

## FIRST ISAPS COURSE IN RUSSIA: A STORY OF MUTUAL ADMIRATION

Catherine Foss – United States ISAPS Executive Director



The Winter Palace, part of the Hermitage Museum complex.

The historic and very beautiful city of St. Petersburg welcomed over 400 plastic surgeons from 29 countries and 34 exhibiting companies for the first official ISAPS Course ever held in Russia. The welcome extended by the local hosts and organizers was overwhelmingly warm and gracious. Those who were visiting for the first time experienced the magnificent art, architecture, ballet, and food during the mysterious and fascinating White Nights. Daylight until nearly midnight and bright sunlight streaming in your window at four o'clock in the morning was a new phenomenon for many of us.

Planned by the ISAPS Education Council, course directors Nazim Cerkes and Renato Saltz worked closely on the program content with Dr. Irina Khrustaleva, the ISAPS National Secretary for Russia and a native of St. Petersburg. We owe a debt of gratitude to Olga Zaseeva of Clovermed and Igor Bogoroditski of Bio Concept Company for their superb management of the logistics that made this meeting run so smoothly. ISAPS, together with our local planning team, were able to bring an outstanding faculty to Russia, covering a vast array of aesthetic surgery techniques, and were rewarded by a most attentive audience. We anticipate many new Russian ISAPS members joining us very soon.



Resurrection of Christ Church, also known as The Church of Our Savior on Spilled Blood

### The Faculty:

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 Mehmet Bayramiçli (*Turkey*)  
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 Vadim Bragilev (*Russia*)  
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 Irina Khrustaleva (*Russia*)  
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 Jan Poell (*Switzerland*)  
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 Dirk Richter (*Germany*)  
 Joao Sampaio Goes (*Brazil*)  
 Cemal Senyuva (*Turkey*)  
 Sergey Shvirev (*Russia*)  
 Henry Spinelli (*USA*)  
 Tunc Tiryaki (*Turkey*)  
 Lina Triana (*Colombia*)  
 Reha Yavuzer (*Turkey*)  
 Akin Yucel (*Turkey*)  
 Roger Wixtrom (*USA*)

Our hosts provided great hospitality, and quite a bit of very good vodka. The highlights were a memorable evening at the world famous Mariinsky Theater to see the ballet, Don Quixote,

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# PRESIDENT'S MESSAGE

Jan Poëll, MD – Switzerland



Dear ISAPS members,

Patient safety is of concern to all of us. The question is: how we can improve it? The answer is: through improved quality of our work!

Quality is achieved through education and that is where ISAPS steps in. We are doing a lot to improve the quality of the work of our members. First, they are all handpicked on the recommendation of two of our members and of the National Secretary for their country. This shows clearly the importance of the National Secretaries to ISAPS. Lina Triana, as their chair, is doing a great job trying to make them aware of their importance. Thank you, Lina.

Quality also means that we all need to be aware of the possible negative influence that our treatment could have on our patients. Fat injections to the breast for reconstruction or augmentation are very popular now. However, are the outcomes truly predictable? Do we know enough about what the stem cells are doing to the breast? Can the stem cells stimulate the growth of tumor cells? There are many unanswered questions that should find an answer before the method is recommended widely. ASPS and ASAPS are currently creating a joint registry to track and evaluate the outcomes of these procedures before they can be recommended to everybody. We have to thank ASPS and ASAPS for their pioneering work in this area and would be glad to join them as soon as the register is ready.

Other problems might be found with new machines and applications recommended to us by industry. These must be reviewed closely by our New Product Evaluation Committee. Some can be dangerous in the wrong hands. Every method is only as good as the surgeon performing it. To do things right, you need training. Don't use these products until they are proven to be safe and all risks and possible complications are known.

Together with other organizations such as the American Society for Aesthetic Plastic Surgery, we should try to influence what industry does for us instead of letting them impose on us what they think is right. We need a close collaboration with industry that will benefit both sides. Without industry support, it would be impossible for us to finance our great meetings. I would like to thank them for their highly appreciated contributions.

Another way to improve quality is EBM (evidence based medicine), a term that is quite well known to all of us, but rarely implemented in our work. Although it might not be so suitable for our kind of surgery, as every surgeon has his own methods, it is at least of importance in all that surrounds our surgery including medications, facilities, anesthesia and so on. In the United States, there was a special meeting on this topic held in Colorado Springs last year and I would

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# MESSAGE FROM THE EDITOR

J. Peter Rubin, MD – United States  
ISAPS News Editor



Welcome to this issue of *ISAPS News*. Our cover story, describing our first official ISAPS course in Russia, demonstrates the expanding reach of our wonderful society across the globe. This outstanding educational event featured a diverse faculty from Russia, as well as numerous other accomplished leaders from Europe, the United States, and South America. This pioneering meeting held in St. Petersburg represented the true essence of the ISAPS mission: fostering exceptional education and camaraderie among our international members in exciting locations. Complimenting the piece on the meeting in Russia is a history of aesthetic plastic surgery in Russia, written by Kirill Pshenisnov, MD, Russian Federation. This very interesting piece emphasizes the need for standardizing training requirements for aesthetic plastic surgeons in Russia.

Another event that we proudly feature in this issue of *ISAPS News* is a report of the very successful 2011 American-Brazilian Aesthetic Meeting held in Park City, Utah. Renato Saltz, MD, United States, ISAPS 2nd Vice President and ABAM Chair, reports the details of this event. Friends from far and wide gathered to discuss new innovations in plastic surgery and enjoy the "best snow on earth."

An awareness of regulations impacting plastic surgery practice is very important among our membership, and *ISAPS News* presents a series of pieces addressing this issue. Our ISAPS National Secretary from Italy, Gianluca Campiglio, MD, briefs us on a new law that will regulate breast augmentation procedures. This law includes a consideration of patient age and guidelines for who is qualified to perform aesthetic procedures. We also have an interesting piece on regulations in Mexico presented by Jaime O. Salcedo-Martinez, MD, ISAPS National Secretary for Mexico. This informative story emphasizes changes in Mexico restricting the practice of plastic surgery to those with specialized certification and regulating the practice setting to authorized establishments. Lina Triana, MD, Chair of National Secretaries, Colombia, briefs us on new Colombian legislation that favors patient safety, and Elizabeth Hall-Findlay, MD, FRCSC, Canada, informs us about Canadian regulations in aesthetic surgery. She emphasizes the importance of ISAPS members getting involved with these efforts.

Also in this issue, *ISAPS News* is proud to present a global perspective on fat grafting. ISAPS representatives from around the world provide commentary on practice patterns and attitudes in their regions. This informative section shows the scope of practice as observed by our ISAPS members.

Richard H. Read, ISAPS Information Technology Consultant, United States, presents an interesting piece on e-mail spoofing and other malicious internet activity. This is a "must read" for all of our ISAPS members. We rely so heavily on the internet, e-mail, and web-based communication that we all need to be aware of methods to protect ourselves from viruses and spam.

On the technical side, Alfonso Barrera, MD, United States, discusses methods for the correction of sideburn alopecia secondary to facelift procedures. This outstanding educational section will be useful to anyone practicing aesthetic facial surgery.

Our *ISAPS News* history piece is presented by Andreas Gohritz, MD and Peter Vogt, MD, PhD, both from Germany. They tell us of the life and times of Eugen Hollander, an unsung hero of aesthetic surgery, fat injection, and medical art history. As we also read of global perspectives on fat grafting, we must recognize the forefathers of fat grafting techniques. Eugen Hollander played a seminal role in fat grafting, and we thank Drs. Gohritz and Vogt for bringing this history to the forefront of our newsletter historical section.

As you can see, the ISAPS membership is working hard to impact plastic surgical care across the globe through education and the advocacy of patient safety. As I look at these recent accomplishments by our ISAPS members, I am so proud and honored to be part of this great society.

With warm regards to my colleagues, 

J. Peter Rubin  
ISAPS News Editor

## CORRECTION OF SIDEBURN ALOPECIA SECONDARY TO FACELIFT PROCEDURES

Alfonso Barrera, MD — United States



Traditionally facelift incisions can result in a variable degree of cephalic and posterior advancement of the temporal hairline and sideburn, creating an unsightly stigma, a tell tale of a poorly performed facelift. These stigmas can predictably and consistently be corrected by the use of modern day hair transplantation techniques, specifically follicular unit hair grafting.

It is key to do this in a way that the hair looks natural of course. To accomplish this, we need very small grafts, single and double hair grafts, have them grow in a consistent and natural direction, downwards on sideburns, perhaps in a slight posterior direction. I initially reported my technique to correct this condition in 1998.

This can effectively remove the stigma, the evidence the patient had a facelift and or forehead lift procedure, this way complementing immensely the final aesthetic outcome. The objective of this presentation is to briefly describe my personal approach and technique in correcting this condition.

We are still unable to create new hair; we can only redistribute hair from one area to another.

So for a patient to be a candidate, he or she must have enough donor hair to work with. Most commonly the donor hair is harvested from the occipital area.

### Patient Selection

Most patients have sufficient donor hair to restore the sideburns, the temporal and retro-auricular hairline, as it is not a large area, but make sure the supply and demand ratio is favorable. Make sure the patient has realistic expectations; explain to the patient that it is not uncommon to do a second session to obtain sufficient density.

### Technique

I typically do between 300 and 1500 grafts per session depending on the degree of alopecia and the size of the area to be covered. This labor-intensive procedure requires an organized and efficient surgical team.

My surgical team consists of three surgical assistants and myself. I remain in the operating room for the duration of the procedure and insert all grafts personally. Efficiency is key when transplanting a large number of grafts

in a single session.

The patient is placed in the supine position and mildly sedated with Midazolam (Versed) 2 to 10 mg and Sublimaze (fentanyl) 50 to 100 ug, which are titrated for each patient. The patient's vital signs, EKG, and O<sub>2</sub> saturation are monitored throughout the procedure.

I use 0.5% bupivacaine with 1:200,000 epinephrine (approximately 20 ml) to localize both the donor area and the recipient sites. A tumescent solution of 0.5% lidocaine with 1:200,000 epinephrine is then infiltrated as well.

The patient's head is turned to the left. Using a #10 scalpel blade, I harvest the right half of the donor ellipse, incising parallel to the hair shafts. If it is a small case 300-400 grafts. The donor ellipse is 1 cm in width and what ever length we may need 3-4 cm. If more grafts are needed we may harvest a longer ellipse.

Under a microscope (10x) or 3.5 lope magnification and background lighting, using a #10 scalpel blade, thin slices 1.5 to 2.0 mm in thickness parallel to the hair shafts are dissected from the donor ellipse. Then my assistants prepare the final grafts with #10 scalpel blades also under background lighting.

The donor site single is closed in a layer closure with 3 "0" Prolene (continuous running). The ideal grafts have intact hair shafts all the way from the subcutaneous fatty tissue to the scalp surface, and contain from one to four hairs. Again they must be handled as atraumatically as possible. The harvested scalp and all grafts are kept chilled in normal saline until transplanted.

They are lined up in rows on a wet surgical towel.

Key points to remember in graft dissection are:

1. Maintain the follicular units as intact as feasible.
2. In patients with dark hair, 3.5x loupe magnification is sufficient to dissect most grafts as follicular units.
3. In patients with light hair or gray hair, surgical microscopes (10x) and background lighting may be needed for more accurate dissection.

Graft insertion: Infiltration of tumescent solution into the recipient area is important for several reasons, the most important of which are to promote hemostasis and

to produce temporary edema (thickening) of the scalp, which facilitates graft insertion. I first inject the anterior region and proceed posteriorly and cephalically.

As fibrinogen turns into fibrin, the grafts adhere better to the recipient slits and we repetitively return anteriorly to insert more grafts placing them densely, minimizing the risk of "popping out" of neighboring grafts. I use 22.5 Sharp point blades to make the recipient sites incisions and immediately my assistant inserts the graft into each site, using my blade as a shoe horn.

Very important to incline the Sharp point blade to the direction and angle to which you want the hair to grow.

For dressings I generally use one or two layers of Adaptic, Kerlex and 3" elastic Ace bandage for the scalp.

### Problems and Complications

This is quite a safe procedure, infection is extremely rare. Hematoma is non-existent as there is no undermining. Often, however we can encounter ingrown hairs especially during the first three months post operatively. I learned that simply leaving the epidermis of the grafts slightly superficial to the epidermis of the recipient scalp prevents this problem. When they occur, they are not a major problem, they mature, come to a head and drain, or you can pop them as a small pustule and drain them.

### Conclusion

The use of follicular unit grafts, micrografts and minigrafts technique as described is safe and predictable, is very effective in the correction of scarring alopecia secondary to facial rejuvenation surgery. It results in great patient satisfaction. 



Figure 1: Sideburn and Temporal Alopecia, secondary to Facelift procedure (before)



Figure 2: Year after reconstruction with follicular unit hair grafting (right side)



Figure 3: Before



Figure 4: After

### References

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2. Barrera, A.. Correcting the Retroauricular Hairline Deformity After Face Lift. *Aesth Surg. J.* 24(2) 176-178, 2004

## JAPAN STRUGGLING TO RECOVER FROM THE EARTHQUAKE AND TSUNAMI

Susumu Takayanagi, MD – Japan  
ISAPS First Vice President



First of all, I would like to express my sincere gratitude to all ISAPS members in the world for sending e-mails of encouragement to us in Japan in the face of this unprecedented crisis. We are deeply touched by the kind thoughtfulness of many friends and feel like we are members of a big family of ISAPS.

When the Tohoku region of Japan was hit by a massive earthquake on March 11, I was very scared by a quite strong and long quake in the middle of performing surgery in Osaka City, which is more than 700 kilometers from the earthquake center.

Meanwhile in Tokyo, people were frightened by a much stronger quake. Many surgeons were also in the middle of performing surgery. They say that some surgeons could not keep standing and crouched down on the floor and some nurses rushed out of the operating room in fear. The entire public transportation system such as trains, subways and buses stopped operation. Many streets were closed due to destruction, ground liquefaction and power outage. Accordingly, a large number of people could hardly find any means to go home. There was terrible confusion, as reported in the world media.

