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ISAPS NEWS

OFFICIAL NEWSLETTER OF THE INTERNATIONAL
SOCIETY OF AESTHETIC PLASTIC SURGERY



**PATIENT SAFETY IN GLUTEAL FAT GRAFTING:
A GLOBAL CALL TO ACTION**



MESSAGE FROM THE EDITOR

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Welcome to this issue of *ISAPS News*!

I am sure that you are as excited as I am about the upcoming ISAPS Miami Congress. Now that we are well into the 2018 calendar year, the Miami meeting is clearly on the horizon. Please start making your plans now to join us for this spectacular global aesthetic educational event. You will see all your colleagues from around the world gathered in one of the most spectacular cities. The great weather in October and November in Miami, the wonderful educational courses, the camaraderie with your colleagues, and of course, the spectacular beaches, all bode well for an incredible experience.

In this issue, I want to draw your attention to the **Safety Advisory** from the Multi-Society Gluteal Fat Grafting Task Force. This unprecedented collaborative effort is in response to the rise in mortality from gluteal fat grafting, as evidenced by high-profile media stories. This is a serious patient safety threat to our specialty, and the international plastic surgery community has responded aggressively and appropriately. The Multi-Society Task Force includes representatives from ISAPS (our own President, Dr. Renato Saltz), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Society of Plastic Surgeons (ASPS), represented by yours truly, J. Peter Rubin, MD, the International Society of Plastic and Regenerative Surgeons (ISPRES), and the International Federation for Adipose Therapeutics and Science (IFATS). Members of the Task Force are internationally recognized clinicians with expertise in gluteal fat grafting, as well as internationally recognized experts in the science of adipose tissue and clinical research. This initial advisory statement highlights the risk of the procedure and presents tangible recommendations on steps that every surgeon can take right now to improve safety with this procedure. Additionally, the Task Force has generated a robust plan for scientific investigation, and anatomic studies will be conducted over the next several months with joint funding from ISAPS, ASPS, and ASAPS. The Task Force is moving rapidly to develop clear guidelines based on solid science to improve safety. I urge everyone to read this advisory statement in detail and share it with colleagues.

James Fernau, MD, Member of the ISAPS Patient Safety Committee, provides a commentary on this statement in an article following the advisory statement. Dr. Fernau's commentary raises many important points and contributes to this ongoing dialogue.

In this issue, we also see the robust educational programs of our international society prominently featured. These include the ISAPS Immersion Course in Periorbital Rejuvenation in Patagonia, Argentina, the ISAPS Symposium in Italy, the first Rhinoplasty Dissection Course in Milan, Italy, and others.

Our Global Perspectives Series focuses on hair restoration and features innovations, practice trends and observations about a specific area of aesthetic surgery, as presented by our members from around the globe. I hope you enjoy this topic, and urge everyone to contribute to future topics.

Our historical article is about law and surgery, presented by Denys Montandon, MD of Switzerland. He presents a highly fascinating piece on the interaction between the legal and surgical worlds throughout history. Thomas S. Davis, MD, of the United States, our ISAPS Historian, presents a wonderful piece on the Ohmori Memorial Lecture, an important cornerstone of the meeting of the Biennial Congress, and a strong tradition in ISAPS.

You will find these features, and much, much more in this issue of *ISAPS News*.

Warm Regards,

J. Peter Rubin, MD
Editor-in-Chief

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MESSAGE FROM THE PRESIDENT

Dear Friends and Colleagues,

2018 is already off to a galloping start. I hope that you and your family and loved ones had a happy and safe holiday season and that you have entered 2018 ready to conquer your goals!

Below is a quick update of some of the many great things you can expect from ISAPS this year.

COUNTDOWN TO THE GREATEST AESTHETIC EDUCATION ON EARTH: THE MIAMI CONGRESS (OCTOBER 31 - NOVEMBER 4, 2018)

Preparations for this year's ISAPS Congress in Miami Beach are at an all-time high. This Congress will be like no other aesthetic meeting you have ever been to – in fact we're calling ISAPS Miami "The Greatest Aesthetic Education on Earth." That's a big promise, we know, but here are just a few of the reasons why the Miami Congress will be so spectacular:

1. 64 master classes taught by "Global Masters" in their field of study
2. An extensive cadaver dissection training session that includes Face and Brow in the morning, Rhinoplasty at midday and Mastopexy or Labiaplasty in the afternoon.
3. The Asian Session – a half-day educational activity focused on Asian Aesthetic Surgery
4. ISAPS Business School – three and a half days of intense sessions taught by leaders in their field to give you the edge in business, marketing and practice management. Bring your Office Manager and your whole practice team!
5. ISAPS Skin & Non-Surgical – a half-day intensive that includes one hour of rotational didactic training to demonstrate advanced techniques, tools and tips!
6. ISAPS Women Surgeons' Symposium – the first ever held by ISAPS
7. ISAPS Residents and Fellows Forum
8. 100 international companies exhibiting their varied products and services – we very much appreciate their important support!
9. Spectacular, vibrant and glamorous Miami Beach with exceptional nightlife, unique art deco architecture, fascinating history, multicultural restaurants and shopping. And the beach!

We have over 400 confirmed international faculty making this the largest gathering of aesthetic education ever assembled! **#AreYouComing?**

LAST CALL FOR ABSTRACTS – ISAPS CONGRESS IN MIAMI 2018

Abstract submission is open now, but the deadline is April 10. We will not extend this deadline so make sure you get your paper(s) entered as soon as possible. The link to the on-line submission program is:

<https://www.isapsabstracts.org/v1/>

I hope you have now received a copy of the final program in the mail. We sent a copy to every ISAPS Member! If you have not received your copy, you can download one here.

Register today at: www.ISAPSMiami2018.com!

ISAPS INTERNATIONAL STUDY OF COSMETIC PROCEDURES

As you already know, ISAPS is the only society to conduct an International Study of Cosmetic Procedures, thanks to your help in completing this annual survey. Last year, we had a record-breaking response which resulted in over \$17.84 million

dollars of free media attention for ISAPS around the world, raising the profile of our specialty on an international level that we have never been able to achieve before.

This year's survey has already begun. We need your help again to complete it. **Our specialty, and our society is depending on you!**

MY GOALS FOR 2018

My agenda is quite busy for the second year of my term as your President. My goals for 2018 include many activities that center around our two important missions: Aesthetic Education and Patient Safety.

1) Finalizing the **Global Accreditation Program**. Perhaps our most important project in patient safety ever! You read the details in the December issue of this newsletter. This issue has a follow up article.

2) Completion of our new **ISAPS website**. This project has taken a year to complete, but it is fantastic for all our members, for prospective patients and for the global media. You'll see that we have made many changes including a new membership portal elevating the global visibility of all our ISAPS plastic surgeons through state-of-the-art search tools and advertising opportunities. The ISAPS website is over 10,000 pages and attracts more than 40,000 unique global views per month. I am sure you will find it a fantastic update for our society.

3) Continue to increase the number of **educational activities** held by ISAPS. Most importantly, we take the ISAPS educational mission to countries never visited before. We have had a record number of "firsts" described in my previous communications to you. This Education Council broke the records in 2017 with over 30 courses, symposia and endorsed programs. The EC has truly carried our mission of *Aesthetic Education Worldwide®* around the world. The latest country is Brazil. After months of negotiations, we have been officially invited to join the Rio de Janeiro Regional Society (Carioca Society) at their Annual Meeting in August 2018 - *ISAPS in RIO!* A long overdue ISAPS presence in our second largest membership country.

4) Work hard and culminate the year making the **24th Congress** in Miami Beach the Greatest Aesthetic Education Event on Earth!

5) Continue to **grow our membership** and to improve **member benefits** to maintain ISAPS as the premier global aesthetic society. The goal is to attract the best aesthetic surgeons in every country on the planet.

6) Continue to grow our **Social Media**. ISAPS has officially passed 100,000 followers on Facebook cementing our status as having the largest social media following of any plastic surgery society!

7) Increase the number of National Societies participating in the **Global Alliance**. A few of the national societies that have joined the Alliance recently include the Chinese Society of Plastic Surgery (CSPS), the Czech Society of Aesthetic Surgery (CSAS), the Northeastern (Russia) Society of Plastic and Reconstructive Surgeons (NESPRS), the Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS) and the Society of Aesthetic Plastic Surgeons of Thailand (THSAPS).

As always, I thank our hard-working Board of Directors, Committees, National Secretaries and Staff for the hard work they do year-round to maintain this society and continually look for ways to improve. Your comments are welcome at any time.

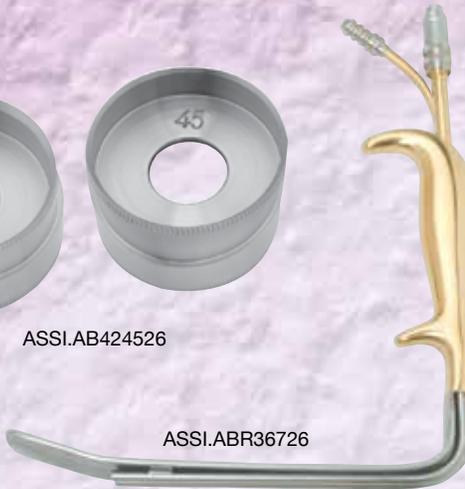
Renato Saltz, MD
ISAPS President

breast instrumentation

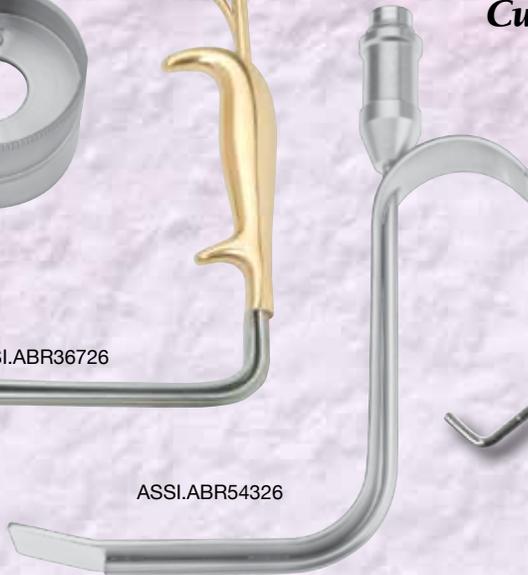
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ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES



1. ARGENTINA – Sociedad Argentina de Cirugía Plástica Estética y Reparadora (SACPER)
2. AUSTRALIA – Australasian Society of Aesthetic Plastic Surgery (ASAPS)
3. AUSTRIA – Österreichische Gesellschaft für Plastische, Ästhetische und Rekonstruktive Chirurgie (ÖGPÄRC)
4. AZERBAIJAN – Society of Plastic Surgery Azerbaijan (SPSA)
5. BELGIUM – Royal Belgian Society for Plastic Surgery (RBSPS)
6. BOLIVIA – Sociedad Boliviana de Cirugía Plástica Estética y Reparadora (SBCPER)
7. CANADA – Canadian Society for Aesthetic Plastic Surgery (CSAPS)
8. CHILE – Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)
9. CHINA – Chinese Society of Plastic Surgery (CSPS)
10. CHINA – Chinese Taipei Society of Plastic Surgery (TSPS)
11. COLOMBIA – Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)
12. CZECH REPUBLIC – Czech Society of Aesthetic Surgery (CSAS)
13. CZECH REPUBLIC – Czech Society of Plastic Surgery (CSPS)
14. DENMARK – Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)
15. DOMINICAN REPUBLIC – Sociedad Dominicana de Cirugía Plástica Reconstructiva y Estética (SODOCIPRE)
16. EASAPS – European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
17. EGYPT – Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)
18. FINLAND – Suomen Esteettiset Plastikkirurgit r.y. (SEP)
19. FRANCE – Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
20. GERMANY – Vereinigung der Deutschen Ästhetisch Plastischen Chirurgen (VDAPC)
21. GREECE – Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)
22. INDIA – Indian Association of Aesthetic Plastic Surgeons (IAAPS)
23. IRAN – Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)
24. ISAPS – International Society of Aesthetic Plastic Surgery (ISAPS)
25. ITALY – Associazione Italiana di Chirurgia Plastica Estetica (AICPE)
26. ITALY – Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)
27. JAPAN – Japan Society of Aesthetic Plastic Surgery (JSAPS)
28. LEBANON – Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)
29. NORWAY – Norwegian Society of Aesthetic Plastic Surgery (NSAP)
30. OSAPS – Oriental Society of Aesthetic Plastic Surgery (OSAPS)
31. PANAMA – Asociación Panameña de Cirugía Plástica, Estética y Reconstructiva (APCPER)
32. PERU – Sociedad Peruana de Cirugía Plástica (SPCP)
33. PHILIPPINES – Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)
34. PORTUGAL – Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPRE)
35. ROMANIA – Romanian Aesthetic Surgery Society (RASS)
36. RUSSIA – Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS)
37. SERBIA – Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)
38. SERBIA – Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)
39. SINGAPORE – Singapore Association of Plastic Surgeons (SAPS)
40. SOUTH AFRICA – Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
41. SOUTH KOREA – Korean Society of Aesthetic Plastic Surgery (KSAPS)
42. SPAIN – Asociación Española de Cirugía Estética Plástica (AECEP)
43. SPAIN – Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)
44. SWEDEN – Svensk Förening för Estetisk Plastikkirurgi (SFEP)
45. SWITZERLAND – Schweizerische Gesellschaft für Ästhetische Chirurgie (SGAC)
46. THAILAND – Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)
47. TURKEY – Turkish Society of Aesthetic Plastic Surgery (TSAPS)
48. UNITED KINGDOM – British Association of Aesthetic Plastic Surgeons (BAAPS)
49. UNITED KINGDOM – United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
50. UNITED STATES – American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
51. VENEZUELA – Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)

GLOBAL ALLIANCE SPOTLIGHT: NESPRS AND 20 YEARS OF DEVELOPMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY IN THE MAJOR MEDICAL REGION OF RUSSIA



PROF. K.P. PSHENISNOV, MD, PHD
Russian Federation
NESPRS Chairman
ISAPS National Secretary for Russian Federation



The non-profit Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS) was founded in October 1997 as a partnership by fourteen plastic surgeons from Ivanovo and Yaroslavl regions.

NESPRS is a public organization that doesn't set their main goal as realizing profit. It doesn't share profit among its members. The objective and goals

of the society are: promotion of formation and development of plastic surgery as a specialty with appropriate training of surgeons; maintaining the highest standards of professional mastership and competence, as well as the behavior of plastic surgeons; the exchange of information among them; providing the public with information about scientific progress in plastic surgery; assistance to the local health authorities and medical institutions by providing highly specialized and emergency assistance with plastic and reconstructive surgery and microsurgery; the protection of legal rights and interests of the members of the partnership; and support of plastic and reconstructive surgeons in the field of public health care.

After the approval of plastic surgery as a specialty in Russia in 2009, the members of the partnership became the chief specialists in their local Ministries of Health. Initially, the code of ethics of the ASPS was used as a model for the NESPRS code of ethics.

The partnership exists on members' fees, income from sales of published books and journals, scientific conferences and charitable donations to the main programs in the field of reconstructive plastic surgery. The expenses of the organization include the provision of publishing activity, travel of members to scientific meetings and their education. NESPRS also raises funds to provide reconstructive surgeries for patients with congenital deformities, results of trauma and oncological operations. Most of them are microtia, facial palsy, Poland deformity and postmastectomy breast reconstruction.

Since 1999, NESPRS has published sixteen issues of the first volume of the journal *Selected Topics of Plastic Surgery*. This is an illustrated methodical overview of modern literature with multiple choice questions for continuing medical education. Currently, the second volume of the journal is being published. In 2010, a group of authors, members of the partnership, their residents and I as the Editor-in-Chief published a two-volume textbook *Plastic Surgery Course*,



Figure 1 - NESPRS Chairman Prof. Kirill Pshenisnov presenting new textbook *Plastic Surgery Course* to ISAPS and NESPRS Life member Prof. Alexey Borovikov at the 60th NESPRS meeting in 2010.

that contains thirty-seven chapters covering all the main areas of the field of plastic surgery (Figure 1). Also, it is the main textbook for our specialty in Russian Federation. The scientific work is based on regularly held conferences and scientific meetings. For the last twenty years, ninety of these types of meetings were held. For example, for the past four years (2013-2017), several events took place: twelve scientific meetings were held; ten speakers were

invited; fifty-one presentations were made; and four clinical demonstrations were presented (Figures 2, 3). Throughout twenty years, all the reports from ninety past conferences have been published in the journal *Annals of Plastic, Reconstructive and Aesthetic Surgery* which is the official organ of the Russian Society of Plastic Reconstructive and Aesthetic Surgery. Best works have been recommended for presentation during international conferences, as well as being published abroad.



Figure 2 - Presidium of the 90th NESPRS conference in celebration of the 20th anniversary of the Society on October 28, 2017.



Figure 3 - A group of NESPRS and ISAPS members with the president of the Yaroslavl State Medical University academician of Russian Academy of Sciences Prof. Yuriy Novikov (in the center).

For the past five years, one of the conferences has been held in a residence near Moscow where members of the partnership come together with their wives, children, their residents and students. First, a volleyball tournament is held; then, a football match is played; after that there is a scientific conference; finally, all surgeons communicate in an informal atmosphere at the BBQ (Figure 4).



Figure 4 - ISAPS members K. Pshenisnov, T. Aliev, E. Shulgin and N. Shemetov after the volleyball match with NESPRS members.

Starting in 2001, the partnership held a series of major conferences in Russia with the participation of well-known plastic surgeons: Oscar Ramirez (United States), Daniel Marchac (France), Rafael De La Plaza (Spain), Ulrich Hinderer (Spain), Julia Terzis (United States), Dennis Hammond (United States), Enrico Robotti (Italy) and many others. The list of full members is constantly being replenished. Currently, surgeons of the Kostroma, Vologda and Moscow regions are participants.

In June 2017, an agreement that NESPRS would join the ISAPS Global Alliance was signed. Right away three members of NESPRS joined ISAPS: M. Sheleg, A. Kubytkin and E. Shulgin. Earlier, K. Pshenisnov, V. Chervyakov and N. Shemetov had joined. ISAPS also includes two members of the partnership as Residents: M. Venediktov and I. Sokolov. In 2017, Ilya Sokolov, a Resident at Yaroslavl State Medical University visited with Dr. Lorne Rosenfield California as part of the **Visit an ISAPS expert** program. The December 2017 issue of *ISAPS News* included a report about this visit.

We hope that in the future both of our societies will work together in the Global Alliance.

ORIENTAL SOCIETY OF AESTHETIC PLASTIC SURGEONS (OSAPS)



FLORENCIO Q. LUCERO, MD

Philippines
OSAPS Secretary-General

The Oriental Society of Aesthetic Plastic Surgeons (OSAPS) was founded in 1988 and there are now nine member countries. We are the regional body representing aesthetic plastic surgery, recognized by the International Society of Aesthetic Plastic Surgeons (ISAPS). Our primary purpose is to promote oriental beauty, to provide continuing quality education for aesthetic plastic surgeons and to always ensure patient safety.



Figure 1 - Prof. Seiichi Ohmori

In the summer of 1988, Prof. Seiichi Ohmori invited some thirty-one leaders in plastic surgery from the various Asian countries who formed the founding members of OSAPS. Until 2010, Dr. Kitaro Ohmori served as Secretary-General when he decided to hand the reins over to Dr. Florencio Q. Lucero. The first congress of the society in 1988 led to biennial congresses hosted by the nine-member National Societies: Japan, South Korea, China, Chinese Taipei, Indonesia, Malaysia, Hong Kong, Thailand, and the Philippines. The National Secretaries of these member countries make up the Executive Committee that governs the activities of the society.

