFI)*** – our long-standing relationship with AAAASFI promotes patient safety by encouraging our members to proceed with the accreditation of their clinics according to international standards. "Quad-A" trains ISAPS members to serve as inspectors so that the review of clinics is carried out by peers.
- ***Relationships with Aesthetic Societies*** – ISAPS seeks to establish and maintain ongoing relationships with all international aesthetic societies.

Member Benefits

- ***ISAPS Insurance*** – this unique, private insurance is only available to ISAPS members. Purchased by the surgeon at very low cost on a case-by-case basis, this program offers patients the assurance that if any revision of their surgery is necessary within two years, it will be paid by the surgeon's insurance. The member decides which patients he wishes to insure once a month, after the surgery is completed. Members should consider this an enhancement to their marketing as those registered are indicated on the website with a special icon. Patients can also search for those members offering this insurance with one click on the website **"Find a Surgeon"** page.
- ***Fast Track Admission*** – a limited program for national societies to easily and quickly admit their members into ISAPS has been developed in the last few years to make the process easier for those who wish to join. National Secretaries should request information from the Executive Office.
- ***Member Plaques*** – as requested, ISAPS now offers for sale distinguished plaques to be displayed in members' waiting rooms that indicate their ISAPS membership to their patients. To order either a gold or silver plaque, simply click on the link on the home page of the members area to download an order form.
- ***ISAPS Logo Lab Coats and Scrubs*** – High-quality lab coats and scrubs with the ISAPS logo can also be ordered from the home page of the www.isaps.org **Member Area** members.isaps.org/members-area-home.html

ISAPS continues to enhance our member benefits and improve programs to make membership in ISAPS both cost effective and universally appealing to qualified plastic surgeons. If you are not a member, consider joining us.

Members, order a plaque for your office. Forms are in the **Member Area** of the website.

SIX FUNDAMENTALS OF BREAST IMPLANT-ASSOCIATED ANAPLASTIC LARGE CELL LYMPHOMA (BI-ALCL)

Mark W. Clemens, MD – United States

In January 2011, the US Food and Drug Administration (FDA) released a statement that women with breast implants "may have a very small but increased risk of developing" Breast Implant-Associated Anaplastic Large Cell Lymphoma (BI-ALCL). This has understandably created concern among the plastic surgery community as well as among the patients we treat. However, the FDA confirms that breast implants are still safe devices. Additional research is critical to identify who is at risk of developing BI-ALCL, characterize the early signs and symptoms of the disease, and determine why this rare event occurs in the first place. Physicians must be aware of this new disease to ensure that patients are treated appropriately and in a timely manner. The following summary of questions and answers are some of the basics of BI-ALCL and represent a common starting point to facilitate a much-needed discussion in our plastic surgery community.

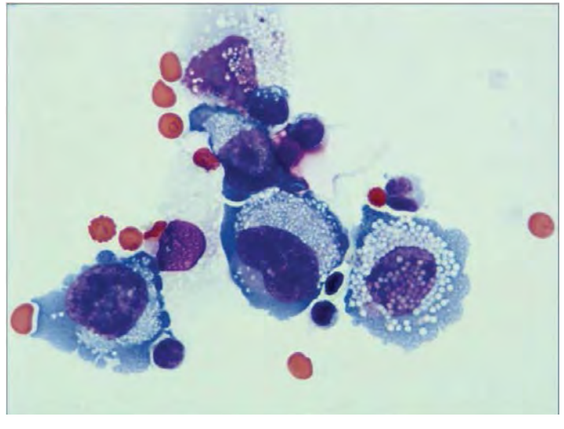

Figure: Breast Implant-Associated Anaplastic Large Cell Lymphoma with characteristic morphology.

1. What is Breast Implant-Associated Anaplastic Large Cell Lymphoma (BI-ALCL)?

This is a rare form of lymphoma which is a cancer of the immune system. Some unique technical characteristics include that it is most commonly a purely T-cell lymphoma, does not have an ALK gene translocation (ALK -), and is CD30 receptor protein positive on immunohistochemistry. There is roughly an even number of cosmetic versus reconstructive patients and saline versus silicone implants involved with a few reported polyurethane shells as well; however, the majority of known devices occur in textured implants.

2. How common is BI-ALCL?

There are an estimated 10 to 11 million women worldwide with breast implants. While total numbers vary in the literature, 93 distinct cases have been reported and our institution recognizes 117 cases of pathologically confirmed BI-ALCL to date from twelve countries worldwide. The only epidemiological study demonstrating an association estimated an incidence of 1 in 300,000. However, determining the true incidence will be dependent upon improved physician awareness and reporting as well as formal disease recognition.

3. How would I know if I had a case of BI-ALCL?

Patients receiving an implant should be aware of common presenting symptoms such as a spontaneous seroma after one year from implantation. Although common causes of a delayed seroma are infection or trauma, suspicious effusions should receive a fine needle aspiration sent for pathologic review. For the treating physician, it is critical to include a clinical history and to direct the pathologist to "rule out BI-ALCL." Ultrasound is an acceptable screening tool for the two-thirds of patients presenting with an effusion or the one-third with a mass. A complete physical examination will help detect the one in eight cases that present with lymphadenopathy. Ideally, the diagnosis should be made prior to a trip to the operating room.

4. How would I treat BI-ALCL?

Definitive treatment for most patients is removal of the implants and total capsulectomy. The role for further adjunctive therapy such as chemotherapy and radiation for unresectable tumors or positive margins is the subject of ongoing research.

5. What is the prognosis of patients who are diagnosed with BI-ALCL?

The disease course is commonly indolent and the majority of patients do very well with rare recurrence if appropriately treated. Presence of a mass has a slightly higher but significant disease recurrence and progression.

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AN UNFORGETTABLE EXPERIENCE IN BIRMINGHAM

Raul Gonzalez, MD – Brazil

When I saw through the window Dr. Luis Vasconez stepping down from his SUV, with a huge smile, waving his hands, and coming to meet me, I was sure that I came to the right place. I was in the waiting area of door A1 of the Hartsfield-Jackson Atlanta Airport, the world's busiest airport, after a long night flight coming from São Paulo, Brazil. I had just arrived. Dr. Vasconez very kindly came from Birmingham having his resident, Dr. Boneti, as driver to pick me up and take me to Birmingham. I was there to visit the Division of Plastic Surgery of the University of Alabama Birmingham (UAB) as part of the ISAPS Visiting Professor Program (VPP). My wife Marlene was with me.

After I had received the honor to have been invited by Dr. Renato Saltz to be part of the ISAPS VPP, I immediately decided to visit the USA. The reason was clear in my mind: America is the most important country in the world in science, research and education in our specialty. American surgeons have been the world leaders in most of our subspecialties, but at the same time there is a gap between their superb education and the knowledge of buttocks aesthetic surgery. ASAPS and ASPS have been very attentive to the increasing demand of buttocks remodeling by American women and have opened a wide space in their meetings for this subject, including both courses and panels. Their efforts have not been in vain; the American surgeons are now aware of the positive future of this new subspecialty and seeing buttocks surgery with new eyes. However, there is still some confusion in the different techniques and procedures available—which are good, which are bad and the indications.

Dr. Gonzalez, center in scrubs, with Dr. Jorge de la Torre on his right and Dr. Louis Vasconez on his left surrounded by UAB residents and staff.

I have had a passionate involvement with the buttocks aesthetic over the last 30 years, working with buttocks implants, fat grafting, gluteal lifting and reconstruction in this area. To have an opportunity to share my experience with an American training service was part of my dream, and it could be a fruitful collaboration. The residents will be working in their own practices in the near future and the staff will be there teaching the next residents. Obviously it would be just a small evolution, but surely the training service can spread infinitely the knowledge in the country, but . . . where to go? How to be invited by a training service? I definitely went to the name of Dr. Vasconez. He has a very open mind, is a good friend and surely will understand the purpose of my visit. And so I did. I sent him an email explaining my project and he did the rest.

Dr. Vasconez woke up at four in the morning to arrive in time to meet us at the airport. Few people do this, mainly having another more comfortable option. He convinced me to do the final part of my travel, from Atlanta to Birmingham, by car. He said that it would be a unique opportunity to chat, and my wife and I enjoyed the Georgia and Alabama landscape. He was correct! The two-hour drive along the I-20 highway was a nice and unforgettable ride. Dr. Vasconez is that kind of gentleman—definitely is a good-humored conversationalist. The time was not enough to enjoy his company. In the meantime, we caught up on the program they had prepared while we appreciated the wonderful green and flat landscape. When we crossed the Alabama border, we were able to see the legendary Talledega Superspeedway from the road. After that, a stop for a cup of coffee and Birmingham appeared on the horizon. Unforgettable!

The UAB has an incredible medical structure. The modern complex with several buildings has more than 1,000-bed facility that serves approximately 35,000 patients annually. The Plastic Surgery division occupies an entire floor with offices, administration facility, meeting space and modern library. Several residents receive here a high-level education and practice training. On the first day, I had the opportunity to chat with the residents, talking about the current panorama of buttocks aesthetic surgery while also getting to know them better.

The program, prepared by Dr. Jorge de la Torre, director of the Division of Plastic Surgery of UAB and Dr. Vasconez, former director and now vice director, was full of didactic activity. The next day, very early in the morning, I met the residents to have breakfast together before we went to the anatomy laboratory where we dissected a fresh cadaver. The gluteal anatomy was thoroughly explained while performing buttocks implants on the cadaver, step by step. Surely, to beginners there is no a better way to understand the procedure as the anatomical planes can be opened to see the exact location of the intramuscular plane and how to produce a sandwich with the muscle to envelop the implant. After lunch in the library, we continued with several lectures to the residents and all the staff. Gluteal retractions, implants, lifting, classification of ptosis, fat grafting and MWL patients were all part of our program. Questions were managed in a very friendly environment. That evening, Dr. de la Torre received us in the elegant Birmingham Country Club for a dinner of local cuisine.

The program over the next two days couldn't have been better. Drs. Vasconez and de la Torre prepared a symposium with several distinguished surgeons from different parts of the country presenting outstanding lectures. Dr. Henry Vasconez, President of the Southeastern Society of Plastic Surgery, Dr. Felmont Eaves from Atlanta and his wife and many other colleagues were present bringing a special shine to the event.

When I left Birmingham, I was gratified. I shared my experience, I learned a lot, I spent three days with young surgeons looking for knowledge and most importantly I was leaving with the feeling of a mission accomplished: I think I left at the UAB a seed for the future. Dr. Luis Vasconez, Dr. Henry Vasconez, my wife and I, left Birmingham to spend the rest of the Labor Day holiday at the Vasconez country house in Dalonega, Georgia, with his charming wife Diane, his daughters, sons-in-law, and granddaughters. It was a weekend to celebrate the friendship and the hospitality of the Vasconez family. We had good food and exceptional wines enjoying the nature of Georgia.

The ISAPS Visiting Professor Program has an extraordinary vision of how important education is for the future of aesthetic surgery. To teach residents and the staff of a training service is ideal to pave the way for a new procedure, solidifying the foundation for the future. Thank you Dr. Vasconez, Dr. de la Torre, and all the residents and faculty at the UAB for the kindness and hospitality we received. Thank you ISAPS for the opportunity.

Clemens, *continued from page 7*

6. Where can I find out additional information and what can I do to help?

A number of credible online resources are available such as FDA recommendations which are posted on the www.fda.gov website. Physician and patient resources can be found on the MD Anderson Cancer Center website to introduce patients to a supportive community where they may receive insights and potential leads on developing therapies.

Most importantly, physicians with confirmed cases have a responsibility to report and share their cases with our national societies as information gathered from every single case brings us closer to a cure.