The earthquake was the greatest one on record in Japan. It triggered an enormous Tsunami that hit the Pacific Ocean side of Japan. More than 27,000 people were killed or reported missing, with 18 doctors killed and 166 clinics and hospitals destroyed. However, to my knowledge, no plastic/aesthetic surgeons died. All ISAPS members in Japan are safe.

The horrible tsunami brought another crisis to us. It damaged the Fukushima nuclear power plant and caused a serious radiation problem. Areas within a 30-kilometer radius of the plant are completely or conditionally off-limits to the public. At this very moment, the struggle against further radioactive contamination is being continued at the Fukushima NPP. The radiation problem seriously affected fishery and agriculture in the neighboring areas. Furthermore, the damage to the plant gave rise to electric power shortages in a wide area including Tokyo.

We are concerned about harmful effects of all the above-

mentioned problems on the near future of Japan. According to some members of ISAPS who live in Tokyo, the number of patients has significantly decreased after the March 11 earthquake, and regulation in the supply of electric power is interfering with surgeries and medical examinations. All kinds of industries have similar problems and accordingly stagnation of the Japanese economy is anticipated to be prolonged. I am afraid that international societies' congresses or meetings will have much lower participants from Japan for several years to come.

The catastrophic disaster and related problems make us feel as if we had strayed into a long dim tunnel. At the same time, however, we believe all people living in Japan can get together as a team and help each other for the recovery and reconstruction of this country. Moreover, to our delight, soon after the earthquake and Tsunami, rescue parties from foreign countries came to Japan and many people around the world sent aid supplies and monetary donations for the sufferers. We are really encouraged and grateful to all the people for their support and friendship.

Donations to the Red Cross to help with disaster relief in Japan are being accepted through their website, [www.redcross.org](http://www.redcross.org)



## ISAPS EDUCATION COUNCIL PLANS MULTIPLE MEETINGS ON A GLOBAL SCALE

Nazim Cerkes, MD – Turkey  
Chair, Education Council



ISAPS Courses, Symposia and Endorsed Programs are expanding rapidly around the world, with many being held in their host countries for the first time. The website [www.isaps.org](http://www.isaps.org) has a current listing of all educational programs, with those officially produced, approved, or endorsed by ISAPS noted with a special icon.

Our first course in Romania was held on April 26-27 in Timisoara, organized by the ISAPS Education Council and the Romanian Society of Plastic Reconstructive Surgery. Course Directors were Nazim Cerkes and Nicolae Antohi with 145 plastic surgeons attending, including 30 from countries outside Romania. Two live surgeries were performed by Nazim Cerkes (Rhinoplasty) and Richard Sadove (Neck Lift). Faculty included: Seyfi Akbay, Turkey; Nicolae Antohi, Romania; Tiberiu Bratu, Romania; Gianluca Campiglio, Italy; Nazim Cerkes, Turkey; Bernard Cornette SaintCyr, France; Vakis Kontoes, Greece; Ioan Lascar, Romania; Csaba Molnár, Hungary; Toma Mugea, Romania; Magnus Noah, Germany; Zsolt Révész, Hungary; Richard Sadove, USA; Cemal Senyuva, Turkey;

Constantin Stan, Romania; Alfred Traub, Hungary; and Akin Yucel-Turkey.

Other official ISAPS Courses planned in the next months will be held in Urumqi-China, Prague-Czech Republic, with a special cadaver course in Brno, Sharm El-Sheikh, Egypt; Debrecen, Hungary; Beirut, Lebanon; again with a live surgery component, Goa, India; and Como, Italy. Several other requests for ISAPS educational programs are under consideration by the Education Council Chair and the Board of Directors and will be announced when they are finalized. Of course planning for the 21st Biennial Congress of ISAPS is well under way in Geneva already. Mark your calendar to attend on September 4-8, 2012.

The various levels of ISAPS educational programs are explained on our website under the Education Council heading. Members who would like to plan a program in their country should contact their country's National Secretary and the Chair of the Education Council, Nazim Cerkes.

President's Message, continued from page 2

like to thank the American Societies for taking the lead in this matter.

Education is of great importance and that is where our Education Council under the leadership of Nazim Cerkes comes in. He organizes courses all over the world with the help of many of our members locally. All those involved deserve applause. We also have many members who would welcome other members interested in visiting them. This makes our society so unique. ISAPS does not only stand for International Society of Aesthetic Plastic Surgery, but also for International Society of Amigos Para Siempre.

Alain Fogli in France is another contributor to our education program. As the chairman of the scientific committee of our next biennial congress in Geneva in September 2012, he will head the program team, as Renato Saltz did for our San Francisco Congress last year. Alain is on track to present to you a magnificent scientific program. As you all know, the next ISAPS Congress is always better than the last one. To help us know what our members are interested in learning, Dirk Richter in Germany, our Assistant Treasurer, has created a questionnaire that will be sent to all plastic surgeons. He, too, is doing a

great job in the preparations for our next congress. Thank you, Dirk.

It is important to have a scientifically supreme program, but also an unforgettable stay in Geneva and its surroundings for all participants is the responsibility of our local host, Kai Uwe Schlaudraff and his wife Anette. They are working day and night to insure that you will enjoy your visit and long remember this Congress on the shores of Lake Geneva.

Of course our Executive Office staff is already managing the many hidden details involved in the production of any major international congress. We owe them a word or two of thanks for

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## NEW LAW TO BE APPROVED IN ITALY WILL REGULATE BREAST AUGMENTATION PROCEDURES

Gianluca Campiglio, MD – Italy  
ISAPS National Secretary



About two years ago, the Vice-Minister of Health in the Italian government, Francesca Martini, decided to create a technical committee in order to institute regional and national registers for breast implants and to regulate breast augmentation procedures.

This national committee met several times at the Health Ministry in Rome. Among the participants were several ISAPS members: Andrea Grisotti, Roy De Vita and Gianluca Campiglio, ISAPS National Secretary for Italy.

The results of these meetings constituted the foundation for Law 2515, entitled **Institution of National and Regional Registers for Breast Implants, Informative Obligations for the Patients, and Prohibition of Breast Augmentation in Underage Patients** which was approved by one of the two chambers of the Italian Parliament on December 23, 2010. This law will also be approved by the second chamber (Senate) in the next few months and then will be in effect for all intents and purposes.

The law deals with four issues:

1. organization of regional and national registers for breast prostheses;
2. minimum age to undergo a breast augmentation;
3. informative obligations for patients who are candidates for breast implants;
4. definition of surgeons who will be allowed to perform aesthetic augmentation mammoplasty.

Concerning the registers, the law indicates their purposes (clinical and epidemiologic monitoring), the type of data which will be collected, the physicians authorized to access this data, and penalties (from 500 to 5000 Euro) for public and private clinics that fail to transmit the information to the regional and national data banks. Interestingly,

the data concerns not only the type of breast prosthesis implanted in the patient (manufacturing data) but will also record all the clinical history of the patient including complications and short and long-term side effects.

Article 2 of the new law prohibits the placement of breast implants in underage patients for aesthetic purposes and sets the penalty at 15,000 Euro. Breast augmentation in malformative or reconstructive cases is still allowed in underage patients.

Another important issue regards obligations to properly inform patients. Every public or private clinic must prepare an information card describing the type of prosthesis, including its supposed duration, the potential complications of the procedure, and its short and long-term side effects. This information card does not replace the informed consent already collected by surgeons before the procedure.

Finally, Article 3 dictates that aesthetic breast augmentations can only be performed by board certified plastic surgeons, or by surgeons who can show an equivalent surgical activity in the previous five years, or by board certified general surgeons, gynecologists or thoracic surgeons. This article is very important as in our country, as in many others, every physician can perform an aesthetic procedure, including breast augmentation. This law, even if it does not restrict this procedure to board certified plastic surgeons, as already established in some countries, represents the first attempt to define surgical competencies in aesthetic surgery in Italy.

Future issues of *ISAPS News* will update our members about the legislative course of this innovative law and the evolution of the debate about surgical competence in Italy.



## A SHORT HISTORY OF AESTHETIC PLASTIC SURGERY IN RUSSIA: A PLEA FOR STANDARDIZED TRAINING REQUIREMENTS

Kirill Pshenisnov, MD – Russian Federation



The history of cosmetic surgery procedures in the former USSR arises from the 1960s when they were performed only in Moscow – the capital of the country. The first Institute of Cosmetology there was under the auspices of the Ministry of Food Industry. The second center for aesthetic surgery used to be the so called Institute of Beauty. These two facilities covered nearly all the needs in the field of the communist country with the population of 200 million people until the 1980s. According to surgeons practicing at that time, the lines of patients waiting to enter these clinics were equal to those at grocery stores and were as long as two stops of the Moscow underground.

Cosmetic surgeons at that time were mostly dental surgeons called stomatologists. According to medical practice regulations postulated in 1982, surgical cosmetology procedures could be done only by those surgeons who had two years' experience in facial surgery. Special training in aesthetic surgery was not required. One could attend one month of lectures (144 hours) and start his practice in cosmetic surgery. In 1995, maxillo-facial surgery was recognized as an entity and licensing committees started to accept documents only from those who had diplomas as maxillo-facial surgeons. At that time, most of them were dental surgeons without general surgery training. In spite of that fact, those surgeons surprisingly performed breast augmentations and reductions without hesitation. Surgical methods at that time were basically routine without proper instrumentation and with a total lack of modern medical devices. Most of those who were practicing aesthetic surgery used to pay for five-month courses and could get diplomas as maxillo-facial surgeons without attending any training program at all.

The collapse of the Soviet Union led to a real boom in aesthetic surgery in the 1990s. Many new private clinics were opened. The real possibility to travel and study abroad was opened. Internet access also gave new knowledge about plastic surgery both to physicians and to their patients. Surgeons had to communicate and collaborate.

In 1994, the first professional organization of those who practiced any form of plastic, reconstructive or aesthetic surgery was created. In 1997, the first medical journal on plastic surgery with aesthetic surgery in the title appeared. Numerous cosmetic surgery courses, master classes and meetings were organized. Medical businessmen developed the attractive concept of aesthetic medicine where surgery was “married” to cosmetology and anti-aging. In 2000, a journal of “aesthetic medicine” started to publish papers on cosmetic surgery and some of the surgeons joined the Society of Specialists in Aesthetic Medicine. It is important to note that in all that time, plastic surgery was not a distinguished specialty in the Russian Federation.

In 2009, plastic surgery finally achieved its place among medical entities in Russia. More than one and a half years after this decision, the Ministry of Health Care did not approve their educational programs and some surgeons were sure that it was aesthetic surgery recognized as a specialty under the name of plastic surgery. Finally in December 2010, medical schools got the published program for professional retraining of general, maxillo-facial, thoracic, pediatric and oncology surgeons, urologists and gynecologists after five years of practice in the main specialty to be plastic surgeons. The education process requires 500 to 720 academic hours (four to five months). In that period, at least three quarters of the time is dedicated to aesthetic surgery. Unfortunately, surgeons must spend all this time in the audience during lectures and seminars with no direct contact with patients and no on-call overnights. There is no way to check the practical capabilities of the doctors who go through these courses.

At the beginning of specialty recognition, the decision was made by council members of the national plastic surgery society that the most experienced plastic surgeons who teach others as published professors will be “grandfathered” and will get their plastic surgery certificates without additional training. The primary list included no more than 20 names. But the newly formed departments of plastic surgery independently extended this list, without

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## NEW LAW APPROVED BY MEXICAN SENATE ESTABLISHES REGULATION OF PLASTIC SURGERY PROCEDURES

Jaime O. Salcedo-Martinez, MD – Mexico

*ISAPS National Secretary*

In the last decade, there was an extraordinary increase of the number of plastic surgery procedures, invasive and non-invasive, performed by non-plastic surgeons in Mexico. The number and severity of complications related to these procedures was high and there was no legislation to regulate the practice of plastic surgery in the country. These bad outcomes were valuable material for the media who took advantage of this kind of news, discrediting all plastic surgeons.

The Mexican Association of Plastic Surgeons (AMCPEP) decided to participate with our Congress to protect the public from all these persons, doctors and non-doctors, who, without ethics, without credentials, and mainly with commercial means, were practicing plastic surgery. After several years of hard work, we finally have a law as outlined in the following text:

The Senate of the Republic endorsed changes to several provisions of the health law to regulate plastic, aesthetic and reconstructive surgery procedures. This initiative is of enormous legislative significance because there is no record of compulsory Specialty Cedula in any branch of medical practice. The Specialty Cedula is an official document given by Educational Institutions when you have finished plastic surgery residency that officially endorses your practice by the Health Department.

This law has two fundamental features: 1) it is now mandatory to have the Plastic Surgery Specialty Cedula to practice Plastic Surgery and 2) it is required that you only perform surgeries in establishments that are duly authorized by the Health Department.

This law may not solve all the problems in the practice of Plastic Surgery in Mexico, but surely it is a great step on the path to protect our specialty. 



**Legal – Russia, continued from page 9**

any control, on the basis of their favorites. Education in the courses costs approximately five thousand US dollars. All the participants get diplomas and certificates as plastic surgeons in spite of the results of tests and oral examination. Nobody checks practical capabilities of the graduates. There is also little attention paid to moral character and ethical behavior of future aesthetic surgeons.

Advertising with pre- and post-op pictures of patients is legal in the Russian Federation. However, some patients complain that they see Photoshop created images instead of real post-op results. There are doctors who do not hesitate to make pre-op pictures without proper lighting and take post-op photos with flash.

Expensive glossy journals carry advertisements from several “top” doctors that present themselves as “one of the five best in the world” with “a unique vision of beauty.” Most of them never attend professional meetings and have no formal education in plastic surgery. Their website advertisements stimulate medical tourism as the prices for surgery are rather low. One should keep in mind that quality and cost of care are the main issues in aesthetic plastic surgery. At the same time, many less qualified doctors overcharge their patients for no reason.

