

ISAPS CONGRESS 2012

See pages 14-17
for information about the
ISAPS Congress in
Geneva, Switzerland
September 4-8, 2012

The PIP Problem

What happened?

In 1991, Jean-Claude Mas, founded a company called PIP (Poly Implants Prothèses)



headquartered in France. He stated that he had developed firm silicone and promoted lifelong durability of his product. In 1997, Monsieur Mas managed to obtain the CE certificate and was regularly inspected by TÜV Rheinland. The approval of implants filled with saline had been refused in the US by the Food and Drug Administration (FDA) in the year 2000 due to considerable quality failure.

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MESSAGE FROM THE EDITOR

J. Peter Rubin, MD – United States

ISAPS News Editor



What does it mean to be a member of ISAPS? It means that you are a steward of our profession and that you uphold and promote the very highest standards of patient safety, excellent practice, and ongoing education in aesthetic plastic surgery. This issue of *ISAPS News* highlights the global crisis concerning PIP implants. Dr. Dirk Richter writes a comprehensive piece covering the history of these implants and the current situation. He implores of us, as surgeons and ambassadors of our specialty, to take the most responsible approach going forward.

A trust has been violated. Even though this was not a transgression by the international plastic surgery community, we are unwilling participants. We are responsible

for the health and welfare of our patients and I applaud Dr. Richter's sage advice. This is a critical time for all plastic surgeons to step up, show our true level of professionalism and compassion, and help our patients through this difficult period. We are responsible for the outcome, even though we did not create the problem.

Also in this issue, we see your society at work producing valuable data to support our specialty practices. ISAPS statistics on aesthetic procedures appear summarized in this issue, and I thank our Communications Committee headed by Dr. Joca Sampaio Goes, our survey analyst Scott Hackworth, and our member surgeons for providing data for this project. I hope that the summary of figures and trends will be informative and useful to you in your practice.

Dr. Mark Jewell presents a very interesting global perspective on lipoplasty that will help frame our current techniques. Dr. Riccardo Mazzola, our resident expert on medical history, tells us the story of fat grafting throughout medical practice. This is a wonderful article, not to be missed.

You will also find information about our 2012 Congress in Geneva as we prepare for that biennial event. I look forward to seeing you in Geneva in September and I hope you enjoy this issue of *ISAPS News*.


J. Peter Rubin
ISAPS News Editor

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PIP Problem, continued from page 1

Dirk Richter, MD – Germany

Chair, ISAPS Patient Safety Committee
Member, ISAPS Board of Directors



In 2009, the French authorities were informed about the increasing frequency of early rupturing and unusually high leakage of the PIP prostheses. In addition, indications of criminal activity led to prosecutors' investigations. Bills were found in the PIP files for unusually high amounts of industrial-grade silicone which had been purchased from a company in Germany since 2001. In contrast to any medical-grade silicone, the substandard silicon had not undergone a cleaning process. A higher amount of low molecular weight species that can be left over as part of the manufacturing process remained and showed high biological activity. This silicone can much more easily pass through the shell by inducing instability thereby causing irritation and inflammatory processes in the surrounding tissues.

By omitting the cleaning process, the company saved about €1 million per year. The implants also contained the lubricant Baysilone, a petroleum product, and the substances Silopren and Rhodorsil which are used in the rubber industry. In April 2010, the implants were withdrawn from the market along with the implants of the company Rofil Medical in the Netherlands, which were manufactured under a PIP license and were "identical."

The prosecutors' investigations revealed that a high degree of heterogeneity existed in the nature of the gel: a

mixture of about 25% medical-grade silicone and about 75% industrial silicone was used. Whenever the TÜV Rheinland announced its inspection – usually ten days in advance – PIP used high-grade medical silicone and returned to the substandard product after the inspectors left. Thus all evidence of illegal activities was eliminated. Furthermore, it was found that since 2006 the previously used two-

By omitting the cleaning process, the company saved about €1 million per year.

layer silicone shell had been replaced by a single-layer shell to reduce production costs.

The French health products safety agency, AFSSAPS, was able to demonstrate through its own investigations an increased inflammatory reaction by the silicone used. The results of the intradermal irritation tests they performed showed an irritant potential of the PIP silicone gel that was not found with the silicone gels from other prostheses, nor with the gel declared in the manufacturer's dossier.

Experiments on mice showed no genetic changes nor were there indications of toxicity or increased carcinogenicity. According to many reports from colleagues, the PIP implants are

associated with increased leaking and a higher rate of rupture. This was confirmed by the investigations of the French authorities. However, the controversial methodology and the statistical results are not fully reliable.

On the 23rd of December 2011, the French authorities recommended that women with PIP implants discuss their removal with their surgeon. The German authorities initially advised to check the implants, but changed the recommendation on the 6th of January 2012 as a result of their own findings. They advised patients to remove the implants, even if symptoms and signs of rupture were lacking. In the European Union, the Netherlands and the Czech Republic followed the German recommendations. Other countries such as Britain, where about 50,000 patients are estimated to have received the PIP implants, plus Spain and Italy advised twice yearly clinical examinations and imaging, such as ultrasound and MRI.

What is the right decision?

How reliable is the data? What should we recommend to our patients and our members? All of these issues arose at the turn of the year 2011/2012 and concerned the Board of ISAPS. Remarkably, we received numerous opinions and estimations from our army of National Secretaries which were very valuable to

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PIP Problem, *continued from page 3*

us, as it helped us to compile recommendations for our members very swiftly.

Based on our mission of patient safety, we have only one option: to advocate the removal of the implants. There have been no studies so far proving that non-medical-grade silicone is harmful and to what extent. But the fact of the matter is this: it has definitely not been tested, is not approved and in particular, there is no study showing that it is harmless. Thus, for us, the only logical and reasonable consequence was to follow the recommendation of the French authorities – the removal of the implants – and to write a press release with our recommendation. The alternatives, monitoring with ultrasound or magnetic resonance imaging, did not seem suitable to us because of the high rate of

false-negative test results. Large studies have shown that a rupture of the implants can be revealed by ultrasound (performed by an experienced examiner) in 30% of cases and by using MRI in 90% of cases. Combining both methods, the “hit ratio” increases to 92% with costs of €1000 per year, which certainly would have to be

assumed in the first instance by the patient herself. In reality, bad results are more likely to be expected, leading the patient to a false sense of security.

Also, implant leakage cannot be detected by any of these tests, only through operative exploration. Waiting for evidence-based studies in order to provide best practice could mean waiting for years. Would we advise the same to our closest relatives?

A recommendation like this is certainly pointing the way ahead and should be the foundation of our patient counselling as a specialist and member of ISAPS. Obviously, this means that we have a particular duty to inform patients, discuss the pros and cons, especially of possible operative risks, individually and settle the coverage of costs involved.