A recent anonymous survey generated by ASAPS was sent out to all ISAPS members around the world, and surgeons are strongly encouraged to participate to generate much needed epidemiologic data. Confirmed cases should be submitted to the PROFILE patient registry, a collaboration between the Plastic Surgery Foundation and the FDA. To submit a case to PROFILE, please visit www.thepsf.org/profile. One of our patients stressed the importance of the registry, remarking in a letter: "It is imperative that my name be included in the FDA's registry. I have suffered much from having ALCL and most especially for receiving the wrong treatment and misdiagnosis. I do not wish anyone else to have to face this. If I can not be counted, then was it all in vain?"

Contributions by a plastic surgeon who encounters a BI-ALCL patient may seem minor, but the return to our global understanding is immense. Surgeons may feel they have little data to proceed on, but the reality is they can participate in a larger network of people who have information on, and experience with, BI-ALCL. Now that is a discussion worth joining.

If you have not yet responded to the current **ASAPS survey on incidence of ALCL,** please go to this link. If you have NOT seen a case, there are only two questions. If you HAVE seen one or more cases, more information is requested.
https://www.surveymonkey.com/s/ISAPSalcl

Dr. Clemens is an Assistant Professor of Plastic Surgery at MD Anderson Cancer Center in Houston, TX, leads a multidisciplinary research team and tissue repository for BI-ALCL, and was a participant in the 2014 RAND Corp. panel on the disease.
mwclemens@mdanderson.org

A MESSAGE FROM THE EDUCATION COUNCIL CHAIR

Lina Triana, MD – Colombia

As we all know, our primary ISAPS mission is aesthetic surgery education worldwide. With this in mind, we can say that in the past four years under EC Chair Dr. Nazim Cerkes our mission was fully achieved. Today, our leadership has assigned me the huge task of being the new EC Chair which I accept with great honor. I am a true ISAPS servant and nothing gives me more energy than great challenges, especially when they involve our beloved ISAPS.

For the next two years, our Education Council has an important mandate: to continue producing high quality courses and symposia worldwide. None of these ISAPS programs can be produced without the help of our National Secretaries who are our ISAPS ambassadors in their own countries. They are the keystones for organizing these programs and must work hand in hand with the EC. Thank you to these ISAPS servants, our National Secretaries team. Your colleagues need you in this task of delivering high quality education in your countries.

The world is constantly changing and plastic surgery is no exception. Today our plastic surgery practice has evolved to include not only surgical procedures. In our last ISAPS survey, we can see that plastic surgery today involves surgical as well as non-surgical aesthetic procedures. In today´s world, when our specialty shares competencies with other core specialists, we can no longer try to cover the sun with our hands. We need to follow this evolution and become the leaders in aesthetic procedures.

Having this in mind, and with the guidance of our president, Dr. Takayanagi, and our ISAPS Board of Directors, we are building a strategic plan together with all the Education Council team to become points of reference for all core specialists. Who better than us to be the leaders? Our specialty truly includes all aesthetic surgical and non-surgical procedures of the face and body. This is why we must expect some changes in our education programs. We will start to include core specialties as faculty, endorse multispecialty non-commercial meetings where only core specialties are included, and work toward having Aesthetic Medicine meetings worldwide.

If our true mission is aesthetic education worldwide, then we need to educate our peers and be the primary reference for them in Aesthetic Medicine procedures. We have organized a great Education Council team, including ISAPS members from all over the world, who will make possible our EC plan. The EC team, with the National Secretaries and ISAPS Board of Directors, is developing a plan to continue with today´s aesthetic trends in our specialty. We hope all of you will support us in our expanded mission.

Please contact me, Catherine Foss, our Executive Director, or your country's National Secretary if you would like to help us organize an ISAPS education program in your country. ISAPS counts on you to maintain the ISAPS mission of education worldwide.

ISAPS COURSE IN BALI, INDONESIA

Another successful ISAPS Course was held in Bali, Indonesia on October 18 and 19 with more than one hundred plastic surgeons attending from fourteen countries. If we consider the economic conditions in Indonesia, and that the country has fewer than two hundred plastic surgeons, we can be especially proud of the outcome of this particular course.

There was great interest in the scientific sessions and many questions were directed to the speakers during discussions. Teddy Prasetyono and the local organizers were most hospitable in a venue that was just perfect, including an opportunity to visit this beautiful island.

New ISAPS President, Susumu Takayanagi, was part of the faculty along with Joao Erfon Ramos (Brazil), Vakis Kontoes (Greece), Tsai Ming Lin (Taiwan), Frank Lista (Canada), Jae Woo Park (Korea), Teddy O. H. Prasetyono (Indonesia), Lee Pu (USA), Graeme Southwick (Australia), Luiz Toledo (UAE), Pedro Vidal (Chile), Woffles Wu (Singapore), and Chang Chien Yang (Taiwan). We thank them all for their time, their expertise, and their willingness to participate as members of our faculty.

This was the last course planned by our Education Council Chair of the last four years, Nazim Cerkes. We are indebted to him for setting very high standards for the level of education and organization of the many courses ISAPS produced under his fine leadership.

WELCOME TO KYOTO IN THE AUTUMN OF 2016

Susumu Takayanagi, MD – Japan

ISAPS President

In inviting you to the Biennial Congress in Kyoto in the autumn of 2016, we are pleased to announce that Japan is a very safe country. "Safety" is one of the biggest virtues of Japan. Japanese are known for their high level of morality. In particular, this could be observed around the world when a massive earthquake hit this country about three and a half years ago. The big earthquake caused chaos with the traffic in Tokyo. People did not push or yell at each other, but were patient and behaved in an orderly manner. This behavior surprised journalists overseas and received great acclaim. In fact, it is often said that if you lose your wallet in Japan, someone will turn it in to the police and, moreover, the cash and credit cards will also be returned without being used. Please do not try it because your wallet does not always return to you. The only problem that you may face is English. Japanese are good at reading and writing in English, but they hesitate to speak in English. If you speak simple English slowly, most Japanese people will understand it.

The best way to come to Kyoto is to fly to Osaka's Kansai airport and take the train to come to Kyoto which takes one and a half hours. However, if you come to Kyoto from Tokyo, it only takes two hours by bullet train called Shinkansen "Nozomi." If you sit by the window on the right side facing the direction you are travelling, you will see Mount Fuji on your right approximately 40 minutes after you leave Tokyo. There are many rice fields and almost no tall buildings in that area so that you can

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Past presidents visit Kyoto

Bryan Mendelson at Komyoin Temple.

Tom Biggs, his wife Katherine and her twin sister in Heian Shrine near the convention center for ISAPS 2016 Kyoto.

In one of the Japanese Restaurants of Kyoto, João Sampaio Góes and his son with Maiko.

Tom Biggs, his wife, her sister, and Misako Takayanagi at the Golden Temple in Kyoto

A MESSAGE FROM THE CHAIR OF NATIONAL SECRETARIES

Peter Scott, MD – South Africa

Greetings to all National Secretaries from South Africa. At the National Secretaries meeting held during the recent 22nd Congress of ISAPS in Rio de Janeiro, Brazil, I was elected as Chair of National Secretaries, a post that I will hold for the next two years. Thank you for your votes and confidence in me.

At this Congress, I made wonderful new friends and rekindled old friendships. I attempted to meet with as many of the National Secretaries as possible and for those of you who did not attend the meeting and those with whom I have not yet chatted personally, I hope to rectify that problem in one of the next meetings or courses.

My thanks go to Gianluca Campiglio for his two-year term as Chair of National Secretaries and his seamless handover of the duties to me. I am delighted that he is still on the Board of ISAPS and is always available for consultation.

David Park from South Korea was elected as my Assistant Chair and he and I have already met to plan the way forward in the next two-year term. We are in close communication and I would encourage National Secretaries to copy David in their communications to me as we will be working as a team.

We have inherited a transparent, democratic National Secretary election process that was initiated by Gianluca and Catherine and her staff. This worked very well in the South African election and I would encourage you to embrace this process.

In addition to the National Secretaries meeting, I also participated in the Board meeting, the Membership Committee meetings, and the Education Council meetings. Ivar van Heijningen has done a wonderful job in streamlining the membership application process and it is our wish that whenever possible, a member of the ISAPS administrative staff will be available to facilitate on-line applications at many more ISAPS meetings. Certain countries have a fairly low membership percentage compared to the total number of plastic surgeons in their region and this is something that David will be looking into.

In my short time in office, I have enjoyed the rapid communication that happens between the members of the Board and we are able to problem-solve efficiently without having to wait for Board meetings.

I have an open-door policy and I would encourage any complaints, problems or compliments to be reported to myself or David so we can pass them on and discuss them with the Board. One of my pathology colleagues asked me what the duties of the Chair of National Secretaries is and after explaining to him carefully he said, "Oh, you are a Shop Steward" and I would like you to think of us as your liaison between yourselves and the Board of ISAPS.

The Education Council will explain the new regional divisions that will attempt to align similar regions, avoid duplicating Instructional Courses in countries close to each other, and possibly introduce different levels of Courses depending on the requirements of the country, always doing this in consultation with the National Secretary of that country.

David and I look forward to serving you for the next two years.

New National Secretaries

We welcome newly elected National Secretaries:

Chinese Taipei	Chien-Tzung Chen, MD
Colombia	Maria Isabel Cardena Rios, MD
France	Michel Rouif, MD – *Assistant NS*
Germany	Joachim Graf von Finckenstein, MD *Assistant NS*
Greece	Panagiotis Mantalos, MD, PhD
Iran	Kamran As'adi, MD
Italy	Giovanni Botti, MD
Japan	Hiroyuki Ohjimi, MD
Japan	Kunihiko Nohira, MD – *Assistant NS*
New Zealand	Murray Beagley, MD
Peru	Otto Ziegler, MD
Philippines	Rene Valerio, MD
Poland	Janusz Sirek, MD, PhD
Qatar	Habib Saied Al-Basti, MD
Slovenia	Tomaz Janezic, MD
South Africa	Ewa Siolo, MD – *Assistant NS*
Thailand	Kamol Wattanakrai, MD, FACS
Tunisia	Atef Maherzi, MD
UAE	Luiz Sergio Toledo, MD
Ukraine	Pavlo Denyshchuk, MD
USA	Nina Naidu, MD, FACS – *Assistant NS*
USA	W. Grant Stevens, MD – *Assistant NS*
Uruguay	Oscar Jacobo, MD
Venezuela	Gabriel Obayi Tahan, MD

COMMITTEE REPORT: ISAPS PATIENT SAFETY UPDATE

Michael C. Edwards, MD, FACS – United States

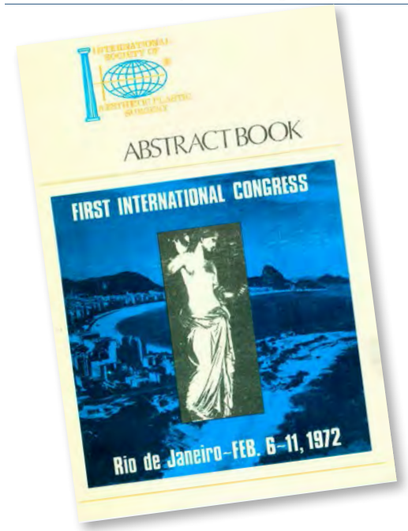
Patient Safety is a world-wide issue with medical tourism and poorly trained providers preying on patients. Many times, ISAPS member surgeons are tasked with dealing with the complications that result from these encounters. ISAPS introduced the patient safety diamond as a means of highlighting the importance of the patient and their general health, the procedure(s) chosen, the importance of the aesthetic plastic surgeon chosen, and the facility where the operation will be performed. A brochure has been created for member surgeons to educate our patients and guidelines are outlined on our website, www.isaps.org. These are very helpful and our committee will review content and presentation and make suggested changes to the board as appropriate.