Membership is only open to certified plastic surgeons from the member national societies but we welcome members from other countries who are interested in Oriental aesthetic surgery. Currently, the Society has more than 600 members.

The 16th Congress of OSAPS in conjunction with INAPRAS and the ISAPS Symposium will be hosted by Indonesia in Bali on July 18-21, 2018. This is led by Dr. Teddy Prasetyono, the President. The next Congress in 2020 will be in Malaysia and in 2022, in the Philippines.



Figure 2 - OSAPS members at the last Congress.

WHERE IN THE WORLD?



See page 43 for the answer



MultiSociety Gluteal Fat Grafting Task Force issues safety advisory urging practitioners to reevaluate technique

Dear Colleagues,

An InterSociety Gluteal Fat Grafting Task Force** has analyzed deaths from gluteal fat injection (*“Brazilian Butt Lift”* or *“BBL”*) and offers the following advisory statement:

The death rate of approximately 1/3000 is the highest for any aesthetic procedure. In 2017, there were three deaths in the state of Florida alone. Every surgeon performing BBLs should immediately reevaluate his or her technique. Some patients have died when their surgeon said they had injected into the subcutaneous fat layer, but all autopsies of deceased BBL patients have had these findings in common: 1) fat in the gluteal muscles; 2) fat beneath the muscles; 3) damage to the superior or inferior gluteal vein; 4) massive fat emboli in the heart and/or lungs. No post mortem has yet shown a case of death with fat only in the subcutaneous space; this means that surgeons have injected more deeply than they had intended. The mechanism of death is presumed to be high pressure extra vascular grafted fat entering the circulation via tears in the large gluteal veins with subsequent embolization to the heart and lungs. The task force, therefore, offers these suggestions*:

- 1)** Stay as far away from the gluteal veins and sciatic nerve as possible. Fat should only be grafted into the superficial planes, with the subcutaneous space considered safest. If the aesthetic goal requires more fat than can be placed in the subcutaneous layer the surgeon should consider staging the procedure rather than injecting deep.
- 2)** Concentrate on the position of the cannula tip throughout every stroke to assure there is no unintended deeper pass, particularly in the medial half of the buttock overlying the critical structures.
- 3)** Use access incisions that best allow a superficial trajectory for each part of the buttock; avoid deep angulation of the cannula; and palpate externally with the nondominant hand to assure the cannula tip remains superficial.
- 4)** Use instrumentation that offers control of the cannula; avoid bendable cannulas and mobile luer connections. Vibrating injection cannulas may provide additional tactile feedback.
- 5)** Injection should only be done while the cannula is in motion in order to avoid high pressure bolus injections.
- 6)** The risk of death should be discussed with every prospective BBL patient.

7) The following are three three helpful articles:

- Staying Safe During Gluteal Fat Transplantation, Plastic and Reconstructive Surgery, January 2018
- Report on Mortality from Gluteal Fat Grafting: Recommendations from the ASERF Task Force; Aesthetic Surgery Journal, July 2017
- Acceptable Risk: Who Decides? Editorial by Foad Nahai, MD, Aesthetic Surgery Journal, July 2017

Research projects overseen by the task force and funded by The Plastic Surgery Foundation (PSF), Aesthetic Surgery Education and Research Foundation (ASERF) and International Society of Aesthetic Plastic Surgery (ISAPS) are underway. They will correlate deep and topographical anatomy, define danger zones, and try to understand the mechanism of embolization. The ability to safely perform this procedure in the future is dependent upon this research.

Members of the task force have also assisted coroners during autopsies, and this has provided invaluable safety information. If you become aware of a fatality, immediately contact the task force cochairs care of Keith Hume, executive director of The PSF, at khume@plasticsurgery.org.

Your societies will keep you updated with all developments.

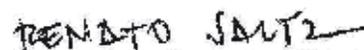
Sincerely,



Dan Mills, MD
Gluteal Fat Grafting
Task Force cochair



J. Peter Rubin, MD
Gluteal Fat Grafting
Task Force cochair



Renato Saltz, MD
Gluteal Fat Grafting
Task Force cochair

** The information in this Advisory Statement while setting forth the strong recommendations of the Task Force, should not be considered inclusive of all methods of properly performing buttock augmentation with fat transfer or as a statement of the standard of care or as a mandate to strictly follow the recommendations of the Task Force.*

This Advisory Statement is not intended to substitute for the independent professional judgment of the treating plastic surgeon nor for the individual variation among patients.

The Members of the MultiSociety Task Force and the participating societies assume no responsibility or liability for injury arising out of any use of the information contained in this Advisory Statement.

*** The InterSociety Gluteal Fat Grafting Task Force represents leading clinical plastic surgery societies, including the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), and the International Society of Aesthetic Plastic Surgeons (ISAPS). Additionally, two scientific societies, the International Society of Plastic & Regenerative Surgeons (ISPRES) and the International Federation for Adipose Therapeutics and Science (IFATS) are represented and provide scientific support. The efforts of the Task Force build upon a foundation of important work by the Aesthetic Surgery Education and Research Foundation (ASERF), the American Society of Plastic Surgeons (ASPS) Regenerative Medicine Committee, and the International Society of Aesthetic Plastic Surgery (ISAPS) Patient Safety Committee. The Task Force is an unprecedented collaborative effort to address a major patient safety concern, investigate factors that lead to increased risk with gluteal fat grafting, perform scientific studies to improve safety, and educate plastic surgeons.*

SAFETY IN GLUTEAL FAT GRAFTING: FROM OFFICE TO OPERATING ROOM



JAMES FERNAU, MD
United States
Member, ISAPS Patient Safety Committee

Many thanks to Dr. Dan Mills, Dr. Peter Rubin and Dr. Renato Saltz and other members of the Multi-Society Gluteal Fat Grafting Task Force for their extremely important patient safety advisory regarding gluteal fat grafting. The task force has identified the mechanism of fat embolism to be either direct puncture and bolus infusion of fat into a gluteal vessel and/or laceration of a gluteal vessel and subsequent siphon effect of the surrounding fat into a gluteal vessel. This indicates fat was injected into the deep gluteal musculature. All autopsies of deceased Brazilian Butt Lift (BBL) patients have revealed fat within and beneath the gluteal muscles and damage to the superior or inferior gluteal vessels with subsequent massive fat emboli in the heart and/or lungs. In this issue of ISAPS, the task force has outlined seven specific recommendations (see pages 8 and 9 of this issue). In summary, recommendations include using instrumentation and techniques to keep the grafted fat in the subcutaneous plane.

I would like to integrate these important suggestions into a clinical scenario. During the consult, all the risks and benefits are thoroughly discussed with the patient. Alternatives are discussed and include the use of buttock implants. The consent form includes the risk of fat embolism and surgical alternatives. Staging the procedure is also discussed to keep the procedure safe and to keep the patient expectations as realistic as possible. The risk of death is discussed with every patient including recent data which suggests approximately 1 in 3,000 patients are at risk for fatal pulmonary fat embolism. (Reference?) Before any procedure, a thorough history and physical exam are performed. The history focuses on risks of bleeding and intake of anticoagulants and herbal remedies, deep venous thrombosis, pulmonary embolism, lower extremity varicosities, especially with sciatic nerve compression, recent long-term travel and previous BBL surgery. Aspirin and NSAIDs are common medications and are blood thinners. Other potent blood thinners include herbs and supplements such as ginseng, garlic, ginkgo, turmeric and St. John's Wort which are found in vitamins, energy drinks and recovery drinks. Vitamin E and Fish Oil are common supplements that can cause profuse bleeding. Bleeding can compress the gluteal vessels and increase the chance of dilatation and subsequent injury from a cannula.

Conditions such as Factor Five Leiden can lead to deep venous thrombosis and subsequent pulmonary embolus. Sciatic nerve compression may be secondary to dilated pelvic vessels predisposing them to injury. Patients traveling long-distance just prior to surgery may have stasis of blood in the pelvis and subsequent dilated gluteal veins predisposing them to injury if the cannula is inadvertently thrust into the deep musculature. A history of prior BBL surgery may have caused scar tracts predisposing flexible cannulas to enter below the gluteus maximus muscle into the deep musculature where the gluteal vessels are at risk of trauma.

A procedure-oriented physical examination includes precise drawings on the patient to delineate the danger zone where the gluteal vessels are located. The patient is marked in the standing position and confirmed in the operating room in the prone jackknife position where the posterior superior iliac spine (PSIS) can be easily palpated and is located just inferior and lateral to small depressions in the lower back often known as venous dimples which delineate the sacroiliac joint. The posterior superior iliac spine (PSIS) is the medial beginning of the iliac crest proper. A line is drawn from the PSIS to the greater trochanter and then drawn from the greater trochanter to the ischial tuberosity. The ischial tuberosity is then connected to the PSIS. The resultant triangle is referred to

as the gluteal danger triangle. Within this triangle lie the gluteus maximus and gluteus minimus muscles. These muscles are considered superficial muscles along with the more lateral gluteus medius and extreme lateral tensor fasciae latae muscle. The gluteus maximus muscle is the most important muscle regarding gluteal fat transfer safety. It is 7-8 cm thick and originates 4-5 cm lateral to the PSIS and extends medially to the ischial tuberosity and inserts into the ileotibial tract. Remarkably, it is the only gluteal muscle that does not insert into the greater trochanter. This is the muscle where fat is preferred to be grafted, especially the superficial 3 to 4 cm.

Only experienced, proficient surgeons should attempt grafting into the superficial gluteus maximus musculature. After drawing and defining the danger triangle, the buttock should be divided into four quadrants. The midpoint of the intersection of the vertical and horizontal lines should represent the point of maximal projection of the buttock which would be equivalent to the level of the pubic bone. The four quadrants include two medial quadrants, superior medial and inferior medial, and two lateral quadrants, superior lateral and inferior lateral. Inside the superior and inferior medial quadrants are where the gluteal vessels are at greatest risk and muscular injection should be avoided in these areas. These gluteal fat grafting safety markings should be made in red and any other markings made in a different color based on the aesthetic evaluation of the patient and the type of frame of the patient.

The patient is then taken into the operating room and placed in the supine position for abdominal fat harvesting. This is performed using tissue liquefaction technology (HydraSolve®) or power assisted liposuction (PAL). The fat is collected in a closed system using two 3-liter canisters. After the first canister is filled, liposuction continues into the second canister and while the second canister is filling the first canister is undergoing separation of fat and blood tinged tumescent fluid which typically takes 15 minutes. After separation the blood tinged tumescent fluid is drained and pure fat is left for grafting. After liposuction of the abdomen, the patient is placed in the prone position, specifically in the jackknife position for greater patient safety, thus allowing the cannula to run parallel to the gluteal musculature. I infiltrate 100 ml of Klein solution into each buttock before liposuction to achieve epinephrine hemostasis in the gluteal region prior to fat grafting. The hip rolls are routinely liposuctioned along with the region of fat overlying the gluteus medius muscle and other areas dictated by the patient's frame. Access incisions for grafting include a midline gluteal crease incision just below the A line and 2 lateral incisions placed in the infragluteal crease in the lateral third of the crease itself.

When grafting fat into the muscle, the lateral incision keeps the cannula insertion away from the medial quadrants. The rigid blunt cannula is directed parallel to the gluteus maximus muscle and away from the danger triangle and away from the medial quadrants of the buttock. After all liposuction is performed the fat has been prepared on the back table by decantation and loading of 60 ml Toomey syringes. Please note Luer-Lok™ syringes are no longer recommended because of the possibility of flexing during grafting and inadvertently penetrating into the deep gluteal musculature with resultant injury to the gluteal vessels.

Additionally, I use a 4.6 mm rigid cannula connected to a Toomey syringe which avoids flexing of the cannula into the deep tissue. The tip of the cannula is

constantly being palpated with the opposite hand being continuously aware of the three-dimensional surroundings of the cannula and underlying anatomy. In the medial quadrants, the fat grafting is in the subcutaneous tissue only. In the lateral quadrants, subcutaneous grafting can be safely performed. If an experienced BBL surgeon is grafting into the gluteus maximus muscle, the lateral quadrants are safe when the cannula is kept in the superficial (3 cm depth) 1/2 of the gluteus maximus muscle.

Selectively liquefied fat allows for easy downward pushing of the syringe and also allows for easy retrograde grafting. The cannula is kept in constant motion. Alternatively, I have used the power assisted liposuction device by Microaire® and attached this unit to a peristaltic pump and grafted fat with this very same device which is used to harvest fat. For this I use an exploded basket 5 mm cannula. This allows for expansion vibration lipofilling described by Constantino Mendieta. Again, the cannula is kept in constant motion and allows for a greater degree of tactile feedback and possibly allowing for a greater degree of fat layering. Knowing where the cannula is three dimensionally located is the most important portion of the procedure. The medial quadrants contain the gluteal vessels. The superior gluteal vessel lies 5 cm inferior to the PSIS and the inferior gluteal vessel lies 10 cm inferior to the PSIS. Both vessels lie approximately 6 to 8 cm from the midline.

Cadaver studies have shown that cannula angulation of 45° or greater always results in fat placed into the deep musculature; whereas, cannula angulation of 30° or less resulted in fat placed into the subcutaneous tissue. Therefore, the most dangerous maneuver would be to place a cannula at a 45° angle into the gluteal musculature from the intergluteal crease incision because the cannula tip would be at the exact position of the greater sciatic foramen. It is at the greater sciatic foramen where the superior and inferior gluteal vessels are separated by the pyramidal muscle and are at greatest risk of injury. The sciatic nerve enters the pelvis at this point and is at risk as well. The veins can be 6 mm or greater diameter near the greater sciatic foramen. Additionally, cadaver dissections have found gluteal vessels to be as large as 4 mm at the junction of the gluteus maximus muscle and the gluteus medius muscle further reinforcing the need to use a blunt large diameter (>4.1mm) cannula. The cannula should be kept in constant motion to avoid a large bolus injection of fat into a vessel. I have found between 400 ml - 1,000 ml per buttock to allow for very good results in buttock augmentation. If the skin appears too tense and/or fat begins to exude from the incisions it is a good time to stop grafting. I recommend avoiding excessive graft fill pressure. I believe most BBLs can be performed with less than 1,200 ml per side. My personal recommendation is to graft no more than 1,500 ml per side. The goal would be to keep the interstitial oncotic pressure less than 30 mm Hg. Theoretically, if the pressure is less than 30 mm Hg the fat cells will not survive because of compromised blood supply. If the surgeon does not have a good sense of the gluteal musculature, good judgment dictates subcutaneous grafting only. In my opinion, only experienced surgeons should attempt grafting into the superficial gluteus maximus muscle. When entering the gluteal muscle, the muscle will twitch. I refer to this as the gluteal twitch sign. Preferably, the surgeon should have performed an intramuscular buttock implant to understand the thickness of the gluteus maximus muscle. During grafting, the opposite hand should always feel the tip of the cannula and make sure the cannula is in the subcutaneous plane. Precise volumes should be recorded, and symmetry evaluated by correlating volumes and visual inspection from different angles.

Immediately after surgery, a compression garment is placed, and the patient is instructed to sleep in the prone position and place no pressure on the buttocks for three weeks. It is for this reason I do not perform abdominoplasty and BBL surgery simultaneously. BBL surgery has greatly surpassed abdominoplasty as the number one cause of mortality. At this point, it does not make sense to combine the two while we are trying to create a safer environment for BBL surgery. Additionally, I have too many referrals of fat necrosis in the buttocks when these two procedures are combined.

Consider pulmonary fat embolism in unstable intraoperative and postoperative patients. Intraoperative acute right heart failure will ensue after pulmonary fat embolism. Signs and symptoms include hypotension, tachycardia, new right bundle branch block, right ventricle third heart sound and tricuspid regurgitation. In the setting of a pulmonary artery catheter there is an increase in the pulmonary capillary wedge pressure. Eventually cardiovascular collapse and death can occur. Percutaneous cardiopulmonary support (PCPS) should be considered as a life-saving measure. PCPS drains blood from the right atrium, bypassing the right ventricle and pulmonary circulation, and oxygenated blood is returned to the systemic circulation. Postoperative pulmonary fat embolism syndrome includes shortness of breath, tachypnea, agitation, delirium, drowsiness and petechial rash on the chest, neck and upper arms. Urgent transportation to the nearest emergency room is essential.

It is my hope that none of us will have to experience this dreaded complication. Many thanks to the Multi-Society Gluteal Fat Grafting Task Force for their extremely important patient safety advisory regarding gluteal fat grafting. This includes ASPS, ASAPS, ISAPS, ISPRES and IFATS. This task force works closely with ASERF to address this major patient safety concern, investigate factors that lead to increased risk with gluteal fat grafting, perform scientific studies to improve safety, and educate plastic surgeons. Dr. Foad Nahai has suggested the mortality rate from this procedure is likely even higher than the current literature suggests and the best way to obtain prospective data is through the immediate establishment of a registry. I could not agree more. All of us need to reevaluate our patient selection and technique to create a safer environment for our patients.

The author has no financial interest in any product of company mentioned in this article.

REFERENCES:

- Email communication from IFATS - Mills D, Rubin JP, Saltz R. Multi-Society Gluteal Fat Grafting Task Force Issues Safety Advisory Urging Practitioners to Re-evaluate Technique, IFATS Notice January 31, 2018 to James Fernau and IFATS Colleagues, February 2, 2018.
- Villanueva NL, Del Vecchio DA, Afroz PN, Carbon JA, Rohrich RJ. Staying Safe During Gluteal Fat Transplantation, *Plast Reconstr Surg*. 2018;141(1):79-86.
- Mendieta C, Stuzin J. Gluteal Augmentation and Enhancement of the Female Silhouette: Analysis and Technique, *Plast Reconstr Surg*. 2018;141(2):306-311.
- Mofid MM, Teitelbaum S, Suissa D, Ramirez-Montanana A, Astarita DC, Mendieta C, Singer R. Report on Mortality from Gluteal Fat Grafting: Recommendations from the ASERF Task Force, *Aesthet Surg J*. 2017;37(7):796-806
- Nahai F. Acceptable Risk: Who Decides? *Aesthet Surg J*. 2017;37(7):852-854
- Dolen U, Cohen JB, Overschmidt Bo, Tennenbaum MM, Myckatyn TM. Fat Grafting with Tissue Liquefaction Technology as an Adjunct to Breast Reconstruction *Aesth Plast Surg* 2016;40(6):854-862.
- Georgantopoulou A, Papadodima S, Vlachodimitropoulos D, Goutas N, Spiliopoulou C, Papadopoulos O. (Greece). The Microvascular Anatomy of Superior and Inferior Gluteal Artery Perforator (SGAP and IGAP) Flaps: A Fresh Cadaveric Study and Clinical Implications *Aesth Plast Surg* 2014;38(6):1156-1163.
- Mendieta, Constantino G. (2011) *The Art of GLUTEAL Sculpting*. Quality Medical Publishing, Inc., St. Louis, Missouri.
- Gonzalez, Raul. (1954) *Buttocks Reshaping, Posterior Contour Surgery: a step-by-Step approach Including Thigh and Calf Implant*. Indexa Editora Ltda, Rio de Janeiro, RJ (Brazil): Indexa, 2006.
- Iarashi M, et al. Use of percutaneous cardiopulmonary support in catastrophic massive pulmonary fat embolism. *Br J Anaesth*. 2006.