By now the scandal has also extended to the titanium coated TiBREEZE implants that were also filled with objectionable PIP silicone. Fortunately, only the relatively small number of 728 implants was sold worldwide, but these were included in the recommendation for explantation by the German authorities, too. ISAPS also proclaimed this recommendation on the same day in a second press release.

But how do we trace our patients? How do our patients find out what type of implants they have once the implant ID card is lost, and the former surgeon cannot be found, or the obligation to store the patient file has expired? These commonly raised questions once again demand a centralized implant registry like those already existing in some countries. A registry can trace each implant from the manufacturer to the patient, comparable to a recall in the automotive industry. Now our own initiative on a national and international level is needed. And we should make use of our influence on legislative authorities.

What else did we learn from this?

We learned that even highly recognized regulatory institutions like the German TÜV Rheinland cannot completely protect both surgeons and patients from criminal activity. We can only hope that the resulting loss of trust in us as physicians will not be too great as the media naturally suggest that the surgeons used cheap implants intentionally and for their own profit. Yet

these implants were not at all cheap, but were sold in the medium price range of comparable products. What we need to postulate at this stage is that an amendment to the act of medical products must be filed. Especially with regard to unannounced inspections which are now possible at the very first suspicion. We, the physicians, have to be ready for a sudden and unexpected inspection by the local health authority every day. Why should there be unequal principles for the industry? The American FDA has proved to be more effective in its controlling function even though it failed by poor communication to its peers worldwide regarding the faulty quality at PIP.

Did you ever wonder why big companies conduct trials in Europe in order to obtain the desired CE certificate? The past has proven this way to be the quickest to an accreditation for a big market whereas an American accreditation is very bureaucratic and tedious, thus cost intensive. Time is money.

One is tempted to believe that Europeans are being used as guinea pigs for the Americans.

Based on our mission of patient safety, we have only one option: to advocate the removal of the implants.

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What about our own reputation?

The past has shown that crises like the Dow Corning scandal in the early nineties, problems concerning saline or hydrogel implants, and the unprecedented recall of soy oil implants, never last long. A woman’s wish for an upsize, or the desire for a breast reconstruction, often exceeds her worries about risks.

This phenomenon is being experienced again by concerned PIP patients today who, almost without exception, all ask for a replacement. Almost none decline new implants as it means a clearly better quality of life. And this is something we should feel proud of as plastic surgeons! Scientifically we are on the right track: studies of the highest evidence level have proven a significantly improved quality of life for women with implants, both for augmentations as well as reconstructions following breast cancer. Even the ten-year survival rate exceeds the one of the matching comparison group. It should be pointed out that the patients with implants have a smaller risk of cancer through better monitoring and a smaller target organ. Additionally, medical silicone is the most researched material for the human body. Medical silicone, that is!

We cannot provide better proof that we are still doing the right thing after all. And if only to protect our own reputation, we should inform the public that the scandal was about cheap silicone as opposed to cheap products for doctors. The only one who gained, if at all, was Monsieur Mas, who is now being held to account. Surprisingly, the guy himself does not feel remorse at all and cannot understand the scaremongering. To him,

our acts are politically motivated and in no way rational. Poor old man!

However, we have to accept some mild reproach from the authorities for apparently not sufficiently attending to our duty to report faulty implants. We obviously know too little about the structured processes and hence it is necessary to clarify the fact that each failure connected to a medical product is subject to report in most countries. This is usually not a big deal and is a necessary requirement for the controlling institution to take note of faulty products that we are already discussing at conventions or private gatherings. Please check if there are similar requirements in your country.

We should not be surprised or even raise our voice about the fact that now, with some delay, actions are taken in a bold yet considerate manner.

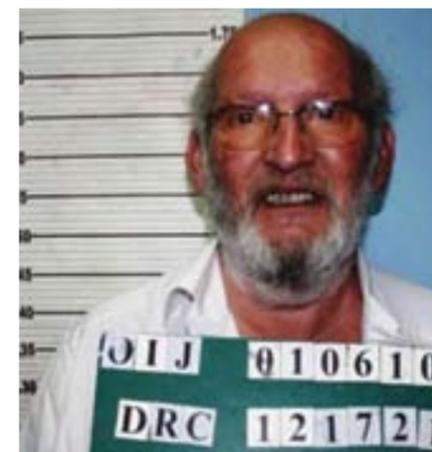
Are we sufficiently attending to our duty to follow up and secure safety information? Or should we rather be awakened by the current events? If patients, worried by daily headlines, cautiously enquire whether implanted prostheses of 1975 have to be checked by now, there must be something wrong. How do we ensure that each patient returns

for an annual routine checkup, really? The annual renewal of a vehicle inspection sticker is compulsory. Why not medical products? And can we sustain lifetime warranties for implants, or are the rupture rates of 10 to 13% after 8 to 10 years for the big manufacturers like Mentor and Allergan hinting at a different conclusion?

Do we have to actively approach our patients and hand out appointment reminder cards like most dentists do already?

We should try to see things positively! As specialists in Plastic Surgery, we bought a regular priced medical product in good faith – a product that was accredited by the German TÜV. And we did the best job possible. We cannot be blamed for criminal activities, the profiteering of unscrupulous manufacturers, or the purchase of cheap products. We can learn a lot from this episode – once again – and should improve on the deficiencies mentioned above: Implant registry + attending to our duty to report + duty to follow up = “customer care”!

We should make use of this opportunity! Hopefully there will not be another chance that soon!



ISAPS INTERNATIONAL SURVEY ON AESTHETIC/COSMETIC PROCEDURES PERFORMED IN 2010

Scott Hackworth, CPA – United States

Senior Vice President, Industry Insights, Inc.



ISAPS global surveys are the work of the Communications Committee under the direction of Dr. Joao C. Sampaio Goes, MD, Brazil.

Methodology:

Survey participants completed a two-page, English-based questionnaire that focused on the number of surgical and non-surgical procedures they performed in 2010.

The International Society of Aesthetic Plastic Surgeons (ISAPS) issued an invitation to participate in the study to approximately 20,000 plastic surgeons whose contact information is housed in their proprietary database. In addition, a request was made that all National Societies encourage their members/constituents to take part in the survey. Three reminder requests were distributed in order to maximize the response.

A total of 698 completed responses were received in time for tabulation.

Final figures have been projected to reflect international statistics and are exclusively based on the estimated number of plastic surgeons in each country and the responding sample. Whereas the U.S.-based study funded by the American Society of Aesthetic Plastic Surgery includes board-certified plastic surgeons, dermatologists, and otolaryngologists, this international survey is focused entirely on board-certified (or national equivalent) plastic surgeons.