In this situation, it is our obligation to protect patients from unqualified doctors even if they have formal diplomas. Russia is only at the beginning of the legislative process in plastic

surgery as a specialty based on aesthetic surgery knowledge, training and successful practice. The situation will hopefully improve when residency programs requiring two to five years with sufficient broad theoretical and clinical training are established and short term courses are closed. Only professionals can improve the situation to protect the brand of our specialty. Creation of a national board of plastic surgery is one constructive way to achieve this goal in spite of the fact that there is no such practice in the Russian health care system at present.

ISAPS can help in this regard by prescribing and then requiring proper educational requirements and adequate training of all their individual members. 

## PLASTIC SURGERY LEGISLATION IN COLOMBIA

Lina Triana, MD – Colombia

*Chair of National Secretaries*



The Colombian Plastic Surgery Society has made a great effort to educate the public about the high risk of some aesthetic/cosmetic procedures in our country. I would like to share with you what the Colombian Society’s Board of Directors has been doing.

We now have an agreement with the Minister of Education which allows us to revise and validate the title of plastic surgeon in Colombia. In the past, this was done directly by our government that did not verify if these titles corresponded to the minimal academic standards that our Colombian plastic surgery programs require.

The Society has recently developed a closer relationship with the INVIMA (similar to the FDA in the USA) to insure that they verify any new product introduced into our country. For example, INVIMA approved silicone gel and other non-absorbable products that are very popular and often injected by non-plastic surgeons in spas. Thus, we had a health problem and social risk with these substances. The INVIMA now understands what can happen in many of these patients where such products are applied in large quantities.

When we speak to the media on aesthetic plastic surgery procedures by non-plastic surgeons, we refer to them as “intrusismo medico” meaning invaders of our field. We think this gives a clear message to everyone. We can do this thanks to a new law that regulates medical specialties in Colombia. Plastic surgery is one

of them; cosmetic surgery is not. We are now working with the government health minister to officially define competencies and regulate our specialty. We are also present at the Colombian medical college and association of scientific societies that help define competencies in the medical specialties. Under this new law, all the general doctors who completed medical school but not a residency program and aestheticians who are doing any kind of plastic surgery must stop. The Ministry of Social Protection is helping us comply with this law. We are educating our Colombian plastic surgeons to play an active role in this process by working with the regulatory agencies we have in Colombia such as the department health secretaries, secretaria de salud departamental, and the health superintendency, superintendencia de salud.

This new law was to include a recertification process, but this part of the law did not pass. The Colombian Plastic Surgery Society is in the process of changing our By-Laws to require recertification every five years. At first it would be voluntary, but once our government approves, it will be mandatory and then we hope the government will consider the society as the entity to manage this mandatory recertification process.

We are working hard for our specialty in Colombia and hope that by sharing this information with you it will help to prove that we, as recognized societies, can make big changes if we put all our forces together. 

**Cover story, continued from page 1**

and a faculty dinner cruise on the Neva River and the many canals of the city to see the famous White Nights celebration when the bridges of St. Petersburg are raised and all the palaces on both sides of the river are brilliantly illuminated.

Several excursions allowed participants to get to know this spectacular city with the Hermitage and Russian Museum housing outstanding collections of fine art, the Church on Spilled Blood with its dramatic interior mosaics,

and Peter the Great’s glorious Peterhof Palace surrounded by the most beautiful gardens and fountains. The history of St. Petersburg, a city that seems an architectural cross between Paris and Venice, is all around you. And of course, the educational value of this meeting was appreciated by our Russian colleagues throughout the meeting. ISAPS looks forward to a renewed and vastly strengthened collaboration with our friends and colleagues in Russia. 

## LEGISLATIVE CHANGES: THE CANADIAN EXPERIENCE

By Elizabeth J. Hall-Findlay, MD, FRCSC – Canada

ISAPS National Secretary



Each province (state) in Canada regulates physicians and this can be quite different from one part of the country to another. Plastic surgeons are required to pass exams, both written and oral, from the Royal College of Physicians and Surgeons of Canada. Surgeons are given the designation of FRCSC after being certified and medical specialists are given the designation of FRCPC.

I practice in the province of Alberta and I have been very involved over the years with the licensing body for the province: the College of Physicians and Surgeons of Alberta. I ended up chairing the committee that set up the standards and guidelines for all surgical facilities in Alberta. We managed to regulate not only the surgical facility itself, but also the privileges for each physician – which meant that we could insist on proper credentials and training for each procedure applied for. A list of procedures was then developed and it was required that they

be performed only in an accredited surgical facility or in an approved hospital – and they were not allowed in an unregulated physician's office.

Being involved was hard work and it required a significant time commitment – but they listened to my concerns. We were able to achieve good physician regulation and there is very little surgery now performed by non-plastic surgeons. This has not been the case in other provinces (such as Ontario where Toronto is located).

We want to ensure that plastic surgery is performed by well trained plastic surgeons. I did not start out by chairing the committee that had this power, but, because I helped out in other areas, the licensing group listened to me and I was able in the end to achieve what I felt was important.

My message is to get involved! You may need to start slowly, but eventually you may be able to achieve similar results. 

President's Message, continued from page 7

their efforts.

Control is inevitable to show you where you stand in your education. In golf, you have a handicap, but plastic surgery is not golf. If you hit a ball into the woods, you just take a new one. Not so in surgery.

In the UK, Simon Myers from the University of London is elaborating a method to measure our education. Foad Nahai is in contact with him and will further orient us as the work goes on. Thank you for your help, Foad!

In Europe, we have regular meetings with the CEN (Centre Européen de Normalisation) where we define standards that will eventually govern who is allowed to do what operations in what facilities and on what kinds of patients.

We need members who are interested in being the best aesthetic plastic surgeons. This requires continuous education that involves all of us. We are glad for every

contribution. Don't do operations that you don't feel competent to perform. There is always an ISAPS member you can ask for help, or even refer your patient to. We don't need members that only join us to get the membership certificate and then don't pay their dues anymore. We will be very attentive in this matter and eliminate all from our membership list who do not conform to our ethical rules. On the other hand, I would like to thank all those members who contribute to the prosperity of our society.

I wish you all a wonderful summer (or winter down under).

Jan Poëll  
ISAPS President

## DISAPPOINTING MEETING ON EUROPEAN STANDARDS

Ivar van Heijningen, MD – Belgium

ISAPS National Secretary



In earlier articles, I explained the need for regulation of aesthetic procedures, facilities and practitioners. A European Standard would help to accomplish this. On May 6 and 7, stakeholders working on the European Standards for Aesthetic Surgery Services (ESASS) document met in Graz, Austria for the third plenary session to try to come to a final draft.

### Comments

In two days, we had to cover a 75-page list of comments which included two tables trying to link procedures to practitioners. It proved to be too much. We lost an entire day covering the comments on clauses we had already discussed at the meeting before this one. Although everybody has the right to suggest amendments, in fact parties joining the mirror committees at a later stage brought up most of the “new” comments on these clauses. To put it another way, many organizations and societies who were either unaware of or not willing to show up at prior meetings now had a lot of comments we needed to review.

### Specialty and training

Considering the number of comments on the clause related to procedures, we started the second day with an overview of all the “pros” and “cons” of specialties versus competence. Traditionally, adequate knowledge and competency is obtained through the training program of a particular specialty, but with the rapid expansion of the number of aesthetic procedures, as well as with the doctors doing these procedures, this becomes less obvious.

### PRO

- The advantages of linking/restricting procedures to certain specialties are:
- the government and European Union of Medical Specialists (UEMS) recognize these specialties
  - training centers are controlled both by the government as well as by specialist societies
  - the content of the training has been established on a European level in the UEMS-syllabi.

This makes the specialist verifiable for patients and thus the non-specialists have a weak legal position.

### CON

On the other hand, not all specialists are competent! Some specialties have become so broad that we cannot expect someone concentrating on one end of the spectrum for years, say hand surgery, to still be competent in another. Not to mention the fact that the number of procedures has expanded enormously and has included a lot of non-surgical procedures such as toxins, fillers, lasers and various devices. If we look at our specialty, some training centers focus mainly

on reconstructive surgery and mentioning an interest in aesthetic surgery is the surest way NOT to get a training position, so the residents trained here are not the ones best prepared for aesthetic procedures. Besides that, there are vast differences in training throughout Europe. Gynecologists in Germany do all breast procedures while in other countries they do none. In addition to that restricting procedures to certain specialties poses big legal problems since some European countries (e.g. Germany, the Netherlands, Spain) have laws delegating the responsibility for what a doctor does to the individual doctor; hence, if he/she feels competent they are entitled to do the procedure.

### Competencies and knowledge

#### PRO

Other specialties, and especially the non-specialist doctors, argue that competence is particularly important. They do a restricted number of procedures, but do these very often. They know everything about these procedures, so they are better qualified to do them than those with a specialist registration. Because they limit themselves, they deliver better quality, just as the sub-specialization within a specialty improves the quality. As mentioned, this is legally correct in some countries. And as long as a doctor is aware of the importance of the Safety Diamond and chooses what procedure is suited for which patient in an

continued on page 14

Legal – EU, continued from page 13

ethical way, and does the procedure in a safe environment, then it is not important what specialty he/she has.

#### CON

OK, so they concentrate on only these procedures, but how did they learn them? By trial and error? At the cost of how many complications? And by whom were they trained? By the laser industry?

Without proper, registered training it is difficult to know what the alternatives are, especially if you don't do these. Not to mention that you must be able to treat the complications as well. The biggest drawback is that this is a self-proclaimed competency that is NOT controllable by anyone. It could be very adequate, but it could be totally insufficient as well.

#### Conclusions and suggestions

After discussing these pros and

cons extensively, it was concluded that we should not look at the chaotic present situation, but at the future. If we want to guarantee patient safety, aesthetic procedures should be restricted to specialists with a recognized training program. This would make it controllable for patients to know who is qualified and who is not. Since there is a multitude of aesthetic procedures, it would make sense to separate aesthetic procedures into two areas: aesthetic surgery and aesthetic medicine. Those interested should do a sub-specialization with a subsequent exam to guarantee adequate knowledge and skill. If taught in a modular setup, this would allow all specialties to gain knowledge and skill in areas not already covered by their own training programs. Some thought that a separate specialization for aesthetic medicine alone would

be a good idea. It would also be good to recognize "Aesthetic Healthcare" as part of medicine so that it is taken more seriously.

We ended the meeting trying to cover as many comments as possible on the procedure clause. Another meeting is planned in Milano in September.

We as plastic, reconstructive and AESTHETIC surgeons did most of the procedures in the past, but especially the non-surgical procedures are rapidly growing both in quantity and in complexity. If we want to keep our position as the experts in this field, we must improve our training in all aspects of aesthetic healthcare and not limit ourselves to the surgical part. Those teaching should be made aware that this should not be taken lightly! 

ISAPS News is pleased to present a global perspective on fat grafting. With the growing worldwide interest in this procedure, ISAPS representatives from across the globe share their thoughts on practices and attitudes in their regions.



## US PERSPECTIVE

J. Peter Rubin, MD – United States

Fat grafting in the United States has a long history of practice in facial aesthetic surgery. Despite wide-spread use, there is much controversy over the best ways to harvest and process fat tissue, and much debate about the best techniques for injection. A major challenge is collecting well-quantified data on the outcomes from fat grafting to the face. Surgeons are using three-dimensional camera systems in an effort to do this. Beyond facial applications, an emerging trend in the United States is the use of fat grafting for breast augmentation and breast reconstruction. This has been a controversial issue in the United States because of strong statements issued by plastic surgery societies against this in the 1980s. However, these positions have been softened recently and there is currently much activity in this area of practice. Fat grafting is being used for both cosmetic breast augmentation and for breast reconstruction, especially lumpectomy defects and for the feathering of implant borders. An interesting development has been the use of external negative pressure in order to expand the skin envelope and treat the recipient site to optimize the results. This technology has been championed by Dr. Roger Khouri in Miami as well as Dr. Dan Del Vecchio in Boston.

The optimization of methods for harvesting, processing and injecting fat grafts is a topic for which much more scientific investigation is needed. It is important that we

move away from anecdotal evidence in this area and collect stronger clinical evidence to support our practices. A newer development in fat grafting in the United States is the concept of stem cell fat grafting. While strongly rooted in the rationale that adult stem cells are highly bioactive and can release growth factors to assist in the healing process, the actual clinical practices are still poorly defined and not standardized. Moreover, a Google search of stem cell facelift and stem cell face breast augmentation returns 200,000 and 300,000 results, respectively. Despite this media presence, strong evidence is still needed to show efficacy in aesthetic surgical treatment. Recently, a combined task force of the ASPS and ASAPS released a position statement drawing attention to the fact that the evidence available to support stem cell therapies in aesthetic surgery does not adequately justify the widespread marketing that is seen. The position paper called for the collection of well-controlled data in this area. While there is great promise for this technology, we are not ready to call stem cell fat grafting a standard of care.

As one considers the numerous scientific variables that can impact outcome in fat grafting, we realize that fat grafting will become an increasingly useful tool as we continue to improve upon existing technologies and make this technique more reliable in the hands of all plastic surgeons. 