OPERATING THEATRE: SOAP, OPERA OR PROFESSIONALISM? 40 YEARS IN THE OR



ASKO SALMI, MD

Finland and Spain

Former ISAPS National Secretary for Finland

Theatre is a place where something is happening in front of everyone who is watching. Opera is a place where all this is happening, but no one is talking. It ends with "bravo, bravo" and before bravos, there is music and singing. Soap opera is most likely a TV show that no one admits to watching, but everyone knows what is happening. Operating theatre is a combination of all of these.

After spending forty years in operating rooms, I started to think about what is going on in these theatres. I always remember my first visit to an operating theatre as a medical student. Main point was to sterilize your hands by scrubbing your skin to death, dress properly and do not touch anything! It did not matter how much you tried, you always did something wrong. There seemed to be invisible eyes all over watching your every move. Later on, I learned that it was not because of me. It was because it had always been like this and those "vestal virgins" who had been baptised with the secrets of operating theatres showed their power in this way.

My initiation to the secrets of surgery was led not only by colleagues, but also by very good, skillful and demanding operating room nurses. Ruth taught me how to do an appendectomy and after surgeries with Gun, I really knew how (and which) instruments are placed in my palm and how to use them. I still appreciate them a lot. As anywhere, in Finland, an OR nurse is a very important player. Usually, there is no one else to help you. Long ago, I was wondering how you can play this game with a nurse who always has her back turned to you and is constantly fiddling with a massive number of instruments. How is it possible to communicate with a back?

One memorable OR team was in Berbera, Somalia where we did war surgery in very primitive conditions, with very limited resources, and with very severe cases. No one was complaining, working was a joy and we did our best. I noticed how much can be done with very little, how to improvise, how to use a few instruments in new ways. Everything was saved and recycled for future use. It was my university of surgery. Ever since, my motto when asked what I need for surgery has been: "spoon, knife and fork." Under the dark skies of Africa, with billions of stars blinking above me, I also made up my mind to become a plastic surgeon.

Surgery can be demanding and frustrating. If it is always demanding, you should consider your career. My first boss was a BOSS and a SURGEON. You got three months to show your invisible talents and skills. Thereafter, you had two options: you'll become a surgeon or you do something else. I know many very good radiologists today.

In those days, it was not rare that instruments got wings and became UFOs crashing on the back wall of the OR. This could happen if plan A was not working. Total silence – except clanging instruments – killed your ears. Lesson learnt was that when starting surgery you always have plan B. It is crucial that you change from A to B without anyone noticing anything special. No instruments with wings inbetween. I also appreciate my first boss because he showed me who is the captain of the ship.

Music has remarkable properties. It cheers you up or brings you down. It has been shown that a surgeon who listens to his/her favourite music operates better. Therefore, from the beginning of time, we used to have a portable

music machine with two hi-fi loudspeakers. Blues music is very relaxing and if you want to check your stress level, play Jimi Hendrix's "All Along the Watchtower". If you can do surgery with Jimi, your stress level is zero.

Over thirty years ago, we started to do microsurgery in far away hospitals. For the first journey, we rented a motor home, took wives and kids with us (many kids) and travelled. We did microsurgery while the kids were skiing. Of course we had our portable audio system with us and since then always when finishing microsurgery Wagner's "Ride of the Valkyries" was heard all over the ORs. It became our brand for over 12 years.

Surgery is a serious job, but surgeons do not have to be robots. Good feelings and good teamwork are essential. In Scandinavia, Finns are considered to be a little bit crazy. On one occasion, we had Norwegian visitors coming to see our new technique. However, they were late and we had to start with surgery. Before they entered the OR, we turned off the lights. One spot illuminated our disco ball near the ceiling which in turn radiated magical light beams all over the OR. This effect was boosted with the deep bass of Gloria Gaynor's "I Will Survive" that came out of the sound system loud and clear. You should have seen their faces! Of course our patient was in on our jest and had as much fun as we did.

The OR is the soul of our hospital. It's the engine that works best if all the cylinders are working for the same purpose and in the same phase. There are no bosses or subordinates. No political or commercial interests. No discrimination or racism. There is just the patient and his/her problem which has to be solved fast, safely and efficiently. No frustration, no flying objects, no bad or missing instruments, no hierarchy, no coffee breaks, no delayed operations, no delays period. You have a skillful and trusted team and you can work in a flow: you forget your existence, the surrounding world - and time. When the job is done, you feel a bit disoriented and empty. Surgery at its best!

My idea of surgery is to keep it simple. Microsurgery can be safely done in a tent and an appendectomy can be fatal in the most modern OR with tons of equipment and more people than you can count. Surgery is difficult if you do not understand what you are doing or you cannot see what is going on. My first boss was right: surgery is not for everyone. Fair is not good enough - we need excellence. Second place has no room in surgery.

I started my career at the age of four when my grandpa bought me a knife which was almost as tall as me. My fingers are full of old scars. However, new ones are rare. Sixty years of practicing with a knife is not enough. I can still improve.



Figure 1 - This is me at about one year with my essential instruments: spoon, knife and fork. I'm a fast surgeon so nowadays I usually do not sleep during surgery.

To answer my own question in the title of this article: soap is for scrubbing, opera comes from the loudspeakers and professionalism is a must. Surgery is serious business, but it can be done with a smile and working must be fun. The thanks come from the patients. Money is always secondary.

MESSAGE FROM THE EDUCATION COUNCIL CHAIR



VAKIS KONTOES, MD, PHD
Greece
Chair, ISAPS Education Council

The ISAPS Education Council (EC) has completed one year in December 2017 from when it took over in Kyoto in 2016.

I am very happy to report a dynamic process during this last year with many “firsts” as already mentioned in our previous updates and a lot of innovative decisions and additions which have standardized different procedures of the educational mission of ISAPS.

Among others, I would like to mention the introduction of a new policy for endorsed events, aiming at the promotion of the ISAPS mission, certificates of attendance of ISAPS educational events with the new logo and standard lay out worldwide, for uniformity reasons, certificates of appreciation to the organizers and National Societies for ISAPS endorsed events, certificates of attendance to the participants of the Visiting Professor Programs and of course the new ISAPS policy for the organization of Courses and Symposia around the globe.

Moreover, the ISAPS EC has contributed to the organization and set up of the ISAPS Video Library which will be finalized soon and will gradually be enriched with video clips of several aesthetic surgery techniques open to ISAPS members, and also for the set up of quarterly webinars on live surgery, also open to ISAPS members, in an effort to increase educational benefits to our members worldwide.

The ISAPS Residents and Fellows Committee has also created an extremely important program for residents and fellows offering the possibility of training in different. More information can be found in our new website following the relevant link.

For more information regarding the organization of ISAPS educational events you can also visit our website and follow the Education Council link.

In the last three months, since our last update, the following educational events were organized.

On the 4th and 5th of December 2017, a tentative Course on periorbital rejuvenation was held in Bariloche, Patagonia, Argentina. An excellent faculty shared in-depth details with the participants on the various techniques in periorbital rejuvenation, with many video sessions and round tables. It was a very successful event and the EC wishes to express its appreciation and thanks to the great support of the Argentinean Society of Plastic Surgery for this outstanding meeting.

In January, the well-established annual ISAPS Aesthetic Dissection Course took place at the University of Liege in Belgium with fully booked attendance and an excellent teaching faculty. Techniques in facial aesthetic surgery and rhinoplasty were demonstrated on fresh cadavers, step-by-step following lectures on the relevant aesthetic surgery topics by the faculty members, with plenty of time for supervised dissection by the participants.

In early February, an ISAPS Symposium in cooperation with the Indian Association of Aesthetic Plastic Surgeons took place in Udaipur with great success. 350

participants attended this ISAPS Symposium which was complimented by a pre-Symposium Visiting Professor Program at the University Hospital of Jaipur attended by 35 residents.

The Education Council has also endorsed many aesthetic Surgery meetings for 2018. A steadily increasing rate of endorsement applications has been received by the EC the last 12 months. This shows the appreciation of the organizers in the ISAPS brand and its dedication to the mission “*Aesthetic Education Worldwide®*”. The EC cordially acknowledges the organizers of these endorsed meetings for their cooperation with ISAPS.

Very interesting upcoming educational events in the next three months are already finalized and ready to go.

By the time you read this, the **Barcelona ISAPS Course** – a “first” event for Spain – on safety and complications in aesthetic surgery will have taken place in Barcelona in early March. In April, the ISAPS Symposium in cooperation with the Korean Society of Aesthetic Plastic Surgery – another “first” – will take place in **Seoul, Korea** and one more “first” will follow with the **Saudi Arabian ISAPS Symposium** in Riyadh. In the end of May, in co-operation with SOFCEP, an ISAPS/SOFCEP Symposium will be held in **Lyon-France**. For more information and details about these upcoming and future educational ISAPS events you can refer to the ISAPS Calendar of events in our new website.

The EC has also contributed in the finalized scientific program of our biennial Congress in Miami Beach coming October-November 2018. A great event, not to be missed by anyone interested in high standard education in aesthetic surgery. Master Classes, Cadaver Dissections, a Residents & Fellows Forum, a Women Plastic Surgeons Symposium and much more are the highlights of this exceptional upcoming Congress. Abstract submission for presentations of free papers is now open in a very user friendly and easy process through our website and the EC will soon start the evaluation procedure of the submitted papers. For more information visit: <http://www.isapsmiami2018.com>

Closing this update, the EC would like to cordially thank its Regional Representatives worldwide, for their dedication, hard work and cooperation in the organization of our educational programs, the travelling Faculty members for their continuous dedication to our mission, the National Secretaries for their leadership and ISAPS promotion in their countries, and all the Board and Committee members involved in ISAPS’ main mission: “*Aesthetic Education Worldwide®*”

We are open to ideas and proposals from our members and we encourage you to contact us when necessary and at your convenience for any issue related to aesthetic education worldwide. You, our members, are the most efficient “weapon” to achieve our exceptional targets.

Thank you all for your support to our mission.

FIRST RHINOPLASTY DISSECTION COURSE IN MILAN, ITALY



GIANLUCA CAMPIGLIO, MD, PHD

Italy

ISAPS Secretary

ISAPS Visiting Professor

On November 30 and December 1, 2017, the *First Rhinoplasty Dissection Course in Milan* was held under the patronage of the Plastic Surgery Post-Graduate School of the University of Milan chaired by Prof. Marco Klingner.



Figure 1 - From the right Prof. Marco Klingner, Chair of the Residency Program in Plastic Surgery of the University of Milan, Prof. Francesco Klingner, Clinical Professor in Plastic Surgery, Prof. Alberto Dragonetti, Head of the ENT Department at Niguarda Hospital, and Prof. Campiglio, ISAPS Visiting Professor and ISAPS Secretary.

I was appointed as Scientific Director of this event together with Prof. Alberto Dragonetti, head of the ENT Department at Niguarda Hospital, one of the largest in Italy. As organizers, we decided to offer one registration as an extraordinary benefit for the 2017 ISAPS membership. The recipient was Dr. Guglielmo Rufolo from Naples who had therefore the opportunity to attend free of charge both the lectures and the dissections thanks to his ISAPS membership.

The scientific program was divided into two parts. The first consisted of lectures on the principles of surgical anatomy of the nose, the different surgical techniques in closed and open rhinoplasty and their main clinical indications. Particular emphasis was put on the functional problems often associated with aesthetic rhinoplasties (septal deviation and turbinate hypertrophy) and their surgical treatment. All presentations were complimented with video-clips and were followed by in-depth interactive discussions. The second part, on the following day, was at the new AIMS Lab in the Niguarda Hospital, was based on fresh anatomical samples, and offered the possibility to the participants to apply what they learned the day before under the guidance of the tutors. The possibility to combine lectures and dissections on fresh cadavers made this Course unique.

A total of sixteen residents in plastic surgery and junior plastic surgeons participated in this intensive course that was accredited for fifteen European CME credits. A distinguished faculty, composed of several ISAPS members, internationally recognized as leaders in the field of rhinoplasty, contributed with detailed presentations and one-on-one tutoring during the dissection day.



Figure 2 - The attendees and some members of the faculty on the day of dissection. In the first row Dr. Rufolo, ISAPS member who profited from the extraordinary benefit (second from right), Prof. Campiglio (third from right) and Prof. Mazzola (fifth from right).

The two Italian societies of plastic surgery, AICPE and SICPRE, both members of the ISAPS Global Alliance, endorsed the meeting.

Apart from the scientific success witnessed by the positive feedback at the end of the meeting, I was very satisfied because the course celebrated for the first time the school of plastic surgery in Milan, one of the oldest in Italy, in the location, Niguarda Hospital, where it has been based for many years - including those of my residency. I have been invited by the University of Milan and Niguarda hospital to organize a second edition of the course that is already planned for November 16 - 17, 2018.



Figure 3 - Prof. Campiglio guiding two residents during the surgical steps of an open rhinoplasty simulated on a fresh cadaver head.

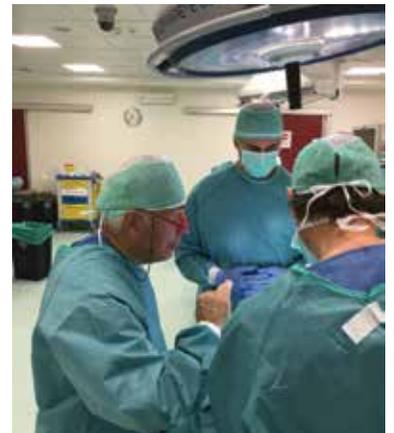


Figure 4 - Prof. Mazzola explaining some relevant surgical details about nose anatomy to two young attendees.



Figure 5 - A panoramic view of the brand-new AIMS Lab inside Niguarda Hospital with 8 tables for dissection each one fully equipped with monitor, PC and camera.

ISAPS SYMPOSIUM – INDIA



MANOJ KHANNA, MD
India
ISAPS National Secretary for India

An ISAPS Symposium was held in the historic city of Udaipur in Rajasthan, India on the 1st and 2nd of February 2018. It was followed on the 3rd and 4th of February by AESURG 2018, the annual meeting of the Indian Association of Aesthetic Plastic Surgeons (IAAPS).



Figure 1 - The 16th Century Udaipur City Palace on Lake Pichola.

This was the largest aesthetic surgery meeting ever held in India with more than 250 attendees. Jam packed halls throughout the day during the entire conference testified to the interest of the audience in the high quality of scientific deliberation throughout the Symposium. My thanks to those involved in the organization of this event, in particular Dr. Rakesh Kalra, ISAPS Assistant National Secretary for India who played an active role in the meeting.

Everyone was extremely happy with the ISAPS faculty that included Drs. Dirk Richter (Germany), Vakis Kontoes (Greece), Gianluca Campiglio (Italy), Kai Kaye (Spain), Allan A. Allan (Germany) and Natalia Manturova (Russian Federation) sharing their knowledge and experience with the everyone.



Figure 2 - ISAPS President Elect Richter, Secretary Campiglio and Education Council Chair Kontoes.

The keynote of this meeting was the extremely cordial interaction between the visiting experts and the delegates and the ever-willing attitude of the Faculty to discuss any query. The entire spectrum of aesthetic surgery was covered during the

Symposium with emphasis on latest trends and developments.



Figure 3 - The faculty including Drs. Richter, Kumar, Khanna, Singh and Davalbhakta.

There were lots of enquiries ever about joining ISAPS and attending the ISAPS Congress in Miami Beach in October-November this year.

Non-surgical aesthetic procedures in aesthetic surgery practice was the focus of the national meeting of the Indian Association of

Aesthetic Plastic Surgeons which followed the ISAPS Symposium which was also thoroughly enjoyed by the delegates.

A memorable four days for everyone.



Figure 4 - Members of the faculty in Udaipur.

THE END OF THE WORLD ISAPS IMMERSION COURSE IN PERIORBITAL REJUVENATION - 4TH & 5TH DECEMBER 2017



FABIAN CORTIÑAS, MD
 Argentina
 National Secretary for Argentina
 ISAPS Education Council Regional Chair
 for South America

The Periorbita is one of the most challenging areas in facial aesthetics and the place of the third most common aesthetic surgeries according to the ISAPS Global Statistics report of 2016. Those facts led us to develop a course dedicated only to periorbital rejuvenation.



We selected our Patagonia, Argentina because it provides a peaceful environment, enormous vistas and breathtaking landscapes combined with the distinction and elegance of The Llao Llao Hotel Golf Resort and Spa.

The course was designed to be an immersion modality with the aim of covering the full spectrum of treatments in the periorbital area in one and a half days. Also, the scientific program included four video sessions in which more than 25 edited videos were presented.



The meeting was declared of municipal interest by the Bariloche City Council and the faculty were considered Honorary Guests of the city.



GUSTAVO ABRILE, MD
 Argentina
 Assistant National Secretary for Argentina

The invited faculty included: Drs. Renato Saltz, Giovanni Botti, Vakis Kontoes, Carlos Uebel, Nelson Letizio, Osman Senel, Sergio Lessa, Antonio Graziosi, Luis Vasconez and Fabian Cortiñas.

We would like to thank the faculty for such a great educational experience and the numerous attendees who shared those intense days in a magnificent location.



ISAPS faculty at the End of the World Meeting in Patagonia, Argentina: Renato Saltz, Fabian Cortinas, Vakis Kontoes, Giovanni Botti, Gustavo Abrile and Nelson Letizio.

GUESS WHO?



See page 47 for the answer

ISAPS VISITING PROFESSOR PROGRAM IN JAIPUR, INDIA



GIANLUCA CAMPIGLIO, MD, PHD
Italy
ISAPS Secretary
ISAPS Visiting Professor



VAKIS KONTOES, MD, PHD
Greece
Chair, ISAPS Education Council

On January 29 and 30, 2018 a Visiting Professor Program (VPP) was held in Jaipur, capital of Rajasthan, one of the biggest states in India. Prof. Vakis Kontoes, ISAPS EC Chair and Prof. Gianluca Campiglio, ISAPS Secretary, spent two intensive days at the Plastic Surgery Department of SMS Medical College of Jaipur where they were hosted by Prof. Pradeep Goil and Dr. Sunil Srivastava, heads of the department, and Dr. Lokesh Kumar, ISAPS Trustee.



Figure 1 - Prof. Kontoes and Prof. Campiglio with the hosts and the attendees of the VPP program.

presenting surgical anatomy principles, clinical cases and operative techniques. The topics presented were facial rejuvenation (face lift, blepharoplasty and non-invasive treatments), rhinoplasty (open and closed approaches), breast surgery (augmentation, reduction and mastopexy) and body contouring (abdominoplasty, liposuction and thigh plasty). All presentations were complimented with video-clips.



Figure 2 - Prof. Goil introduces some colleagues from the Plastic Surgery Department of SMS Medical College of Jaipur to Prof. Kontoes and Prof. Campiglio.

Eighteen Residents of the SMS Medical College of Jaipur program (one of the largest in India) attended this VPP, together with the consultants of the department and junior Fellows practicing in Rajasthan – a total of 34 participants. An interactive, in-depth discussion followed every presentation and a lot of questions were raised by the participants, which were clarified in detail by the professors. Dr. Kumar also contributed to this didactic activity with additional presentations.



Figure 3 - Prof. Kontoes and Prof. Campiglio during the visit to the Burn Unit of the Plastic Surgery Department.

The second day was completely dedicated to live surgery and opened with rounds in the huge plastic surgery department of the hospital where the two ISAPS Visiting Professors met surgeons, patients and nurses. Interaction with the Consultants and Residents on complicated plastic surgical cases such as severe burns, cleft lip and palate and other reconstructive entities took place during this very interesting session. The public hospital of Jaipur is one of the largest in India and every year receives more than 100,000 patient admissions. The plastic surgery department has an average of 1,500 admissions per month which provides an opportunity to the Residents to deal with a wide spectrum in reconstructive surgery.