The ISAPS Patient Safety Committee met in Rio in September to review our current status and to discuss new ideas that should be focused on in an effort to improve the education of member surgeons and to the worldwide public. We will be reaching out to the 82 National Secretaries in a survey to determine what requirements and challenges exist in their region. We will determine what requirements, if any, exist in terms of facility accreditation, governmental reporting and malpractice coverage. Through AAAASFI more member surgeons are stepping up and having their surgical facilities inspected and accredited in an attempt to ensure their patients they believe a safe surgical environment is important. Equally important is the education of the public. ISAPS has stepped up a social media presence and we expect this will continue. We need to assist our members on how to roll out this educational process in their region knowing needs are different globally. Through our worldwide educational meetings we will also help develop patient safety panels where standards of care can be discussed openly. There should be a patient safety component to each educational presentation. We also propose considering updating our educational process with the phrase: An ISAPS Surgeon is a Safe Surgeon.

Your ideas are welcome and participation in patient safety education is not limited to this committee. Please forward best practices and ideas as well as concerns to my attention:
dredwards@plasticsurgeryvegas.com

ORIGINAL ISAPS CONGRESS ABSTRACT BOOK FOUND

Cristino Suárez López de Vergara – Spain



A rare book was found by Dr. Miguel Chamosa Martin from Madrid, Spain when he was looking for something around old furniture at an antique shop. Suddenly, he saw a discarded book on some shelves, which turned out to be the *Abstract Book of the First ISAPS Congress* held in Rio de Janeiro on February 6-11, 1972.

While I was spending a week at Miguel's home last June, he showed it to me. I was surprised to see this jewel with works from the fathers of plastic surgery. Miguel was so impressed by my reaction that he decided to give it to me as a present. Keeping the book for myself would have been very selfish of me, so I have decided to share it with the International Society of Aesthetic Plastic Surgery.

This is one way to honor my friend and mentor Dr. Ulrich Hinderer whose important contribution to ISAPS has helped us get where we are now.

To see this publication, go to www.isaps.org. Click on **Medical Professionals** in the menu at the top of the home page; then click on **ISAPS History** in the menu. There is a link to the 70-page program book on the **Summary** page.

Kyoto, *continued from page 11*

see Mount Fuji in its entirety. For approximately nine minutes, after the Shinkansen passes the Fuji River until it enters a long tunnel, please enjoy the graceful Mount Fuji, which has been the subject of many works of art.

Now, let me speak about Kyoto, the most famous tourist spot in Japan—the place where I grew up. More than a thousand years ago, there were no samurai (warriors) and Japan was a society controlled by aristocrats centered around the emperor. Kyoto was the capital at that time. The most famous work of classical literature in Japan, the *Genji-Monogatari* (Tale of Genji) depicted court life in those days. The hero, Hikaru Genji, was praised by the author, Murasaki Shikibu, as a perfect nobleman. In the story, however, he took advantage of his father, the emperor, who adored him and seduced women right and left. He could not stop loving the empress and kidnapped a beautiful girl who looked like the empress, while being afraid of the crime of betraying his father. He drove a young man crazy and to death because the young man cheated with Genji's young wife, whom Genji married after he reached his prosperity. He seems to be a very controversial person. It makes the story very exciting, very human, and full of love-hate drama. Famous scenes from this story have been depicted in many paintings. You can see Genji and his mistresses, who are in colorful twelve-layered kimonos with shining straight hair long enough to hang from their head to their ankles in paintings at many art museums. After the samurai took control of the real political power in Japan in place of the aristocrats, the Japanese emperor continued living in Kyoto with the aristocrats until approximately 150 years ago. Therefore, the graceful aristocratic culture represented by the *Tale of Genji* continued to be upheld. You can find this cultured atmosphere in Japanese fans, lipstick in seashells, and oil blotting papers that are popular souvenirs of Kyoto.

At this time, I recommend that you visit Heian Shrine, which is only a few minutes' walk from the congress venue. The vermillion-lacquered building backed by a clear autumn sky is beautiful and very photogenic. The extensive gardens surrounding the shrine pavilion are divided into four areas: east, center, west, and south. This is the best place to walk and relax. There are two great art museums in the neighborhood.

If this is your first visit to Kyoto, I recommend that you visit the two most famous temples: **Kiyomizu-dera** temple and **Kinkakuji** (Golden Temple). There is also the **Fushimi Inari Shrine**, which is has recently been rapidly gaining in popularity.

Kiyomizu-dera temple: There is a saying in Japanese, "as if jumping from the stage of Kiyomizu." This phrase is used to prepare for and take drastic action. This "stage" was built on a cliff at the height of approximately 13m with horizontal and vertical crossed columns. It provides a panoramic view of Kyoto. Part of Kiyomizu-dera temple was used for the poster of the current ISAPS Kyoto Congress.

Kinkakuji (Golden Temple): It is fancy and luxurious. Its exterior wall is covered with gold leaves. The true beauty of this temple is in the view of the beautiful mountains behind the temple, with the golden temple reflected on the surface of the pond. This is a symbol exhibiting the power of the highest man of the day; however, it is also a structure built based on an elaborate calculation placing the most importance on harmony with its surroundings. Kinkakuji was set on fire by a trainee monk and burned down in 1950, then rebuilt five years later. A dramatic novel written by Yukio Mishima based on this arson case increased the magnificent image of Kinkakuji. The gold leaves on the exterior wall were placed thicker than before after additional construction.

Fushimi Inari Shrine: To be honest, I have never been here; however, I was surprised to learn that this is the most popular place among tourists from overseas. One of my friends told me that there are many gorgeous things to see, including the famous "Senbon Torii," where thousands of torii gates stand and to form something like a tunnel. I am sure that you will be very impressed.

When you are hungry after walking and sightseeing, you can enjoy Japanese cuisine in Kyoto at famous and luxurious restaurants where key government and business leaders go to eat, but there are also many inexpensive and delicious places for college students because Kyoto is also a town of universities and colleges. You can find many popular cafes for students, ramen (noodle) shops where taxi drivers (who know the good places) line up for lunch and dinner, and other places around Kyoto University—my old school. People in Japan are considered to be closed or shy to outsiders; however, they are very kind to all the people including tourists.

Kyoto and its people welcome visitors pleasantly. I hope when you come to the 2016 Congress, you will make time to see the best of Kyoto, my hometown.

EXTREME BODY MODIFICATION: TOO MUCH OF A NOT GOOD THING

David B. Sarwer, PhD – United States

Professor of Psychology, Departments of Psychiatry and Surgery
Consultant, The Edwin and Fannie Gray Hall Center for Human Appearance
Perelman School of Medicine, University of Pennsylvania

There is a good chance that you have heard the name Valeria Lukyanova. Depending on the story you heard or the article you read, you likely recall that she is a twenty-something woman from Ukraine who looks like a Barbie doll. Some websites and articles have indicated that she uses make-up and clothing to resemble the doll; others believe that her look is the result of excessive diet and exercise. Still others claim that she has undergone a number of cosmetic procedures to achieve her look. The truth probably lies somewhere between the webpages and the video clips.

Ms. Lukyanova is not the only one who has modified her appearance in one way or another to look like someone else. There's also Justin Jedlica who, again, based on information found on the Internet, has reportedly undergone over 100 cosmetic procedures to look like a Ken doll, Barbie's long lost boyfriend. And, guess what? According to an article in GQ magazine in April 2014, the real life Barbie and the real life Ken have met www.gq.com/women/photos/201404/valeria-lukyanova-human-barbie-doll. Unfortunately, according to the article, their meeting did not end with Ken driving Barbie's pink convertible off into a Malibu Barbie sunset.

Source: GQ.com

Ms. Lukyanova and Mr. Jedlica are just two of the most recent examples of individuals who have used aesthetic procedures, likely along with other non-invasive appearance enhancements or treatments, to dramatically change their looks. As a society, we are fascinated by the concept of the dramatic appearance makeover. It has been a theme of stories, books, television programs and movies for decades. Approximately ten years ago in the United States there were at least three "reality based" television programs dedicated to the topic—"The Swan," "Extreme Makeover" and "I Want a Famous Face." Some of these shows may still be on television in other parts of the world.

These depictions of extreme body modification are far removed from the day-to-day practice of most physicians who offer aesthetic treatments. Most patients who present for aesthetic procedures report a heightened dissatisfaction with a specific feature of their appearance. The statistical data from most of the major international societies suggest that most patients request a single procedure and less than half return for a second procedure at some point in time in the future. Relatively few patients present to a surgeon and state "You are the beauty expert, fix me!" and request the extreme makeovers that make for engaging television watching or reading.

From a psychological perspective, patients who present with an increased degree of body image dissatisfaction focused on a single appearance feature are likely psychologically appropriate for a given procedure. This is in contrast to patients who present with extreme degrees of body image dissatisfaction and are focused, if not preoccupied, with one or more concerns about their appearance. Intense dissatisfaction, particularly if coupled with obsessive thinking and interruption of daily activity (such as maintaining a job or romantic relationship) can be suggestive of a number of psychiatric conditions, including body dysmorphic disorder. It also can be suggestive of other forms of severe psychopathology with a delusional component.

At the same time, motivations for multiple procedures can be suggestive of psychological inappropriateness for treatment. Patients should be intrinsically motivated for an aesthetic treatment and present with a desire that that treatment will help them feel better about the skin they are in. Patients should not be motivated by some potential "secondary gain"—such as a new romantic relationship or employment opportunity. Similarly, patients should have reasonable expectations about the impact a change in their appearance will have on their daily lives. Studies suggest that the vast majority of patients are satisfied with the results of cosmetic procedures, would do them again and recommend them to others. Patients also report improvements in their body image. However, there is little evidence to suggest that undergoing a cosmetic procedure leads to dramatic improvements in psychosocial functioning, employment or financial status.

The more one reads about Ms. Lukyanova, the more confused one becomes. It is hard to figure out what is real and what is not. Nevertheless, her story, as well as the stories of others like her, still leave readers with a negative reaction to extreme body modification as well as perhaps also a negative reaction to the health care professionals who partner with these individuals to produce these radical appearance transformations. Prospective patients may be turned off by these dramatic examples and view all physicians who offer these treatments with a healthy degree of cynicism—concerned that their request for a minimally invasive, anti-aging treatment will be "upsold" into a total appearance makeover.

Cases of extreme aesthetic surgery bring a black cloud over the field of aesthetic surgery—no differently than individuals who charge thousands of dollars for non-evidence-based treatments for mental health issues bring a dark cloud over the fields of psychology and psychiatry. All of us who work in the field of aesthetic medicine need to work to educate patients about the reality of the specialty and make sure that their impressions are not colored by the extremes.

David B. Sarwer, PhD is a recognized authority on the psychological aspects of physical appearance and their relationship to both cosmetic and reconstructive treatments. His work in this area over the past two decades has been published in peer reviewed journals covering plastic surgery, dermatology and psychology. He has co-edited two books: Psychological Aspects of Reconstructive and Cosmetic Plastic Surgery *(Lippincott, Williams & Wilkins, 2006) and* Presurgical Psychological Screening *(American Psychological Association, 2013). He also serves as an Associate Editor for Body Image and Health Psychology and serves on the Editorial Board for Aesthetic Surgery Journal and Plastic and Reconstructive Surgery. We are pleased to have Dr. Sarwer as a regular contributor to* ISAPS News.

Guess Who!

See page 38 for details.

GLOBAL SURVEY OF AESTHETIC PROCEDURES

Leigh Hope Fountain – United States

ISAPS Public Relations Director

ISAPS recently released our first statistical data in two years. It was well-received by various top-tier international media outlets, many of which had been inquiring about this data for quite some time, as well as business organizations looking for our statistics due to their global financial implications.