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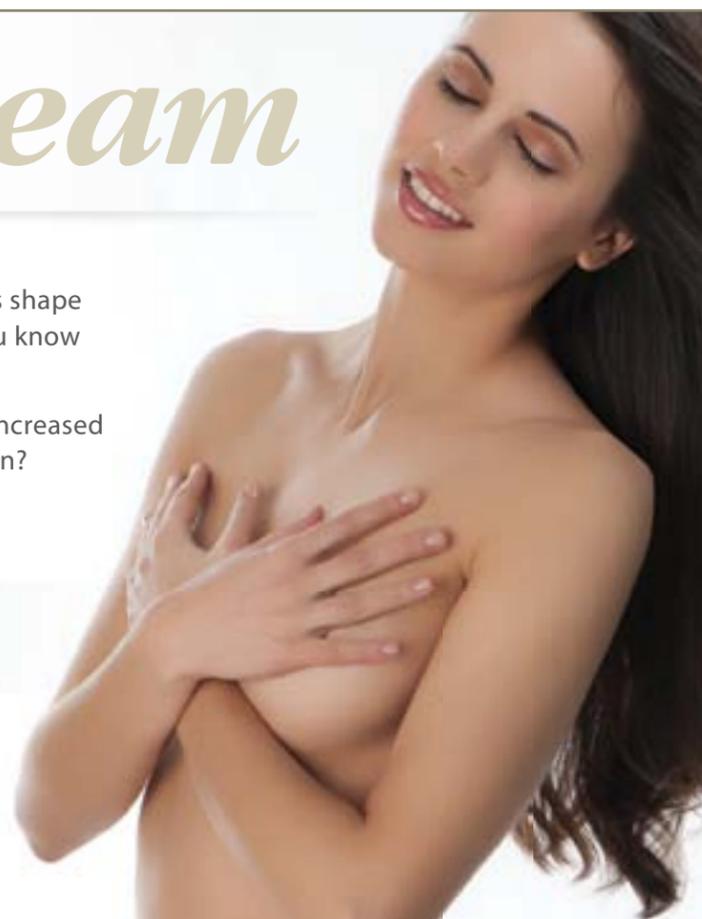
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## MIDDLE EAST AND MEDITERRANEAN PERSPECTIVE

Tunc Tiryaki – Turkey

Traditional notions of beauty vary across cultures and generations. While regional stereotypes may have held true in the past, globalization of both our patients and our discipline is challenging these beliefs. As societies place more and more emphasis on an “international” standard of beauty, the number of people seeking aesthetic procedures is increasing across populations.

In spite of these forces, which are attempting to harmonize our perceptions of beauty, regional variations do indeed influence both patients and surgeons. These sometimes subtle and not so subtle anatomical variations translate into different procedures and emerging trends.

As an example, populations around the Mediterranean and the Near East do not have very prominent cheekbones, resulting in a hollow malar area as well as premature mid-facial aging. As a result, fat transfer for facial rejuvenation is a very popular procedure and structural fat grafting, as popularized by Coleman, is one of the most common facial operations in the region.

Beyond the face, autologous tissue injection for breast

augmentation is becoming more and more popular in the Mediterranean and Near East. This interest is in part due to the guidance document issued by the ASAPS Task force in 2009. Despite the popularity, the long-term predictability of volume maintenance remains a limitation of fat transfer, especially in cases of high volume transplantations. To help overcome the limitations associated with large volume fat transfers, autologous adipose-derived regenerative cells (ADRCs) are increasingly used to enhance revascularization, improve survival rate of grafts, and reduce postoperative atrophy.

To isolate such cells, there are now commercially available systems which prepare populations of autologous cells from fat for use within the same surgical procedure. Such systems are becoming increasingly popular throughout Europe and The Middle East.

Preliminary results suggest that regenerative cell enriched tissue injections might have advantages compared to traditional fat transplantation. This may be particularly true in vulnerable grafts such as large volume fat transfers seen in breast augmentation or damaged, radiated or fibrotic tissues.

As our discipline continues to expand and we share more as colleagues, our regional differences in practice approaches will ultimately make a global impact. 



## AUSTRALIAN PERSPECTIVE

Craig Layt, MD – Australia

Whilst Australia ranks sixth in the world for obesity rates, not a lot of that fat will be utilized for breast augmentation at the moment due to the current regulatory environment. As the use of fat transfer for edge defects in breast reconstruction has become mainstream and fat transfer has become a standard part of most facial rejuvenation practices, indemnity insurers are currently reluctant to insure the practice of breast augmentation using fat. The largest insurer excludes “transfer or injection of non-vascularized fat into the breast(s) as a cosmetic enhancement procedure, except as part of breast reconstruction after mastectomy or trauma.”

The last systematic review of the literature performed by the Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S) was in September 2010 and reflected the increase in evidence of safety and efficacy from the previous review of 2002. This review, along with the exponential increase in research into the area that was evident at the recent Boston Breast Workshop and ASAPS 2011 will hopefully allow the current insurance situation in Australia to change in the near future. Certainly at the above meetings it was “all about the fat!” 



## EUROPEAN PERSPECTIVE I

Marita Eisenmann-Klein, Prof.h.c., Dr.med. Dr.h.c. – Germany

Innovative plastic surgeons like Jose Guerrerrossantos in Mexico, Abel Chajchir in Argentina, and Sydney Coleman in the US, always were well respected in Europe. Later on, pioneers like Emanuel Delay and his group in France, Gino Rigotti in Italy, and Michael Schefflan in Israel presented long-term follow-ups with encouraging clinical results. Subsequently more and more plastic surgeons in Europe became interested in these techniques. Researchers like Norbert Pallua in Germany prepared the scientific background.

A break-through occurred after Roger Khouri in the US introduced the combination of fat grafting with the vacuum-assisted Bra system. During the past few years many national societies of plastic surgery published statements regarding fat grafting procedures, mostly for the purpose of encouraging their members to inform their patients about the lack of long-term studies and thus indicating that not all potential risks can be judged at present. They also called for long-term studies with larger series.

“We currently are preparing guidelines for the safe and responsible use of fat grafts. We see an urgent need since more and more patients are requesting these procedures,” states Peter Vogt, President of the German Society of Plastic Reconstructive and Aesthetic Surgeons.



This is amazing, since all societies in Europe were cautious about informing the public in order not to create unrealistic expectations. Health authorities in Europe usually do not interfere with medical procedures as long as the European Tissue Law is respected. Therefore, there are no restrictions for application as long as the tissue transfer is done in one procedure. For manipulation of tissue outside the operating room, restrictive requirements exist.

The overwhelming applause for Roger Khouri receiving the best paper award at the European Association of Plastic Surgeons (EURAPS) meeting in Mykonos, Greece on June 2nd, 2011 demonstrates better than anything else that fat grafting is considered a major asset if not a paradigm shift in plastic surgery practice in Europe. 

## EUROPEAN PERSPECTIVE II

Kai-Uwe Schlaudraff, MD – Switzerland

One hundred years after the first report on autologous fat transfer in Europe, Sidney Coleman described his technique of fat injection thus defining the starting point of modern fat grafting and triggering renewed interest for adipose tissue in both research and clinics.

In Europe, the idea of using the patient’s own adipose tissue remained controversial for many years – mainly over concerns of its efficacy and safety in particular in the breast. Initially critically reviewed and banned by plastic surgery societies in the breast, fat grafting would only be adopted by few European plastic surgeons and limited in their use to “safe indications.”

Today, things have changed: the outstanding work of E. Delay, G. Rigotti, C. Calabrese, M. Eisenmann-Klein, M. Schefflan and many others have led to a more refined understanding of the fat and its cellular components like adipose derived regenerative cells (ADRCs). Impressive reconstructive and aesthetic results and positive reviews by most national plastic surgery societies – for example the German society in 2009 – have encouraged European

plastic surgeons since risks associated with autologous fat transplantation are at present considered to be minor. New approaches like cell-enriched fat grafting might offer additional advantages and are currently evaluated in several European centers.



Europeans are highly pleased by the concept of a “natural” treatment using autologous tissue thus avoiding foreign bodies and patients are increasingly requesting fat grafting procedures. However, the experience with the 1992 ban of silicone implants in the USA and parts of Europe due to a lack of scientific data should motivate us to take proactive measures by (1) formulating best practice guidelines for harvesting, injection and follow-up volume measurements, (2) reviewing European tissue laws regulating adipose tissue banking and (3) establishing a European register for fat grafting to the breast.

We are witnessing a paradigm shift: the fat, for now neglected in its functions and unwanted by everybody, will soon be broadly discussed as a source of regeneration and healing – in plastic surgery and beyond. 

## ASIAN PERSPECTIVE

Kotaro Yoshimura, MD – Japan

In Asian countries, liposuction is much less frequently performed than in western countries due to the lower number of obese people. However, fat grafting is a relatively popular procedure as a facial filler, especially in South Korea. Fat grafting and its application to the breasts has been getting more attention in Asia in the last few years. Although the face is the most frequent site, large volume lipofilling is increasing as specific devices and machines for large volume processing and injection become commercially available. Lipofilling to the breasts is still controversial, but some plastic/cosmetic surgeons do fat grafting to the breasts as their predominant method for breast augmentation. Lipofilling to the buttock, the hand, and for scarring remains rare.

Centrifugation is the most common processing of injection fat tissue compared to other procedures such as gravity precipitation or filtration. Coleman instruments and techniques are popular for fat grafting to the face in many Asian countries, especially in South Korea. Lipokit is also becoming popular for fat centrifugation in larger volume such as for the breasts. In general, syringe aspiration is used for a small volume, while suction-assisted lipectomy is used for a large volume.

Stem cell application is being used by a limited number of surgeons. Manual isolation of stromal vascular fraction is done in an aseptic cell processing room or with a clean-bench isolation system placed in an operating theater. Full-automatic or semi-automatic machines provided by Korean or American companies are also used by a limited number of clinics and hospitals in South Korea and Japan. Platelet-rich plasma is also combined by some surgeons.

In Japan and Hong Kong, invasive procedures are less popular than in other Asian countries. Hyaluronic acid products are frequently replaced by lipofilling in some applications of the face and breast in Japan.

The downtime after surgery is always an issue of fat grafting to the face. If patients do not mind the downtime, fat is over-injected so that the one session of lipofilling is sufficient to get a satisfying result. If patients are concerned about post-operative swelling, a relatively small volume of fat is injected with delicate and careful techniques and multiple sessions are required.



## SOUTH AMERICAN PERSPECTIVE

Carlos Oscar Uebel, MD PhD – Brazil

In 1983, Abel Chajchir from Buenos Aires published the first paper on fat grafting. He opened a new era in South America followed by surgeons, especially from Brazil, were Luiz Toledo, Ronildo Storck, Carlos Uebel, Luiz Haroldo and many others improved continuously this technique using not only in the face, but also in breast and body contouring. In the beginning of the 1990s, with the high fillers marketing promoted by the products of PMMA, Collagens, Hyaluronic acid etc., fat grafting suffered a tremendous decline. But now a days, with the appearance of intense fillers, complications and sequels, fat grafting got again its podium and has become a very common procedure done by almost all plastic surgeons.



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## EMAIL SPOOFING AND OTHER MALICIOUS INTERNET ACTIVITY

Richard H. Read — United States

ISAPS Information Technology Consultant



We've had reports recently from people receiving spam emails that appear to be coming from isaps@conmx.net. Our email system has been carefully audited and we know that these messages do not in fact come from our servers or from

ISAPS staff. Still, you should know that we are aware of this problem. I would like to tell you about a few common ways that spammers operate. While I cannot provide a comprehensive explanation of spam email in one short article, I would like to tell you about one method by which you might appear to be receiving spam from conmx.net – when in fact we did not send it.

The content of the recent spoofed malicious messages included a link to a malicious web page, which has since disappeared. This method, called a drive-by download, is a common way for the spammer to get his malware installed on your computer. The web site – and sometimes they are legitimate web sites – has been hacked in such a way as to install the spammer's software onto the computer if the user clicks on a dialog box, or if it is missing security updates or other protection.

So where do these messages come from if not from ISAPS? This question opens the subject of email spoofing. This happens when someone (generally a spammer) intentionally sends email, almost always with malicious intent, making it look like the message was sent from someone else. This is possible when there is no authentication (proof that the sender is who he says he is) on the Internet.

It benefits the sending spammer to make it look like the message came from a trusted party, in this case isaps@conmx.net, since the recipient is more likely to open an email from someone they know.

So how does the spammer know that you are sometimes a recipient of legitimate email from conmx.net? There are millions of machines on the Internet that are compromised. That is, they were not suitably protected or, even if they were, the user was tricked into running a program created by the spammer. Now that machine is said to be

“owned” by the spammer. The spammer's malware can do a search of the entire hard disk of this “owned” computer, searching address books and other data files for pieces of data that look like email addresses. The spammer's malware might find messages that had been sent by isaps@conmx.net as well as people who had received that message. With this information, the malware could resend spam messages apparently originating from conmx.net, but with subject and content of the spammer's choosing.

Once this spammer has a list of such addresses, he can sell it to other spammers. And on it goes. Symantec, a leading anti-spam provider, released a report last month saying that about three quarters of all Internet email is spam. This does not help when we rely so heavily on email to communicate with our members.

The vast majority of spoofed email simply goes away in a few days. It can take that long for the spam filters to get updated, but spoofing attacks do eventually stop.

So what to do about this tidal wave of spam that is meant to mislead recipients and get them to click on something they should not? Here are some tips for safer computing:

- Use an email provider that has built-in anti-spam tools, and be sure the tools are turned on. This will keep the bulk of spam from getting to your inbox.
- If the message content does not look like it came from the person who sent it, delete it or verify the sender before opening.
- Keep your operating system updated with the latest patches and protective software.
- NEVER click on any links in suspected spam messages.
- Do not click on attachments or pop-ups if they are not expected. Doing so will allow the spammer to install malware.

These are standard practices for handling any email. We follow these guidelines in the ISAPS Executive Office, and hope you will, too. Until the spammers are put out of business, it pays to stay alert.