The live surgery day consisted of video-presentations with step-by-step surgical techniques on face-lift, blepharoplasty, rhinoplasty, breast and body contouring surgery. These step-by-step videos invited interactive participation of the Residents and of the other attendees and clarified many important issues related to each procedure.



Figure 4 - Prof. Goil and Dr. Kumar accompanying Prof. Kontoes and Prof. Campiglio during rounds in the Plastic Surgery Department where they met patients and nurses.

The VPP concluded with a traditional Indian ceremony to celebrate the event: the Professors, the Consultants and the hosts conducted the lighting of the lamp in front of the God of Knowledge. Prof. Malti Gupta, one of the legends of plastic surgery in Rajasthan and former head of the department, also participated in this exciting service and contributed to the discussions with the Residents and the rest of the attendees.



Figure 5 - Prof. Kontoes during a lecture about eye surgery on the first day of the VPP.



Figure 6 - Prof. Campiglio during a lecture on breast surgery. The upcoming MIAMI 2018 biennial Congress was also presented to the attendees at the end of the presentation.

The Visiting Professors had the opportunity to enjoy the excellent hospitality of the hosts of this VPP with superb social events at the end of each didactic day and a wonderful tour of Jaipur on the afternoon prior to the scientific program.

The overall satisfaction of the participants was very high as witnessed by their positive feedback at the end. Once again, the importance and the necessity of such educational events was evident as the aesthetic surgery training of



Figure 7 - A picture of the traditional Indian ceremony of the lighting of the candle of knowledge. On the right is Dr. Malti Gupta who chaired the department for many years and is one of the first women in India to be appointed Professor of Plastic Surgery.

Residents in Indian public hospitals is limited, the same applying also in many other countries around the world - proof of the importance of ISAPS' main mission "Aesthetic Education Worldwide®" and our Visiting Professor Program.

UPDATE: GLOBAL ACCREDITATION COMMITTEE



OZAN SOZER, MD
 United States
 Co-Chair, ISAPS Ad Hoc Global Accreditation Committee
 Vice Chair, ISAPS Education Council

The Global Accreditation Committee has started working on organizing rules and regulations for a safe surgical environment that can be applicable throughout the world. Included here are the first regulations that the committee suggests:

1. A final verification of the procedure should be done right before starting the procedure and should be documented. This will avoid any erroneous procedures.
2. The surgery center should have separate waiting room, business office, sanitary lavatory, toilet and exam rooms.
3. If the medical office is in the same building, the surgery center should be separated with a secure door allowing limited access for authorized personnel only.
4. The operating suite should include a scrub area and separate post anesthesia area.
5. Instruments can be cleaned and sterilized in the same room as long as there is enough dedicated space to wash, dry, pack, sterilize and store the instruments.
6. An exam room can be used as a minor procedure room for procedures no greater than removal of skin lesions such as moles or sebaceous cysts. For example, bilateral upper blepharoplasty is NOT considered a minor procedure.
7. There should be sufficient temperature control. This can be a local or central system.
8. The minimum size of the operating room should be 20 m2

Clearly, this is just a start and a very small portion of the complete set of regulations. Many aspects of a safe environment still need to be discussed. As we progress, we will be posting additional regulations in each issue of *ISAPS News*.

Committee Members include:

Co-Chairs	Ozan Sozer, US Ivar van Heijningen, Belgium
South America	Fabian Cortinas, Argentina Ricardo Ribeiro, Brazil
Central America	Bertha Torres, Mexico
North America	Foad Nahai, US Robert Singer, US
Europe	Michel Rouif, France Kirill Pshenisnov, Russia Andreas Printlau, Denmark Claude Oppikofer, Switzerland
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HUMANITARIAN PROGRAM – AICPE ONLUS



MARCO STABILE, MD

Italy

Co-founder and President, AICPE Onlus

AICPE Onlus was founded in Italy five years ago. It is a young association of volunteer plastic surgeons, a branch of AICPE (Italian Association of Aesthetic Plastic Surgeons) dedicated to charity. The volunteers donate their professional time to carry out charitable activities to help disadvantaged people who suffer from unfavorable psycho-physical or economic-social conditions, in particular in developing countries. We have been concentrating on Africa and South America.

Currently, we have four open missions in Togo, at the San Jouan de Dieu hospital in Afagnan, Paraguay, in Guatemala and last year a brand new mission in Benin. All who are involved work pro bono and we have no administrative costs. We have sent 16 surgical missions since the beginning of the project in March of 2013.

We are dependent on fundraising that we used to do at Italian conferences and independently by spreading the purpose of our missions during convivial dinners. Everything we receive from our donors is used during our missions.



Figure 1 - Market in the village of Afagnan.

My first humanitarian mission was in Togo, one of the poorest countries in Africa where the need for help is huge. It was a thunderbolt of emotions that forever remain under the skin, ready to re-emerge during every new mission. Everything is different from Italy: the heat, the smells, the lifestyle, the local customs and the people. Even the diseases are very

different and amazing. Large adamantinomas of the maxilla and jaw that I've never seen before, only in textbooks, giant skin tumors, sequelae of burns with retracting scars of the limbs and neck, congenital malformations, cleft lips and palate still open in adulthood, double pressure sores in paraplegics. All pathologies appear to be amplified.

Sometimes the delay in treatment is due to the patient's visiting the village's sorcerer who performs various tribal customs and ceremonies - without results. There is a local "tam tam" (word of mouth) between the villages and the local radio that helps spread the news of our arrival. People make great sacrifices to come to the village hospital. Sometimes they walk long distances to visit and be operated. Most of the people who come to the hospital wait patiently for their turn, often for hours without question. This struck me deeply.

Usually, the first day we do pre-operative visits in order to plan the procedures for the week. The dignity of these patients is admirable. The operating theaters are poorly equipped and there is a huge



Figure 2 - Chupa chups (lolly pops) donated as "pre anesthesia" in the OR.

need for everything; sometimes we must bring medicines and almost everything we need to be able to work such as surgical tools, instruments, sterile gloves without talc and sutures. Each mission involves two or more surgeons and they are coordinated by the mission's chief. We generally plan to stay for one or two weeks which we self-finance. Sometimes the organization of work and delivery of patient care is very complicated, but the people are so grateful because they cannot get any treatment from their own medical system without money.

For four years, AICPE Onlus has also supported Nemyatyro Paraguay (life-changing surgery is the translation from Guarany) the name of the humanitarian program in Paraguay where Dr. Bruno Balmelli, Director of the Burn Center of Asuncion, organizes free clinics several times a year with all his staff.



Figure 3 - Dr. Marco Stabile with operated patients.

Another project we have been developing is a collaboration with an Italian humanitarian non-profit association, On the Road, that operates in Guatemala.

Usually, during each mission we evaluate over 100 patients and perform almost 50 procedures: malformation repair, flaps, skin grafts, and wound debridement are the most common. We are used

to operating and simultaneously teaching the local doctors. In Togo, I have introduced regenerative surgery with fat grafting for chronic wounds and scars.

AICPE Onlus also supports people affected by serious natural disasters with donations. In January 2014, we donated €10,000 for the devastating typhoon that hit the Philippines. In November 2016, we donated €6,000 to the Italian Red Cross for the earthquake in the Marche region of Italy.

Last but not least, AICPE Onlus will promote new projects, both independently or in association with other international organizations, in order to bring our expertise directly where it can be helpful, and to show the strong link between plastic surgery and charity, without any mediation or any other interest, except for the right of all people to good healthcare. My life has been certainly changed by this great experience.



Figure 4 - Curiosity about the white doctor.

I want to thank all the volunteers of AICPE Onlus who have taken time from their busy schedules to participate in our missions.

For information: marcostabile@gmail.com

MESSAGE FROM THE CHAIR OF NATIONAL SECRETARIES



PETER SCOTT, MD

South Africa
ISAPS National Secretary of South Africa

Dear Colleagues,

We now have 100 National Secretaries!

By now you would have had a chance to see and use our new look website. As Chair of National Secretaries (NS), on your behalf, I would like to congratulate Julie Guest and the team who have worked tirelessly behind the scenes to put this all together.

A new educational initiative is the ISAPS Webinar Series. I watched Nazim Cerkes, master rhinoplasty surgeon, take an extremely difficult rhinoplasty problem and step-by-step achieve an amazing result. Watch out for more of these webinars in upcoming newsletters.

We have concluded two elections since our last newsletter: Yoram Wolf, our new NS for Israel and Bianca Ohana, 2nd ANS for Brazil. We welcome them to these positions. I would like to thank Marcos Harel for his services as the previous National Secretary for Israel. In Brazil, Bianca Ohana will be joining Andre Cervantes Garcia Rodrigues, 1st ANS, and Luis Perin, NS. They will make a formidable team in promoting ISAPS in Brazil.

2018 will be a very busy year for Catherine Foss and her staff in organising NS elections that must conclude by mid-year. We have eight NS's who have served ISAPS for eight years who will need to be replaced and twenty NSs

and ANSs who are up for re-election or replacement. I would appeal to these NSs and ANSs to look carefully among your fellow members for candidates who are as committed as you have been and ask them to contact Catherine to confirm their willingness to be added to the ballot. We have been fortunate to have a very motivated family of NSs and ANSs over the last few years. A list of newly elected NSs and ANSs will be included in the next issue of *ISAPS News*.

At the same time, I would like to remind you that we will elect both a new National Secretaries Chair and an Assistant Chair at the Miami Congress in October. We will be sending emails about that nearer the time. If you are interested in putting your name in nomination for one of these positions, please contact Catherine Foss.

During the ASAPS meeting in New York, we will again have an informal lunchtime meeting of those NSs who are present on Saturday, April 28 at the Javits Center.

Finally, I encourage all our NSs and ANSs to attend the 24th Congress of ISAPS on 31 October through 4 November in Miami Beach, Florida USA and especially plan to attend the NS meeting on Tuesday, 30 October. We had a near full house of NSs and ANSs at the meeting in Kyoto, Japan in 2016 and it would be wonderful if we could repeat this attendance.



To our non-member readers, we invite you to join ISAPS.

Among the many benefits of membership, registration for the Congress is significantly less expensive for ISAPS members.

For information about membership go to
<https://www.isaps.org/how-to-join-isaps/>

JOURNAL UPDATE: MESSAGE FROM THE EDITOR OF *Aesthetic Plastic Surgery*



BAHMAN GUYURON, MD
United States
Editor-in-Chief

One of my goals when I accepted my position was to return *Aesthetic Plastic Surgery* (APS) to what was the intention of its founding father and to come in line with the mission of the society that it represents. Many articles were being published in the journal that had no aesthetic inferences. It took some time to clear those articles that were already in the review process, and for close to a year now we have not published articles that do not have aesthetic connotations. I owe this seamless transition to many of you who have enriched the journal inventory by submitting mission-appropriate articles, thus eliminating the need to accept articles without aesthetic overtones.

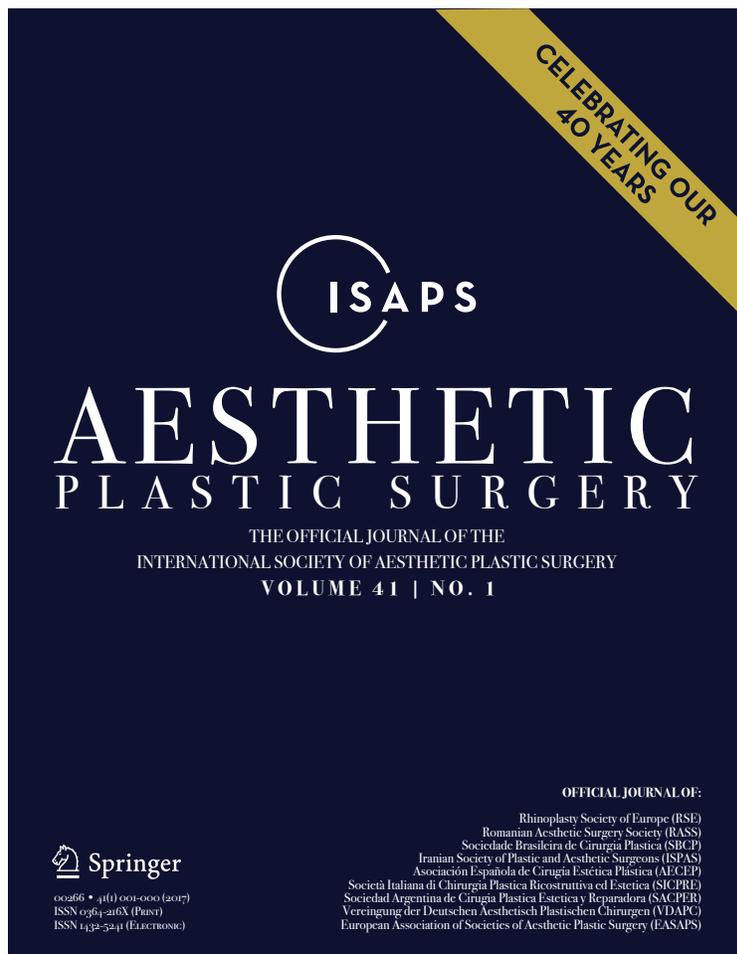
I am sure that you have also noticed that the number of published articles has increased since the number of submissions has increased, even with the limitation posed in the focus of the journal.

I hope you enjoy reading the “Invited Commentaries” by field experts. My hope is that these experts can help you to sort out the value of the articles and see their pros and cons, especially those that are related to topics that may not be familiar to you. The June issue will have an emphasis on facial fat injection. I predict that this will be very informative and one of our most popular issues.

With the increase in submissions, our need for reviewers has also increased. Again, if you are interested in evaluating submissions to APS, please send me an e-mail to let me know what types of articles and topics you are interested in reviewing. bguyuron@guyuron.com

My deepest gratitude goes to all of you who design and conduct research, analyze the data, write an article, edit many times, prepare graphics, gather publishable photographs and related consents, and submit the article for publication. It does not end there. You often must revise the article, sometimes two or three times, until the product of your extremely hard work is considered publishable. For those who do not write articles, the complexity of the process and the enormity of the time and energy that is devoted to each article is unimaginable. It is for this reason that I make every effort to ensure that each article receives the utmost attention, and I carefully analyze the recommendation of the reviewers before reaching the final decision, especially if the decision is a rejection.

I look forward to receiving your articles. Our publisher offers help to improve the quality of writing before articles are accepted. Those of you who do not have English as your first language may want to take advantage of this service.



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13 WAYS TO BRING NEW BUSINESS TO YOUR AESTHETIC PRACTICE



JULIE GUEST

United States

ISAPS Chief Marketing Officer

Attracting enough quality leads might just be every aesthetic plastic surgeon's biggest headache. But it doesn't need to be! Often, it can just be a matter of doing one or two things differently, and setting yourself apart from the crowd. To get you started, here are a few ideas you may want to try. Some of them are back-to-basics – easy strategies that you simply may not have thought of. Others are a little more ambitious, but you might find they're really enjoyable, and you'll certainly find they make a difference in your lead attraction! Print out this list and keep it next to your computer, or share it with your team to integrate into your marketing plan.

1. Host your own "TV show" – which can be broadcast on YouTube or another video platform (like Vimeo or Facebook Live). Give your show a name. Segments can be any length you like – from just five or 10 minutes for a quick tour of your beautiful offices, to an hour or so for something more in-depth. Put yourself in your patients' shoes, and think about topics that would be useful and interesting to them. Interview guests on your show. Give demonstrations. Watch some late night TV, or some of the plastic surgery shows, to get ideas for your shows – there's a reason they are so successful!
2. Contact your local newspaper and offer to write a beauty column for their online edition. Give some sample topics. Make sure you have done your research first, and don't forget to get their permission for you to use the content from the column to promote in your own marketing!
3. Author a book. Really! (But notice I didn't say, "Write a book.") If writing is not your passion, then you can get a ghost writer to help you. Together you can design the content, and he or she can write it in your voice. And if you're looking for your own book fast (within 30 days), consider investing in a "pre-written" book. This contains content already written for your target market (which is then customized specifically to you), with a unique title, cover and foreword by you. (You are welcome to email me with any questions about ghost-authored books at marketing@isaps.org.)
4. Implement a formalized referral program. This can be very simply done, by including a Referral Form with each patient's discharge material, or by having one that can be filled out on your website (for example, on your Contact page). Always thank your patients for referrals – you'd be amazed at how people respond to a personalized note from you! Offering a gift or incentive can be a great way to say "Thank you," too, but you'll want to check applicable laws for what is permitted in this area, as it can present legal issues.
5. Foster business relationships within your local community that allow you to cross-promote yourself with their businesses. (You promote them, and they promote you.) Some good examples are fitness centers, hair salons, high-end clothing boutiques, makeup bars, dental practices, etc. – any business that helps its clients look and feel good – especially where their target market coincides with yours.
6. Ask your happiest patients if they would consider being a more engaged referral for your practice. List them (along with 15 to 25 others) to be contacted by prospective patients (and be sure to reward them for their generosity with their time – again, check your local laws).
7. Host an evening seminar or cocktail hour, or even an afternoon Open House, where you can hold demonstrations, offer free sample products and give a presentation. Encourage those invited to bring a friend or two!
8. Sponsor a local charity and get its permission to use its logo in your marketing, so that patients are aware of your support. Blog about it. Include photos of your support and attending their events on social media. It's also a great idea for your YouTube show!
9. Start a quarterly print "magazine" for your practice. Re-purpose some of your well-written blogs on popular topics. Include a column written specifically by you, along with photos of your family vacation, pets, golfing exploits, etc., to help build rapport.
10. Marketing using email is not dead – but badly written email campaigns certainly are. Avoid doing "special offer" e-mail blasts that just generically list this month's offers. Think of an interesting subject line, one that gets your patients' attention. Make your email promotions personal, informative and rapport-building, and always make them entertaining. You will know how well you are doing at this based on the number of opt-ins and opt-outs you receive. When you get it wrong, just keep tweaking until you get it right.
11. Implement online chat on your website so that prospective patients can interact with your team instantly to ask questions, without having to pick up the phone.
12. Get local news coverage by sending out your own press releases to your top media outlets. Develop relationships with the top reporters (print, radio and TV), and let them know of your willingness to be interviewed at short notice.
13. Shower the top 20% of your patients with thank you cards, unexpected gifts and recognition of their birthdays. You would be surprised at the power of this strategy. A little recognition goes a long way!

Finally, do some competitor research. Make a list of what your top three competitors are doing (not just the services they offer, but what the entire patient experience is), and make sure that EVERYTHING you are doing is different, and better. Offer an espresso in the waiting room. Cross-promote with high-end childcare for Mommy Makeover patients. Set aside some time every day to personally follow up with the previous day's appointments (by phone or by email).

You might offer many of the same procedures as your competitors, but by no means does that make the experience you offer the same. By giving your patients a completely different encounter, you make yourself stand out from the rest. Remember – if you don't know what to do, just do something different!

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- Stephen J. Ronan, MD
Board Certified Plastic Surgeon, ISAPS Member

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GLOBAL PERSPECTIVES: HAIR RESTORATION

ISAPS News Global Perspectives series features new innovations, practice trends, and observations about a specific area of aesthetic surgery. We are pleased to share these insightful articles about hair restoration in this issue.