While we did receive significant media coverage when the data was released this past summer, we missed out on a variety of additional media opportunities because we were only able to provide data for the ten countries that had a significant enough number of respondents to validate the data as statistically sound. This was unfortunate for a number of reasons:

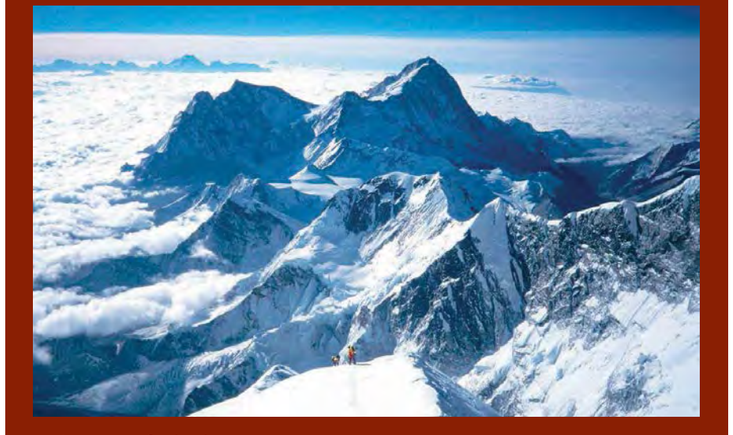
1. We are the only international society reporting on global data for aesthetic plastic surgery. Likewise, ISAPS has become the source where businesses and the media turn when they need this information. When we cannot deliver a truly "global" report that includes far more than figures for ten countries, it reflects poorly on us as a society and it decreases our survey's legitimacy.
2. The only way to improve the outcome of this annual survey, which in turn generates more awareness for ISAPS, is to insure significant participation. This year only 1567 surgeons participated. We want to triple that number next year so that we can report a minimum of twenty countries' statistical data.
3. This survey helps YOU as an individual member. The more awareness we generate for ISAPS, the more we drive traffic to the ISAPS site, which is where people seek out board-certified plastic surgeons around the world.

We need to have greater participation and are therefore refining the survey this year to be more comprehensive and more aligned with the ASAPS annual survey to better combine our data with theirs. We will be conducting another survey starting in January of 2015 and have already begun the process. Please help us make this endeavor a success. Your participation is truly valuable and we appreciate your dedication to the society. Together, we can insure that ISAPS remains the comprehensive resource for information that it has become in the global aesthetic community.

Thank you in advance for your participation and your help.

ISAPS

Where in the World?



See page 39 for details.

ISAPS INSURANCE IS THERE FOR YOU

Jose Carlos Parreira, MD – Portugal

Chair, ISAPS Insurance Committee

Patients agree on a price for their cosmetic surgery and then look forward to the results of their planned procedure. But, what if through no fault of the patient or the surgeon they need a revision. ISAPS insurance pays for the revision and frees the patient from the worry of raising additional money.

An ISAPS insurance committee has now been formed and it is the intention of the committee to listen and serve patients and surgeons alike to ascertain where we can improve and deliver even more peace of mind. To this end, we are going to work together as a team and that means not only the committee, but also with the surgeons who already benefit from using ISAPS insurance. If you are an ISAPS member surgeon and you are interested in hearing about another surgeon's experience with this program, please contact Stephanie King by email Stephanie@isapsinsurance.com or by telephone +44 374 4022 (UK). Stephanie will put you in touch with a surgeon who can discuss their own experiences of insuring patients including how easy it is to file a claim.

Information on the ISAPS insurance is available at www.isapsinsurance.com. There is no fee to join and you may apply to be added at this website. There is also a surgeon directory to enable patients to see who is promoting ISAPS insurance. Likewise, those in the program have a small icon after their name on the ISAPS website. You can also select the list of current participants by checking the box in the **Find a Surgeon** page that says: **Show doctors who offer ISAPS Insurance.** We will be back soon with feedback from patients and surgeons.

You may also request contact details of an ISAPS member surgeon who is already using the ISAPS Insurance Program to ask their opinion of the cover and the service provided. ISAPS

ISAPS Insurance Committee

Dr. Jose Carlos Parreira, Portugal – *Chair*
Dr. Gianluca Campiglio, Italy
Dr. Wayne Perron, Canada
Alison Thornberry, UK – *Ex officio*

ISAPS Insurance is managed by our partners at Sure Insurance in London and is underwritten by certain underwriters at Lloyd's.

A personalized patient guarantee is created for each ISAPS member surgeon


ISAPS Insurance
Insurance for Aesthetic and Plastic Surgeons

Dr Andrea Margara

Gentile paziente

Il Suo chirurgo può offrirle una copertura assicurativa ISAPS (*International Society of Aesthetic Plastic Surgery*).

Si tratta di una copertura aggiuntiva che potrebbe rendersi necessaria dopo il Suo intervento. Copre gli eventi accidentali (fisiologici) che possono manifestarsi come complicanze di ogni intervento chirurgico.
Nella sfortunata evenienza che il Suo chirurgo (o un chirurgo membro dell' ISAPS nella sua nazione di residenza, qualora si fosse rivolto/a all'estero per le sue cure chirurgiche) diagnostichi una delle suddette complicanze, questa polizza coprirà le spese (fino al massimale concordato con la compagnia di assicurazione) per gli interventi correttivi da parte del Suo chirurgo o di un chirurgo membro dell' ISAPS nella sua nazione di residenza.

Questa garanzia copre i 2 anni successivi dalla data dell'intervento (escludendo i primi 28 giorni).

Il suo chirurgo è in grado di farle sottoscrivere questo tipo di polizza perché e membro dell' ISAPS, l' associazione di categoria che ha rigidi parametri di selezione e verifica delle credenziali, dell'esperienza e della formazione del chirurgo specialista in chirurgia plastica ricostruttiva ed estetica.

Visita il sito www.isapsinsurance.com per vedere la pagina del Suo chirurgo sul nostro sito. Se ha ulteriori domande su questo tipo di copertura la preghiamo di contattare la il call center della copertura assicurativa ISAPS al +44(0)2073744022 o di inviare una e mail a team@isapsinsurance.com

ISAPS Insurance is a partnership between ISAPS and Sure Insurance Services Ltd.
Sure Insurance Services Ltd is authorised and regulated by the Financial Conduct Authority.

Cost of Surgery $ € or £	Cost of Insurance $ € or £
2,000	120
3,000	180
4,000	240
5,000	300
6,000	360
7,000	420
8,000	480
9,000	540
10,000	600
11,000	660
12,000	720
13,000	780
14,000	840
15,000	900

Procedures Covered

Abdominioplasty	Genioplasty	Mammoplasty
Blepharoplasty	Facelift	Mastopexy
Brachioplasty	Fat Grafting	Male Pectoral
Breast Augmentation	Gluteoplasty	Implants
Calf Augmentation	Buttock Implants	Otoplasty
Cheek Augmentation	Gynecomastia	Rhinoplasty
Chin Augmentation	Liposuction	Thighlift
Mentoplasty	Labisplasty	

Congress, *continued from page 1*

We have never seen so enthusiastic a group of surgeons, especially the young residents seeking new horizons in plastic surgery and aesthetic medicine. Every meeting room was crowded from early in the morning to late in the afternoon. The Opening Ceremony lecture was presented by Prof. Ivo Pitanguy discussing his extensive scientific and professional life. The Ohmori Lecture was given by Prof. Ricardo Baroudi, Past President of ISAPS and one of the leaders in aesthetic surgery in the world – both renowned Brazilian professors who honored our Congress with their extraordinary lectures.

Our Scientific Program Committee, chaired by Jorge Herrera, did an exhaustive and wonderful job. They invited a distinguished faculty group of more than 375 surgeons from around the world and prepared a program including both facial and body contouring surgery. As the program was presented in two rooms simultaneously, this gave the opportunity to the attendees to select the subjects of most interest to them. We increased the time of discussions in the panels and round tables and selected moderators with great experience that really made the difference. Interactive sessions provided an opportunity for the audience to vote on questions raised by the moderators.

Surprisingly, we received 392 abstracts from which the program committee selected 240 Free Paper presentations. These abstracts were edited and included on a DVD that was distributed to all participants.

Two prizes were presented during the Congress. The Body Contouring Research Foundation award was given for the best two papers on clinical and research topics. The judging was supervised by Luiz Toledo. A new prize for the best paper on Ideas and Inovations was also awarded by three judges – all ISAPS Past Presidents – and chaired by Niveo Steffen. The winners are listed elsewhere in this issue of ISAPS News.

No Congress can be as successful as what we experienced in Rio without the support of the many aesthetic industries and companies that were present in our two exhibit halls. These spaces were full to capacity during every coffee break and lunch period. We owe our sincerest thanks and appreciation to these attentive and dedicated exhibitors, many of whom travelled from Europe, Asia and the United States to join us in Rio.

The social activities were a great success—and we know how difficult it is to entertain more than 2000 people. Our Local Arrangements Committee was headed by our dearest colleague Ruy Vieira, who passed away two months before the Congress, and Eduardo Sucupira, Arnaldo Miro and Luiz Heredia who organized such excellent parties. The Opening Ceremony, the Faculty Dinner, and the Presidential Dinner were all superb. My thanks to everyone involved in planning these events.

We need also to thank Catherine Foss, our Executive Director, and Carolina de Almeida Prado in São Paulo for their enthusiastic support. During more than two years, they and their staff members worked very hard to create one of the most beautiful meetings that ISAPS has organized in its 44 years. We didn't give this responsibility to any company or any meeting bureau to set up our Congress, but only to these two persons who under our Executive Committee's umbrella, created a successful Congress.

We thank the Brazilian Society of Plastic Surgery for their endorsement that was very important to our Congress to attract so many registrations from Brazil and South America. ISAPS realized an excellent profit in Rio from registrations and exhibitor support and this will certainly allow us to begin many new projects for our members' benefit. And be sure that ISAPS is prepared for the future to continue its long journey toward providing excellence in Aesthetic Education Worldwide.

In my name and that of my wife, Walderez, we would like to thank everyone who came to Rio and for your support during these two wonderful years. And we wish Susumu and Misako an outstanding next Presidential term.

With kind regards,

Carlos Uebel, MD, PhD
ISAPS Past President

NORTH AMERICA: UNITED STATES

Henry M. Spinelli, MD

I tell my residents and trainees at New York Presbyterian Hospital-Weill Cornell Medical Center and elsewhere that the learning curve for becoming facile in primary rhinoplasty is not steep but protracted. I was told by my mentors (Tom Rees, Donald Woodsmith, Joe McCarthy, and Calvin Johnson, to name just a few) that one needed to see a significant number and independently perform at least one hundred cases before one becomes comfortable with the virginal or primary rhinoplasty. In the case of secondary, tertiary and quaternary (etc.) cases, many of which I see, the requisite experience is likely significantly more.

However, it's the underlying endogenous anatomy and physiology of the nose which must be understood in order to apply the technical aspects in a reliable fashion and avoid some of the classic pitfalls of the procedure. Additionally, any good rhinoplasty surgeon must be able to perform functional nasal/airway surgery either concomitant with the aesthetic rhinoplasty or independently. Nasal septal and turbinate procedures as well as the understanding of the ramification must be fundamentally mastered and understood.

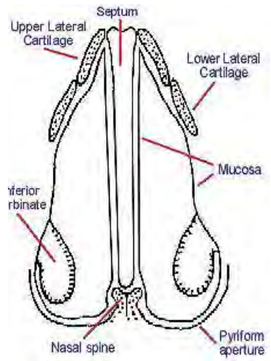
The competent rhinoplasty surgeon should also be facile in obtaining autogenous tissues including septal, rib and auricular cartilage, fascia and other structures for grafting into the nose. My earliest training and experience was with the closed rhinoplasty approach, followed by cartilage (especially lower lateral) delivery techniques and culminating in open rhinoplasty.