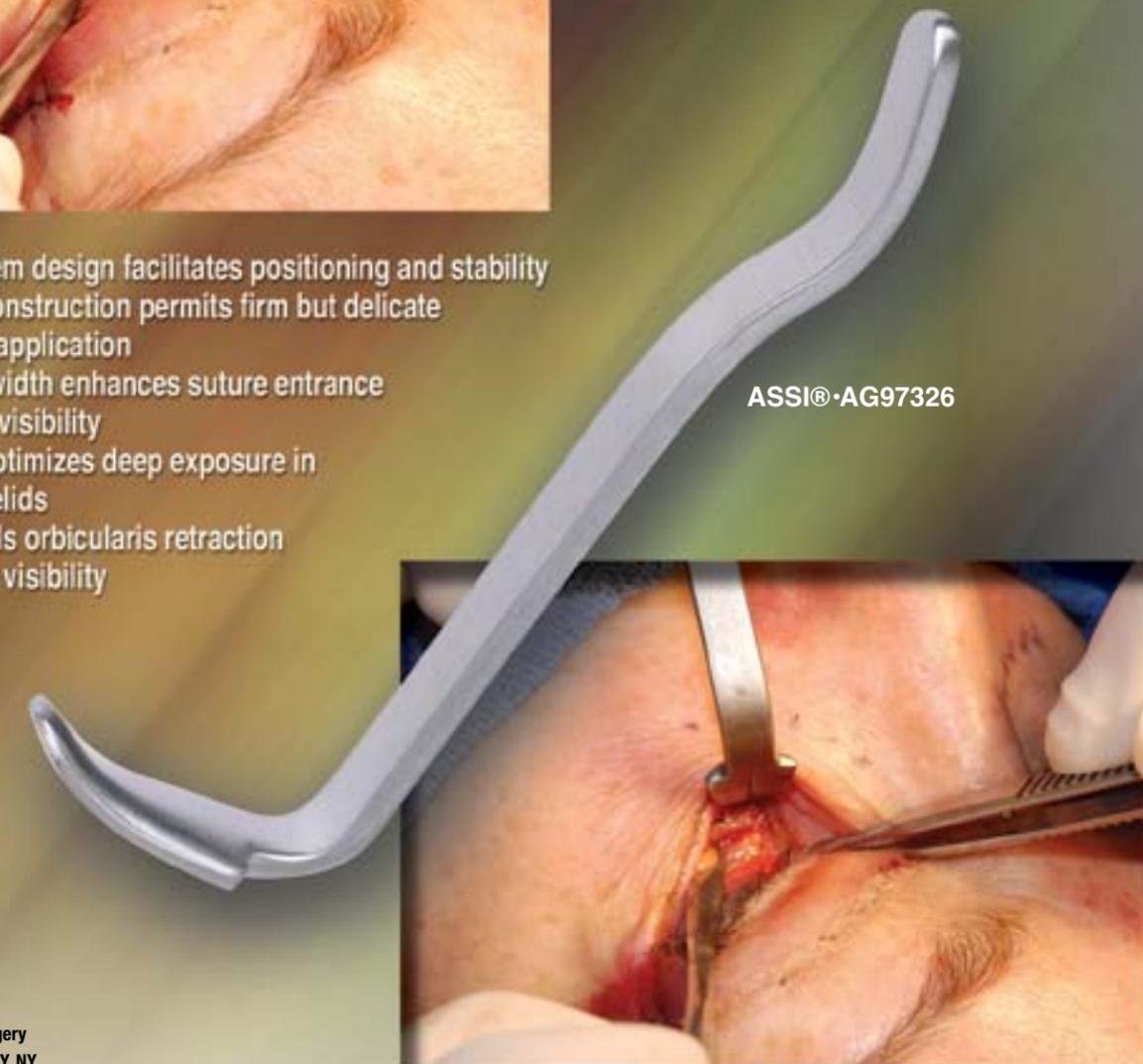
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## 2011 AMERICAN-BRAZILIAN AESTHETIC MEETING – PARK CITY, UTAH

Renato Saltz, MD – United States

ISAPS 2nd Vice President and ABAM Chair



The 3rd American-Brazilian Aesthetic meeting held in Park City, Utah from March 4-7, 2011 attracted registrants not only from the US and Brazil but also from 15 other countries. We had a record attendance of over 250 including plastic surgeons, residents, nurses and aestheticians – and their families – perhaps the largest attendance ever at any ski meeting in the United States.

Endorsed by ISAPS, ASAPS and ASPS, this year's ABAM and was made possible through the generous support of many exhibitors and sponsors.

The scientific program was quite intense and once again offered a unique opportunity for residents and young colleagues to present their work at an international educational event. The panels focused on the main topics of aesthetic surgery and cosmetic medicine with recognized leaders from the US and abroad debating the same topic and sharing their unique experience with the audience. Three workshops offered by Allergan, Silhouette Lift and Sculptra and a special skin care panel presented by leaders of the Society of Plastic Surgical Skin Care Specialists attracted a lot of participants and enhanced the scientific quality of the meeting.

With the continued support of a world class faculty and new surgical and skin care techniques presented at the third ABAM meeting, I am sure this annual meeting will continue to attract new (and past) registrants and to achieve recognition in the future.

Once again, the program was planned to allow the group to enjoy the great outdoors. The “Best Snow on Earth” and the record-breaking snowfall this year was a nice bonus for all who attended. On our final day, nearly half of the group participated in our traditional snowmobile trip in the nearby Uinta Mountains. It was an epic day in the snow.

My sincere thanks to my co-chairs, Drs. Foad Nahai, Joca Sampaio Goes, Mark Jewell and Ricardo Ribeiro for their outstanding work; to ISAPS, ASAPS and ASPS for endorsing the meeting; to the many companies that exhibited and sponsored this event and who continue to support the American-Brazilian Aesthetic meetings; and to all the participants who came to Utah from around the world.

Our 2012 meeting is already being planned. The dates are set for February 2-5 on the Island of Florianopolis, Brazil. Save the date as more details will be released soon. Come enjoy this summer paradise in Southern Brazil and share your experience in aesthetic surgery and cosmetic medicine with ISAPS Members from all over the world.



**Program Committee:** Mark Jewell, Joca Sampaio Goes, Foad Nahai, Ricardo Ribeiro, and Renato Saltz.



Beautiful vistas, spectacular skiing.



A great day of snowmobiling in the Uinta Mountains.

## EUGEN HOLLÄNDER (1867-1932) – A WIDELY FORGOTTEN PIONEER OF AESTHETIC SURGERY, FAT INJECTION AND MEDICAL ART HISTORY



Andreas Gohritz, MD and Peter M. Vogt, MD, PhD – Germany

*I would like to introduce Dr. Andreas Gohritz, a plastic surgeon working at the Medizinische Hochschule in Hannover (Germany) and keen on the history of our specialty. His paper on Holländer demonstrates the first clinical application of fat injection into the face and breast. —Riccardo Mazzola, MD – Italy – ISAPS Historian*

### Abstract

Autologous fat grafting has been recently rediscovered as a highly versatile method for soft tissue correction or augmentation. Yet little is known about the first minimally invasive fat injections performed as early as 1906 by the German surgeon Eugen Holländer (1867-1932) whose reputation has fallen into oblivion.

The objective of this article is to remember the life and work of this forgotten pioneer who contributed important innovations to aesthetic plastic surgery.

Holländer invented a method for reconstructive rhinoplasty using breast flaps in 1913 and in 1924 introduced a surgical therapy for “pendulous breasts.” In 1910, reporting “A case of progressive fat atrophy and its cosmetic replacement by human fat” he described injecting a mixture of human and ram’s fat using thin cannulas for soft tissue correction and later also applied fat injections for a variety of other reconstructive indications including post-mastectomy breast deformities and painful scars.

He also became a cultural historian, founding the medical art history movement in Germany. Sadly, his unique collection of thousands of medically interesting art subjects was lost during World War II, but can still be admired in his numerous books. He died in 1932 from a stroke. His fame was suppressed by the Nazis because of his Jewish origin and his family was forced to emigrate.

Eugen Holländer was a multi-talented physician whose work gives insights into the history of aesthetic plastic surgery and is still an inspiration from a surgical, medico-historical and cultural point of view.

### Introduction

Fat tissue transfer is not a new idea in plastic surgery and since it was reported for the first time at the end of the

19th century, ideas and techniques have greatly changed. During the last decades, autologous fat grafting for tissue augmentation and reconstruction has attracted renewed interest. Coleman and other authors recommend strict methodology and specific material to reduce reabsorption and increase adipocyte survival. Atraumatic liposuction and centrifugation is combined with the re-injection of purified adipocytes placing small amounts in multiple tunnels to enhance contact and vascular supply between transplanted adipocytes and surrounding tissues.

Curiously, the first minimally invasive fat injections performed since about 1906 by the German surgeon Eugen Holländer have been scarcely mentioned in the literature, although they represent an important milestone in the history of filler materials.

### Beginning of Fat Grafting

The first reports of the use of free fat grafts date from the end of the 19th century when Gustav Neuber (1850-1932) in 1893 transplanted walnut-sized fat lumps from the upper arm to the orbit for scar revision with a “pleasing” result. Vincenz Czerny (1842-1916) in 1895 restored the breast contour by lipoma transplantation from the buttock, reportedly much to the satisfaction of the affected female dramatic singer. Erich Lexer (1867-1937) dedicated a chapter of more than 280 pages in his famous work *The Free Transplantations* (1919). He applied this technique to treat facial defects (e.g., hemifacial microsomia), depressed or adherent scars, breast asymmetry, reconstruction of eye sockets, prevention of skin adhesions after tendon or nerve reconstruction and also to fill in wrinkles and folds. Interestingly, not even Lexer in his extensive references gives credit to Holländer and his contributions, although he worked at the same time as Holländer in Berlin.



Figure 1

**The Surgeon**

Eugen Holländer (figure 1) started his medical career as a ship doctor in 1891, before entering his surgical training of 15 years under the guidance of James Israel (1848-1926). Israel is recognized as a world-famous pioneer of renal surgery and plastic surgery, above all facial and nose reconstruction, at the Jewish Hospital in Berlin.

Holländer himself invented a method for nose reconstruction using a distant flap from the breast (1913w) (figure 2) and a surgical technique to lift up “pendulous breasts” (1924). He also devised a now obsolete therapy for lupus using hot air,



Figure 2

chinin and iodium. During the First World War, Holländer was appointed as interim chief of surgery at the Charité Hospital which enabled him to perfect his skills in plastic surgery. Later, he dedicated himself to

aesthetic surgery in many famous patients in Berlin, the cultural and political center of Germany, including film stars and the Persian Shah and numerous women in his harem.

**Early Face Lift Operation**

Holländer probably performed the first face lift as early as 1901. A Polish aristocrat consulted him with a drawing and asked him to remove pieces of facial skin in front of the ear to achieve a favorable adjustment of the nasolabial folds and elevation of the corners of the mouth.

At first, he tried to escape the idea of performing such an operation, especially because he would have been probably the first to attempt such an unknown procedure. However, “as a victim of feminine persuasion,” he finally removed skin at the borders of the hairline and in the natural aging skin folds to “freshen up” the woman’s wrinkles and drooping cheeks.

Not until 1932, probably aware of the increasing number of articles dealing with face-lifting techniques, did Holländer write that it was actually in 1901 that he had performed this operation for the first time. He judged his results in these early cases as “inferior,” as they had only little effect on wrinkles in the lower portions of the face. He pointed out, however, that the patients were mostly very satisfied and reported a positive “effect on the soul.”

**First Fat Injection**

In 1910, Holländer published “About a case of progressive fat atrophy and its cosmetic replacement by human fat” in a 21-year-old woman who, due to her extreme bilateral facial lipodystrophy, did not dare to leave her home anymore (figure 3). He decided to inject human fat to



Figure 3a



Figure 3b

prevent the notorious risks of paraffin injections, such as painful swellings, migration, infections, blindness and pulmonary embolism which had turned this method, introduced by Robert Gersuny (1844-1924) and Leonhard Corning (1855-1923), from a “miracle” to a catastrophe.

Holländer stated that after gaining experience with fat injections for about four years, he preferred a mixture of human and ram’s fat. He regarded this blend as the secret of success to avoid reabsorption and stabilize the result by some kind of inflammation and resulting “inner intumescence.”

One may observe that his technique greatly differed from modern “atraumatic” techniques, but it also

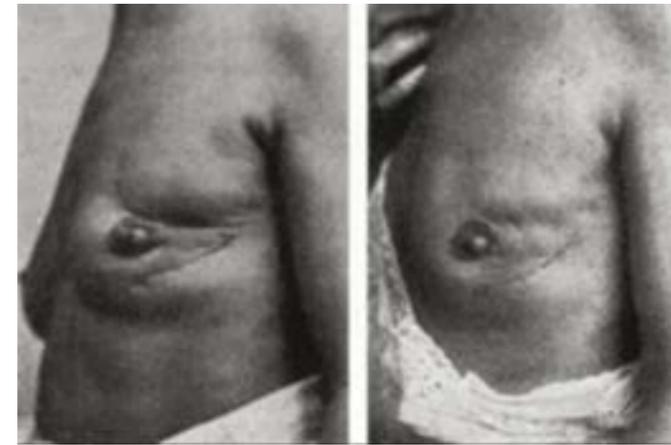


Figure 4a

Figure 4b

shows some surprising similarities. He usually harvested fat from hernia, lipoma or grafts, then cooked it for three hours before the fat had to rest for two days. After re-cooking immediately before the planned use, he composed his special mixture with ram’s fat. Holländer recommended “homogenous filling” using thin cannulas “without particular pain” and voluminous over-filling and over-correction to anticipate the partial re-absorption. As he concludes in his case report, the young patient was “very pleased” with the “lasting” correction of the “repulsive skull-like appearance of the face” and after some months resumed her job. Holländer was obviously also satisfied with his approach, as he used fat injections until his death in 1932 and also applied the technique for other indications besides facial defects, for example in breast deformities or painful scars on the chest wall after mastectomy (figure 4).

**Cultural Historian**

After 1912, Holländer devoted himself intensively to writing several outstanding books that dealt primarily with medicine and surgery as depicted in paintings, sculptures, illustrations, caricatures, and satire in the entire historic period from the art of Ancient Greece to his time. Holländer’s unique collection of thousands of medically interesting art subjects personally assembled on his countless travels through Europe became the foundation of a permanent exhibition in 1906 at Kaiserin-Friedrich-Haus for public education in Berlin. He became curator and a titular professor in 1907.

Sadly, the material of this permanent exhibition was almost completely lost in the chaos after the Second World War in 1945. It was probably transported to Russia – the

exact whereabouts are still unknown.

Serendipitously, great parts of this treasure can at least be observed in Holländer’s many beautiful books like *Medicine in Classical Painting* (1905), *Caricature and Satire in Medicine* (1905) and *Plastic and Medicine* (1912). Holländer himself characterized his passion as a “happy activity outside one’s profession.” His books were acclaimed widely and the judgement of Karl Sudhoff, the leading medical historian of the time, remains valid until today: “This work will be for today’s plagued physician a relaxing refreshment, a fresh drink of water, taken from the deliciously sparkling well of the past.”