GLOBAL PERSPECTIVES: HAIR TRANSPLANTATION



ALFONSO BARRERA, MD, FACS
United States

I have been doing hair transplantation since 1993 inspired by the work of my good friend and colleague Dr. Carlos Uebel (Brazil).

Initially, I started treating primarily cases of male pattern baldness, and subsequently female pattern alopecia and reconstructive cases of scarring alopecia of the face and scalp due to tumor removals, trauma, or birth defects.

My preference, and that of most surgeons, is using very small 1-2 hair follicular unit grafts at the front hairline, providing a no-line hairline that is intentionally a little irregular to mimic nature as best as possible.

About 1-2 cm posterior to the front hairline, you can use slightly larger grafts (2-3 hairs) by using very small blades or needles to create the recipient site to completely avoid or minimize any detectable scarring.

As to the harvesting of the donor hair, in almost all cases I use the traditional donor ellipses (also called strip harvesting or FUT) from the occipital and temporal regions.

I feel that harvesting a long and narrow horizontal ellipse from the occipital-temporal areas, using 3.5 loupe magnification incising accurately parallel to the hair shafts and doing a tension free closure, leads to a very fine, usually non-detectable, donor site scar in most cases, unless the patient plans to shave his or her hair in the donor area. Most of my patients wear their hair at least 1-2 cm long in the donor area.

If the patient plans to shave or wear very short hair, then Follicular Unit Extraction (FUE) would certainly be the best option to eliminate any risk of detectable linear donor scar. This is done by using 0.8-1 mm punches and manually extracting the follicular unit grafts one by one. There are multiple options of FUE punch systems available including Devroye's Trumpet punch system, NeoGraft®, Harris S.A.F.ETM System, ARTAS® Robotic Hair Restoration, and more.

My Typical Case: The patient is treated under IV Sedation (Midazolam and Fentanyl) and local (0.5% Marcaine with epi 1:200.00) in the supine position. The head is turned to the left, the donor ellipse is injected with tumescence solution (the ellipse is usually about 1-1.5 cm in width and 10cm – up to 30cm in length), the right half is harvested, and the closure is done tension-free with a single layer of simple running 3"0" Prolene®. Then the head is turned to the right and the left half is harvested and closed the same way. After this, under 10 power magnification using a Manthis Microscope and background lighting, 1-2 mm thick slices are made carefully preserving the intactness of the follicular units, and subsequently these slices are divided into individual follicular unit grafts. It is extremely important to have complete and intact hair follicles and to manage them a-traumatically to insure they grow well. Following these steps, we can save approximately 95% of the follicles. The grafts are then temporarily stored in chilled saline solution, then lined up on a wet towel in groups of 100 (10 by 10's) as this is how we keep the count.

Then they are transplanted one by one by the "stick and pace" technique using a 15 or a 22.5 degree Sharp point blade. I personally make each incision on all my patients, selecting the direction of intended hair growth and location, and my assistant inserts the graft into the slit using my blade as a guide. Again, you want to achieve a no-line hair line, trying to mimic nature as best as possible.

We typically do 1500 to 3000 grafts per session depending on the degree of hair loss. A year later, if the patient desires more density, we do a second session and if a year after that the patient still desires additional density, and has sufficient donor hair available, we may then do additional grafting. Of course, the possibility of optional additional sessions to increase density must be clearly explained prior to the first session.

I have three experienced surgical assistants, some of whom have been working with me for over 20 years. A good surgical team is critically important.



Figure 1 - 54 Yr old man before (front).



Figure 2 - 2 Years after a single session of 2,160 grafts (front).



Figure 3 - Looking down before.



Figure 4 - Looking down after.



Figure 5 - Left side before.



Figure 6 - Left side after.



Figure 7 - Back before.



Figure 8 - Back after, no donor site scarring detectable scarring.

The author has no financial or other interest in any company or product mentioned in this article.

A BRIEF STORY OF OUR HAIR RESTORATION ODYSSEY



CARLOS OSCAR UEHEL, MD, PHD
Brazil
ISAPS Past President and Board Trustee

In 1975, Jose Juri, and later in 1978 Abel Chajchir, both from Buenos Aires, Argentina, opened to the world a new technique for a surgical treatment for baldness describing the “temporo parietal occipital flap.” This was at that time something extraordinary using a twice delayed flap procedure. We started using such flaps with very interesting results. After that, in 1983, we described the “single stage angular flap” that could be rotated without being delayed. It was a randomized flap with a “boomerang” shape (Figure 1). Although it was a wonderful flap for patients with high hair density, we couldn’t totally hide the frontal hairline, and seeing the papers of Marrit and Nordstrom, we have split some hair punches into single hair and implanted in the frontal line achieving very successful results.



Figure 1 - 42 year old patient submitted with a randomized hair bearing flap rotated in a single stage without delaying procedures.

From these single hair contribution, why not extend it to the entire balding area? And so in 1991, we published the paper “Mega Sessions with Micro and Mini Grafts” that really opened a new window for so many new advances in hair restoration surgery - and what a success with the 1000 micro grafts in one single stage (Figure 2). We presented this technique for the first time in Washington in 1991 during the ASAPS meeting and again in San Francisco in 1995 where they honored us with the Raymond Vilain Award. At that time, we didn’t use the term Follicular Units, but we introduced many words that we still use today including: scalp ballooning, hair bearing scalp, stick and place, and punctiform technique, among others. It was a new technique that spread very fast in the world and a great contribution for male and female pattern baldness treatment. It is certainly one of the most common procedures still in use today.



Figure 2 - One of our first patients operated in a “stick and place” mega session of micro and mini grafts. Post-operative at 2 and 17 years maintaining good hair quality.

In 2006, we published another important paper, “The role of platelet plasma growth factors in male pattern baldness surgery” that brought an important achievement to young patients with very thin hair in the donor area. Why

not for older patients with less hair density? With a concentrate rich platelet plasma that we transform from the same patient blood and activate with calcium chloride, we mixed the follicular units for 15 minutes to stimulate the stem cells found in the hair shaft bulge. We have observed up to 54% more density and growth using this procedure. This is especially indicated for patients with a very thin and weak donor area (Figure 3).



Figure 3 - 82 year old female patient with a very thin donor area submitted by a follicular units mega session enriched with plasma platelets growth factors and finally, post-operative at 18 months.

Today, we perform the same STRIP technique with a linear scar in 70% of our patients and in 30% the FUE (follicular unit extraction) technique that was introduced to us many years ago by our friend John Cole. Although we can obtain better density with our STRIP technique, we are convinced that the FUE technique will increase in the future allowing better scars in the donor areas. But, we must maintain the limits and the balance between donor and recipient areas in which the linear hair bearing strips can offer the largest amount of hair, and from where we can harvest high density hair. We cannot forget that well performed strip excision procedures can be repeated two or three times in cases of progressive baldness.



Figure 4 - A 52 year old patient in whom we did a linear STRIP technique 10 years ago and more recently a FUE technique. Pre- and post-operative result after two and a half years.

REFERENCES

- Uebel CO: Improvement of the frontal hairline with the angular flap and micrografts. Transaction Intl Adv Hair Replacement Symposium AAFPRS Birmingham, AL, 1982.
- Uebel CO: The Punctiform Technique with micrografts – A new method for pattern baldness surgery, free paper presented at Jornada Carioca Cir Plast, Rio de Janeiro, RJ, 1986.
- Uebel CO: Micrografts and minigrafts: a new approach for baldness surgery, Ann Plast Surg 27:476-487, 1991.
- Uebel CO, da Silva JB, Cantarelli D, et al. The role of platelet plasma growth factors in male pattern baldness surgery. Plast Reconstr Surg 118:1458-1466; 2006

HAIR RESTORATION - PATIENT SELECTION AND EVALUATION



JACK FISHER, MD
United States

HAIR HISTORY

The modern era of hair transplantation began in the 1950s when Dr. Norman Orentreich performed hair transplantation, coining the term “donor dominance,” which proved that transplanted hair would continue to display the same characteristics as the hair from where it was taken.

From then and throughout the 1970’s, hair transplant procedures used large graft punches, often consisting of 10-20 hairs at a time (more commonly known as “hair plugs”), making a natural result very difficult. Over the next twenty years, scientific and technical advances were made to provide both surgeons and patients with consistent, safe and, most importantly, natural-looking results. Since that time, two dominant techniques have emerged: Follicular Unit Transplantation (FUT) and Follicular Unit Extraction (FUE).

FUT VS. FUE

FUT requires a strip of hair to be surgically removed from the scalp and then dissected into follicular units. This procedure requires closure of the donor site with either sutures or staples. This type of closure produces a linear scar which may be visible if the patient prefers to wear their hair short.

FUE allows hair follicles to be extracted directly from the scalp in their naturally-occurring groups of 1-3 hairs without a strip of scalp having to be surgically removed. Manual FUE involves the surgeon using small devices in order to remove the follicular units. Depending on the manual technique, it may be necessary to remove the follicular units with other small surgical instruments. Automated FUE is assisted by pneumatic pressure, once the follicular unit has been adequately mobilized and freed from its surrounding tissue.

BRINGING HAIR INTO MY PRACTICE

Hair transplantation has been an increasing and significant part of my practice for over three decades and therefore has evolved into the majority of my practice’s revenue. As refinements in technique and technology have evolved, it has also become a significant factor in patient satisfaction. I began my hair transplantation practice using the strip harvesting technique and it has only been in the last few years that I introduced automated FUE using the NeoGraft® device. Driving this evolution in my practice is the fact that a substantial number of patients today are asking to have a follicular unit extraction hair transplant.

PATIENT SELECTION AND EVALUATION

Both FUE and FUT techniques are widely used in my practice to this day, as they are both integral to creating excellent patient outcomes, but there are other key components to the success of hair restoration:

- proper patient selection
- establishing realistic expectations
- assembling an experienced clinical team
- determining optimal procedure technique
- appropriate post-op care of the donor and recipient sites

Patient evaluation must take into consideration the individual’s progressive nature of hair loss. Using the Norwood Classification or Ludwig Classification system is important to properly evaluate my patients. Based on numerous factors, some patients may not be ideal candidates for an FUE procedure, while some may not be ideal for an FUT procedure. These factors not only include the patient’s anatomy and/or their family history, but also include many issues related to their lifestyle. By offering both methods, I’m able to retain these patients in my practice and educate them on which procedure makes the most sense for them to achieve their desired outcome.

I have over 2,000 strip harvesting patients in my practice. In many of these patients, it would be difficult to perform further strip procedures because of tightening of the scalp. It becomes very difficult to harvest any more hair. By bringing in the automated FUE technique with NeoGraft®, I now have the ability to bring the patient back and offer further procedures.

I live close to one of the largest military bases in the United States. I’ve had many individuals from the military come to my practice asking to speak with me specifically about NeoGraft®. In this patient population, there is very little chance they would consider a strip procedure because they routinely keep their hair cut short.

Patient selection and evaluation are cornerstones to a successful hair practice. By incorporating the NeoGraft® model using an experienced clinical team and outstanding customer support, there was no disruption to continuing my traditional strip practice. One technique is not necessarily better than the other from a clinical perspective; however, by offering both options to my patients, I can increase their satisfaction as well as expand on the opportunities in my practice.

Dr. Fisher is Chief Medical Officer of NeoGraft®.

GLOBAL PERSPECTIVES: FUTURE THEMES

June 2018 : Otoplasty

Deadline: April 15

September 2018: Genital Surgery

Deadline: July 15

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

FOLLICULAR UNIT EXTRACTION HAIR RESTORATION IN OUR PRACTICE



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Hair restoration has become a tremendous addition to our practice in Charlotte, North Carolina, USA. We utilize NeoGraft® (Dallas, Texas, USA) technology which uses a follicular unit extraction (FUE) device for hair transplantation. This technology has significantly changed our practice by rapidly increasing our presence amongst the male population. We firmly believe the scalp and hair are a critical component to facial as well as the overall aesthetics. In utilizing this technology, we have found the female population is a prime candidate for a multitude of reasons. FUE transfer has been used for eyebrow restoration, temporal recession of the feminine hairline, and restoration of the vertex.

The approach to patients is fairly simple, especially when discussing facial rejuvenation procedures. When the appropriate patient is identified, we inform them about temporal hair restoration as part of overall facial aesthetics as well as other methods to increase hair density in places with reduced density. Most patients are keen on pursuing this technique when informed there is an option with essentially no donor site morbidity. Also, the ability to perform under local anesthesia, with minimal to no significant downtime, is a strong value for these patients.

This has been a financially rewarding addition to our practice as we have not had to provide a significant amount of staff or overhead commitment. This is due in part to the fact that NeoGraft® is a collaborative company that works with us to provide infrastructure, technicians to assist us and help to steer new patients to our practice. The interesting fact about this technology and its value is it tends to speak for itself.

In my practice, my two partners, Dr. Joseph Hunstad and Dr. Bill Kortesis, both have undergone hair restoration using this FUE hair transplantation technique and have both had wonderful results. In addition, many of my friends have had the procedure and have had only positive feedback. The comment we typically make with our potential patients is "If you have concern about your hair, then utilizing this technology is almost a no-brainer." The word-of-mouth referrals you receive from FUE are extremely powerful and have been our number one source for new patients. In addition, the company provides multiple campaigns that are available for each individual practice that uses

this technology to assure they have an adequate influx of patients to support the device. We believe FUE hair transplantation technology will continue to become a more popular treatment modality across the world as NeoGraft® continues to refine their technologies and improve their devices to have an even more predictable process and shortened operative time. We would highly recommend the addition of FUE hair restoration to any aesthetic practice.

Images provided by NeoGraft®.



Figure 1 - Before female photo demonstrating reduced density prior to treatment in a female.



Figure 2 - After female photo demonstrating improvement after one procedure using 1200 grafts.



Figure 3 - Before male photo demonstrating reduced density prior to treatment in a male.



Figure 4 - After male photo demonstrating the improvement after one procedure using 2600 grafts.

FUE MEGASESSIONS, BEYOND THE LIMITS



İLHAN SERDAROĞLU, MD
Turkey

Hair transplantation in the form of FU's (Follicular Units) constitutes the cornerstone of hair-replacement surgery. It is the most common plastic surgery procedure in Turkey due to the fact that although there is no genetic predisposition for baldness among races, people care much about baldness and try to reconstruct hair loss in the middle east and other eastern populations.

Harvesting follicular units directly from the donor area by using punches is described as FUE (follicular unit extraction) technique, and it eliminates the need for excision of a hair-bearing strip. It is very young surgical technique: Concept of FUE was first published in Australia on October 15, 1995 by Dr. Woods and Dr. Campbell as a top-up microsurgical technique. Drs. Bill Rassman and Bob Bernstein officially described the term FUE in 2002.

The loss of hair is perceived as a loss of power and a cause of low self-confidence since the hair was perceived as a symbol of strength and authority of a man throughout history. Large bald areas are always hard to reconstruct for a plastic surgeon and needs several thousand grafts to restore pre-existing hair. Megasections with FUE have been developed with the requirement from multiple sessions of strip harvesting several hundred grafts to thousands of grafts over time and gave us the ability to cover large areas of hair loss (grade 5-7 Norwood scale) in one session of hair transplantation (HT). Although there is no established definition, megasections are accepted as 2500-3000 FU's implanted during big sessions of HT. Outcomes of large bald areas achieved from sequential procedures with strip harvesting technique on the same donor are poor or suboptimal. Therefore, FUE is my preferred approach in patients with large bald areas when we consider scar quality, donor harvesting and total yield. That preference is not just because it affords to eliminate a long and visible scalp scar, but because of the ability to harvest a much big number of grafts without the need for scalp laxity as in the strip technique.

TECHNIQUE:

We prefer to perform a high density HT with FUE both for primary cases and for the revision of poor post-operative hair growth results that is done in other clinics. We are able to create real looking hair with greater coverage and greater density in one session.

Follicular units are harvested with micromotor by using different punch sizes basically between 0.7 to 0.9 mm. Grafts are picked up from the harvest site with a curled tipped forceps by medical assistants. Recipient sites for grafts are prepared by different sized custom-made blades. We cut the blade as the length of the longest graft or follicular unit or 0.1 mm shorter. When we implant the follicular units, spacing of grafts is very important. We use a repeating diamond shape pattern during implantation of FU's in small pre-made thousands of canals. FU's are replaced differentially or graded in those

small channels by thin tipped forceps. Gentle handling of grafts with forceps during placement of follicles is very important for survival. Epidermis of grafts remains approximately a half millimeter above the epidermis of the scalp.

Three points are important in hair transplantation in order to get natural results. First is frontal hairline design. This is the heart of hair restoration surgery. The goal of frontal hairline restoration is to reframe the face in proportion. Second, cosmetically natural appearing HT needs implantation of 30-45 grafts/FU's per square centimeter. Although it is asserted that 10-20 grafts per centimeter square implantation has the greatest survival rate, it results in low density. Third, angle of incision determines the exit angle of growing transplanted hair and should mimic the lost hair or surrounding existing hair to create natural flow after growth. Miniaturized hairs are almost always present as a guide to incision angle.

For rejuvenating a patient's face, we do botulinum injections, fillers, midface lifts, brow lifts, face lifts and skin resurfacing procedures. But a single procedure, hair transplantation, is actually a very important tool for a plastic surgeon to rejuvenate the face of a male patient and results in a 10-20 years younger looking patient after operative achievement. In essence, performing a dense packing megasection FUE operation leads to a significant improvement in the quality of a patient's life and increases self-confidence.

FUE hair transplantation is rapidly becoming the mainstream and performed in all centers and hospitals in this era of globalisation. However, this technique demands experienced hands of plastic surgeons who are dedicated to HT and should not be left in the hands of inexperienced technicians.



Figure 1 - Patient has one session of FUE HT with 3300 grafts. Pre, per and 1 year post operative photos.



Figure 2 - Patient has one session of FUE HT with 3800 grafts. Pre and 1 year post operative photos.

HAIR TRANSPLANTATION IN EYEBROWS, EYELASHES, SIDEBURNS AND OTHER SPECIAL AREAS WITH ALOPECIA



OSCAR MARINACCI, MD
Argentina

No doubt, over the last several years, hair micro transplantation has become the best cosmetic result in hair restoration surgery in androgenetic alopecia, either male or female.

However, alopecia may also be present in other parts of the body, appearing as a result of different etiologies, from congenital to acquired diseases, trauma or surgery sequelae. Among these we can find eyebrow, eyelash, sideburn or scalp alopecia by lichen scarring sequelae, collagen disease or previous surgery.

Hair micro transplantation surgery can achieve highly natural and top quality cosmetic results in other kinds of alopecia from different etiologies and presentations.



Figure 1 - Pre- and Post-Hair Micro transplantation for Androgenic Alopecia.

Figure 2 - Pre- and Post-Hair Micro transplantation for Androgenic Alopecia.

The transplant unit is called follicular unit (FU) and it comes from the separation under the microscope from a strip of scalp (FUSS, Follicular Unit Strip Surgery technique), in which the "closure" of the donor of the occipital region area leaves a thin scar. Another other way to get the units, Folliculares, is through direct removal by a micropunch of 0.8 or 0.9 mm diameter of the posterior donor area (FUE, Follicular Unit Transplantation), leaving a scar not detectable in micropuntiforme simple view. Since both techniques have pros and cons, the surgeon should be trained in both techniques to offer the patient the best option. The second technique is often elected by patients because they believe it is less traumatic, but to obtain the grafts, the donor area must be shaved for a good number of grafts. On the other hand, for the FUSS (Strip) technique, it is not necessary to remove hair from the donor area, though it leaves a fine line of posterior scar.