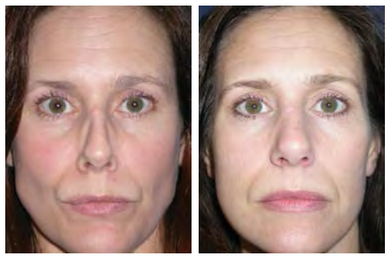
A question which frequently arises is how often do I utilize the open technique in our current practice and the answer is short of small revisional work which is usually performed in a closed fashion approximately 80-90% of my primary rhinoplasty cases are performed open with a transcolumella and rim degloving approach and almost 100% of my secondary, tertiary, quaternary and reconstructive cases are performed by way of an open technique.

Parenthetically, we should all seek to perform one good septo/rhinoplasty and the only ones we should be seeing are someone else's secondary, tertiary cases, etc. That being said, the first means of achieving this goal is in the choice of patients. Congruence of surgeon and patient in goals to be achieved in rhinoplasty are paramount and the convergence of form and function is paramount. There is no point in over resecting the upper or lower lateral cartilages even if a patient requests it. The airway will be compromised as a result and the appearance is less than ideal.

Keep in mind that it's been reported that 50% of patients are unhappy with their rhinoplasty. Since it is unlikely that 50% of rhinoplasty surgeons are incompetent, it is more likely that initial patient choice is the likely problem. Be wary of the older male rhinoplasty patient. The old adage attributed to Freud is that in the older male, the nose serves as a psychological substitute for another midline organ.

A typical primary rhinoplasty then is performed as an open procedure with generous degloving in order to clearly visualize





Inverted "V" deformity and internal nasal valve collapse after two previous rhinoplasties.

Post Operative internal nasal valve reconstruction with spreader grafts.

continued on page 29

MIDDLE EAST AND MEDITERRANEAN: TURKEY

Nazim Cerkes, MD

ISAPS 2nd Vice President

Rhinoplasty is one of the most complex and humbling aesthetic operations we perform. The nose is in the middle of the face where even minor irregularities are easily detected after the surgery. Since every patient has different nasal deformities and different facial features, there is not a standard operation for patients. Every patient must be planned according to her/his deformities and different approaches should be used to achieve an optimal outcome. Rhinoplasty surgery has a long learning period. A rhinoplasty surgeon should perform a certain number of basic operations to get sufficient experience. All these factors add up to the challenging aspects of rhinoplasty surgery.

In the last two decades, there have been a lot of conceptual changes in rhinoplasty techniques. In the past, rhinoplasty was a routine reduction operation and functional aspects were not taken into consideration as today. Overresection of important cartilaginous and bony structures often resulted in permanent functional problems in many patients. At the present time, we do not consider rhinoplasty a routine reduction procedure of the nose. It is rather a balancing procedure in which the reduction of some skeletal structures and simultaneous augmentation of the deficient parts are performed together, for aesthetic and functional improvement. Recently, open rhinoplasty technique is more commonly preferred by surgeons with its certain advantages, such as allowing better visualization and easier application of some surgical maneouvers.

Anatolia is the homeland of Turkey that has hosted many civilizations since the beginning of history and many ethnic groups lived together side by side in this geography for several thousand years. This gives us an opportunity to see patients with a large variety of facial features and operate on a multitude of different types of noses. Although many patients possess a varied combination of individual characteristics, the common features of the Anatolian and Eastern Mediterranean

population are a prominent dorsal hump, wide and long bony vault, a large septum cartilage, ill-defined bulbous nasal tip, droopy nasal tip, weak cartilages and fairly thick sebaceous nasal tip skin. The rate of functional problems is quite high due to overdevelopment of septal cartilage.

Rhinoplasty is one of the two most common aesthetic surgical procedures in Turkey. Many plastic surgeons have the chance to operate on more than one thousand rhinoplasty cases during their professional life. This increases the demand to learn rhinoplasty procedures among the young plastic surgeons in the country. The Turkish Society of Plastic and Reconstructive Surgery and Turkish Society of Aesthetic Surgery organize teaching activities on rhinoplasty frequently to teach the most recent techniques and developments to the younger colleagues. In recent years, open rhinoplasty techniques are preferred more commonly because it is a more efficient technique to deal with the common problems in our group of patients.

Rhinoplasty comprises almost eighty percent of my practice. The greater part of my primary rhinoplasty patients are seeking reduction of the dorsal hump and adjustment of tip projection and position. The number one demand is to have a natural nose. The majority of the patients desire a nose that retains its specific ethnic traits, such as a slightly higher dorsum and a less obtuse nasolabial angle. Almost all of my patients are concerned about the prevention of an overreduced ski slope shape of the nasal dorsum which was a common feature twenty years ago. This is similar to the male rhinoplasty concept in which it is imperative that masculine features are preserved.

It is my observation that my patients have more realistic expectations today compared to ten or fifteen years ago. However, the patients are more demanding and expect perfect results. Since they get a lot of information from the internet,

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NORTH AMERICA: UNITED STATES

Ashkan Ghavami, MD

I have had the good fortune to travel the world sharing my personal rhinoplasty adventures and lessons learned with my beloved international colleagues. As it also happens, now more than ever, terms such as "ethnic rhinoplasty" and "multicultural rhinoplasty" have become popular (almost trendy) topics of discussion at meetings and amongst prospective patients worldwide. While some of this is marketing driven, it is relevant to our modern lifestyle and preferences. Global interest in rhinoplasty by both patients and surgeons alike has increased exponentially. Patients from all nationalities now come to their surgeon after seeing numerous surgical videos, reading rhinoplasty facts and fiction online, and seeing images of the lower lateral crura, strut grafts, and nostril shaping on their smart phones. In addition, there are phone apps that they use to morph their nose to show their friends at dinner and surgeons at the initial consult. They chat and share experiences on numerous social media sites. The stigma has been lifted to a large degree for all patients, regardless of ancestry, to feel more secure in their desire to undergo a "nose job." However, the fear of looking "operated" and "ethnically incongruent" or "imbalanced/unnatural" is still prevalent despite all our efforts in teaching, learning and writing about rhinoplasty. The reason is, frankly, that there are lots of sub-optimal results seen in everyday life.

Figure A: Hispanic patient.

Figure B: African-American patient.

Figure C: Middle-Eastern patient.

At least 50% of my patient volume in my Beverly Hills practice is from outside California as well as internationally based. Why is this? It has been a blessing, an honor, and a great challenge. Guiding an international patient base in navigating their pre and post-operative care along with their online research efforts can be daunting. Fortunately, the doors have opened via the internet for a more internationally diverse patient pool to feel more at ease in seeking the ideal naso-facial balance no matter what location they have to visit. I hear the same from my rhinoplasty colleagues around the world. This necessity to travel is a testament to the continued challenges we face in learning and teaching rhinoplasty.

I am often asked to gear my presentations toward an "ethnic" twist so that the difficult nasal skin envelope, flared nostrils, flat or over-sized dorsal profile can be approached by more surgeons with greater confidence and less worry. In reality, one should see every nose as a potential concern as no nose is an "easy nose job." Advanced techniques such as transection of the lower lateral crura, cartilage flaps, diced cartilage, and meticulous struts must now be in every rhinoplasty enthusiast's toolbox. Patient expectations are heightened now more than ever. They are misinformed and misguided by unrealistic, airbrushed and photo-shopped images in the media, on their smart phones, as well as by other patients or potential patients who are active and even fanatical on social media.

If I had a dollar or better yet, a Euro, for every patient who brings in photos of a celebrity who has been professionally altered at the hands of a makeup artist and post production graphic artist to look near perfect at every angle, then I would be . . . well, I would still be pursuing that elusive and unattainable perfect rhinoplasty result. It is the operation that first drew me to plastic surgery and its immaculate unpredictability are what motivate me endlessly to teach it, learn it, re-learn it, and to travel the world because of it.

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EUROPE: ITALY

Gianluca Campiglio, MD, PhD

ISAPS Secretary

Rhinoplasty is among the three most requested surgical procedures in Italy along with liposuction and breast augmentation. This data reflects the same trend internationally revealed by the last ISAPS survey thus proving that the demands of Italian patients are aligned with those of the rest of the world, and that the standards of beauty are more and more globalized. Also Italian men and women do not like artificial results, such as pinched tips or overcorrected profiles such as the ones that were in fashion in '70s and '80s, and prefer more natural contours. This is especially true for male patients.

According to the 2014 ISAPS global statistics, a total of 15,200 nose surgeries were performed in 2013, but this number is certainly underestimated as it does not consider the procedures executed by ENTs and maxillo-facial surgeons. In Italy, we do not have reliable data, but based on my personal experience, I estimate that almost 70% of the rhinoplasties are performed by plastic surgeons, 25% by ENTs and only 5% by maxillo-facial surgeons.

For a complete rhinoplasty, very few colleagues suggest local anesthesia with sedation. This form of anesthesia is usually not requested by the patients (as opposed to other surgical procedures), and not loved by the anesthesiologists who prefer general anesthesia because of the difficulties in airway control in case of bleeding. For reshaping of the nose tip only, local anesthesia can be a good choice, but in my practice this is a very limited group of patients. There are usually some associated minimal defects of the dorsum which deserve to be corrected, thus improving the final aesthetic result.

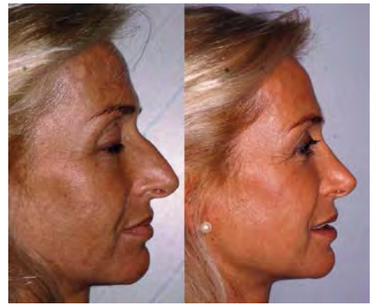


Figure 1: Closed rhynoplasty with reshaping of the dorsum and tip

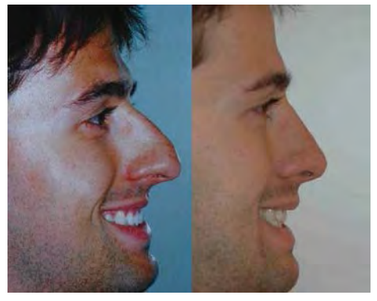


Figure 2: Aesthetic procedure associated with a functional correction

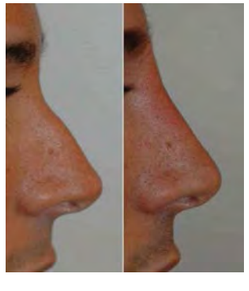


Figure 3: Non-surgical rhinoplasty with hyaluronic acid injection

As I always say to my patients, you cannot restore a house in pieces and once you have built the walls, probably you have to tinker with the roof, too.

In very selected circumstances, when patients do not want to or cannot undergo a surgical operation, I suggest a reshaping of the nose with hyaluronic acid which is resorbable and can be removed with hyaluronidase in case of overcorrection. More than half of these patients will subsequently switch to a surgical rhinoplasty once they have acquired confidence with the type of result that is achievable.

Most of my primary rhinoplasties are performed using a closed approach which allows me to obtain satisfactory results in the majority of cases. When indicated, I resort to cartilage grafts (columellar struts, tip or spreader grafts) or to stitches, to reshape the tip. I restrict the open approach to secondary cases or patients with a very difficult tip (asymmetries, malformation or even ultraprojecting). This personal choice is due to three factors: first, I started with the closed approach many years ago and my learning curve is based on this procedure; second, patients are usually satisfied and do not ask for more; and third, the closed approach allows me to immediately and continuously check the result of my procedure while the open operation always requires control between what has been done on the skeleton and how the shape is after the skin is unrolled over it—and sometimes there are differences. As I once joked with a colleague, I prefer to judge the beauty of a woman looking at her and not at her skeleton!