**Death and Loss of His Fame**

Holländer’s fame was suppressed politically because of his Jewish origin by the Nazis who came to power only a few months after his death (1932) in Germany. His wife was forced to write the word “Jew” in red color over the name plate of his practice and later she, with two sons and one daughter, had to emigrate. Holländer’s ashes were taken from Berlin in a sarcophagus to Vienna. Unfortunately, during the following decades there was no institution or pupils to care for his reputation and his merits fell largely into oblivion.

**Conclusions**

Holländer was a multi-talented physician whose work gives insights into the history of our specialty of plastic and aesthetic surgery. His life and work is still an inspiration from a medical, cultural, and historic point of view and remains a source of and personal pleasure for every bibliophile surgeon. 

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## TEAM WORK

Lina Triana, MD – Colombia  
Chair of National Secretaries



We all know we can work together for our specialty and our society as a team. I am convinced that if we share our experience in our diverse countries, we can help each other, and also strengthen ISAPS. We National Secretaries are the voice of our members. It is important that we communicate freely. As Chair of National Secretaries, I am open to suggestions and appreciate the board's support that we hold National Secretaries meetings when we gather at major international events.

We had two National Secretaries meetings in May: one during the ASAPS meeting in Boston and the other during the IPRAS meeting in Vancouver. In total, more than thirty-five members participated. Both of these informal meetings generated positive input from those National Secretaries who attended.

ISAPS board members at each meeting reinforced the importance of National Secretaries to our organization. Dr. Nazim Cerkes, Chair of our Education Council, explained how educational programs can be organized in any country to meet our goal of offering high quality aesthetic surgery courses worldwide. Alison Thornberry, representing our insurance partners in London, explained how the ISAPS insurance program advances our patient safety initiatives. She answered many questions both during and after each meeting, correcting misperceptions, so our National Secretaries understand and appreciate how this program really works. We now have members enrolled in twenty-five participating countries and encourage all National Secretaries to contact Alison for information. Here email is [alison@sureinsurance.com](mailto:alison@sureinsurance.com). Thank you to all who have already joined to help create the global public directory of ISAPS surgeons in this program.

We addressed each National Secretary's experiences, problems, and ideas to help grow ISAPS with only the best qualified members making us the largest body of international aesthetic plastic surgeons. We must focus on quality care and patient safety and be aware of the non-core doctors doing cosmetic surgery. We have an increasing number of benefits including an excellent journal, high quality educational programs, an interesting newsletter, ISAPS insurance that strengthens our patient safety program, and are doing our best to gather global statistics on aesthetic surgery. We need to promote these benefits among our colleagues who can also promote the importance of ISAPS membership to the

general public.

### Look at the Geese: nature's masters of teamwork

Next autumn when you see the geese flying south for the winter, notice how they fly in a "V" formation. Studies show that this augments their power by 70%. *People who work together and share the same direction arrive at their goals faster because they support and strengthen each other.*

When a goose leaves the formation, he feels the air resistance, realizes how difficult it is to fly alone, and quickly returns to the "V" to regain the power of the group. *If we do all we can to go beyond our differences, we can share one direction and serve with the best of ourselves.*

When the leader of the geese gets tired, another goose takes his position. *We will get better results if we take turns doing the hard work, instead of letting a few carry all the weight.*

Biologists observe that the geese at the back of the "V" make special sounds to encourage those in front to maintain their speed. *One encouraging word can produce big benefits. Stimulation motivates and comforts.*

If a goose gets sick or injured, two other geese leave the formation and follow him to help and protect him. They stay with him until he can fly again. *National Secretaries can work together to help each other – to help ISAPS – to help our patients.*



### International Study of Aesthetic Surgery Procedures

Dear Plastic Surgeon Colleagues,

Our global survey of aesthetic procedures is successfully attracting many participants. We want to ensure that all plastic surgeons have a chance to participate.

I encourage you to complete the 2nd ISAPS study of global aesthetic surgery procedures. Thank you if you have already submitted your data.

To participate in this global study, go to [www.isaps.org](http://www.isaps.org) and click on the link under NEW: Global Statistics Survey in the General Info & News column on our homepage.

Joao C. Sampaio Goes, MD, PhD (Brazil)  
Chair, ISAPS Communications Committee

## ISAPS INSURANCE PROGRAM: AN UPDATE

James Frame, MD and Alison Thornberry – United Kingdom



The ISAPS insurance message is slowly but steadily travelling through our international society with very positive results. Managing Director of Sure Insurance, Alison Thornberry, has joined with ISAPS staff at conferences in Brazil, Romania, the United States, and Canada to help members understand the program. Her brief and patient one-on-one explanation of how Surgery Shield will help our members and their patients has gone a long way to clarify how our insurance program works. She is looking forward to traveling to more ISAPS Courses and national society meetings in the near future.

Included here are a few statements, to clarify the most common misunderstandings.

- The insurance can be used for all patients, both at home and abroad;
- ISAPS Insurance does not promote medical tourism;
- Surgeons can promote to their patients that they are covered by ISAPS insurance and can offer a "patient guarantee";
- Should a patient travel to an ISAPS member surgeon who is covered by the ISAPS insurance and subsequently suffers a complication, they can be treated in

their home country by another ISAPS member surgeon, but only after the original surgeon has given their permission; and

- Patients cannot make a claim, only the surgeon can decide if remedial work is necessary.

Countries with ISAPS members now listed in the new Public Directory of ISAPS surgeons participating in this program include:

Argentina	France	South Africa
Brazil	Germany	Spain
Canada	Israel	Tunisia
Colombia	Italy	Turkey
Costa Rica	Lebanon	United Arab Emirates
Cyprus	Mexico	United Kingdom
Ecuador	Qatar	United States of America
Egypt	Romania	
Estonia	Singapore	

Please go to [www.isapsinsurance.com](http://www.isapsinsurance.com) should you wish to join. There is no cost to be included in the Public Directory. To request further information, email [alison@sureinsurance.com](mailto:alison@sureinsurance.com)

WWW.AESTHETICSURGERYNY.COM

# THE CUTTING EDGE 2011

## ADVANCED BODY SCULPTING HEAD TO FOOT

### NEEDLE, LASER, CANNULA, KNIFE

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DANIEL C. BAKER, M.D.  
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Course Chairmen

## 31<sup>ST</sup> AESTHETIC SURGERY SYMPOSIUM

THE WALDORF ASTORIA HOTEL GRAND BALLROOM, NEW YORK, NEW YORK DECEMBER 1, 2, 3, 2011

- CURRENT AND FUTURE STEM CELL SCIENCE AND BIOLOGY WITH CLINICAL APPLICATIONS
  - MOST POPULAR TECHNIQUES FOR HARVESTING, PREPARATION, AND TRANSFER OF FAT: WHICH IS BEST? ADVANTAGES, DISADVANTAGES, DONOR SITES, FUTURE TECHNIQUES
  - SPECTRUM OF FILLERS NEW AND OLD: CHOICE, SAFETY, VOLUME, LONGEVITY, COMPLICATIONS
  - SCULPTING INDIVIDUAL ANATOMIC REGIONS WITH NON-INVASIVE AND MINIMALLY INVASIVE TECHNIQUES COMPLEMENTING OR REPLACING TRADITIONAL SURGERY:
- |                        |           |                               |
|------------------------|-----------|-------------------------------|
| EYELIDS AND PERIORBITA | ABDOMEN   | THIGHS, KNEES, CALVES, ANKLES |
| FACE AND NECK          | BUTTOCKS  | ARMS AND BACK                 |
| BREAST                 | GENITALIA | HANDS AND FEET                |
- AN INTERNATIONAL FACULTY OF SCIENTISTS AND SURGEONS WILL MAKE THIS A HIGHLY EDUCATIONAL, COMPREHENSIVE, MULTIDISCIPLINARY AND CONTROVERSIAL SYMPOSIUM
  - SURGICAL VIDEO THEATER: THE MASTERS AT WORK
  - ALLERGAN ACADEMY\*

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# GLOBAL SURVEY OF ANTIBIOTIC PROPHYLAXIS IN AESTHETIC SURGERY

Felmont F. Eaves III, MD – United States



The ISAPS Global Survey series has provided invaluable insights into international trends and perspectives, and the latest survey is no exception, highlighting significant regional differences in the approach to prophylactic antibiotic utilization. While some of the surveys may elucidate differences in personal perspective, philosophy, or approach of aesthetic surgeons worldwide, the timing, selection, and duration of antibiotic utilization should be driven by an evidence-based approach rather than personal preferences. As such, the ISAPS Global Survey of Antibiotic Prophylaxis in Aesthetic Surgery creates a baseline of current utilization and a benchmark against which the impact of evidence-based driven educational efforts going forward can be measured.

## THE SURVEY

Over several months, a series of blast emails was sent to approximately 21,000 addresses with 1,734 responses received as of May 29, 2011. The greatest numbers of respondents were from Europe (547, 31.6%) followed by North America (438, 25.3%), South America (350, 20.2%) and Asia (219, 12.6%). More than half of the respondents, or 943 (54.4%) were ISAPS members, representing 51% of the total 1,835 Active and Candidate ISAPS membership, and 790 non-members. The proportion of members to non-members varied by region, with the United States having 120/390 (30.8%) members and 270/390 (69.2%) non-members and Europe with 355/547 (64.9%) members and 192/547 (35.1%) non-members as the most varied. A broad range of ages was represented with 23.9% (415) in practice 1-10 years, 33.3% (578) in practice 11-20 years, and 39.9% (692) in practice more than 20 years. More than half (n=982, 56.7%) were in solo or small group (up to three surgeons) private practice with about a third (n=529, 30.5%) in institutionally-based academic, university, or hospital practices.

Respondents indicated their typical antibiotic prophylaxis regimen for eight different types of procedures (no antibiotics, single dose, up to 24 hours, etc.) (see Figure 1). Antibiotic use varied significantly among the procedures, with the lowest rate of utilization during blepharoplasty

(55.8% of respondents) and highest for breast augmentation (97.5%), abdominoplasty (94.0%), and breast reduction/mastopexy (92.8%). Regardless of the procedure, about one fourth (21.9% to 27.5%) of the participants used a single dose only regimen, and an additional one tenth (8.1% to 10.8%, blepharoplasty excluded) used a 24 hours regimen.

Totals for regimens following a 24 hour OR LESS protocol, often advocated by infectious disease specialists, ranged from 27.6% to 38.3%. Individual twenty four hour or less protocols were distributed as follows:

- blepharoplasty [382(23.0%)/76 (4.6%)=27.6%]
- face/brow/neck lift [448(27.5%)/176(10.8%)=38.3%]
- rhinoplasty [408 (25.5%)/149(9.3%)=34.8%]
- breast reduction/mastopexy [421(24.9%)/173(10.2%)=25.1%]
- augmentation mammoplasty [424(25.1%)/143(8.5%)=33.6%]
- abdominoplasty [372(22.0%)/153(9.0%)=31.0%]
- liposuction [456(27.3%)/145(8.8%)=36.0%]
- fat grafting [391(25.1%)/126(8.1%)=33.2%]

## GEOGRAPHIC VARIATION

Of some concern is the finding that more prolonged courses of antibiotics were routinely seen in virtually all geographic regions and procedures, potentially a mechanism of the development of antibiotic resistance. Many public health and infectious disease experts warn of the overutilization or underutilization of systemic antibiotics, and in the United States, for example, reimbursement for certain surgical procedures may be denied if antibiotic prophylaxis is not started on time (recommended 30-60 minutes prior to incision) or is continued past twenty-four hours. Canadians appeared to have the lowest overall utilization of antibiotics, with no prophylaxis between 6.3% (augmentation) and 91.3% (blepharoplasty) of cases, and many procedures mid-range (e.g. rhinoplasty 59.1%, liposuction 47.9%, and fat grafting 57.1% with no prophylaxis). European and Asian surgeons were the next most common groups not using prophylaxis. On the other end of the spectrum, significantly prolonged therapy (five days or

	None	Single dose	24 hours	2-5 days	5-7 days	longer	Response Count
Blepharoplasty	44.2% (735)	23.0% (382)	4.6% (76)	20.2% (335)	8.7% (145)	0.1% (2)	1,662
Face, brow, or neck lift	14.8% (241)	27.5% (449)	10.8% (176)	27.7% (451)	20.1% (328)	0.4% (6)	1,630
Rhinoplasty	14.8% (237)	25.5% (409)	9.3% (149)	29.2% (468)	21.8% (349)	0.9% (15)	1,602
Breast reduction/pexy	7.2% (122)	25.0% (422)	10.2% (173)	28.8% (486)	28.2% (477)	2.4% (40)	1,690
Breast augmentation	2.5% (43)	25.2% (425)	8.5% (143)	30.5% (515)	32.0% (540)	3.1% (53)	1,688
Abdominoplasty	6.0% (101)	21.9% (372)	9.1% (154)	28.1% (476)	32.8% (556)	4.4% (75)	1,695
Liposuction	15.5% (259)	27.4% (457)	8.7% (145)	26.2% (437)	21.6% (361)	1.6% (27)	1,670
Fat grafting	18.1% (283)	25.1% (392)	8.1% (126)	25.9% (405)	22.5% (351)	1.3% (20)	1,561
						answered question	1,724
						skipped question	10

Figure 1. Responses to the question “Which of the following antibiotic prophylaxis do you routinely use in the following types of elective aesthetic cases?” Results are show for all respondents and are not filtered by geographic region, age, membership or practice type. Respondents were instructed to leave blank procedures that they do not perform hence varied totals are present.

longer) was most common in Central and South America followed by Asia (see Figure 2). Extended antibiotic use was most common in abdominoplasty, with 66.2% of Central American, 52.8% of South Americans, and 53.8% of Asia surgeons using such a protocol. Extended antibiotic use was also common in augmentation mammoplasty, with rates ranging from 18.8% (Canada) to 64.5% (Central America). Although varied, all regions had a significant number of surgeons who utilized extended antibiotic prophylaxis.