The FUE technique also allows us to extend the possibilities of obtaining hair from other parts of the body (beard, chest, limbs) which allows us to give more possibilities for solutions to complex alopecia.

All patients presented a high survival of hair graft, even those with collagen disease who were administered steroids previous to the surgery and after it to avoid collateral effects.



Figure 3 - Pre- and Post-eyebrow restoration by FUSS technique.



Figure 4 - Pre- and post-eyelash restoration tumor resection sequel.



Figure 5 - Pre- and post-sideburn restoration. Face lift sequel.

Though in special alopecia areas such as eyebrows, eyelashes or sideburns we can find different hair restoration options (flaps, strip grafts), hair micro transplantation (FUE or FUSS technique) has no doubt become the best aesthetic result obtained in surgical treatment.

All of the surgeries are performed with local anesthesia on an outpatient basis. The hair will grow within three months after surgery, at a speed of one centimeter per month. During the consultation process, options to treat each specific problem must be discussed to adapt patient expectations to the best aesthetic result.

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UPDATE IN HAIR TRANSPLANTATION SURGERY



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Hair loss is usually caused by genetic determination. Androgenic alopecia is the major cause of male hair loss. The pattern is quite common starting from frontal receding. Di-hydro testosterone (DHT) acting together with genetic weakness of follicular genes play important roles in affecting male hair loss. Men usually get bald at various ages. Hair Restoration Surgery has been known to gain back the hair over the bald area.

There are many surgical techniques in the history of hair restoration surgery.

1. Regional flap. In the past, we used flap surgery where the full hair bearing portion was rotated to cover the bald patch. The example is temporo-parieto-occipital flap (TPO). This technique is no longer popular due to the aggressive scarification of the donor tissue while the result is not as natural as it should be.
2. Scalp Reduction. The bald patch in the center was cut out pulling surrounding tissue to enclose, known as Frechet's Flap. This method is no longer popular due to the unsightly scar that would expose once the hair loss is progressive.
3. Tissue expansion. This method is still useful for children with alopecia patches, especially in cases of burn scars. Because hair transplantation requires only local anesthesia, children are not very co-operative and because hair transplantation take many hours, general anesthesia is too risky for the child. Tissue expander and flap rotation may give the faster result.
4. Hair Transplantation. We use the term "Hair Transplantation" to refer to the procedure where we take healthy follicles from a donor site (area across the back side of the head) to implant onto the bald area on the top. This method was first described by a Japanese doctor after the successful transferring of hair follicles onto eyebrow scars. After the development of techniques over more than three decades, we are now using the term "Follicular Unit Transplantation" as a standard terminology.

FOLLICULAR UNIT HAIR TRANSPLANTATION

The most common harvesting techniques nowadays are FUT and FUE. FUT is known as strip harvesting method where the donor hair bearing skin is resected and converted to follicular grafts under a microscope. The follicular grafts are isolated and transferred to implant to the bald area. The scar from strip or FUT is a thin linear line across the donor site. FUE is known as 'Follicular unit extraction or excision' where the follicles are extracted by small customized punch, as small as 0.1 mm. The scar from FUE is dot-like spreading all over the donor area.

FUT HAIR TRANSPLANTATION

This is the standard method of hair transplantation and is not very popular because the physician needs surgical skills to do it. Moreover, a team effort is required. Even if FUE is more popular now, FUT is the answer to every hair type and can offer the best quality and the most grafts in one surgery. There is the "Trichophytic closure technique" to help camouflage the scar.

FUE HAIR TRANSPLANTATION

This is up to date and more popular now. The follicles are drilled and punched out to pore-sized grafts so the process does not need much man power. The follicular graft is already well prepared by punching. The scar turns out to be very minimal and pore size. The scatter of dots will make it easier to cover up with existing hair even when cut short. The pain is less and recovery is faster. This is widely acknowledged in the public as "Scar-less" or "Non-surgical" hair transplantation which is incorrect. The International Society of Hair Restoration Surgery (ISHRS) has now attempted to re-educate the public that FUE is a surgical procedure and produces scars.

Comparison between the two methods:

	FUT	FUE
Success rate	Almost 100%	Range from 95-99% according to the scalp's properties
Time of recovery	Longer The tenderness and swelling along the donor site incision takes 1 week to recover	Quicker The donor site heals fast
Limitation by shaving	Shaving is needed only along a thin strip which can be covered immediately after surgery	Shaving is of a large area. The higher the number, the larger area in need of shaving.
Pain	More pain after surgery. The cut on the back side of the head is sore for 3-4 days. Pain relief-medication is required.	Less pain, almost 0. Some cases feel tingling of the donor site for 2-3 weeks. Just annoying.
Long term	Longer life cycle. All the grafts are taken from the strongest strip of hair bearing scalp, therefore, almost all should last a lifetime.	Shorter life cycle. Not all the grafts are taken from the strongest hair bearing part, some of the transplanted hair might last only 20-30 years, not a lifetime.
Scar	Linear line along the back of the head can be covered with existing donor hair. The average length that is capable to cover strip or FUT scar is 2 cm.	Pore size scars distribute all over so the patient can wear shorter hair style to cover.
Color of hair	Capable for white hair	Capable for white hair

The two methods have pros and cons. The best suited depends on the individual patient's condition. Currently, there are some surgeons pioneering with a combination of FUT and FUE techniques. In one session, there can be the cut from a strip and punches from FUE.

The ideal is to get the maximum number of grafts that cover a broad area in Class 6-7 NH male pattern hair loss which FUT or FUE solely cannot accomplish.

The current innovation in hair transplantation is toward more efficient tools to harvest the most quantity and quality grafts. The trend is less scar, less pain, less recovery period and maximum success rate. More efficient machines and punches are now developing for example higher x magnification loupes, and smaller and more defined punches.

Apart from surgery, there are many updates in development and studies of biological treatments, for example cell therapy, stem cells, PRP, LASERS that can be useful alongside surgical procedures. In combating hair loss problems, these may be the bright future that is coming.



Figure 1 - Pictures show the recovery appearance of donor site after FUE harvesting.



Figure 2 - Pictures show the combination of FUT and FUE techniques and immediate outcome after surgery.



Figure 3 - Pictures show the recovery phase after FUT technique from immediate to 7 days.



Figure 4 - Before and after FUT hair transplantation 3600 grafts, the result at 1 year.



Figure 5 - Before and after FUE hair transplantation 2500 grafts, the result at 1 year.

HAIR TRANSPLANT - DILEMMA OF FUT VS FUE



MANOJ KHANNA, MD
 India
 ISAPS National Secretary for India

Hair transplant surgery is the most common aesthetic procedure in the male population today. FUT and FUE techniques are used for harvesting the permanent hair. The Strip Technique commonly known as FUT remains the Gold Standard technique and needs surgical skills best possessed by a plastic surgeon. FUT is an easier technique and helps adding to the yield and is a good option for smaller procedures. Aesthetic plastic surgeons should not refrain from doing hair restoration surgery, lest it slips away from their armamentarium, like many other procedures.

Recent advances to create absolutely natural looking results have immensely increased the demand of this procedure. Strip, commonly known as FUT, and FUE are the two common techniques used.

The author has experience of more than 6,000 hair transplants over the 22 years since 1996 which include more than 900 FUEs. Hair transplant surgery began in 1939 where the Japanese used large punches of 4 to 5 mm to harvest hair from the permanent donor zone. The appearance appeared artificial and there was a Barbie-doll appearance in the transplanted areas. Strip harvest came into vogue in the 1980s, but punches were used to create recipient sites. Finer punches of 1.0, 1.25 and 1.5 mm were used from 1994 to create more natural looking results. Headington (1) described the Follicular Unit in 1984 and it transformed the concept of producing natural looking results by replicating the pattern of implantation with the previously existing hair morphology. FUE harvest to pluck out hair using finer punches from 0.7 to 1.25 began being used after Rassman et al (2) published the first paper on the subject. FUE and FUT are the cornerstone of hair transplant surgery today.

FUT demands better surgical skills and good team work by cutters to dissect the grafts. The technique gets the maximum yield of permanent hair in one sitting. Better surgical ability, possessed by the plastic surgeon, is necessary to do good FUT. On the other hand, FUE is a much easier procedure needing less surgical finesse and is marketed aggressively by other practitioners.



Figure 1a - Grade 7 Baldness before a hair transplant.



Figure 1b - Grade 7 Baldness after a hair transplant by FUT only.



Figure 2a - Grade 7 Baldness after a hair transplant by FUT only.



Figure 2b - Grade 7 Baldness after a hair transplant using FUT and FUE together.

FUT leaves a permanent scar at the back of the head which is visible when the head is shaved, or even if the hair is worn very short. This is the biggest challenge for a FUT surgeon. Trichophytic closure of the donor wound, which incorporates removing a thin strip of epidermis <1 mm in width and <1 mm depth along either border of the stitch line allowing the hair follicles to grow

through the scar, has improved scar quality and visibility significantly. Also, the author uses a non-absorbable suture (2-0 Monofilament Nylon) in the deeper layer, instead of absorbable sutures (3-0 Vicryl or Monocryl). All absorbable sutures lose 50% of tensile strength in 3-6 weeks, and the scar stretches for 6 months to 2 years. Non-absorbable sutures avoid the scar from stretching in the post-operative period and thereby minimise scar width. Harvesting, deep suturing, trichophytic closure and good wound closure - all these need good surgical skills, which are best possessed by the aesthetic surgeon.

FUT has numerous advantages. It gets the maximum yield of permanent hair in one sitting. The permanent hair bearing zone, known as "Safe Donor Area" (SDA) (3) is limited to a maximum yield of 15,000 to 20,000 hair follicles, or 5,000 to 8,000 follicular unit grafts (FUGs) in any individual (4). In FUE, one should extract 1 in every 3 or 4 FUGs to avoid excessive thinning in any individual in the long term, which means that a maximum of only 2,000 to 3,000 FUGs can be harvested. But in the Strip Technique, the majority of the FUGs can be harvested resulting in a much bigger yield. Over exuberant FUE surgeons transgress the SDA and also extract more than the ideal 1:4 ratio, leading in a moth-eaten scalp and non-permanent hair.

FUE requires trimming the hair to 2 to 3 mm in the donor area and this usually requires trimming or shaving the entire head. The hair takes 2 to 3 months to grow back and the tell-tale signs of a hair transplant are there during this period. No shaving or trimming is necessary in FUT and there is no visible sign in the donor area after the procedure.

FUE is a blind technique and there is a transection and loss of 5-15% in the best of hands using this technique, compared to Strip which is done under direct visualisation using magnification, and the loss usually being 1-3.

Cumulative scarring is actually much greater in FUE rather than Strip (5). If one has extracted 2,000 grafts using a 1.0 mm punch, the total scarring is $2,000 \times 3.14 \text{ sq. mm} = 6,000 \text{ sq. mm}$ app. A strip usually leaves a scar of 1-2 mm width, and if the length of the scar is 30 cm, the total area of scarring is $300 \times 2 = 600 \text{ sq. mm}$. Thus, the total area of scarring is much less in a strip.

FUE has the definite advantage of being able to harvest additional hair follicles from other areas like the beard and body hair. The beard (6) is an excellent source for very good hair of coarser diameter with better coverage, and any individual can yield an extra 1,000 to 3,000 hair follicles from the beard. In cases of severe baldness, hair can be harvested from other secondary areas like the chest, abdomen, arms and legs, although these sources have hair with lesser diameter, shorter anagen phase and much thinner hair compared to scalp hair.

The biggest fear about FUE extracted hair is longevity (7). Besides, going beyond the boundaries of SDA during FUE and extracting hair which is not permanent and will not survive when other hair in that donor area fall, there is a risk of damage to the hair anatomy and physiology during the technique of blind extraction of FUE. Finer punches of 0.65 to 0.7 mm often damage the stem cell on the shaft of the hair which is responsible for regrowth. Also,

BALDNESS SURGERY EVOLUTION: BALDNESS SURGERY REPRESENTS A HIGH TECHNOLOGICAL AND SCIENTIFIC DEVELOPMENT FOR ALOPECIA TREATMENT



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Argentina

Throughout my long professional career, I have met lots of professionals who assisted me, interested in specializing in different hair recovery techniques.

As a more valid solution, the surgical part provided excellent results, so they evolved after the era of wigs, cylindrical transplants, bandages, reduction of the alopecic area, tissue expansion with expanders, flaps, micro-transplant, follicular unit hair by hair, pigmentation, FUS, FUE, and now Robots.

In some cases, the technique of using flaps gives very good results, as in occipital scars that can be done with expanders and flaps. One of the most important technological advances in this century is the evolution in the area of Robotic Medicine. In this regard, it can be said that this is an advanced technique that is undoubtedly undergoing a lot of growth.

The process of extracting follicles with the robot is very precise because it manages to obtain a significant number of hair follicles in good condition. We consider that the key to success for the treatment of this entity is "The Follicular Unit" obtaining more natural results and fulfilling the objectives of the medical team and patients.

Over the years, experience with the infinity of male patients, women, aesthetics, accidents, burns, reconstructive surgery, and tumors we can say that the result has been successful over time increasing the interest and need, not only to improve the aesthetic part, but to improve the overall image of the patient, enhance and improve their self-confidence and quality of life.

The important thing is not the chosen method, that will depend on the physician and the patient, but the final result.

KHANNA CONTINUED

in FUE, the hair is stripped of most of its soft tissue covering including the surrounding fat cells, which also contain stem cells. There are many occasions where the transplanted hairs do not grow back, are shed permanently, or are much thinner and weaker in the next cycle of their growth. This has been noticed in many well-known personalities including the Indian cricketer Virender Sehwag and the English footballer Wayne Rooney. Transplanted hair of FUT, if properly harvested, lasts much longer, and usually remains lifelong.

All these put together make the Strip Technique the more versatile and better technique for hair restoration surgery. It is important to also be able to master FUE to add to the yield from the beard and body in extreme cases if desired by the patient, and in cases where the scalp is inelastic and extraction by FUT alone may be inadequate. The plastic surgeon has in recent times been ignoring hair transplant and is allowing this procedure to slip away into the grasp of other specialities, and the sooner this malaise is addressed the better.

References:

1. Headington JT. Transverse microscopic anatomy of the human scalp: a basis for morphometric approach to disorders for the hair follicle. *Arch Dermatol* 1984; 120: 449-56.
2. Rassman WR, Bernstein RM, McClellan R, et al. Follicular unit extraction: minimally invasive surgery for hair transplantation. *Dermatol Surg* 2002; 28: 720-8.
3. Unger W. The donor site. In: Unger W, ed. *Hair Transplantation*, 3rd ed. New York: Markel Dekker Inc., 1995: 183-212.
4. Martinick JH. The latest developments in surgical hair restoration. *Facial Plast Surg Clin N Am* 12(2004) 249-52.
5. Martinick JH. The latest developments in surgical hair restoration. *Facial Plast Surg Clin N Am* 12(2004) 252.
6. Yu JM and Amy YY. Beard to scalp. In: Unger W, ed. *Hair Transplantation*, 5th ed. New York: Informa healthcare, 2011: 299-303.
7. Unger W. Follicular unit extraction. In: Unger W, ed. *Hair Transplantation*, 3rd ed. New York: Markel Dekker Inc., 1995: 291-98.



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COUNTDOWN TO ISAPS MIAMI CONGRESS 2018 STARTS NOW!



It seems like it was just yesterday when we began talking about the ISAPS 2018 Congress, to be held in Miami Beach, Florida. Last year, the idea of the next Congress was exciting, but it was still a speck on the horizon. We had only just wrapped up the 2016 Congress in Kyoto, Japan and there was still so much time — to make plans, get things ready, book tickets, register. And now suddenly, here it is! 2018! The Congress will be here in a heartbeat. We certainly know that *tempus fugit*, but wow, did 2017 fly by quickly! No more time to waste, because the countdown has begun!

We've been talking about the ISAPS 2018 Congress for a while now primarily focusing on the location. Miami Beach, Florida is one of the most exciting places we've ever had a Congress. Its unparalleled beaches, architecture and amenities make it an incredibly popular vacation hotspot, and we will be "smack in the middle" of it all at the Loews Miami Beach Hotel. It's just a 12-minute walk to the main venue at the newly renovated Miami Beach Convention Center. But now, it's time to get down to the details of the Congress: the events we're holding and the faculty that will be attending.

We've opened abstract submission for the ISAPS 2018 Congress. All submissions must be in English. The deadline is April 10, 2018, with this year's categories being:

- Abdominoplasty and Body Contouring
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- Face & Neck Rejuvenation
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- Rhinoplasty

With the Congress fast approaching, the list of exhibitors and faculty is fast solidifying, and new additions are coming in every day. Our list of faculty attending the Congress is over 386 and growing daily, and our list of exhibitors is already at 72! If you'd like to get more global exposure for your company by having an exhibit at this year's Congress, you can contact Catherine Foss, ISAPS Executive Director, by telephone (1.603.643.2325), fax (1.603.643.1444), or email her at ISAPS@isaps.org.

As anyone who has attended an ISAPS Congress in the past will tell you, it isn't all exhibitions and classes. There will also be a vast number of fun social events where you can get to know your international colleagues better. To kick things off, our Opening Ceremony will be held on November 1st, from 8:00 to 9:00 p.m., at the Miami Beach Convention Center. This Welcoming Reception will also be a Halloween Party, and we encourage you to go all out and get your Halloween Costumes ready! There will be more events throughout the Congress, and we will provide all the details as soon as we have them.

Now that the countdown to the ISAPS 2018 Congress has started in earnest, it's time to book your spot. We have special "early bird" rates until May 31st, for all fee types. Your registration fee includes entry to all scientific sessions and the exhibition hall, a daily lunch, a daily morning and afternoon coffee break, a Congress bag, and a copy of the program/abstract book. After May 31st, the price of the Congress will rise to our mid-range rates. These mid-range rates will be in place from June 1st until September 20th. After that, you will have to pay our on-site rate in order to attend. So, as you can see, it pays to book ahead of time! Not only will you be able to save money on the fee, you will also be able to save on airfare prices, as well as guarantee that you will be able to get a room at the Loews Miami Beach Hotel and reserve a spot at the Congress.

Just think, in only a few more months, you will be attending the ISAPS 2018 Congress, the world's finest Global Aesthetic Meeting and the Greatest Aesthetic Education on Earth! By registering now, you will guarantee that you will be there, along with some of the most outstanding ISAPS plastic surgeons from around the world! We can't wait to see you in Miami Beach!

REGISTER NOW!

MIAMI BEACH, SOUTH BEACH: A SHORT HISTORY



CATHERINE FOSS
United States
ISAPS Executive Director

While Americans have a relatively short history, the area of South Florida, and in particular southeast Florida where Miami Beach is now, was inhabited by the Tequesta, a Native American tribe whose roots date back to the third century BCE. They remained in South Florida for about 2,000 years, until the mid-18th Century. At the time of initial contact with European explorers, the Tequesta numbered under 10,000. We learn in school that the Spanish Conquistador, Ponce de Leon, discovered Florida searching, in vain, for the mythical fountain of youth. In fact, his ships landed on the northeast coast, near what is now St. Augustine, in 1513.



Figure 1 - The Tequesta built villages throughout South Florida and the Florida Keys.

A map dating from 1630 by the Dutch cartographer, Hessel Gerritsz (1581-1632), labels the Florida peninsula as “Tegesta” after the tribe, while maps from the 18th century indicate the area as “Tekesta” and archeological records indicate a presence from about 700 BCE until just after European contact. At the time when Spain surrendered Florida to the British in 1763, the remaining Tequesta,

and Indians from other tribes in the area, were taken to Cuba, their villages abandoned.