To aid in tallying the worldwide number of plastic surgeons, representatives from National Societies provided the counts for over 90% of the 33,000 total estimated plastic surgeons. For cases in which the National Society did not provide its country's total, a regression equation was created to estimate the number of plastic surgeons in the country based on its population size and gross domestic product.

In cases where a country received an insufficient survey response, the projection base included respondents from the country's continent. A weighting system was employed to emphasize responses from the particular country.

Caution is urged when comparing against prior years,

Rank	Country	Plastic Surgeons	% of Total Plastic Surgeons	% of Total Procedures	Rank in 2009
1	U.S.	5,970	18.1%	17.9%	1
2	Brazil	5,024	15.2%	13.6%	3
3	China	2,000	6.1%	6.8%	2
4	India	2,000	6.1%	6.2%	4
5	Japan	1,831	5.5%	6.4%	6
6	Mexico	1,518	4.6%	4.9%	5
7	Italy	1,500	4.5%	4.4%	13
8	Korea, South	1,250	3.8%	4.2%	7
9	France	953	2.9%	2.8%	14
10	Colombia	950	2.9%	2.7%	18
11	Germany	863	2.6%	2.4%	8
12	Turkey	700	2.1%	2.3%	9
13	Spain	567	1.7%	1.6%	10
14	Russia	515	1.6%	1.5%	12
15	United Kingdom	450	1.4%	1.3%	17
16	Canada	425	1.3%	1.4%	15
17	Venezuela	383	1.2%	1.1%	22
18	Taiwan	350	1.1%	1.2%	16
19	Argentina	347	1.1%	1.0%	11
20	Greece	286	0.9%	0.9%	19
21	Thailand	265	0.8%	0.9%	20
22	Australia	228	0.7%	0.8%	21
23	Saudi Arabia	225	0.7%	0.8%	23
24	Netherlands	215	0.7%	0.6%	24
25	Romania	200	0.6%	0.6%	*

because studies such as this can experience substantial variances within specific procedures. In addition, the overall methodology was slightly modified and National Societies from several countries materially restated their estimated number of plastic surgeons for 2010. Figures for 2009 were not recomputed.

Though the confidence intervals change by procedure and by country – depending on the sample size and response variance of each – the overall survey portion of this research holds a standard error of +/- 3.67% at a 95% level of confidence.

The International Survey on Aesthetic/Cosmetic Procedures Performed in 2010 was compiled, tabulated, and analyzed by Industry Insights, Inc. (www.industryinsights.com), an independent research firm based in Columbus, Ohio. 

PERSPECTIVES ON LIPOPLASTY

Mark Jewell, MD – United States



Lipoplasty remains the “gold standard” for contouring surgery. Its evolution over the last 27 years in America has produced remarkable advances in clinical outcomes that make surgical lipoplasty the most common form of aesthetic surgery in the United States. Having been around from the start of lipoplasty to where we are in 2012, it is interesting for me to look back and review progress in this procedure. There have been all sorts of techniques and technologies applied, yet few have consistently produced safer and better outcomes than simple measures of epinephrine-containing wetting solutions and limiting lidocaine to <35mg/kg body weight. Ultrasonic solid probe lipoplasty appears to have overcome technologic shortcomings of earlier devices and causes less blood loss than conventional lipoplasty.

What is remarkable about this procedure is both its safety and the predictability of its outcomes when performed by a well-trained practitioner. Former problem areas of lidocaine toxicity, blood loss, and poor aesthetic outcome appear less frequently due to the educational efforts of plastic surgery societies. Americans have learned from their Brazilian colleagues that lipoplasty can be safely performed at the time

of excisional body contouring in order to improve contouring in all aesthetic units. The lipoabdominoplasty procedure appears to have outcome benefits including reduced seroma incidence and less reliance on quilting sutures to abolish dead space.

Laser-assisted lipoplasty, while marketed by manufacturers as a “fat melting” technology, appears not to be capable of delivering improved outcomes over existing lipoplasty technology. The same can be said for radiofrequency (RF)-assisted lipoplasty. Tissue thermodynamics become problematic beyond 43° Celsius for damage, yet do not reach the 55-60° Celsius required to tighten collagen. Tissue just does not like being heated to near-lethal temperatures with RF or laser under the guise of “tissue tightening.”

The use of lipoaspirate for autologous fat grafting (AFT) has become a popular technique in the United States. While this may be an unintended consequence, what was discarded is now being recycled (reinjecting). Gluteal reshaping is largely dominated by AFT and implants are a rarity. AFT within the face, performed at the time of facial rejuvenation procedures, is well accepted by surgeons to address attritional lipoatrophy of aging. Even

lipoplasty outcomes had been shown to be improved with the reinjection of limited amounts of lipoaspirate.

The other areas of interest in lipoplasty are the emergence of non-invasive lipoplasty devices, based on High-Intensity-Focused Ultrasound (HIFU) and cryolipolysis. Both approaches have been extensively studied and have a solid basic science mechanism of effect. While both of these technologies cannot inherently match the outcomes of surgical lipoplasty, neither has the downtime of a surgical procedure. Strategically, these devices have the potential to fill an unmet need of body contouring in men who are interested in losing waist circumference, but who cannot take time off from work to recover from surgical lipoplasty. Men seem inclined to want to invest about as much time as it takes for a teeth cleaning procedure in terms of using one of these non-invasive technologies to improve body contour.

Plastic surgeons are well-positioned to offer patients seeking body contouring the entire spectrum of options, from non-invasive, to minimally-invasive, to combination excision/lipoplasty procedures. 

ISAPS-LEAP Strike Force

Tunc Tiryaki, MD – Turkey



What started as a conversation on a boat on the Neva River in St. Petersburg, Russia last June has rapidly developed into a new ISAPS humanitarian program. The Boards of Directors of ISAPS and The LEAP Foundation (LEAP) have agreed to collaborate to create a new ISAPS-LEAP Strike Force. In global disasters such as the recent earthquakes in Haiti and Turkey, the tsunami in Japan, and extensive flooding in Thailand, attention to the victims by various aid organizations, the military and surgical teams within hours is vital. However, what happens in the following days is the focus of this new initiative.

While not generally addressed in most plastic surgery

societies' plans, recent natural disasters around the world suggest that it would be prudent for health professionals to improve their preparedness for a mass casualty incident.

While acute search and rescue is usually carried out by governmental organizations, these efforts are limited to the first 72 hours after which the hope of rescue diminishes rapidly. Immediate triage and surgical intervention by emergency medical personnel during this period is critical; however, between the 3rd and 10th days, there is a major shortfall in both

the triage activities and the first surgical interventions on the injured. These interventions are very often related to plastic surgery.