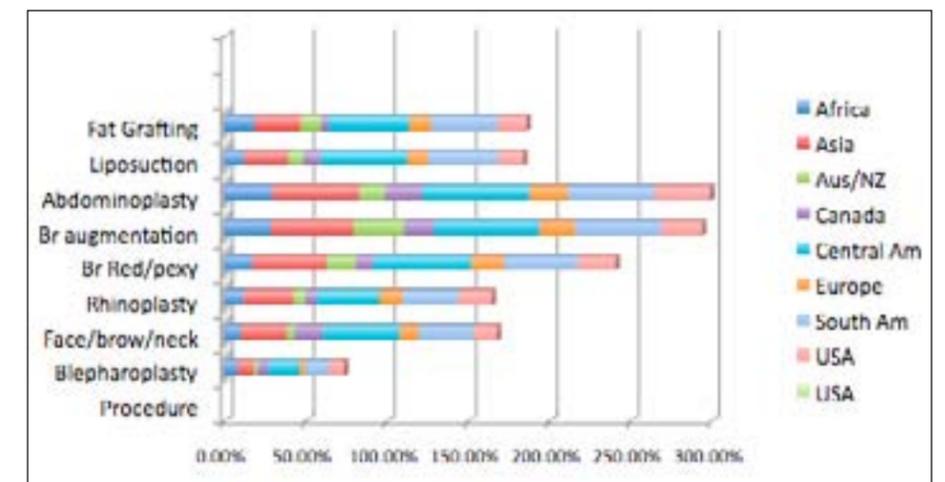
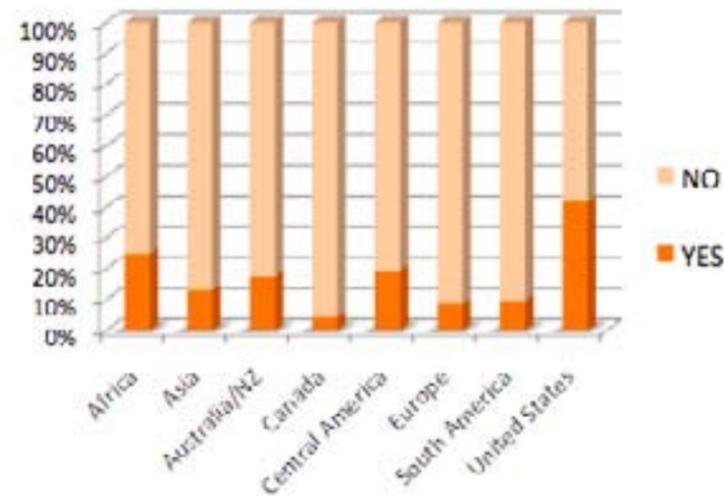


Figure 2. Antibiotic prophylaxis extending five days or longer by case and region, percent of respondents per country



**Figure 3.** Have you ever had an elective aesthetic surgical patient develop a postoperative MRSA infection? By region.

Initiation of therapy in the prescribed time period (one hour) was the protocol advocated by 68.8% of the respondents, while 17.1% began therapy the day before to two hours prior to the procedure and 8.5% began prophylaxis after the procedure. The presence of drains did not alter the course of antibiotics in most (n=1058, 61.6%), although 10.3% (n=176) would increase duration of antibiotics if drains were in place and 26.0% (n=448) leave the patient on antibiotics until the drains are removed.

#### Methicillin Resistant *Staphylococcus Aureus* (MRSA)

One of the most common antibiotic resistant organisms is MRSA. Respondents were asked if MRSA had been reported in their hospital or clinic, and if reported whether there were only a small number or numerous reports. Overall 39.5% (n=673) reported no MRSA in their system, a similar number (n=660, 38.7%) had a reported a small number of reported cases in their area, and 372 (21.8%) stated that there were numerous reports. Respondents also indicated whether or not they had ever had an aesthetic patient diagnosed with MRSA (Figure 3). Of course an individual physician's antibiotic regimen is only part of the story in the development of MRSA; there is a significant impact from the overall level of antibiotic use in their country, the location of services (hospital versus outpatient), tendency to test for MRSA, and the frequency of MRSA in their own community. For example, although the US physicians reported the highest rate of MRSA in individual

patients (52.3%), the same physicians also reported the highest rates of MRSA reports in their community (57.6% numerous reports, 32.5% rare reports, only 9.9% no reports).

#### Antibiotic Selection

Most respondents (n=1454, 85.2%) used a cephalosporin as their first choice for antibiotic prophylaxis in non-penicillin allergic patients. In penicillin allergic patients, cephalosporins were still used in 35.4%, but the quinolones were used in 40.7%, clindamycin in 28.9%, and vancomycin in 8.1%. Quinolones may have a higher chance of leading to MRSA emergence and vancomycin is often "held in reserve" for treatment of MRSA should it be diagnosed. Respondents were also asked how they would manage a patient who developed diarrhea after antibiotic treatment. Most would discontinue antibiotics and give supportive, conservative treatment (n=1130, 66.5%), while 18.9% (n=322) would continue the antibiotics and only 14.6% (n=248) would perform a stool culture which could indicate the presence of *C. difficile*.

Of note, such a robust data set as generated by the large response lends itself to some interesting cross-analysis. For instance, those surgeons who used quinolones for routine prophylaxis were more likely to treat for longer (5 days or more) periods in all procedures surveyed (e.g. augmentation mammoplasty 51.7% versus 35.1%, abdominoplasty 58.8% versus 37.2%, breast reduction/mastopexy 49.7% versus 30.6%). Additional analysis of the data will be performed to look at academic versus private practice, physician age, antibiotic selection, and other factors to identify trends.

The way in which we utilize antibiotic prophylaxis for the prevention of surgical site infections is particularly amenable to the incorporation of evidence based medicine principles. Clearly the wide variability in prophylaxis regimens represents a tremendous educational opportunity to share these principles and incorporate more consistent patterns of therapy worldwide, and this survey can function as a baseline measurement as we assess the effectiveness of our educational efforts.

The leadership of ISAPS would like to thank all of the survey respondents who help provide this important information for the specialty. 

#### ERIC LETROSNE – France

Richard Abs, MD – France



This year began with very sad news. Our friend and colleague, Eric Letrosne, died Sunday, January 2, 2011 – a victim of his passion for extreme sports. He was swept away by an avalanche in the Alps while skiing. Many of you did not know him because he was timid, but Eric was a very kind friend, and he will be greatly missed. Aged 54, he lived in Aix en Provence, France where he developed a very good cosmetic and breast surgery practice. Eric was an avid sport biker having raced in the Moroccan Atlas mountains in November. He loved sailing and participated in round-the-world sailing competitions for more than 20 years – and he loved the mountains. He was married with two daughters.

#### DAVID RALPH MILLARD, JR., MD – United States

Mark Jewell, MD – United States

National Secretary for the United States



David Ralph Millard, Jr., MD, died on June 19, 2011. Dr. Millard was an amazing gentleman who had a life-long dedication to the art and science of plastic surgery. Initially trained in general/pediatric surgery, he was a trainee under Sir Harold Gillies and studied with Sir Archibald McIndoe and Jack Mustarde and served in both WW II and the Korean Conflict as a plastic surgeon. While serving in Korea, he developed a new type of cleft lip repair that became the standard of the world's reconstructive surgeons. Ultimately, he published his lifework in a 3-volume series, *Cleft Craft*. These books established Millard as one of the greatest authorities in the world of plastic surgery.

Dr. Millard was actively involved in leadership positions within ASPRS (now ASPS), the Plastic Surgery Educational Foundation, and the American Board of Plastic Surgery. In 1988, he received the highest award of the American Society of Plastic and Reconstructive Surgeons in recognition of "his development of the specialty of plastic surgery and his outstanding scientific contributions to the advancement of its practice." He received an Honorary Medal from the People's Republic of China for "his achievements in cleft lip repair which has opened a new era of cleft lip surgery" and was guest lecturer at the Chinese Plastic Surgery Society in Beijing.

His achievements throughout his career included numerous books, scientific articles and research studies. He received numerous awards and honorary memberships in various plastic surgery societies and medical associations for his advancements. Dr. Millard was described as "the most brilliant and creative plastic surgeon we have alive. His work and publications speak for themselves." Dr. Mark Gorney wrote, "Ralph Millard, MD, during my lifetime, is the living personification of what I have always tried to impart to all residents I have been privileged to teach; the only difference between an ordinary plastic surgeon and a truly extraordinary one is the degree of imagination he or she brings to the table." In 2000, Dr. Millard was nominated as one of only ten Plastic Surgeons of the Millennium by the American Society of Plastic Surgery. His full biography can be accessed at [http://calder.med.miami.edu/Ralph\\_Millard/](http://calder.med.miami.edu/Ralph_Millard/)



Hildebrando LANDAZURI, MD, Peru



Paule RENAULT, MD, Canada (1915-2008)

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**June 2011**

**Meetings:** 3rd International Eurasian Aesthetic Surgery Course **ISAPS-OFFICIAL COURSE**  
**Location:** Istanbul, Turkey  
**Venue:** Hilton Convention Center  
**Contact:** Nazim Cerkes, MD  
**Tel:** 90-212-283-9181  
**Fax:** 90-212-219-0588  
**e-mail:** ncerkes@hotmail.com  
**HomePage:** <http://www.eurasian2011.org>

**July 2011**

**DATES:** 06 JULY 2011 - 10 JULY 2011 **ISAPS-ENDORSED PROGRAM**  
**Meetings:** 2011 Plastic Surgery Congress  
**Location:** Queensland, Australia  
**Venue:** The Gold Coast Convention Centre  
**Contact:** Christopher Edwards, MD  
**Tel:** 61-2-9437-9200  
**Fax:** 61-2-9437-9210  
**e-mail:** caedwards@plasticsurgery.org.au  
**HomePage:** <http://www.plasticsurgery.org.au>

**August 2011**

**DATES:** 18 AUGUST 2011 **ISAPS SYMPOSIUM**  
**Meetings:** ISAPS Symposium – Urumqi, China  
**Location:** Urumqi, China

**DATES:** 18 AUGUST 2011 - 20 AUGUST 2011

**Meetings:** X VEMI – International Course in Video Endoscopic Plastic Surgery and Minimal Invasive Procedures **ISAPS-ENDORSED PROGRAM**  
**Location:** Curitiba, Brazil  
**Contact:** Ana Zulmira Diniz Badin, MD  
**Tel:** 55-41-3223-8886  
**Fax:** 55-41-3323-1392  
**e-mail:** clinicaathena@cmathena.com.br

**DATES:** 25 AUGUST 2011 - 28 AUGUST 2011

**Meetings:** 3rd European Plastic Surgery Research Council  
**Location:** Hamburg Harbor, Germany  
**Venue:** Freighter MS Cap San Diego  
**Contact:** Isabelle Laerz  
**Tel:** 49-3641-311-6320  
**Fax:** 49-234-325-2080  
**e-mail:** info@epsrc.eu  
**HomePage:** <http://www.epsrc.eu>

**September 2011**

**DATES:** 13 SEPTEMBER 2011 - 13 SEPTEMBER 2011 **ISAPS SYMPOSIUM**  
**Meetings:** ISAPS Symposium – Sarajevo **ISAPS SYMPOSIUM**  
**Location:** Sarajevo, Bosnia-Herzegovina

**DATES:** 23 SEPTEMBER 2011 - 27 SEPTEMBER 2011

**Meetings:** Plastic Surgery 2011 (ASPS)  
**Location:** Denver, Colorado  
**Venue:** Hyatt Regency Denver  
**Contact:** American Society of Plastic Surgeons  
**Tel:** 1-847-228-9900  
**Fax:** 1-847-228-9131  
**e-mail:** [registration@plasticsurgery.org](mailto:registration@plasticsurgery.org)

**DATES:** 30 SEPTEMBER 2011 - 03 OCTOBER 2011

**Meetings:** ISAPS Course Prague-Czech Republic **ISAPS-OFFICIAL COURSE**  
**Location:** Prague, Czech Republic **ISAPS-OFFICIAL COURSE**  
**Contact:** Nazim Cerkes, Bohumil Zalesak  
**e-mail:** [ncerkes@hotmail.com](mailto:ncerkes@hotmail.com), [zalesak@iexpo.cz](mailto:zalesak@iexpo.cz)  
**HomePage:** <http://www.isapsprague2011.com>

**October 2011**

**DATES:** 21 OCTOBER 2011 - 22 OCTOBER 2011  
**Meetings:** Third Annual Melbourne Advanced Facial Anatomy Course  
**Location:** Melbourne, Australia  
**Venue:** Department of Anatomy, University of Melbourne  
**Contact:** Suzanne Ali, ASAPS Executive Secretary  
**Tel:** 61-2-9437-0495  
**e-mail:** [sali@plasticsurgery.org.au](mailto:sali@plasticsurgery.org.au)  
**HomePage:** <http://www.mafac.com.au>

**DATES:** 28 OCTOBER 2011 - 30 OCTOBER 2011

**Meetings:** ISAPS Course – Sharm El Sheikh-Egypt **ISAPS-OFFICIAL COURSE**  
**Location:** Sharm El Sheikh, Egypt **ISAPS-OFFICIAL COURSE**  
**Contact:** Nazim Cerkes, MD **ISAPS-OFFICIAL COURSE**  
**e-mail:** [ncerkes@hotmail.com](mailto:ncerkes@hotmail.com)

**November 2011**

**DATES:** 04 NOVEMBER 2011 - 06 NOVEMBER 2011  
**Meetings:** 9th Annual IFATS Meeting  
**Location:** Miami Beach, Florida  
**Venue:** Eden Roc Renaissance Hotel  
**Contact:** Catherine Foss  
**Tel:** 1-603-643-2325  
**Fax:** 1-603-643-1444  
**e-mail:** [ifats@conmx.net](mailto:ifats@conmx.net)  
**HomePage:** <http://www.ifats.org>

**DATES: 11 NOVEMBER 2011 - 11 NOVEMBER 2011**

**Meetings:** ISAPS Symposium – Goiania  
**Location:** Goiania, Brazil  
**Contact:** Prado Neto, MD  
**Tel:** 55-14-3621-6206  
**Fax:** 55-14-3621-6207  
**e-mail:** clinicapradoneto@gmail.com