Finally, in Italy the debate between the two approaches is still open and there are very distinguished surgeons on both sides. On the other hand, as we say in Italy "finally all roads lead to Rome."

ASIA: THE PHILIPPINES

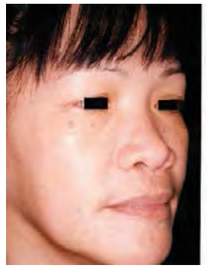
Carlos I. Lasa, Jr., MD, FPAPRAS, FPCS

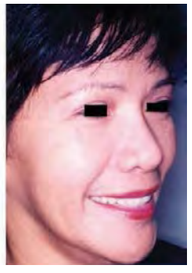
President, Philippine Association of Plastic Reconstructive & Aesthetic Surgeons, Inc.

The Philippines is a country which has been described as a "melting pot" of cultures. Anthropologists have described the groups that migrated to Southeast Asia as "Austronesian," a Malayo-Polynesian-speaking people that includes those from Indonesia, Philippines and Malaysia. Hence, if one travels among these three countries, it is interesting to note the similarity in physical features between these three nationalities. In the Philippines, the influx of Chinese, Arab and Indian traders, Spanish colonialists, and later American settlers have contributed to the mixture of features seen in present-day Filipinos.

The majority of Filipinos will still have the typical Malay nose which has been described to have the following characteristics: skin which is thick (in comparison to Caucasians) with large pores, a nasal dorsum which is low, a nasal tip which is rounded and bulbous, and a nasal base that is wide.

Thus the type of rhinoplasty which is usually performed on Filipinos will typically include augmentation of the nasal dorsum, projection of the nasal tip and reduction of the width of the nasal base. These procedures may be done singly, or in combination, depending on the particular needs/preferences of the patient.





The procedure involving augmentation of the nasal dorsum is most commonly known as a "noselift," and is the most commonly requested nasal surgery in the Philippines. Currently, the three most common materials used to increase the height of the nasal bridge are silicone implants, ePTFE (polytetrafluoroethylene) implants, and autogenous cartilage grafts. The factors which commonly determine the choice of augmentation material are patient preference and cost. While autogenous cartilage grafts harvested from the nasal septum or ear cartilage may seem like ideal materials to use, often the volume required to augment the nasal dorsum may not be enough. Patients may also express a strong dislike for an operation in another area which will create a scar in the donor area. There is also the added cost of the prolonged operating time. In these patients, Filipino plastic surgeons will use either solid silicone implants or ePTFE implants in order to increase the height of the nasal bridge. These implants are shaped like inverted canoes which extend from the root of the nose to the supratip area.

Nasal tip projection is done with either cartilage strut grafts or the use of L-shaped silicone nasal implants. While numerous cases of extrusion of the silicone nasal implants through the nasal tip have been reported in the literature, oftentimes these procedures were done by inexperienced doctors who are not board-certified plastic surgeons. (In the Philippines, any doctor who has passed the government board examinations for physicians can legally practice surgery.)

Experienced plastic surgeons are aware of this possible complication and will use an L-shaped silicone nasal implant to increase the projection of the nasal tip only if certain conditions are met. First, the patient should have nasal skin which is thick. Second, the result of the "skin blanch test" should be favorable. If the skin color of the nasal tip becomes paler or whiter after placement of the L-shaped nasal implant, this implies that there is too much tension at the nasal tip. The experienced surgeon will remove the implant and carve the bend of the L-shaped implant to make it less bulky and shorten the length of the columellar portion of the implant so that there will be no tension at the nasal tip area that will make the skin blanch. Currently however, I prefer the use of cartilage grafts for tip projection.

Many Filipino patients will also need an alar plasty procedure to decrease the wide nasal base. Small wedges of skin are removed to straighten the outward bulging of the ala, and if needed, excision of part of the nostril floor is done to bring the ala medially closer to the midline to narrow the width of the nasal base.

I emphasize to my plastic surgery residents that whenever implants are to be used, these implants should be sculpted to blend and conform to the shape of the patient's face, in order to have a surgical result which look natural. The skillful surgeon takes great care in creating the look that is most suitable to the patient's face and features.

ASIA: SOUTH KOREA

Man Koon Suh, MD

Rhinoplasty takes the greatest portion of the overall aesthetic plastic surgery in Korea next to eyelid surgery. Korean plastic surgeons are now one of the leading groups in the Asian rhinoplasty fields in the aspect of advanced knowledge and skills.

The East Asian nose is anatomically different from the Caucasian nose, so the techniques themselves should be quite different from those of the Caucasian nose. The Asian nose is usually characterized by a flat dorsum, thick skin, weak and small alar cartilage, and a wide alar base, even though there are some exceptions.

Therefore, unlike Caucasians, the most common procedure in Korea is the augmentation of the nasal dorsum and over 90% of dorsal augmentations go with tip plasty together for the tip projection or bulbous tip correction.

The materials for the nasal bridge augmentation are implants and autogenous tissue. The most commonly used autogenous tissue in Korea is dermofat which is harvested from the sacrococcygeal area. Temporal fascia, rib cartilage and diced cartilage are also used. There is no doubt that autogenous tissue is the safest material; however, there are some limitations when we only use autogenous tissue. Dermofat and diced cartilage tissues cannot achieve the desired amount of augmentation due to resorption and thus are less predictable. As well some patients do not want to have the extensive surgery for the rib cartilage. In fact, dorsal augmentation procedures using autogenous tissue hasn't shown a lesser rate of re-surgery in Korea due to dissatisfaction with the resulting shape.

Left: This patient did dorsal augmentation with silicone implant 10 years ago and now her nose shows visible implant margin and dorsal skin redness.

Right: POD #6 months, Improvement of dorsal skin redness and visible implant contour by revisional surgery (dermofat graft)

Considering the unique characteristics of Asian nasal skin and the different aesthetic demands of the East and West, implants still play a crucial role in Asian rhinoplasty.

It is true that Korean plastic surgeons are in a dilemma about using autogenous tissue or implants. Implants are still more common in Korea and the knowhow which can make them safer and create more natural results are much more developed.

Tip plasties in Korea are used for the correction of low tips, bulbous tips and short noses in the order of frequency.

The procedure is usually suture technique, onlay graft and supporting graft. These procedures are usually combined. Remarkably, septal cartilage usage has recently increased in comparison to the past which used simply conchal cartilage onlay graft.

We have seen three interesting trends of rhinoplasty in Korea.

Firstly, the patients' demands are changing, from high dorsum with sharp nasal tip like Caucasian to a natural dorsal and tip height with maintaining their ethnic identity and they require not only the shape improvement, but also the mobility and softness of the nasal tip. So with the surgeons' efforts through a variety of research activities and symposiums they are able to enhance their tip plasty techniques within Korea.

Secondly, the demand for secondary rhinoplasty has drastically been increasing recently. There are many revision cases though these are usually due to the patient's dissatisfaction with appearance which is subjective. There are also other cases such as side effects of implants and deformed nasal tip after tip plasty or functional problems. Aside from infection, other side-effects of implants are in order of most frequent in Korea are: visible implant contour or margin, color change of the dorsal skin and scar/capsule contracture (see figure).

The most common revisional cases of the nasal tip are subjective complaints about the height or shape, followed by asymmetry of the tip, pinched deformity, and tip skin thinning by implant or cartilage graft.

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Spinelli, *continued from page 22*

all structures. Typically one may then either deal distally to proximally or as some prefer proximally to distally. Rasp down dorsal nasal bone hump consequentially then reduce upper lateral cartilage either by resection or folding to create autogenous spreader grafts along with reduction of the dorsal aspect of a prominent septal cartilage. Keep in mind that maintaining any middle vault support is important in avoiding the inverted V deformity and middle vault collapse on inspirate with resultant airway obstruction. The net upper lateral cartilage should be slightly lower than the nasal bone prominence and the dorsal septal slightly lower than the upper lateral cartilage to avoid deformities like that of the so called "poly beak" look.

Lower lateral cartilages can be trimmed in their cephalic margins again leaving enough support to avoid the "pinched tip" look and external nasal valve compromise. Finally, nasal bone osteotomies may be performed with infracture to avoid the open roof deformity. I genuinely favor some dorsal only cartilage graft harvested from the nasal septum to smooth out irregularities in the dorsal nasal construct. Submucous resection of the septal cartilage (SMR) should be performed judiciously, preserving much mucoperichondrium and a generous L strut for coverage and support respectively. Taping and then splinting can then be performed and internal stenting and or splinting is generally not necessary unless an SMR and turbinate procedure are concomitantly performed in order to avoid synechiae.

Finally, in rhinoplasty the caveat should be "less is more" and whenever possible preserve endogenous tissue. Good luck in your next septo/rhinoplasty procedure.

Suh, *continued from page 27*

Lastly, there has been a large number of patients from many Asian countries and western countries visiting Korea for rhinoplasty. Thus the Korean plastic surgery market has been focusing on medical tourism because the domestic situation has slowed down and become highly competitive!

Ghavami, *continued from page 24*

Why do we all still submit ourselves to learning and continuing to dive into the elusive abyss of this "millimeter by millimeter" mystery of nasal anatomy shaping? Rhinoplasty is perhaps plastic surgery at its finest. The ever-increasing global interest by young and more "seasoned" surgeons alike, combined with the refreshing dissolution of that typical nose job look, has increased the diversity in patients and, thus, the nasal anatomy presented. The adventures to be had are expansive and demand continued creative efforts by societies, surgeons, and "responsible" social media to increase the predictability of results and decrease trepidation by surgeons still interested in this "holy grail" of plastic surgery.

Cerkes, *continued from page 23*

they are more knowledgable about surgical techniques and possible outcomes. Today, I spend considerably more time during consultation and try to explain every detail of the surgery using simulation programs. These programs are particularly useful in understanding the specific expectations of the patient. Proper patient selection, spending enough time to understand the specific desires and expectations of the patient, careful evaluation of the deformities, and accurate planning are the key elements for success.

Global Perspectives – Future Themes

March – Non-Invasive Aesthetic Treatments

July – Optimizing Wound Healing and Scar Quality

If you would like to contribute an article of 500-750 words, please forward to isaps@isaps.org

This is 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 region?

ISAPS-LEAP UPDATE

Ryan Snyder Thompson – United States

ISAPS-LEAP Surgical Relief Teams© is saving limbs and restoring lives. Since launching our response to treat war-wounded Syrian refugees, we have sent 24 international surgeons and 6 surgical assistants on 15 surgical missions to provide emergency and essential surgical care in Jordan. To date, ISAPS-LEAP volunteers have conducted 383 patient evaluations, selecting 217 patients for surgery. In order to further assist the Amman-based Treating the Wounded Syrian Program, additional teams are scheduled to deploy through the beginning of 2015 and will continue to be organized according to plastic, reconstructive and orthopedic caseloads.

Dr. Andrew Rosenthal (ISAPS USA) and Dr. Mahmoud (Syrian Program) examine a young woman for a rhinoplasty in treatment of a shrapnel injury that cut off the tip of her nose.

Expanding the Reach of ISAPS-LEAP Surgical Relief Teams©

During my most recent trip to the Middle East region, I participated in an initial site assessment of two Syrian American Medical Society (SAMS) facilities in Lebanon in order to determine the severity of need and capacity to treat patients requiring mainly soft-tissue reconstructive procedures. While a timetable has not yet been established for future surgical missions, the visit was very productive. SAMS Lebanon project coordinators are confident that there is sufficient patient volume to necessitate regular surgical missions. As the population of externally displaced Syrian civilians continues to steadily accumulate through the country as a result of heightened levels of violence in central and northern Syria, the need for expert level surgical care will very likely increase as well.