What started as a conversation on a boat on the Neva River in St. Petersburg, Russia last June has rapidly developed into a new ISAPS humanitarian program.

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For more information please go to <http://www.leap-foundation.org/about/disaster-relief/>

The screenshot shows the LEAP (Life Enhancement Association for People) website. At the top, there is a navigation menu with links for 'ABOUT', 'COUNTRIES', 'MEDIA', 'GET INVOLVED', and 'DONATE'. Below the navigation, a breadcrumb trail reads 'You are here: Home / About / Disaster Relief'. The main heading is 'Disaster Relief'. The text below explains LEAP's collaboration with ISAPS to create a global resource for international surgical teams to respond to worldwide disasters. It mentions sending 19 surgical teams to support the Haiti Earthquake of 2010. A call to action asks if the user is with an organization interested in partnering with LEAP for disaster relief, and provides a link to a brief form.



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THE INTRIGUING STORY OF FAT GRAFTING: From ram fat to stem cells

Riccardo F. Mazzola, MD – Italy

ISAPS Historian



Use of fat grafting to improve contour deformities or correct sequelae of scars goes back to the end of the nineteenth century, when the German surgeon Gustav Neuber (1850-1932) first reported the transplantation of adipose tissue harvested from the arm into the orbital region to correct adherent scars from osteomyelitis.¹ Shortly afterwards, in 1895, another German, Viktor Czerny (1842-1916) transferred a lipoma to the breast to re-establish symmetry, following unilateral partial mastectomy for fibrocystic mastitis.²

In 1919, the German maxillo-facial and plastic surgeon, Erich Lexer (1867-1937) devoted more than 300 pages of his two-volume book *Die Freien Transplantationen (Free Transplantations)* to fat grafting with an incredible range of clinical applications, from the correction of contour deformities for sequelae of facial traumas, to hemifacial microsomia, microgenia, breast asymmetry, post-traumatic hand-stiffness and Dupuytren's disease to restore the gliding tissue around the tendons.³ The source of adipose tissue was the lateral thigh.

Lexer first used fat also in the facially disfigured from World War I, to reconstruct the eye socket so as to accommodate a prosthesis (fig. 1), or to improve depressed or retracted facial scars from gunshot wounds in soldiers injured in WWI.



Fig. 1-a and 1-b – Pre- and post-operative view of a soldier injured in WWI whose eye socket was reconstructed using skin flap, cartilage and fat graft, so as to accommodate a prosthesis (from: Lexer E. *Die Freien Transplantationen*, 1919)

In the beginning, surgeons enthusiastically favored the technique of fat grafting, alone or in combination with skin flaps, as it often represented a unique tool to easily solve major problems. But in the '30s, with growing experience, clinicians realized that the very encouraging early results worsened at long term due to unpredictable reabsorption rates and a tendency to form cysts and become fibrotic. This is the reason why use of fat transplantation was considered questionable.

In the '50s, Lyndon Peer (1898-1977) accurately investigated the fate of autogenous adipose tissue transfer at one year and demonstrated that about 50% of fat cells rupture and die after transplantation and the graft structure is replaced by fibrous tissue. Cells which do not rupture survive and these constitute the adipose tissue that remains. The new blood circulation in free autogenous fat graft arises at about the fourth day through anastomosis between host and graft blood vessels. If this does not occur, early death of cells may develop with oil cyst formation in areas that have not been revascularized.⁴

Due to these considerations, fat grafting to the face fell from favour, gradually becoming an almost obsolete procedure.

At the end of the nineteenth century, paraffin was popular among beauty doctors to correct depressions, re-establish contour and modify sunken noses. These unpleasant deformities – charlatans advertised – could be easily modified in beauty salons and drugstores by simple local injections, avoiding any surgical procedure. Disasters appeared soon. Paraffin migrated causing not only hard swellings, difficult to remove, the so-called paraffinomas, but also pulmonary embolism and infections. This recalls the recent story of liquid silicone injections, with the devastating side effects, the siliconomas, which affected the plastic surgery scenario from the '60s onwards.

In the first decade of the twentieth century, to contrast the paraffin complications, the German surgeon Eugene Holländer (1867-1932) proposed the injection of fat, a more natural

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filler. Adipose tissue, harvested from “healthy patients,” was mixed with a harder type of fat collected from rams to minimize reabsorption. The cocktail of human and ram adipose tissue was moderately heated until it became fluid and ready for introduction at blood temperature, so as to improve unaesthetic deformities like depressions, facial atrophy or post-mastectomy scars (fig. 2). The author reported that patients suffered a painful rash for about 2-3 days. The technique was published in 1912.⁵

In 1926, across the ocean, the US cosmetic surgeon Charles C. Miller (1880-1950) from Chicago recommended a variety of fillers like *gutta percha*, ground rubber and fat to correct nasolabial folds, crow's feet and saddle nose.⁶ He harvested a piece of adipose tissue from the abdomen, inserted it into a screw piston syringe, and injected it subcutaneously to fill in depressions (fig. 3).

However, fat injection never became popular among the plastic surgical circles and was seldom employed until the advent of liposuction. On the contrary, for numerous years paraffin remained the filler of choice for nose and breast

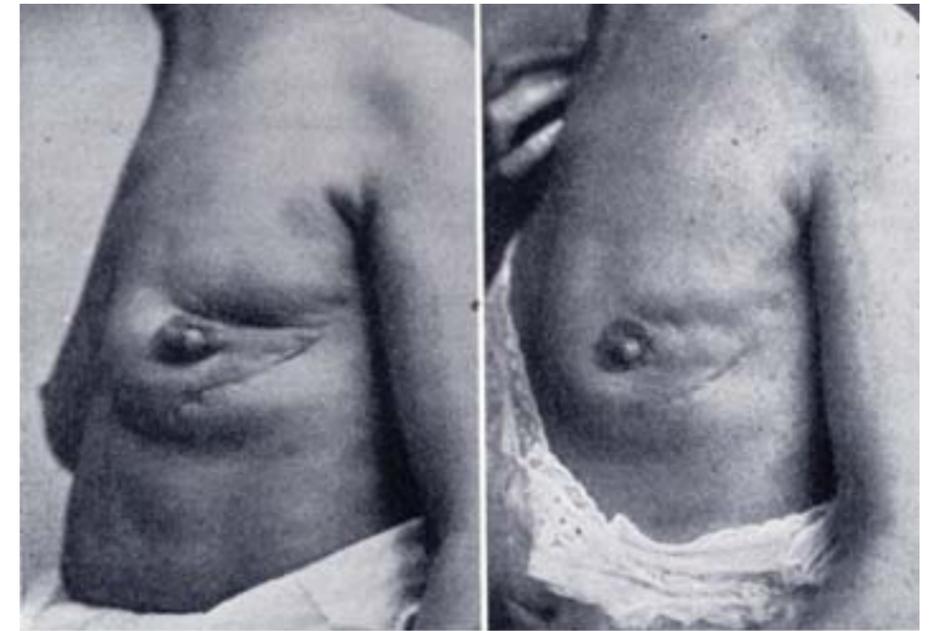


Fig. 2-a and 2-b – Pre- and post-operative view of a post-mastectomy patient, treated with fat injection (from: Holländer E. *Die kosmetische Chirurgie*, 1912)

augmentation despite its dramatic consequences.