ISAPS SYMPOSIUM

**DATES: 11 NOVEMBER 2011 - 12 NOVEMBER 2011**

**Meetings:** ISAPS Course – Hungary  
**Location:** Debrecen, Hungary  
**Venue:** Kölcsey Conference Centre  
**Contact:** Czaba Molnar and Vakis Kontoes  
**e-mail:** molnar.csaba@eliteclinic.hu; myvakis@hotmail.com

ISAPS-OFFICIAL COURSE

**DATES: 12 NOVEMBER 2011 - 12 NOVEMBER 2011**

**Meetings:** Canadian Laser Aesthetic Surgery Society Annual Symposium  
**Location:** Toronto, Ontario Canada  
**Venue:** Park Hyatt Hotel Toronto  
**Contact:** CLASS  
**Tel:** 1-905-837-1124  
**Fax:** 1-905-831-7248  
**e-mail:** into@class.ca <mailto:into@class.ca>  
**HomePage:** http://www.class.ca

**DATES: 17 NOVEMBER 2011 - 20 NOVEMBER 2011**

**Meetings:** ASAPS Non Surgical Symposium  
**Location:** Sydney, Australia  
**Venue:** Sydney Hilton Hotel  
**Contact:** Suzane Ali  
**Tel:** 61-29437-0495  
**Fax:** 61-2-9437-9609  
**e-mail:** sali@plasticsurgery.org.au  
**HomePage:** http://www.asaps.org

**DATES: 18 NOVEMBER 2011 - 19 NOVEMBER 2011**

**Meetings:** Advances in Breast Surgery  
**Location:** Munich, Germany  
**Contact:** Axel Feller, MD  
**Tel:** 49-89-211-1300  
**e-mail:** a.m.feller@professor-feller.de  
**HomePage:** http://www.professor-feller.de

ISAPS-ENDORSED PROGRAM

**DATES: 25 NOVEMBER 2011 - 27 NOVEMBER 2011**

**Meetings:** ISAPS Course – Body Contouring Live Surgery  
**Location:** Beirut, Lebanon  
**Venue:** Metropolitan Hotel  
**Contact:** Sami Saad, MD  
**Tel:** 961-01-754-734  
**e-mail:** executive@trust-traders.com  
**HomePage:** http://www.lspras.com

ISAPS-OFFICIAL COURSE

**DATES: 26 NOVEMBER 2011 - 27 NOVEMBER 2011**

**Meetings:** CATFAS Asia 2011  
**Location:** Phuket, Thailand  
**Venue:** Movenpick Hotel and Resort  
**Contact:** Elien Van Loocke  
**e-mail:** elien@coupurecentrum.be  
**HomePage:** http://doctorseminar.com/catfas2011/catfas.php

ISAPS-ENDORSED PROGRAM

**DATES: 27 NOVEMBER 2011 - 28 NOVEMBER 2011**

**Meetings:** World Congress of 19th International Society of Laser in Surgery and Medicine and Asian Pacific Aesthetic Plastic Surgery Symposium 2011  
**Location:** Seoul, Korea  
**Venue:** Baek Beom Musium and KOFST Building.  
**Contact:** Prof. Jin Wang Kim  
**Tel:** 82-2-511-3713  
**Fax:** 82-2-517-3713  
**e-mail:** khg000@unitel.co.kr  
**HomePage:** http://www.islsm.kr

**December 2011**

**DATES: 01 DECEMBER 2011 - 03 DECEMBER 2011**

**Meetings:** The Cutting Edge Aesthetic Surgery Symposium 2011. Advanced Body Sculpting Head-To-Foot: Needle, Laser, Cannula, Knife  
**Location:** New York, NY  
**Venue:** Waldorf Astoria Hotel  
**Contact:** Lauren Fishman  
**Tel:** 1-212-355-5702  
**Fax:** 1-212-308-5980  
**e-mail:** registration@astonbakersymposium.com  
**HomePage:** http://www.aestheticsurgeryny.com

ISAPS-ENDORSED PROGRAM

**DATES: 09 DECEMBER 2011 - 10 DECEMBER 2011**

**Meetings:** International Conference on Aesthetic Surgery of the Dutch Society for Aesthetic Surgery: Forehead, Brow and Periorbital Aesthetic Surgery  
**Location:** Amsterdam, The Netherlands  
**Contact:** Ren Nio, MD  
**Tel:** 31-20-510-8670  
**Fax:** 31-20-510-8704  
**e-mail:** cr.nio@slaz.nl  
**HomePage:** http://www.nvepc.nl/congress2011

ISAPS-ENDORSED PROGRAM

**DATES: 13 DECEMBER 2011 - 15 DECEMBER 2011**

**Meetings:** 2nd International School of Plastic Surgery & Cosmetology  
**Location:** Moscow, Russia  
**Contact:** Natalya Polonskaya  
**Tel:** 8-499-142-6401  
**e-mail:** school@pscj.ru  
**HomePage:** http://http://www.pscj.ru

**January 2012**

**DATES: 20 JANUARY 2012 - 22 JANUARY 2012**

**Meetings:** ISAPS Course Goa, India  
**Location:** Goa, India  
**Venue:** Grand Hyatt  
**Contact:** Dr. Lokesh Kumar  
**Tel:** 91-112-922-8349  
**e-mail:** isaps@dacindia.com

ISAPS-OFFICIAL COURSE

**February 2011**

**DATES: 02 FEBRUARY 2012 - 05 FEBRUARY 2012**

**Meetings:** American-Brazilian Aesthetic Meeting 2012  
**Location:** Florianopolis, Brazil  
**Venue:** Il Campanario Villaggio Resort  
**HomePage:** http://www.americanbrazilianaestheticmeeting.com

ISAPS-ENDORSED PROGRAM

**March 2012**

**DATES: 11 MARCH 2012 - 12 MARCH 2012**

**Meetings:** Secondary Aesthetic Surgery  
**Location:** Munich, Germany  
**Contact:** Axel Feller, MD  
**Tel:** 49-89-211-1300  
**e-mail:** a.m.feller@professor-feller.de  
**HomePage:** http://www.professor-feller.de

ISAPS-ENDORSED PROGRAM

**DATES: 12 MARCH 2012 - 12 MARCH 2012**

**Meetings:** ISAPS Symposium – Boracay Island  
**Location:** Boracay Island, Philippines  
**Contact:** Susumu Takayanagi, MD  
**Tel:** 81-6-6370-0112  
**Fax:** 81-6-6327-0584  
**e-mail:** info@mega-clinic.com

ISAPS SYMPOSIUM

**June 2012**

**DATES: 01 JUNE 2012 - 03 JUNE 2012**

**Meetings:** ISAPS Course – Facial Aesthetic Surgery  
**Location:** Como, Italy  
**Contact:** Enrico Robotti, Gianluca Campiglio  
**e-mail:** erobotti@ospedaliriuniti.bergamo.it, info@gianluca-campiglio.it

**DATES: 06 JUNE 2012 - 08 JUNE 2012**

**Meetings:** Rome Breast Surgery 2012, Reconstruction and Aesthetic: Excellence as the common challenge  
**Location:** Rome, Italy  
**Contact:** Organizing Secretariat  
**Tel:** 39-06-3228-2204  
**Fax:** 39-06-322-2038  
**e-mail:** breastsymposium2012@alfa-international.it

**DATES: 06 JUNE 2012 - 09 JUNE 2012**

**Meetings:** XVIII Interntaional Course on Plastic & Aesthetic Surgery  
**Location:** Barcelona, Spain  
**Venue:** Clinical Planas  
**Contact:** Course Secretariat  
**Tel:** 34-93-203-2812  
**Fax:** 34-93-206-9989  
**e-mail:** cursos@clinica-planas.com

**DATES: 09 JUNE 2012 - 11 JUNE 2012**

**Meetings:** VII International Plastic Surgery Course  
**Location:** Ekaterinburg, Russia  
**Contact:** Irina Vlokh, Elena Tselikova  
**Tel:** 7-343-371-8802  
**Fax:** 7-343-371-8999  
**e-mail:** irinav@plastic-surgery.ru, org@plastic-surgery.ru  
**HomePage:** http://www.b-med.ru

ISAPS-ENDORSED PROGRAM

**DATES: 13 JUNE 2012 - 17 JUNE 2012**

**Meetings:** 57th Plastic Surgery Research Council  
**Location:** Ann Arbor, MI  
**Venue:** University of Michigan  
**Contact:** Catherine Foss  
**Tel:** 1-603-643-2325  
**Fax:** 1-603-643-1444  
**e-mail:** psrc@conmx.net  
**HomePage:** http://www.ps-rc.org

August 2012

**DATES:** 23 AUGUST 2012 - 26 AUGUST 2012

**Meetings:** 4th European Plastic Surgery Research Council  
**Location:** Hamburg Harbor, Germany  
**Venue:** Freighter MS Cap San Diego  
**Contact:** Isabelle Laerz  
**Tel:** 49-3641-311-6320  
**Fax:** 49-234-325-2080  
**e-mail:** info@epsrc.eu

September 2012

**DATES:** 04 SEPTEMBER 2012 - 08 SEPTEMBER 2012

**Congress:** 21st Congress of ISAPS **ISAPS OFFICIAL CONGRESS**  
**Location:** Geneva, Switzerland  
**Venue:** Centre International de Conférences Geneve  
**Contact:** Catherine Foss  
**Tel:** 1-603-643-2325  
**Fax:** 1-603-643-1444  
**e-mail:** isaps@conmx.net  
**HomePage:** http://www.isapscongress2012.org

**DATES:** 12 SEPTEMBER 2012 - 15 SEPTEMBER 2012

**Meetings:** LaserInnsbruck 2012: Advances and Controversies in Laser and Aesthetic Surgery  
**Location:** Innsbruck, Austria  
**Venue:** Faculty of Catholic Theology of the University of Innsbruck  
**Contact:** Katharina Russe-Wilflingseder, MD  
**Tel:** 43-512-25-2012  
**Fax:** 43-512-25-2737  
**e-mail:** office@laserinnsbruck.com  
**HomePage:** http://laserinnsbruck.com

October 2012

**DATES:** 04 OCTOBER 2012 - 07 OCTOBER 2012

**Meetings:** IFATS 10th Annual Meeting  
**Location:** Quebec City, Canada  
**Contact:** Jordan Carney  
**Tel:** 1-603-643-2325  
**Fax:** 1-603-643-1444  
**e-mail:** ifats@conmx.net  
**HomePage:** http://www.ifats.org

MENS SANA IN CORPORE SANO

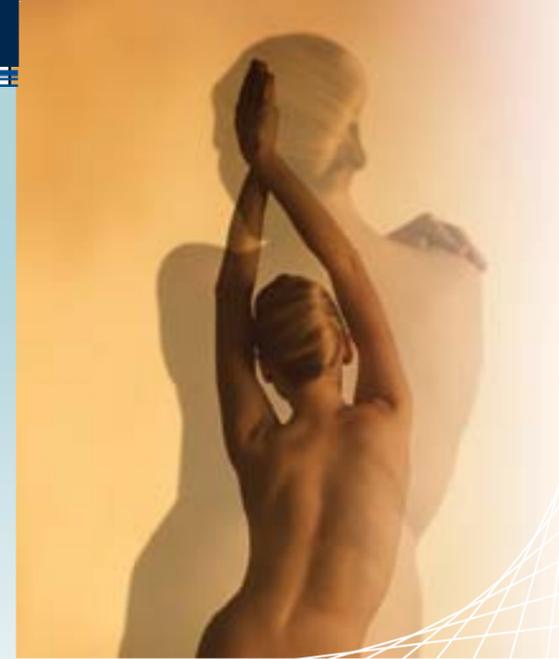
Igor Niechajev, MD, PhD – Sweden

A healthy mind in a healthy body, wrote Roman poet Juvenal, expressing what people should desire in life. An excellent way to keep your body and soul in good shape is skiing. Alpine racing has many similarities with surgery. Make an assessment of the task, be cool but move speedily forward from gate to gate, always have an overview of the next three gates ahead, and do not stop until you finish. You will be applauded both on the ski race course and in the operating room.



The 38th Ski World Cup for Medical Doctors, Dentists and Pharmacists took place during March 23-26, 2011 at Wolkenstein/ValGardena, South Tyrol in Italy. At the same time, the small evening congress *Medicine and Ski* was conducted with positive fiscal aspects for the participants. The 140 skiers, men and women from nine countries, competed in slalom, giant-slalom and Super-G with the dramatic scenery of the Dolomites in the background. There is a good number of expert skiers among plastic surgeons – and even more of us think they are experts. I therefore encourage and warmly recommend to our colleagues to join in and challenge the others. The details about last and next year’s program can be seen at the site: <http://www.med-skiworldcup.de/>

Finally a hint about the most effective training: *keep torturing your body, or your body will torture you!*



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## 9<sup>TH</sup> ANNUAL SYMPOSIUM ON ADIPOSE STEM CELLS AND CLINICAL APPLICATIONS OF ADIPOSE TISSUE

*IFATS provides a premier international venue for leading basic science, clinical, and translational investigators from academia and biotech to exchange state of the art information on the development and use of adipose tissue and cells for cosmetic and reconstructive surgery and therapy. The Society is dedicated to an open exchange of ideas and concepts based on sound science and international standards of ethical patient and animal care.*



# IFATS 2011 MIAMI

Eden Roc Hotel  
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November 4-6, 2011

[www.ifats.org](http://www.ifats.org)

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Johann UMSCHADEN, MD

### Belgium

Joan VANDEPUTTE, MD

### Brazil

Carlos Alberto GOMEZ VALDIVIESO, MD\*  
Eduardo LANGE HENTSCHEL, MD  
Avelino MONTEIRO DE ABREU, MD  
Luis Fernando SALET, MD  
Roberto SEBASTI á PEIXOTO, MD

### Chinese Taipei

Chang-chien YANG, MD

### Colombia

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Maria Cristina JAIMES PLATA, MD  
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Egidio RIGGIO, MD  
Luca SILIPRANDI, MD  
Vincenzo VINDIGNI, MD, PhD

### Japan

Hideo IIDA, MD, PhD  
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