In recognition of our continued work treating injured Syrian refugees residing in Jordan, ISAPS-LEAP Surgical Relief Teams© was honored as "Friends of SAMS" during their recent National Symposium and Gala Dinner hosted by their Houston, Texas Chapter. On the sidelines of this event, I was invited by several members of the SAMS Turkey Committee to visit their project facilities and consider sending plastic and reconstructive surgical teams to assist their ongoing operations. Similar in scope to the Lebanon site visit, the purpose of this assessment trip would be to evaluate the prospects of recruiting and deploying international surgical teams to treat some of the more emergent cases coming out of northern Syria into Turkey's southern provinces. The visit is tentatively scheduled for January 2015 and will include multiple surgical centers. Should the assessment team identify a pronounced need and sufficient capacity on the part of SAMS to utilize ISAPS-LEAP surgeons and their assistants, we will immediately begin organizing teams of ISAPS-LEAP volunteers for short-term surgical missions.

In addition to these opportunities to provide lifesaving and life-altering surgical services in Lebanon and Turkey, ISAPS-LEAP has been invited to recommend a select number of surgeons to participate in week-long seminars as visiting professors of plastic and reconstructive at Gaziantep University. ISAPS members with substantial teaching experience are invited to inquire about these opportunities. Depending on availability, surgical mission opportunities at SAMS facilities may be added onto the end of these educational activities.

Finally, during the recent ISAPS Congress in Rio de Janeiro, Brazil, ISAPS-LEAP was approached by the new Ukrainian National Secretary, Dr. Pavlo Denyshchuk, and the immediate past National Secretary, Dr. Gennadiy Patlazhan, requesting ISAPS-LEAP surgical missions to treat Ukrainians injured in the recent fighting in the Donetsk region. A patient database of surgical candidates is currently being assembled which will likely consist of predominantly soft-tissue reconstruction, including some specialized maxillofacial cases. ISAPS-LEAP teams would be hosted by Central Military Hospitals in Kiev and/or Odessa. Temporary medical licensure permitting ISAPS-LEAP international volunteers to perform surgical procedures would be authorized by the hosting hospital facility in coordination with the Ukrainian Government. Upon receiving a formal request with a clearly defined need for the assistance of higher competency plastic and reconstructive surgeons, ISAPS-LEAP will respond by coordinating surgical teams to treat those cold cases elected for surgical reconstruction.

ISAPS members interested in participating in any of these surgical mission opportunities are strongly encourage to complete the Disaster Relief Medical Volunteer form on the LEAP Foundation website. A member of our International Disaster Relief team will be in contact with you shortly thereafter. Those ISAPS members interested to financially support upcoming surgical missions are invited to visit the LEAP Foundation website

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REFLECTIONS ON THE SYRIAN CONFLICT FROM A DOCTOR'S PERSPECTIVE

Patricia Eadie, MD – Ireland

For one week at the beginning of June 2014, I travelled as part of a medical team to Amman, Jordan to help treat casualties of the Syrian conflict. This was facilitated via ISAPS-LEAP Surgical Relief Team©, a combined humanitarian organization between Life Enhancement Association for People (LEAP) and the International Society of Aesthetic Plastic Surgeons (ISAPS), of which I am a member. The two organizations formed a collaboration agreement in 2012 and teams of plastic surgeons have been travelling to Amman to help reconstruct some of the horrific war injuries.

As the tenth team, our path was in many ways somewhat paved, but was greatly helped by the presence of a representative of LEAP, Ryan Synder Thompson. Our team consisted of two plastic surgeons, Dr. Christian Carrasco from Spain and me and Ciara Donohue, a nurse from Beaumont Hospital. Like going to any new place, the first day is difficult, but we quickly knuckled down to work—of which there was plenty.

The Al-Makassed Charity Hospital rents 40 beds to the Treating the Wounded Syrian Programme, which is run by Syrian doctors who have fled the conflict. However, these doctors are not registered to work in Jordan so they must work under the supervision of Jordanian doctors and registered doctors such as our team. There are a number of different specialists, both Syrian and Jordanian, but the availability of reconstructive surgery is limited, hence the need for plastic surgeons from other countries. The chief of the program had been running secret field hospitals in Syria; however, as one of his co-workers was caught, tortured and killed, he had to flee Syria, but continues to help his countrymen from across the border.

The majority of the patients we saw and treated were young men who had been injured either by barrel bombs or land mines. Many women and children had also sustained life changing injuries. It was so sad to see the devastation that had been inflicted on previously healthy people who having already often lost their home, family members, livelihood and a peaceful existence, also had to cope with a significant change in how they would be able to live their lives.

Unfortunately, the most common injury we treated was the subsequence of an amputation of all or part of a limb, usually a leg. The barrel bombs and landmines cause widespread destruction of both bone and soft tissue. I thought that over my almost thirty years in plastic surgery I had seen it all, but during one week in Jordan I had to treat worse injuries than I ever had before. Removing all the dead tissue, getting the fractures stabilized and the wound healed is the overall aim of treating these patients and I feel we did contribute in some way to this.

It appeared to us that the patients were so accepting of what had happened to them. One night, three new casualties, all young men, were transported from the border. All of them had been injured by the same bomb. All were seriously injured, but lay so still in their beds while being examined and assessed that they seemed unconscious. On being spoken to, it was apparent that they were all fully alert, just lying still. It is not what we would be used to and it affected us all.

Once the patients are healed, many will have to go back to Syria—to what we don't know. Jordan is not taking as many refugees as previously—they already have 600,000 of the total of 2.5 million who have fled Syria—and this is putting a significant strain on their resources. Syria has been torn apart and only time will tell the outcome of this brutal conflict. As a doctor, I feel privileged that I have been able to contribute in a very small way to help some of these people and I will keep them in my thoughts and prayers.

PIETRO SABATTINI (1810-1864) AND THE LIP SWITCH FLAP

Riccardo Mazzola, MD – Italy

Among the numerous techniques available for lip repair, one of the most challenging is the lip switch flap. In 1838, an innovator in our craft, ***Pietro Sabattini,*** described a triangular flap outlined in the lower lip containing skin, muscle and mucosa, vascularized by the circumlabial artery and transposed it to the upper with the aim of restoring a lip defect, re-establishing the interrupted sphincteric continuity at the same time. Although small, this flap anticipated the musculocutaneous flap revolution of today.

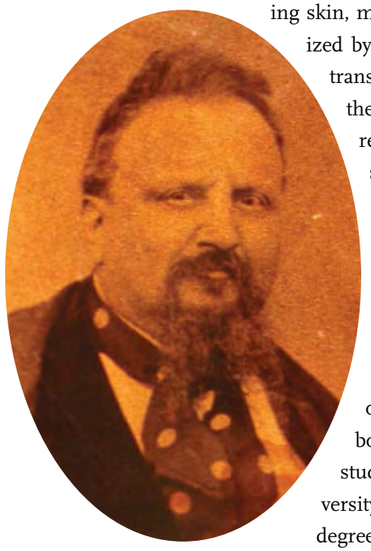

Fig. 1 – Portrait of Pietro Sabattini

LIFE

Pietro Sabattini (fig. 1), son of a Bolognese physician, was born in Bologna in 1810. He studied medicine in that university, and having obtained the degree of Medical Doctor, became assistant surgeon at Ospedale della Vita e della Morte, the same hospital where Gaspare Tagliacozzi practiced almost three centuries before. In 1838, he was appointed head surgeon at Ospedale S. Maria della Scaletta in Imola, an historical city 20 miles east of Bologna. He served the Imola Hospital continuously as head surgeon and later as administrator. He lived in a beautiful palazzo in Imola, where he died unmarried in 1864, aged 54, after a short disease. He was buried in the Imola cemetery.

SCIENTIFIC CONTRIBUTIONS

Sabattini wrote four scientific papers: on simultaneous nasal and lip repair *(Cenno storico dell'Origine e Progressi della Rinoplastica e Cheiloplastica . . . , 1838);* on the use of trephination in head lesions *(Sull'utilità del Trapano nelle lesioni del capo, 1847);* on a large post-traumatic aneurysm of the femoral artery *(Storia di un vasto aneurisma spurio . . . dell'arteria femorale, 1848);* on gunshot wounds *(Sulle ferite d'arma da fuoco, 1857).*

CENNO STORICO

Dell' Origine e Progressi

DELLA

RINOPLASTICA E CHEILOPLASTICA

SEGUITA

DALLA DESCRIZIONE DI QUESTE OPERAZIONI

Praticamente eseguite

SOPRA UN SOLO INDIVIDUO

Dal Dottor Medico

PIETRO SABATTINI

PROFESSORE CONDOTTO DI ALTA CHIRURGIA

IN IMOLA

BOLOGNA

Tipografia Delle Belle Arti.

1838.

Fig. 2 – Title page Sabattini's publication procedures are available. "It is better—he says—that the surgeon should invent cheiloplasty according to each particular case, rather than learning methods by heart."

THE REPORT ON THE LIP SWITCH FLAP

Cenno storico dell'Origine e Progressi della Rinoplastica e Cheiloplastica seguita dalla Descrizione di queste Operazioni praticamente eseguite sopra un solo individuo (An historical account on the origin and evolution of Rhinoplasty and Cheiloplasty followed by the description of these operations performed on the same individual),[1] a 23-page pamphlet, elegantly printed, was Sabattini's most innovative publication. It contains an engraved plate, repeated in outline, which shows the different steps of the procedure and is dedicated to "the most illustrious gentlemen of Imola," to celebrate the new appointment as head surgeon at Ospedale S. Maria della Scaletta in Imola.

The work begins with a survey on the history of rhinoplasty and the value of the forehead flap. Then it continues with the lip repair, where the author emphasizes that numerous procedures are available. "It is better—he says—that the surgeon should invent cheiloplasty according to each particular case, rather than learning methods by heart."

Fig. 3 – Preoperative view of the patient

He describes the case of a coach driver who received a blow with a sword, which cut off the nose and the upper lip completely and passed into the two lateral portions of the lower lip, so that it was hanging down. The patient was treated on emergency to stop the bleeding, but no attempt of either nasal or upper lip repair was envisaged. He was discharged from hospital in this dramatic situation, apart from having the lower lip margins sutured together. A few weeks later he was brought to the attention of Dr. Sabattini, who planned the restoration of the missing parts. At seven months from the event, nasal repair, with transposition of a midline forehead flap, was successfully performed. One month later, reconstruction of the upper lip defect was initiated by a new method which included the harvesting of "enough tissue from the lower lip to restore almost all the upper lip without creating a deformity in the former."

To quote Sabattini's description:

> I conceived the idea of excising a portion of it (i.e., lower lip) and using this to construct the upper lip. . . . This would provide to the upper lip its shape, thickness and specific character that could not be supplied by any other tissue. With this operation I could even manage to replace the moustache. . . . I started to freshen the deformed margins. . . . After having taken the lower lip between the thumb and the index finger of the left hand, I incised the lining of the mouth to allow its extension in a downward direction. With a mildly bellied scalpel, I began to incise the lip on the free margin at a distance of half an inch from the left angle and extended the incision toward the symphysis of the chin. After that . . . I transfixed the lip and cut until I connected with the original incision so that I obtained a portion of lip cut in the shape of a pyramid with the tip toward the chin and the base above corresponding to the free margin of the lip. This base remained attached by a pedicle at its right side. . . . I turned up this flap and with a stitch I joined the apex to the upper part of the upper lip defect, so that the left margin of this base corresponded to the freshened right margin of the missing upper lip and the right one remained pulled and contracted downward. Then I united the whole left margin of the upper lip with a twisted suture. Then I closed the lower lip with three needles in a manner similar to the operation for harelip. However this was not entirely possible because of the presence still of the everted portion of the lip and its pedicle. . . . In the following days there was no setback. . . .
>
> On the fifth day I performed the first dressing and found the right side of the new lip completely united. . . . I severed the pedicle on the seventh day and united the planned pyramid to the left superior margin of the missing lip. . . . Within fifteen days they were perfectly united. The base of the pyramid which had previously formed the free margin of the lower lip now constituted the free margin of the upper lip. [2]

Fig. 4 – Final result

Sabattini concludes by saying that both procedures had a successful outcome.