THE ADVENT OF LIPOSUCTION

In the 1980s, Pierre Fournier and Yves-Gerard Illouz, both from Paris, independently introduced a new procedure for removing fat from the abdomen and thighs of wealthy, overweight Parisian ladies. Liposuction was an incredible success which spread all over the

world rapidly. On occasion, a too enthusiastic aspiration of fat resulted in disappointing contour irregularities with depressions and holes. Reintroduction of the lipoaspirate using a syringe was regarded as the solution of choice. But within a few weeks complete or almost complete reabsorption of the re-injected material was reported.

Fat injection

Despite this unpleasant drawback, the idea of filling contour depressions concurrent with liposuction using the same adipose tissue just harvested, awakened new interest in autologous fat re-injection.

At the end of the 1980s, the Argentinean plastic surgeon, Abel Chajchir, described favourable and long-lasting results using fat injection.⁷ He considered cautious manipulation of the adipocyte to reduce potential rupture of its fragile cell, rinsing the lipoaspirate in saline to eliminate dead cells and

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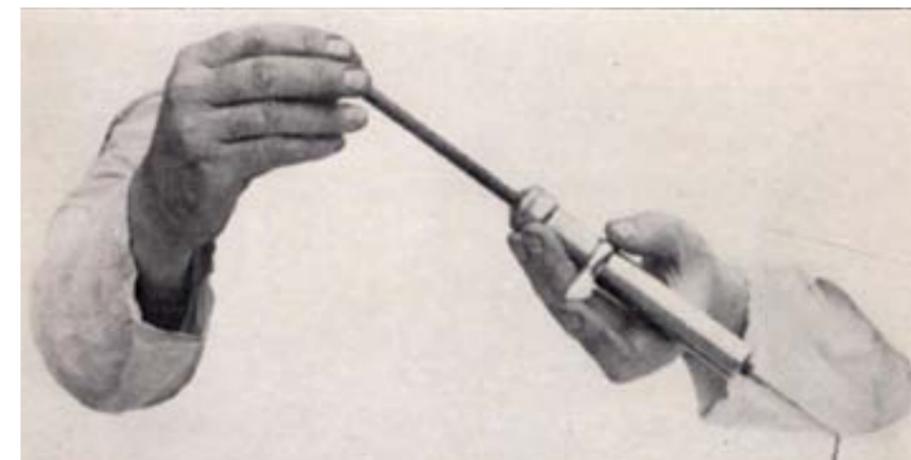


Fig. 3 – The syringe used by the US cosmetic surgeon Ch. Miller in 1926 to inject fat

History continued from page 11

debris, and finally grafting fat into close contact with well vascularized tissue – crucial steps to minimize failure.

In the 1990s, New York plastic surgeon Sydney Coleman systematized the procedure. His recommendations were: harvesting fat using a 3mm blunt cannula connected to a 10ml syringe at low negative pressure to reduce adipocyte trauma, purification by means of centrifugation for separating the oily, aqueous and adipose components, and finally placement in multiple tunnels and in tight contact with well vascularized surrounding tissue, using a 18G cannula. He called this technique *Lipostructure*.

In 1998, the first course on autologous fat graft was organized in Marseille by Prof. Guy Magalon, having Sydney Coleman as guest speaker. This made the diffusion of the technique in Europe easier. At that time, indications were mainly correction of contour deformities, post-burn scars, Romberg disease, hemifacial microsomia, and chronic sores of the leg. In 2005, Coleman published the first book on fat grafting, where the procedure is exposed in detail along with numerous clinical applications coming from his experience.⁸

THE ADIPOSE-DERIVED STEM CELLS: A crucial discovery

At the beginning of the new millennium, the University of Pittsburgh's team of plastic surgeons and researchers coordinated by Bill Futrell, made a crucial discovery: that adipose tissue is the greatest source of adult mesenchymal stem cells, the so-called Adipose-Derived Stem Cells (ADSCs), capable of differentiating into other types of tissues.⁹⁻¹⁰ This accounts for the reparative properties of fat for replacing damaged or missing cells, once transferred into another part of the body. Gino Rigotti and co-workers¹¹ applied the therapeutic effects of the ADSCs, for the first time in a human being. He successfully managed the radiation tissue damage with complete *restitutio ad integrum* of the treated tissues, through a process of replacement in a series of patients. This could be considered an example of Regenerative Medicine.

In May 2006, during the 17th Annual Meeting of the European Association of Plastic Surgeons (EURAPS), Riccardo Mazzola, at that time president of the association, organized the first international panel: *Fat injection, expanding opportunities*. A wide variety of clinical applications of fat transfer in the field of Regenerative Medicine were presented by the faculty.

The impact of the panel was significant. The procedure was regarded as one of great clinical value. From that panel evolved the first textbook on this topic, *Fat Injection from Filling to Regeneration*, which was published soon afterwards.¹²

CONCLUSIONS

Fat injection, empirically started 100 years ago to correct contour deformities by combining human and ram fat,⁵ nowadays ranks among the most popular procedures, for it provides the physician with an incredible range of aesthetic and reconstructive clinical applications with amazing regenerative effects on the surrounding tissues.

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ISAPS JOURNAL IS VASTLY UPDATED

Henry Spinelli, MD – United States

Editor-in-Chief, Aesthetic Plastic Surgery



The latest issue of the official ISAPS Journal, *Aesthetic Plastic Surgery*, has undergone a number of changes to improve its already stellar quality. Over the past several months, we have reformatted the journal to be more reader-friendly by adding colored tabs at the top of each page signifying six different topical sections: Aesthetic, Breast, General Reconstruction, Non-Surgical Aesthetic, Craniofacial/Maxillofacial, and Experimental/Special Subjects. In a newly negotiated contract with our publisher, the page count has been increased to accommodate submissions that are currently at an all-time high.