By the end of the 1800’s, what is now Miami Beach was farmland with coconuts as the primary crop. In 1870, a 165-acre parcel of land was purchased from the Federal Government for 25 cents an acre by Henry and Charles Lum who, when their agricultural efforts failed, eventually sold it to John Collins and Thomas Pancoast. By 1913, John Collins and Carl Fisher became partners, and Fisher unsuccessfully engaged in agriculture along the beachfront before envisioning a mangrove barrier island. With the help of the Army Corps of Engineers, the thick mangroves were dredged and a man-made island paradise was created – Miami Beach.

Seeing its potential for residences and hotels, Fisher loaned Collins the money required to build a three-mile long bridge across Biscayne Bay from Miami – the longest wooden wagon bridge in the world. In a relatively short time, Miami Beach was incorporated as a city and soon restaurants and hotels began to open. One of the first was the legendary



Figure 2 - Opening of the Collins Street Bridge - 1913

Joe’s Stone Crab which Joe Weiss, a Hungarian immigrant who had moved to Miami from New York for his health, opened in 1913 as a small, beachside lunch counter and which is still operating today at 11 Washington Avenue. The first hotel to open was the W. J. Brown, in 1914.

The 1920’s saw a building boom when mansions were built along a three-mile piece of land that came to be known as Millionaire’s Row and many small hotels



Figure 3 - South Beach, 1914

opened on Collins Avenue and Ocean Drive to help bring Miami Beach out of the Great Depression. Later, that area became the famous Art Deco District now known as South Beach, or SoBe.

During the Second World War, half a million military personnel passed through Miami Beach, a major training center, with many of them coming back to live after the war so that by the 1950’s South Florida had doubled its pre-war population. The 1959 revolution in Cuba meant that a half a million Cubans came to this area of Florida, radically changing the face of Miami.

Miami Beach’s Art Deco District was officially listed on the National Register of Historic Places in 1979. Today, the district is the largest collection of Art Deco architecture in the world including hundreds of structures that were built between 1923 and 1943. Celebrating its 100th anniversary in 1996 (since its founding as a city), Miami Beach represents a success story like no other, with an international flair, vibrant arts scene, culture and gastronomy that make it a highly sought-after tourist destination.



Figure 4 - Miami Beach’s Art Deco District

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Go to <http://www.isapsmiami2018.com/abstracts/>

MASTER CLASS SCHEDULE

Master Class	Wednesday 31 October	Thursday 1 November	Friday 2 November	Saturday 3 November	Sunday 4 November
7:00 - 8:00 am					
MC1 - Face Lift	Timothy Marten	Bryan Mendelson	Foad Nahai	Daniel Baker	Mario Pelle-Ceravolo
MC2 - Brow Lift	Luis Vasconez	Grady Bruce Core	Chia Chi Kao	Renato Saltz	Bahman Guyuron
MC3 - Blepharoplasty	Susumu Takayanagi	Dirk Richter & Vakis Kontoes	Glenn Jelks	Guy Massry	William Mack
MC4 - Rhinoplasty	Nazim Cerkes	Rod Rohrich	Wolfgang Gubisch	Dean Toriumi	Paul Nassif
MC5 - Breast Augmentaion	Ricardo Ribeiro & Barbara Machado	Gianluca Campiglio & Giovanni Botti	James Grotting & Mark Jewell	Luis Fernando Perin & Laurie Casas	
MC6 - Breast Reduction/Mastopexy	Moustapha Hamdi	Joao Sampaio Goes	Ruth Graf	Frank Lista	
MC7 - Abdominoplasty		Osvaldo Saldanha	Joseph Hunstad	Ozan Sozer & Carlos Del Pino Roxo	Fabio Nahas
MC8 - Buttock Augmentation		Constantino Medieta	Alfredo Hoyos Ariza	Ashkan Ghavami & Arturo Ramirez Montanana	Raul Gonzalez
5:00 - 6:00 pm					
MC9 - Body Contouring Surgery in the MWL Patient	J. Peter Rubin	Dennis Hurwitz	Al Aly	Jean Francois Pascal	
MC10 - Hair Transplantation		Alfonso Barrera & Carlos Uebel	Jeff Epstein	Jack Fisher	
MC11 - Vaginal Rejuvenation	Gary Alter	Lina Triana	Jennifer Walden & Christine Hamori	Khalil Khatri	
MC12 - How to Maximize Profit in an Aesthetic Practice		W. Grant Stevens	Jason Pozner	Robert Singer	Steven Dayan
MC13 - Strategies for Marketing & Branding your Aesthetic Practice	Catherine Maley	Karen Zupko	Gaylon McCollough	Dana Fox	
MC14 - Successful MediSpas		Jason Pozner & Renato Saltz	Louis Bucky & Laurie Casas	Julius Few & Keith Marcus	
MC15 - Non-Surgical Devices that Work for Me		Barry DiBernardo	Susan Van Dyke	Sabrina Fabi & Steven Dayan	
MC16 - Injectavles that Work for Me		Haideh Hirmand & Heidi Waldorf	Joel Schlesinger	Claudio De Lorenzi	Rami Batniji



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SHORT CASE STUDY: UNILATERAL BREAST PTOSIS/HYPERTROPHY WITH SYNCHRONOUS CONTRALATERAL BREAST HYPOPLASIA



CHARALAMBOS (BABIS) RAMMOS, MD
United States

INTRODUCTION

Breast asymmetry is a distressing condition that may have a significant impact on patient well-being, and also the ability to fit in clothing. This case study focuses on the following presentation: unilateral hypomastia with contralateral mammary hypertrophy and ptosis.

A proper diagnosis is of paramount importance, before correcting any problems. Clinical examination involves assessment of the breast and chest wall. Patient input is important, and expectations pertaining to size and appearance are extensively discussed at consultation. Correction involves surgical intervention, that may be quite challenging, and sometimes may require staging or subsequent revisions. A combination of aesthetic techniques is used such as breast augmentation, and augmentation mastopexy.

The goal is to recreate symmetrical lower poles and good upper pole fullness and symmetry, and achieve high patient satisfaction.

MARKINGS

Synchronous Augmentation Mastopexy and Breast Augmentation

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

1. Breast Augmentation

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

2. Augmentation Mastopexy

- The new nipple location is marked by transposition of the inframammary fold to the front of the breast, at the level of the meridian.
- The top of the areolar opening is marked 1-2 cm above the new nipple position. With the use of a keyhole breast reduction marker (42 mm), the areola opening is marked
- The breast is displaced, first laterally and then medially. Vertical lines are drawn from the lower portion of the new areola to a point 1 cm above the inframammary fold
- Measurements are made bilaterally, from sternal notch to nipple, and from midline to ensure symmetry. Finalized markings are shown (Figures 1a-c).



Figure 1a - Preoperative frontal view markings of a 33-year-old female with left grade II ptosis and right breast hypoplasia.



Figure 1b - Preoperative left lateral view markings of a 33-year-old female with left grade II ptosis and right breast hypoplasia.



Figure 1c - Preoperative right lateral view markings of a 33-year-old female with left grade II ptosis and right breast hypoplasia.

TECHNIQUE

The patient is brought to the operating room and placed in the supine position on the operating table with the arms extended up to 90 degrees and well secured to the arm boards. Both shoulders should be at the same height. The patient is sat up to evaluate the preoperative status (Figure 2). The operation commences with the ptotic breast. An augmentation mastopexy is performed using the Wise pattern technique with a short horizontal scar. A small implant is used in the ptotic/hypertrophied breast to achieve superior pole fullness. The incision is made through the mastopexy resection pattern and a subpectoral pocket is created. The tester gel implant is placed, and



Figure 2 - Intraoperative frontal view of the patient positioned on the operating table. The patient is placed in an upright seated position for initial appreciation.



Figure 3 - Intraoperative frontal view of the patient positioned on the operating table. The patient is placed in an upright seated position for final appreciation. A left Wise pattern augmentation mastopexy and a right breast augmentation were performed.

temporary tailor tacking of the skin is performed. The formal implant is then placed using the Keller funnel® and the no touch technique, and the pocket is closed. The nipple areola complex is left *in situ*, and the intervening skin is deepithelialized. A superior pedicle is created, and appropriate vertical and horizontal amount of tissue is removed, and recorded. The lower areola to inframammary fold distance is chosen on average at 7 cm. Vertical pillar sutures are placed, and the wounds are closed in layers. This is followed by augmentation of the hypoplastic breast. After conclusion of the procedure, the patient is placed again in an upright seated position for final appreciation. (Figure 3).

Continued on page 46

HISTORY: THE SEIICHI OHMORI MEMORIAL LECTURE



THOMAS S. DAVIS, MD
United States
ISAPS Historian

It was Dr. Seiichi Ohmori's dream to fund a lecture series to be presented at each Biennial Congress as a legacy for his beloved plastic surgery society. Dr. Ohmori was the 6th President of ISAPS (1981-1983) and a Charter Member of the Society. He served as a Traveling Professor (1985-1987) and was the local arrangements chair for several postgraduate courses in Japan.

Following his death in March of 1989, his son Kitaro approached the Executive Committee at the Biennial Congress in Zurich, Switzerland in September, 1989 expressing his father's wish to create a lecture series in his name.

Soon afterward, Kitaro received a letter from Rodolphe Meyer, then President of ISAPS, and the Treasurer, Frederick Nicolle, that said, "If the Ohmori family would make a donation to ISAPS, the appropriate amount of lecture fees would be given to each Ohmori lecturer from the interest generated by the fund. The suggested amount is \$70,000." The money was remitted to ISAPS shortly thereafter.

The selection of the Ohmori Lecturer is the privilege of each ISAPS President. It is a tradition to recognize an individual's lifetime achievements and contributions to the field of aesthetic plastic surgery. Currently the honorarium is \$3,000.

Seiichi Ohmori Lecturers

Nicholas G. Georgiade, United States	Guadalajara, Mexico - 1992
Jaime Planas, Spain	Paris, France - 1993
Salvador Castanares, United States	New York, New York - 1995
Rodolphe Meyer, Switzerland	Sao Paulo, Brazil - 1997
Ulrich T. Hinderer, Spain	Tokyo, Japan - 2000
Blair O. Rogers, United States	Istanbul, Turkey - 2002
Melvin Spira, United States	Houston, Texas - 2004
Ivo Pitanguy, Brazil	Rio de Janeiro, Brazil - 2006
Thomas M. Biggs, United States	Melbourne, Australia - 2008
Joca Sampaio Goes, Brazil	San Francisco, California - 2010
Foad Nahai, United States	Geneva, Switzerland - 2012
Ricardo Baroudi, Brazil	Rio de Janeiro, Brazil - 2014
Kitaro Ohmori, Japan	Kyoto, Japan - 2016

WHERE IN THE WORLD



ANSWER:

A drone shot view of Richard Hamilton, ISAPS Assistant National Secretary for Australia, in The Painted Desert near Arckaringa in the Great Outback of South Australia where he was making a film about his father. It was taken just at sunrise. It is extraordinary country, almost like the surface of the moon or a distant planet such as Mars.

LAW AND SURGERY: A LONG HISTORY



DENYS MONTANDON, MD
Switzerland

“Can we allow a surgeon to reconstruct a criminal’s nose, which has been cut off as a punishment?” – Paolo Zacchias 1630

If lawsuits against doctors for malpractice or lack of informed consent are nowadays quite frequent, they have in fact a long history. Among the most ancient law texts, from India, Mesopotamia, Persia, Greece and Rome, written by lawmakers, philosophers, theologians or physicians, one can find prescriptions or rules to be observed for allowing the practice of surgery, and the punishments incurred when the rules are infringed or violated. Interestingly, these rules were rarely the same for surgery that was carried out on free individuals, upper cast people or slaves.

MESOPOTAMIA

For example, in the Acadian civilization in Mesopotamia, the most ancient Sumerian cuneiform writing on surgical interventions is a legal text: the Hammurabi Code (c. 1800 B.C.), engraved on a black marble stele and preserved in the Louvre (Figure 1). The Code very precisely prescribes the duties of the operating practitioner, without, however, conferring on him a particular name or title. In contrast, the scalpel or the lancet used is given a specific name: the “naglabu” represented by a cuneiform ideogram reminiscent of a barber’s razor (Figure 2).



Figure 1 - Hammurabi’s table of laws.

One can read: “If a physician performed a major operation on a free man with a bronze lancet and has saved his life, or if he removed a tumor in the eye socket and saved the eye of the patient, he shall receive ten shekels of silver; if it was a seignior’s slave, his owner shall pay two shekels of silver to the physician. If a physician performed a major operation on a free man with a bronze lancet and has caused his death, or if he removed a tumor in the eye socket and has destroyed the seignior’s eye, they shall cut off his hand. If the same complications happened on a slave, the physician shall pay to his owner half the slave’s price in silver.” Unfortunately for the surgeon, hand transplantation was not yet available!

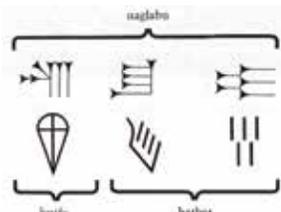


Figure 2 - Naglabu

PERSIA

In ancient Persia, one can read in the Vendidad, one of the surviving texts of the Zend-Avesta, the religious principles of Zarathustra, that a surgeon was not allowed to operate a member of the Mazda sect (higher class) before he had performed successfully the same operation on three occasions on members of the Divyasnan sect, considered as infidels. If he failed, he was banned as a physician for eternity. However, incantations were considered superior to surgery for treating diseases.¹

¹Of all the healers O Spitama Zarathustra, namely those who heal with the knife, with herbs, and with sacred incantations, the last one is the most potent, as he heals from the very source of diseases.

INDIA

In India, Sushruta, known to plastic surgeons for his method of nasal reconstruction, also made recommendations about who and how surgery should be practiced. “Defective Surgical Operations: The eight forms of operations may be attended with dangers of four different kinds such as those arising from an insufficient or over performance, or from the slanting or oblique deviation (of the knife or the instrument), or from an act of self-injury on the part of the physician. A physician (surgeon) making a wrong operation on the body of his patient either through mistake or through the want of necessary skill or knowledge, or out of greed, fear, nervousness or haste, or in consequence of being spurned or abused, should be condemned as the direct cause of many new and unforeseen maladies. A patient, with any instinct of self-preservation, would do well to keep aloof from such a physician, or from one who makes a wrong or injudicious application of the cautery, and should shun his presence just as he would shun a conflagration or a cup of fatal poison.”

Sushruta also encouraged a good relationship between the patient and his physician. “The patient, who may mistrust his own parents and relations should repose an implicit faith in his physician, and put his own life into his hands with the least apprehension of danger; hence, a physician should protect his patient as his own begotten child. A surgical case may yield to a single incision, or require two, three, four or more than that number to effect a cure. By doing good to humanity with his professional skill, a physician achieves glory, and acquired plaudits of the good and the wise in this life, and shall live in Paradise in the next.”

GREECE AND ROME

In ancient Greece and Rome, there existed no legal authorization to practice medicine or surgery and patients were not protected against charlatans who were very numerous in Rome particularly. However, in his dialogues on laws, Plato makes a distinction between real doctors and others who are doctors’ assistants. The latter might be free-born or slaves who acquired their art by experience, under the direction of their masters and not from the study of nature, whereas the free-born doctors learned their art and then taught it to their children and apprentices. Since patients may be either slaves or free men, doctor-slaves who did not give the slave any information about his illness nor accept any discussion about it treated the slaves. The free-born doctor, however, treated mainly free men. He asked for information from the patient himself and from his friends about the commencement and the course of the illness. And after having gathered all the necessary data, he should inform the patient, so far as possible, about the nature of his illness and should not give him any prescription until he has gained the patient’s consent, and only then should he attempt to make the patient well, soothing him with advice and preparing him persuasively.

One of the fundamental principles of Plato’s philosophy is that the “knowledge of good” is inherent in every human being. According to Plato, the patient knows what is “good” for him, and thus the role of the physician is to help this hidden knowledge emerge from the patient’s soul by using the proper arguments. It is worth noting that Plato requires consent from the free men in

contrast to slaves. In this way, he shows the relation of consent to autonomy of the person as the expression of his right to self-determination and free will.

The risk of being punished, in case an operation did not prove to be successful or satisfactory, was very high when a surgeon had to operate an important personage and sometimes doctors were reluctant to be involved in a patient's treatment which may end up with a death penalty. For example, Alexander the Great was seriously wounded during the siege of a town in India in 326 BC. Critobulus, a physician of distinguished skill, was terrified at the prospect of failure and tried to avoid surgical intervention. Alexander understood his hesitation and encouraged him to proceed with the operation, assuring his immunity by calling the wound *a priori* "incurable."

"For what event or moment are you waiting, and why do you not free me as soon as possible from this pain and let me at least die? Do you perhaps fear that you may be blamed because I have received an incurable wound?" Critobulus' pride and self-esteem were touched and he proceeded to the operation with success.

In the Roman Empire, it was only after the second century that medical practice was restricted to the *valde docti* or *archiatri*, who had acquired some knowledge and competence. However, the most renowned doctors were reluctant to operate on an illustrious patient knowing what could happen to them in case of failure, whereas operating on slaves or gladiators had no risk.

MIDDLE AGES

In 578AD in the Byzantine Empire, the Emperor Justin II was suffering very severely from bladder stones and was imploring his surgeons to either operating or kill him. The surgeons feared a severe punishment if they failed. They finally accepted on condition that the operating-knife was given to them by the own hand of the Emperor, meaning that he was fully aware of the dangers of the operation. This type of securing an "informed consent" was apparently common during the Middle Ages. Justin II did not survive, although we do not know if it was due to the surgery.

The first official regulation dealing with the practice of medicine and surgery was established at the University of Salerno by the Norman King of Sicily Roger II, in 1140. "Who, from now on, wishes to practice medicine, has to present himself before our officials and examiners in order to pass their judgment. Should he be bold enough to disregard this, he will be punished by imprisonment and confiscation of his entire property. In this way, we are taking care that our subjects are not endangered by the inexperience of the physicians. Nobody dare practice medicine unless he has been found fit by the convention of the Salernitan masters." To be the Pope's surgeon was a dangerous task during this period. For example, Pope John XXII (1316-1334) condemned to death two of his physicians, accusing them of having attempted to kill him using poisons or witchcraft.

THE LEGACY OF NASAL RECONSTRUCTION

The Byzantine Emperor Justinian II (668-711AD), called the *Rhinotmetos* (ὁ Ρινότμητος, "the slit-nosed"), was an ambitious and passionate ruler who was keen to restore the Roman Empire to its former glories, but he responded poorly to any opposition to his will. Consequently, he generated enormous opposition to his reign, resulting in his deposition in 695 in a popular uprising. His nose was cut off to prevent him seeking the throne again; such mutilation was apparently common in Byzantine culture (Figure 3). Justinian returned to the throne in 705 with the help of a Bulgarian and Slav army. His nose had



Figure 3 - Justinian's nose amputation

been replaced by a gold epithesis². His second reign was even more despotic than the first, and it too led to his eventual overthrow in 711, abandoned by his army who turned on him before decapitating him.