By reading the account, it is amazing to note that the lip switch procedure described in 1838 is still used today, practically unchanged. The fame of this new operation was limited. It was seldom quoted afterwards and Sabattini's name does not appear in major plastic surgery textbooks, possibly because the pamphlet had restricted visibility, or because Sabattini did not try to circulate his procedure in the academic world. Priority for the lip switch flap was wrongly attributed to Robert Abbe (1851-1928) who published a similar procedure for the correction of a sequelae of bilateral cleft lip in 1898, 60 years later.[3]

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2. Mazzola RF, Hueston JT. "A forgotten innovator in Facial Reconstruction: Pietro Sabattini." *Plast Reconstr Surg 1990;* 85: 621-26
3. Abbe R. "A new plastic operation for the Relief of Deformity due to double Harelip." *Med Rec 1898;* 53: 477-78

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Thompson, LEAP Update, *continued from page 31*

to make their secure contributions. ISAPS members wishing to donate urgently needed surgical supplies and equipment should contact me at ryansnyderthompson@leap-foundation.org in order to coordinate the delivery of materials.

ISAPS-LEAP is doing very rewarding work as highlighted in the article by Irish ISAPS member Dr. Patricia Eadie who chronicles her experience in Amman in this issue. Stories like this abound among those who have played a part in our missions. Visit the ISAPS-LEAP Surgical Relief Teams© participant page on the ISAPS website to connect with colleagues who have already served on a team http://members.isaps.org/surgical-relief-teams.html. Even more rewarding are new requests for help that we are receiving now that ISAPS-LEAP has become more established.

IN MEMORIAM

DR. SIA TIONG GAM – 1930-2012

Florencio Lucero, MD – Philippines

Dr. Sia Tiong Gam was 82 when he joined his creator on October 12, 2012 after a long battle with pneumonia. He quietly laid in his sick bed and did not bother his colleagues.

He was survived by his wife, Esperanza, and three grown children, Frederick, Dr. Kendrick and Charmane.

Dr. Sia returned to the Philippines in the late '60s after his training in the United States in plastic surgery at the Roswell Park Memorial Institute. He immediately took an active role in the Philippine Association of Plastic, Reconstructive and Aesthetic Surgeon which led to his election as President in 1996. In his small ways, his encouragement and mentoring of young plastic surgeons and his active role in scientific discussions contributed to the healthier status of the Association.

November 2014

DATE: NOVEMBER 30-DECEMBER 1, 2014 ISAPS-ENDORSED PROGRAM
Meeting: 3rd World Plastic Surgery Congress
Location: Monté Carlo, MONACO
Contact: Elise Michel
Email: elise.michel@plasticsurgery-monaco.com
Tel: +33 0 9 54 76 70 73
Website: http://www.plasticsurgery-monaco.com

December 2014

DATE: DECEMBER 4-6, 2014 ISAPS-ENDORSED PROGRAM
Meeting: The Cutting Edge 2014 Aesthetic Surgery Symposium
Location: New York, New York, UNITED STATES
Contact: Bernadette McGoldrick
Email: registration@astonbakersymposium.com
Tel: 1-212-327-4681
Fax: 1-646-783-3367
Website: http://www.astonbakersymposium.com

January 2015

DATE: JANUARY 22, 2015 ISAPS-ENDORSED PROGRAM
Meeting: 8th Annual Oculoplastic Symposium
Location: Atlanta, Georgia, UNITED STATES
Contact: Susan Russell
Email: srussell@sesprs.org
Tel: 1-435-901-2544
Fax: 1-435-487-2011
Website: http://www.sesprs.org/

DATE: JANUARY 23-25, 2015 ISAPS-ENDORSED PROGRAM
Meeting: 31st Annual Atlanta Breast Surgery Symposium
Location: Atlanta, Georgia, UNITED STATES
Contact: Susan Russell
Email: srussell@sesprs.org
Tel: 1-435-901-2544
Fax: 1-435-487-2011
Website: http://www.sesprs.org/

DATE: JANUARY 23-24, 2015 ISAPS-OFFICIAL COURSE
Meeting: ISAPS Fresh Cadaver Aesthetic Dissection Course on Facial Anatomy
Location: Liège, BELGIUM
Contact: Mrs. Anne-Marie Gillain
Tel: 32 (0)4 242-5261
Fax: 32 (0)4 366-7061
Email: info@dissectioncourse.com
b.hendrickx@duinbergen-clinic.be
Website: www.dissectioncourse.com

February 2015

DATE: FEBRUARY 12-14, 2015 ISAPS-ENDORSED PROGRAM
Meeting: 49th Annual Baker Gordon Educational Symposium
Location: Miami, Florida, UNITED STATES
Contact: Mary Felpeto
Email: maryfelpeto@bellsouth.net
Tel: 1-305-854-8828
Fax: 1-305-854-3423
Website: http://www.bakergordonsymposium.com/

DATE: FEBRUARY 15-18, 2015 ISAPS-ENDORSED PROGRAM
Meeting: 7th American-Brazilian Aesthetic Meeting (ABAM)
Location: Park City, Utah, UNITED STATES
Contact: Susan Russell
Email: srussell@gunnerlive.com
Tel: 1-435-729-9459
Fax: 1-435-487-2011
Website: http://www.americanbrazilianaestheticmeeting.com/

March 2015

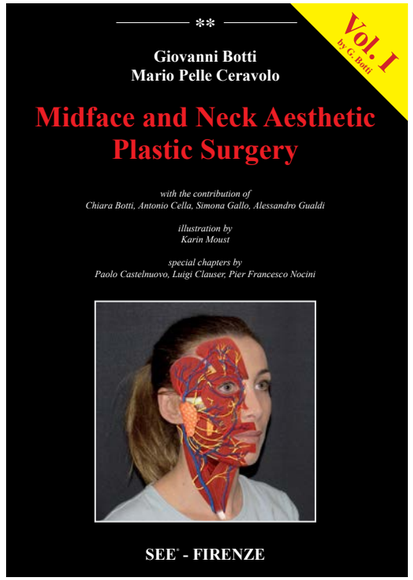
DATE: MARCH 11-14, 2015 ISAPS-OFFICIAL COURSE
Meeting: Plastic Surgery at the Red Sea
Location: Eilat, ISRAEL
Contact: Einat Bar-Ilan
Email: einat@duetevents.co.il
Tel: 972-54-4304045
Website: http://www.redseaplastics2015.com/

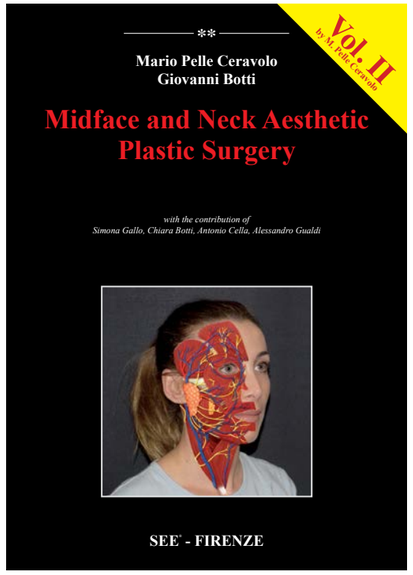
May 2015

DATE: MAY 14-19, 2015
Meeting: ASAPS/ASERF Annual Meeting & ISAPS Board Meeting
Location: Montreal, QC, CANADA
Contact: American Society for Aesthetic Plastic Surgery
Email: asaps@surgery.org
Tel: 1-800-364-2147
Fax: 1-562-799-1098
Website: http://www.surgery.org/professionals

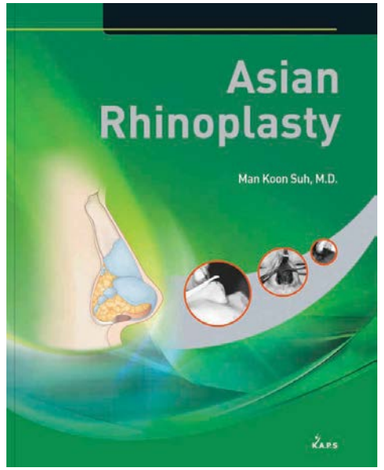
June 2015

DATE: JUNE 4-6, 2015 ISAPS SYMPOSIUM
Meeting: ISAPS Symposium – Nice, France
Immediately preceding the 28th SOFCEP Congress
Location: Nice, FRANCE
Contact: SOFCEP
Email: sofcep@vous-et-nous.com
Tel: +33-05-3431-0134





Asian Rhinoplasty



There have been numerous textbooks about rhinoplasty; however their main themes are usually the Caucasian nose, even though some pages might have been dedicated to ethnic rhinoplasty—including Asian rhinoplasty.

Dr. Man Koon Suh, the author of *Asian Rhinoplasty,* says in the preface of his book: "The structure of the nose for Asians is fundamentally different from that of Caucasians. Thus, the principle of surgery and surgical materials are significantly different."

As one of the leading rhinoplasty surgeons in Korea, Dr. Suh has educated many surgeons from Asian countries and he felt the need to publish a textbook focusing on Asian rhinoplasty.

This book deals with all fields of rhinoplasty with special attention to the Asian nose-specific fields, like characteristics and carving technique of each implant, implant-related complications and the process to solve them, as well as including contracted short nose correction and Asian tip plasty.

Within the 357 pages of this hardcover book, the reader will find descriptive and interesting illustrations and photos of many Asian noses which will help readers have a better and more realistic understanding and learning of Asian rhinoplasty. Published in 2012, the book is in its second printing in September 2014.

This book will be of great help for those who are interested in Asian rhionplasty, especially for doctors who are performing nose surgery on eastern and south-eastern Asian patients.

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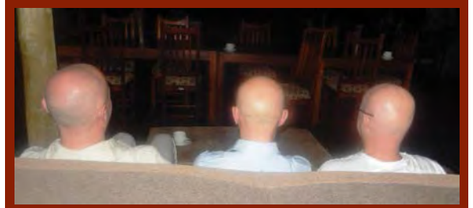
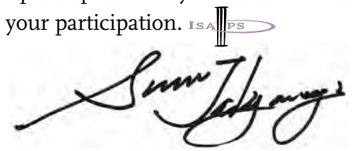


Answer: Photo taken by Mario Pelle Ceravolo (Italy) at the ISAPS Course in Cape Town, South Africa in March. The three include from left Drs. Nuri Celik (Turkey), Giovanni Botti (Italy) and Osvaldo Saldanha (Brazil).

President's Letter, continued from page 3

our society to operate in a way where requests by our members from all over the world are reflected in a well-balanced manner.

The next biennial congress will be held in Kyoto, Japan from October 24 to 27, 2016. Kyoto is called a Millennium City because it has long been a center of government in Japan. There are many temples and shrines designed with traditional Japanese beauty. One of them, Chion-in Temple, was used in filming *The Last Samurai*. Many tourists visit Kyoto each year. Please book your accommodations well in advance. The Local Organizing Committee, which includes Dr. Kitaro Ohmori, honorary local chair, Dr. Yoshiaki Hosaka, local chair and Dr. Hiroyuki Ohjimi, local chair and National Secretary for Japan, has already started its preparations to welcome you. I will do my best as President of ISAPS to organize a meaningful congress and welcome many ISAPS member participants to Kyoto in the autumn of 2016. We look forward to your participation.



Susumu Takayanagi, MD
ISAPS President 2014-2016

Where in the World?

Answer: I took this picture from the Everest Balcony, 2013.

– Pedro Vidal (Peru)

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