Most importantly, we have replaced the previous Editorial Board with Section Editors who will help us streamline the review process to ensure that accurate decisions are made regarding publication of submitted manuscripts. Our esteemed

group of 113 Section Editors, distributed over 29 areas of expertise, are individually assigned manuscripts to oversee through the review process. Furthermore, we have added a new Advisory Board to help philosophically guide the journal into the future. The masthead has been altered to reflect the addition of the new Section Editors and Advisory Board members and our newest affiliation with the Brazilian Society of Plastic Surgery. The first issue with these changes will be the March/April edition.

We anticipate that these changes will result in an even higher quality publication, and we are committed to continuously making improvements. As always, we welcome comments from our members regarding the direction of our journal.



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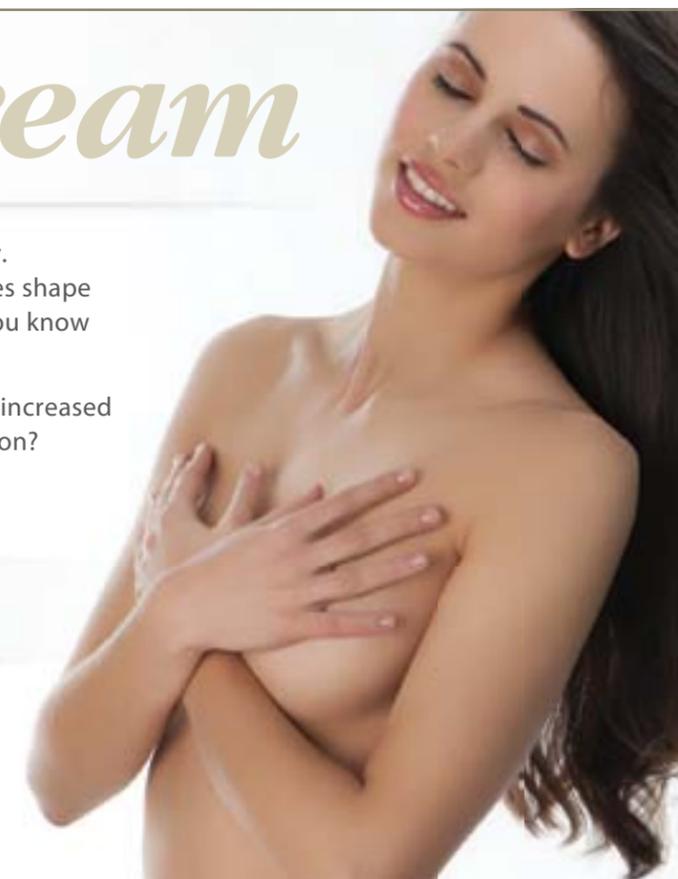
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View of Geneva to the south. Mont Salève (in France) dominates the foreground, with the white summit of Mont Blanc just visible behind it and 70 km away to the southeast. To the left of Mont Blanc is the point of Le Môle.



Attractions fêtes de Genève

Geneva is situated in the southwestern end of Lake Geneva, where the lake flows into the Rhône River. It is surrounded by two mountain chains, the Alps and the Jura, and is part of the Canton of Geneva.

Second most populated city after Zurich

Official language of Geneva – French

Temperature in September – 10-20°C (50-70°F)

Population – 192,000

Elevation – 375 meters (1230 feet)



Geneva is the seat of the European headquarters of the of UN international co-operation center with New York, the United Nations High Commissioner for Refugees, the World Health Organization, the World Intellectual Property Organization, World Meteorological Organization, World Trade Organization, World Organization of the Scout Movement, International Federation of Red Cross and Red Crescent Societies, International Committee of the Red Cross and Médecins Sans Frontières (Doctors Without Borders). Multi-national corporations with offices in Geneva include Serono, Eli Lilly, Colgate-Palmolive, Givaudan, Gillette, Procter and Gamble, Caterpillar, Reuters, Rolex, Patek Philippe, Richemont, Verisign, Oracle, Lexmark, Lockheed-Martin, Hewlett Packard, AMD, Agilent, and McDonalds.

The Geneva Conventions, comprised of four treaties and three additional protocols, establishing the standards of international law for the humanitarian treatment of victims of war were signed in Geneva in 1864, 1906, 1929 and 1949.

The city has been referred to as the world's most compact metropolis and the "Peace Capital."

Geneva first appears in history as a border town, fortified against the Celtic tribe Helvetii, which the Romans took in 121BC.

The name, Geneva, is probably of Celtic origin with one theory proposing that Geneva is derived from Genévrier, the French word for juniper.



Geneva

ISAPS CONGRESS SOCIAL EVENTS PLANNED

Kai-Uwe Schlaudraff, MD – Switzerland

Local Arrangements Chair



Ain Fogli (France) and Nazim Cerkes (Turkey), the ISAPS Scientific Program Chairs, have gathered together a stellar faculty of more than 165 world renowned plastic surgeons for the 21st Biennial Congress of ISAPS in Geneva. The scientific program offers five days of intense training, round tables, hands-on courses and video presentations to keep you up to date with the latest surgical techniques plus advice from our Masters in Plastic Surgery during sixteen Master Classes. Jan Poëll and I are honored to welcome both ISAPS members and visitors from all over the world to Geneva in September.

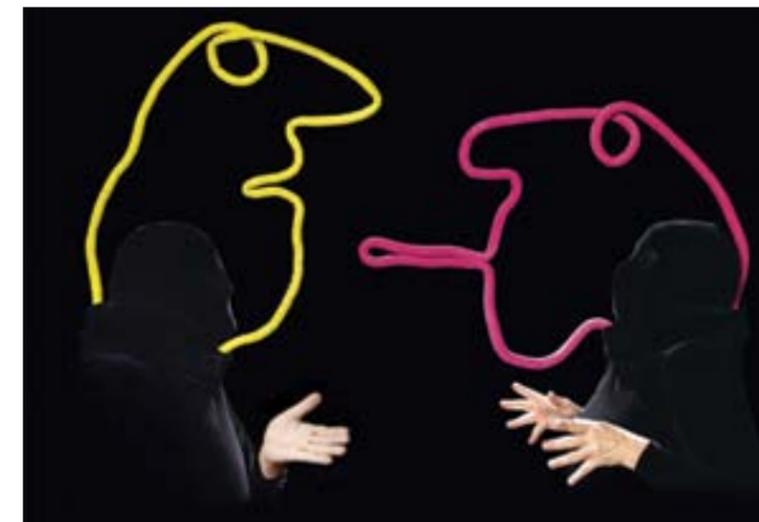
Discover a vibrant city that combines Swiss traditions with the flair of a multitude of International Organizations headquartered in Geneva.

Enjoy authentic Swiss food, wine and traditional music at the Opening Ceremony and let yourself be carried away by the incredible Mime-Masque Theater, Mummenschanz.