Figure 4 - Paolo Zacchias

Paolo Zacchias (1584-1659) was an Italian physician, teacher of medical science, jurist, philosopher and poet (Figure 4). He is said to have been the personal physician to two Popes and legal adviser to the highest Papal court of appeals and is often considered as the father of legal medicine. In his most well-known book, *Quaestiones medico-legales*, first published in 1630, one chapter is devoted to the surgeons: *The mistakes of the surgeons and other specialists of the same profession*. "The most common mistake of the surgeons is to practice surgery without having studied it before, without the necessary

knowledge and without theoretical science, and being satisfied with it. For this reason, he is not punished by hazard for badly administered care." The surgeon is less excusable if he makes a mistake than the physician who treats diseases, as the latter should make use of conjectures for his diagnosis and his treatments in most cases. However, the ignorance of a physician who gives the wrong remedy should also be punished, according to Zacchias. Among the list of errors perpetrated by surgeons, one can find the incision of a nerve during a phlebotomy, resulting in the member's paralysis, as happened to Charles IX, the King of France, or to remove too much blood and leave the patient in "hypothermia." The problem of amputated noses, organs of respiration and beauty, attracted the attention of Zacchias for a long time, as cut off noses were not uncommon during the Renaissance, either during a fight or as a legal punishment. No wonder the possibility of reconstructing a nose with the person's own flesh, as initiated by the Branca family in Catania (Sicily), and later described and illustrated in detail by Tagliacozzi (1545-1599) had a large impact in Italy. Moreover, the rumors (fake news of the time!) of transplanted noses from other individuals were frequent and even published by serious doctors. The possibility of re-implanting a nose was even so widespread that the organ was sometimes destroyed so as to be certain that it would not serve as a graft. In this context, Zacchias questioned the law to know if one should allow a surgeon to reconstruct the nose of a criminal who had his nose cut off as a punishment. After debating the pros and the cons, he finally concludes that the law should not be opposed to a reconstructive rhinoplasty, "all the more since the extremely painful and lengthy operation (the arm flap) can be considered in itself as a punishment."

THE COLLABORATION WITH JUSTICE

Zacchias' work also contains superstitious views on magic, witches, and demons, which were widely held at the time. Both theological and medical knowledge was required to differentiate natural cases of sickness from supernatural causes, which might require the attention of the Catholic Church. Zacchias was known for a skeptical approach that attempted to eliminate natural causes before diagnosing phenomena as witchcraft. Medical practitioners were also made available to diagnose and distinguish between miracles and natural causes. For example, to consider a woman (more rarely a man) as a witch, one had to find on her typical stigmata, "the satanic marks" that had to be assessed by at least three doctors, mostly surgeons essentially trained for this practice. The examination had to be carried out in a bright and clear space and repeated three times in the same location. The signs were not specific.

² A few historians speculate that while in exile Justinian had reconstructive surgery done by an itinerant Indian plastic surgeon to repair his damaged nose.

MONTANDON CONTINUED

It could be a mole or a spot on the skin that could be pricked with a needle without inducing either pain or bleeding. If the spot was located deep in the body, like in the throat or the anus, it was definitely a diabolic mark (Figure 5). The sorceress was then tortured in order to draw further proof of her allegiance to Satan and then condemned to death in the worst manner.

Although this collaboration between surgeons and justice is repugnant to our present knowledge, it could be compared to doctors who nowadays help in devising methods of interrogation with specific tortures or the ones who accept to do the so-called “anal test” to prove that a man is a homosexual³.

BIBLIOGRAPHY

Dalla-Vorgia P, Lascaratos J, Skiadas P, Garanis-Papadatos T: *Is consent in medicine a concept only of modern times?* J Med Ethics 27:59-61, 2001

Remensnyder JP, Bigelow ME, Goldwyn RM. *Justinian II and Carmagnola: a Byzantine rhinoplasty?* Plast Reconstr Surg. 63 :19-25, 1979

³Theories behind such tests date back to Zacchias' writings on sodomy and to an 1857 treatise by the French doctor Augustin Ambroise Tardieu who thought he could identify signs of “habitual pederasty,” such as “funnel-shaped deformation of the anus” and the “relaxation of the sphincter.” At least eight countries in the world still allow examination of the anal sphincter by surgeons as a proof of homosexual practices.



Figure 5 - In search of the satanic marks.

RAMMOS CONTINUED

RESULT

This 33-year-old female had significant breast asymmetry with right mammary hypoplasia and left mammary hypoplasia and ptosis (Figures 4a-c). She preferred the size of her left breast.



Figure 4a - Preoperative frontal view of a 33-year-old female with left grade II ptosis and right breast hypoplasia.



Figure 4b - Preoperative left lateral view of a 33-year-old female with left grade II ptosis and right breast hypoplasia.



Figure 4c - Preoperative right lateral view of a 33-year-old female with left grade II ptosis and right breast hypoplasia.



Figure 6 - 1-week postoperative frontal view after left augmentation mastopexy with a 210 ml smooth round silicone implant and right breast augmentation with a 520 ml smooth round silicone implant.



Figure 7 - 1-month postoperative frontal view after left augmentation mastopexy with a 210 ml smooth round silicone implant and right breast augmentation with a 520 ml smooth round silicone implant.

A left superior pedicle augmentation mastopexy was performed, with a 210 ml smooth round moderate profile silicone implant and a 200 Gm breast resection. This was followed, in the same operative setting, by a right subfascial breast augmentation with a 520 ml smooth round silicone implant with full projection. Implant sizes and amount of tissue to be excised were chosen based on the VECTRA 3D imaging and simulation system used at the time of consultation (Figure 5). She was pleased with the early postoperative outcome (Figures 6, 7).

The author has no financial interest in any company or product mentioned in this article.

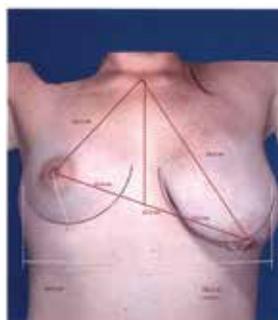


Figure 5 - 3-dimensional photograph of a 33-year-old female using the VECTRA 3D imaging device. Breast differences are shown, specifically sternal notch to nipple distance, and volume.

IN MEMORIAM



BIJOY METHIL, MD - 1973 - 2018
India

Dr. Bijoy Methil was a Consultant Plastic Surgeon at the Jaslok Hospital and Saifee Hospital in Mumbai, both premier healthcare institutes in the country. He was board certified in Plastic and Cosmetic Surgery and had qualifications of MCh (Masters-super specialty) and DNB (Diplomate National Board) in Plastic Surgery.

He was a member of the Association of Plastic Surgeons of India (APSI), the International Society of Aesthetic Plastic Surgeons (ISAPS), the World Society of Reconstructive Microsurgery (WSRM), the Indian Society of Reconstructive Microsurgery (ISRM), the American Society of Plastic Surgeons (ASPS) and the Indian Medical Association (IMA).

Following his training in plastic surgery at the Baroda Medical College, Baroda, he went on to do an advanced fellowship in microvascular reconstruction at the Chang Gung Hospital in Chinese Taipei. Dr. Methil's cosmetic surgery exposure began since his training in plastic surgery and was reinforced with exposure to cosmetic surgery in the Chang Gung Hospital, the National University Hospitals and at the Plastic and Hand Surgery Medspa in Singapore. He was subsequently awarded an advanced fellowship in cosmetic surgery at the St. Vincent's Hospital in Sydney, Australia where he operated with some of the best cosmetic surgeons in Australia and gained immense knowledge about the art and science of cosmetic surgery.

Dr. Methil had a special interest in cosmetic surgery, specifically facial cosmetic surgery, non-surgical facial rejuvenation, cosmetic breast surgery and body contouring) as well as head and neck reconstruction and breast reconstruction. He had also been developing a sub-specialty interest in autologous fat transfer, stem cells and regenerative medicine. He was always a keen proponent of using evidence-based protocols in aesthetic surgery. He personally operated on more than 3,000 cases.

Dr. Methil was an avid trekker and bikes were his passion. He had been on several adventure trails around the country. Being an experienced biker, he had led some of these bike rides, too. He met with a fatal accident while returning home from one of these rides on January 29, 2018. He is survived by his wife, Dr. Anju Methil, and two lovely children, Aditya, seventeen, and Anya, eight.

GUESS WHO?



ANSWER:

Photos taken by Asko Salmi, MD - Finland
Left - photographed in the Philippines during an ISAPS Course in Boracay in 2012

Right - Icaros in the picture taken in Mallorca, Spain.

Both images are entered in Fotofinlandia 2018, the biggest photo competition in Finland for pros and amateurs and are in the top 24 from hundreds of entries.



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[Link to: https://isaps.memberclicks.net/assets/docs/isaps_autorenewal_enrollment_form.pdf]

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Thank you for your time and participation!

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Modern Methods of Facial Rejuvenation 2018

Date: 16 March 2018 - 17 March 2018
Location: Kiev, UKRAINE
Contact: Dr. Pavlo Denyschuk
Email: den@anacosmo.com
Tel: 380-444-832-178
Website: www.icamps.com.ua



GLOBAL ALLIANCE - Aesthetic Plastic Surgery 2018 - Korean Society for Aesthetic Plastic Surgery

Date: 07 April 2018 - 08 April 2018
Location: Seoul, SOUTH KOREA
Contact: Prof. Seung-Kyu Han
Email: ksaps@ksaps.or.kr
Tel: +82-2-3472-4243
Fax: +82-2-3472-4243
Website: <http://www.aps-iae.com>



Endoscopic Transaxillary Breast Augmentation Hands-on Workshop on Fresh Human Species and Live Surgery

Date: 27 April 2018 - 28 April 2018
Location: Vienna, AUSTRIA
Contact: Dr. Kloppel & Kollegen
Email: training@drkloppel.com
Tel: 49-89-790707805
Fax: 49-89-79070727
Website: <https://www.drkloppel.com/en/training/>



2nd Buttock Surgeries Course

Date: 23 March 2018
Location: Paris, FRANCE
Contact: International Plastic Surgery Advanced Course
Email: contact.ipsac@gmail.com
Tel: 33-04-72837769
Website: <http://www.ipsac.eu/>



10th Aesthetic Body Contouring Course by J. F. Pascal, MD

Date: 13 April 2018 - 14 April 2018
Location: Geneva, SWITZERLAND
Contact: Geraldine Buffa
Email: geraldine@ipsac.eu
Tel: +33 4 78 24 59 27
Website: <http://www.ipsac.eu>



Abdominal Wall Robotic Workshop

Date: 16 May 2018
Location: Singapore, SINGAPORE
Contact: Dr. Marco Faria Correa
Email: drmarco@drmarco.com
Tel: 65-6464-8075
Fax: 65-6464-9157
Website: <http://www.drmarco.com/abdominal-wall-workshop/>



ISAPS Course - South Africa

Date: 23 March 2018 - 25 March 2018
Location: Somerset West, SOUTH AFRICA
Contact: Hendrika van der Merwe
Email: congress.isaps@eliteconfer.co.za
Tel: +27-21-981-3081
Website: <http://www.isapscourse.co.za>



ISAPS Symposium - Saudi Arabia - immediately preceding the Saudi National Congress

Date: 14 April 2018 - 15 April 2018
Location: Riyadh, SAUDI ARABIA
Contact: Dr. Jamal Jomah and Dr. Fuad Hashem
Email: info@saudiplasticsurgery.org
Website: www.saudiplasticsurgery.org



6th Live Surgery Course Marbella

Date: 24 May 2018 - 25 May 2018
Location: Marbella, SPAIN
Contact: Dr. Alexander A. Aslani
Email: eventos@cirumed.es
Tel: +34 952 775346
Website: http://www.livesurgery.cirumed.es/index_english.html



Dr. Nazim Cerkes - Open Rhinoplasty Hands-on Course

Date: 29 March 2018 - 01 April 2018
Location: Istanbul, TURKEY
Contact: Yagiz Tutuncuoglu
Email: yagiz@seveneventcompany.com
Tel: 90-533747 1423
Website: <http://istanbulapsc.org/>



GLOBAL ALLIANCE - The Aesthetic Meeting - American Society for Aesthetic Plastic Surgery

Date: 26 April 2018 - 30 April 2018
Location: New York, NY, UNITED STATES
Website: <http://www.surgery.org/meeting2018>



ISAPS Symposium - France, immediately preceding 2018 SOFCEP meeting

Date: 31 May 2018 - 02 June 2018
Location: Lyon, FRANCE
Contact: SOFCEP - Marie Cristol Souviron
Email: sofcep@vous-et-nous.com
Tel: +33(0)5 34 31 01 34
Website: <http://www.congres-sofcep.org>



16th BEAULI Symposium

Date: 09 June 2018 - 10 June 2018
Location: Berlin, GERMANY
Contact: Wibke Bodensiek
Email: info@pk-bw.de
Tel: 49-(0)3303-513-4000-0
Fax: 49-(0)3303-513-4000-90
Website: <http://www.beauli.de/>



MIPSS 2018 - Marbella International Plastic Surgery Summer School

Date: 21 June 2018 - 23 June 2018
Location: Marbella, SPAIN
Contact: Dr. Kai Kaye
Email: info@oceanclinic.net
Tel: 34-951-775518
Website: <http://www.mipss.eu/>



ISAPS Course - Turkey, 10th Eurasian International Aesthetic Course with Live Surgeries

Date: 21 June 2018 - 24 June 2018
Location: Istanbul, TURKEY
Contact: Yagiz Tutuncuoglu
Email: yagiz@seveneventcompany.com
Tel: +90-5337471423



MIPSS 2018 - Marbella International Plastic Surgery Summer School

Date: 21 June 2018 - 23 June 2018
Location: Marbella, SPAIN
Contact: Dr. Kai Kaye
Email: info@oceanclinic.net
Tel: 34-951-775518
Website: <http://www.mipss.eu/>



11th Post-Bariatric Body Contouring Course by J. F. Pascal, MD

Date: 29 June 2018 - 30 June 2018
Location: Geneva, SWITZERLAND
Contact: Geraldine Buffa
Email: geraldine@ipsac.eu
Tel: +33 4 78 24 59 27
Website: <http://www.ipsac.eu>



ISAPS Symposium - Indonesia - immediately preceding the OSAPS meeting

Date: 18 July 2018
Location: Bali, INDONESIA
Contact: Dr. Theddeus O. H. Prasetyono
Email: teddyohp@yahoo.com
Tel: 62-21-31931424
Fax: 62-21-31931424



First International Aesthetics and Art Meeting

Date: 10 August 2018 - 11 August 2018
Location: Zurich, SWITZERLAND
Contact: Dr. Mathias Treppe
Email: mtreppe@me.com
Tel: 41-44-211-8260
Fax: 41-44-212-8203
Website: <http://www.swissaesthetics.ch>



ISAPS Course - China

Date: 06 September 2018 - 07 September 2018
Location: Shandong Province, CHINA
Contact: Dr. Li Yu
Email: yuoli@163.com
Tel: 86-21-6313-5715
Fax: 86-21-5307-8025



Live Plastic Surgery - State of the Art

Date: 20 September 2018 - 22 September 2018
Location: Monte-Carlo, MONACO
Contact: Dr. Henry Delmar
Email: henry@henry-henrydelmar.com
Tel: 33-04-93670101
Website: www.liveplasticsurgery-monaco.com



IMRHIS 2018

Date: 29 October 2018 - 31 October 2018
Location: Miami Beach, FL, UNITED STATES
Contact: Susan Russell
Email: srussell@hdplanit.com
Tel: 1-435-602-1329
Fax: 1-435-487-2011
Website: <http://www.IMRHIS2018.com>



24th Congress of ISAPS

Date: 31 October 2018 - 04 November 2018
Location: Miami Beach, FL, UNITED STATES
Contact: Catherine Foss
Email: isaps@isaps.org
Tel: 1-603-643-2325
Fax: 1-603-643-1444
Website: <http://www.isapsmiami2018.com/>



The Learning Curve

Date: 19 January 2019 - 20 January 2019
Location: Palo Alto, CA, UNITED STATES
Contact: Dr. Lorne Rosenfield
Email: drr@drrosenfield.com
Tel: 1-650-692-0467
Fax: 1-650-692-0110

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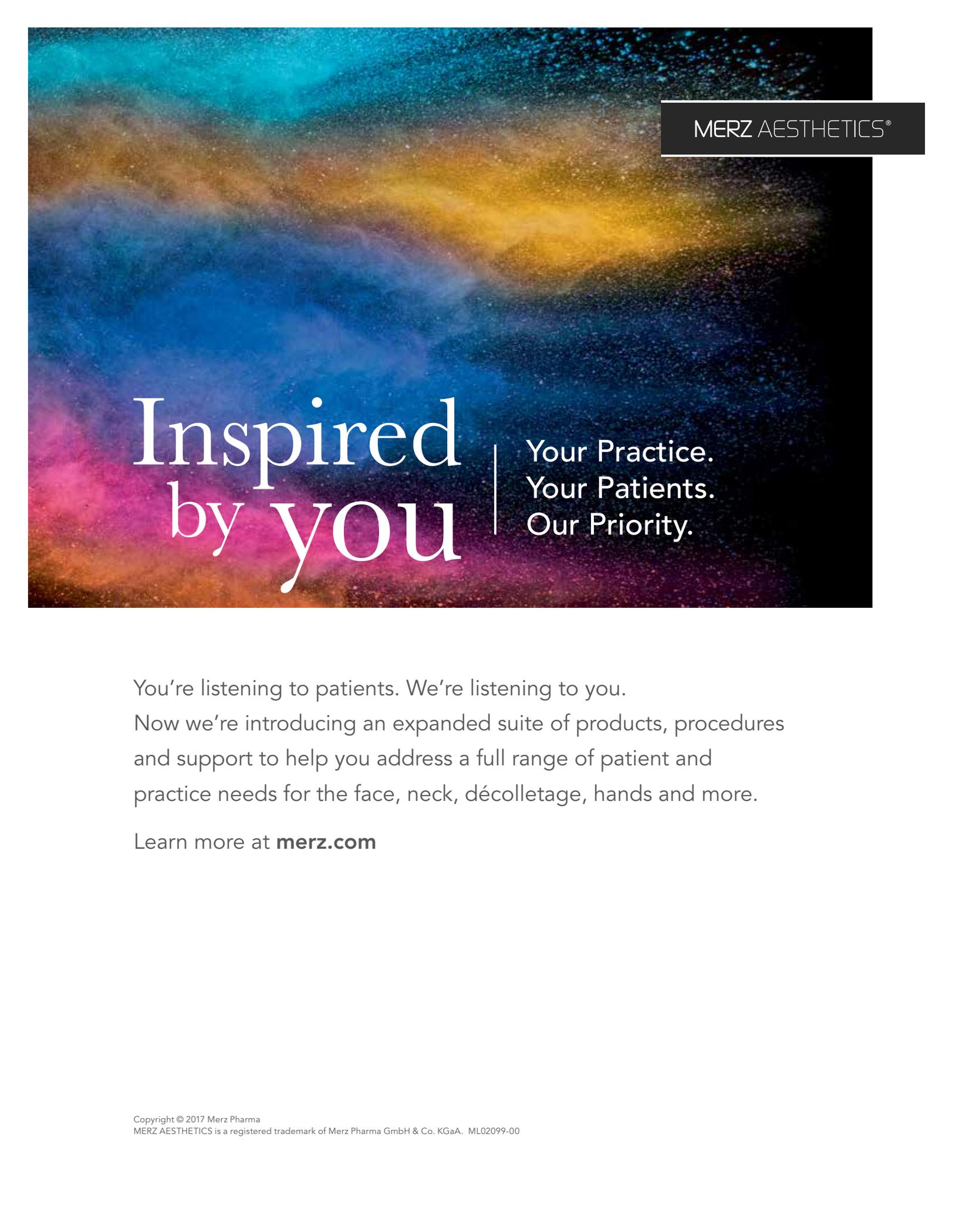
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