Indulge in famous Swiss chocolate on one of our special tours, discover the world's finest watches and jewelry on Rue du Rhône, and experience a truly incredible night at Circus Knie.

Learn about the stunning technology of the Large Hadron Collider (LHC) at the European Organization for Nuclear Research, the famous CERN, and hear our honored guest speaker tell us about the origin of our universe, or simply enjoy nature in the breathtaking mountain scenery of Verbier, Gstaad, Zermatt or Mont Blanc.

Join us in Geneva for an unforgettable experience. We are looking forward to having you here in September 2012!



Opening Ceremony features world renowned Mummenschanz



Swiss singers and dancers will add local flavor to ISAPS Congress.



Large Hadron Collider, CERN



NATIONAL SECRETARIES

WHEN EVERYONE WEARS THE T- SHIRT

Lina Triana, MD – Colombia
Chair of National Secretaries



Today I bring you an interesting perspective about two employees working in the same company. As you read these words, think about our organization, ISAPS.

John works hard and loves his job. Diana regularly sends her CV to other companies and obviously is not happy where she works. Interestingly, they work at the same company with identical salaries and the same boss. Why is John happy with his job and Diana is not?

The reason is pretty simple: they have different views about what their company sells. Diana thinks the company's product is ordinary, with no real value. John knows his company is innovative in the field, continually making improvements that provide extra value for their customers. Diana believes that working in this company was not what she had dreamed of when she started her career and therefore has problems promoting the product to her customers. John knows he is successful because he works for a company that makes it possible for all of us all have a better life.

The difference is the symbolic value that each of them sees in their company. If we analyze their productivity, we discover that John sells more than Diana, his clients are more loyal, and this contributes to make him more enthusiastic about his job.

Sometimes we think innovation comes from the outside, when in fact there is great opportunity to impact directly on service to our clients, customers, members from the inside. We need to develop the value of our brand. Once customers (or members) connect emotionally with the organization, they will "wear the company T-shirt" and begin to increase their productivity and results and make a difference with their customers.

We need to make what our company does more visible to everyone. How is our product used so customers can benefit from it without forgetting what make us different from others and why our innovations make it possible for others to have a better life. The difference between John's vision and Diana's is understanding that innovations expand the company's vision. How we can transform the symbolic value of our product to values that our clients and collaborators will understand and appreciate is the challenge.

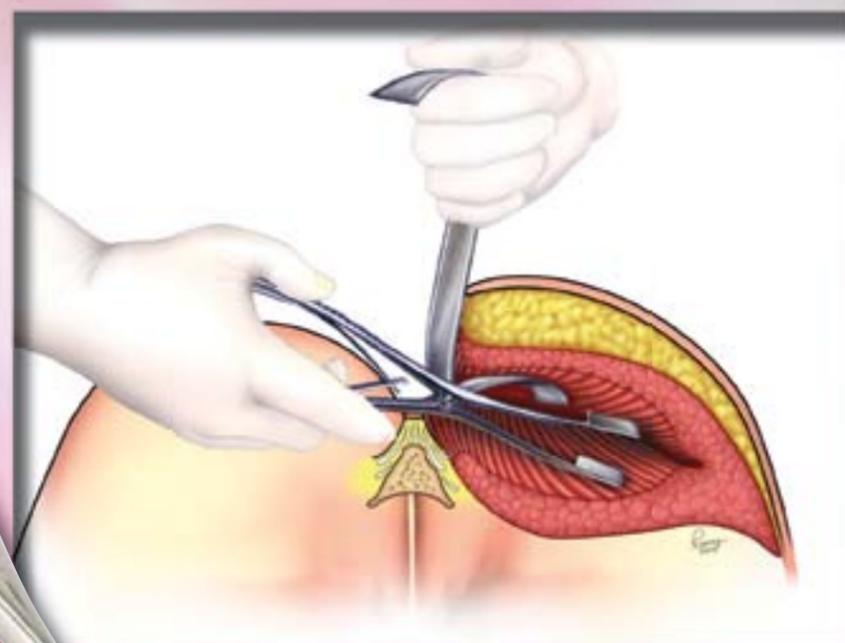
The difference between a proud and happy employee and one that is not lies in the symbolic value of the brand. What is the symbolic value of the ISAPS's brand?



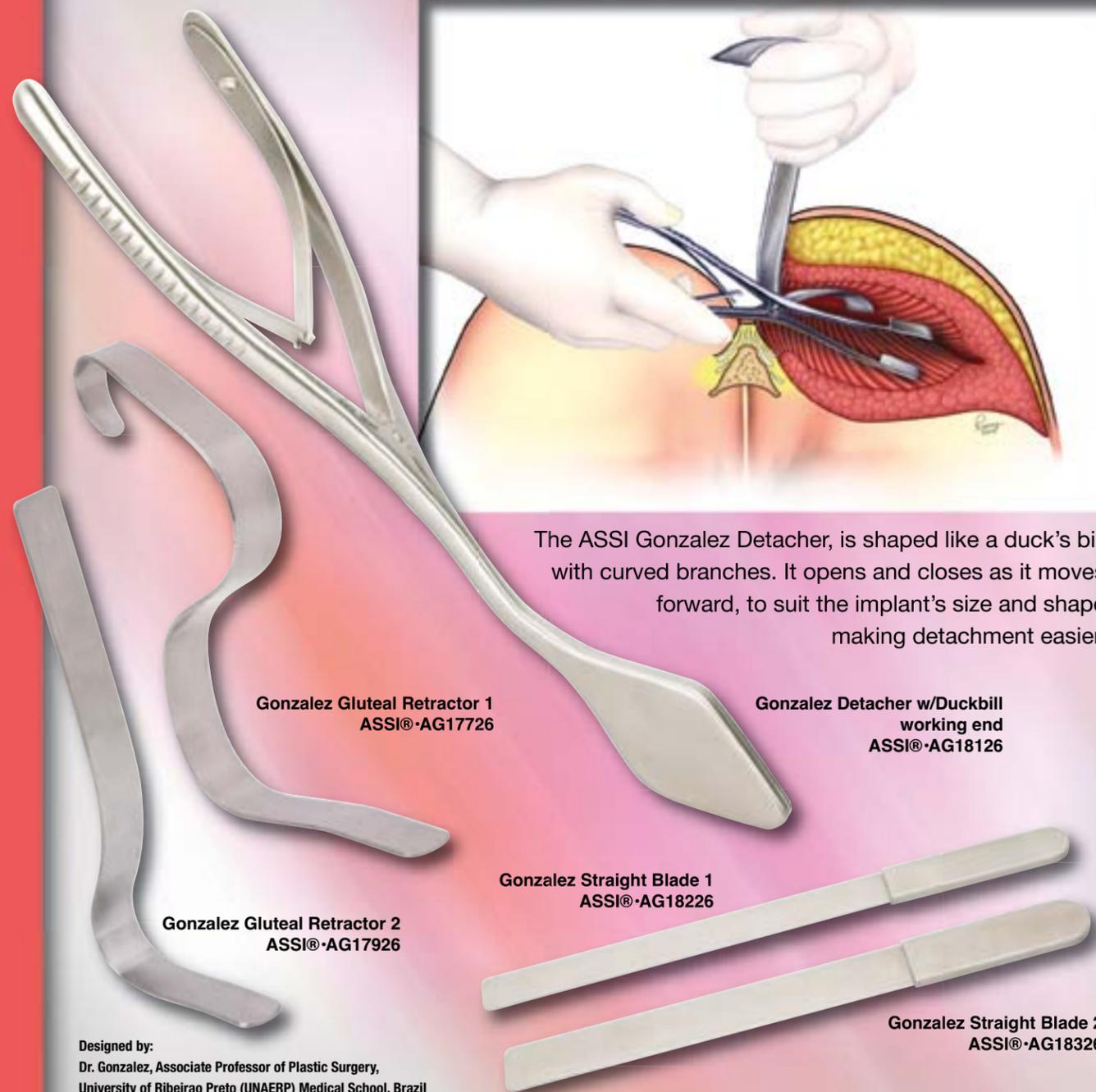
ISAPS has 74 National Secretaries in our 93 member countries. Any country with at least three members is eligible to elect a National Secretary to represent them in the leadership of ISAPS. Two new countries now qualify for a National Secretary and are highlighted in bold. Recently elected National Secretaries are also highlighted in bold text.

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ABAM MEETING IN FLORIANOPOLIS, BRAZIL

Renato Saltz, MD – United States
ISAPS 2nd Vice President

The Fourth American-Brazilian Aesthetic Meeting took place in the beautiful island of Florianopolis, Brazil on February 1-5, 2012. Colleagues from 15 countries attended this year's meeting endorsed by ISAPS, ASAPS and SBCP (The Brazilian Society of Plastic Surgery).

New features at this year's meeting were simultaneous translation during all sessions, an extra day of Instructional Courses, a Resident Review Course, and a 3-hour Live Injection Evening Session. All these educational activities took place before the meeting even started on Thursday morning.

The attendance was over 300 plastic surgeons who enjoyed the beautiful beach resort of Jurere International with their

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families. The social events held every night were fully attended and many people enjoyed the Brazilian hospitality until the early hours of the morning.

For the first time since its inception in 2009, the American-Brazilian Aesthetic Meeting was sold out two months in advance. Attendees and industry representatives had a great time and are already planning to return for the next one when ABAM moves back to the United States for the weekend of February 14-18, 2013. We have reserved the Park City Marriot during President's Weekend (US) and Carnival Holidays (Brazil).

Visit our website and reserve your place for next year's meeting, www.americanbrazilianaestheticmeeting.com



March 2012

DATE: 16 MARCH 2012 - 17 MARCH 2012

Meeting: International Symposium for Plastic Surgeons:
 Secondary Optimizing Aesthetic Surgery
Location: Munich, Germany
Venue: Sofitel Munich Bayerpost 
Contact: Theresa Brackmann
Email: tbrackmann@bb-mc.com
Tel: +49 (0) 89 - 1890 46 28
Fax: +49 (0) 89 - 1890 46 16
Website: <http://www.sos-2012.eu/>

DATE: 23 MARCH 2012 - 25 MARCH 2012

Meeting: XIII International Symposium of Plastic Surgery
Location: São Paulo, Brazil
Venue: Sheraton Convention Center 
Contact: Hanna Stutz
Email: assistente@relations.com.br
Tel: 55-11-5543-4142
Fax: 55-11-5543-4142
Website: <http://www.simposiointernacional.com.br/>

April 2012

DATE: 11 APRIL 2012 - 13 APRIL 2012

Meeting: XLVII Congress of the Spanish Society of Plastic, Reconstructive and Aesthetic Surgery (SECPRE) and I Iberian-Scandinavian Congress on Plastic, Reconstructive and Aesthetic Surgery
Location: Palma de Mallorca, Spain
Venue: Nuevo Pueblo Español
Contact: Carlos Lázaro
Email: c.lazaro@bnyco.com
Tel: 34 91 571 93 90 / 34 91 571 92 10
Fax: 34 91 571 93 90 / 34 91 571 92 10
Website: <http://iberian-scandinavian-secp-re-congress.com>

May 2012

DATE: 03 MAY 2012 - 08 MAY 2012

Meeting: The Aesthetic Meeting 2012
Location: Vancouver, British Columbia
Venue: Vancouver Convention & Exhibition Centre
Contact: American Society for Aesthetic Plastic Surgery
Email: asaps@surgery.org
Tel: 1-800-364-2147
Fax: 1-562-799-1098
Website: <http://www.surgery.org/microsite/meeting2012>

DATE: 05 MAY 2012 - 09 MAY 2012

Meeting: 36th Annual Meeting of Iranian Society of Plastic Surgeons
Location: Tehran, Iran
Venue: Razi Convention Center, Tehran University of Medical Sciences
Contact: Mehdi Fathi, MD
Email: info@plasticsurgeons.ir
Tel: +98 21 8850 6456-7
Fax: +98 21 8850 6456-7
Website: <http://www.plasticsurgeons.ir>

DATE: 18 MAY 2012 - 20 MAY 2012

Meeting: CATBBAS: Controversies, Art and Technology in Breast and Body Contouring Aesthetic Surgery
Location: Ghent, Belgium
Contact: Elien Van Loocke 
Email: elien@coupurecentrum.be
Tel: +32-9-269-9454
Fax: +32-9-269-9495
Website: <http://www.coupureseminars.com>

June 2012

DATE: 01 JUNE 2012 - 03 JUNE 2012

Meeting: ISAPS Course: Como
Location: Como, Italy
Contact: Karen Rogerson
Email: isapscomo@cq-travel.com
Tel: +39 02 49542901
Fax: +39 02 43911650
Website: http://www.isapscomo2012.com

ISAPS-OFFICIAL COURSE

DATE: 06 JUNE 2012 - 08 JUNE 2012

Meeting: Rome Breast Surgery 2012, Reconstruction and Aesthetic: Excellence as the common challenge
Location: Rome, Italy
Contact: Organizing Secretariat
Email: breastsymposium2012@alfa-international.it
Tel: +39 (0)6 32282204
Fax: +39 (0)6 3222038

DATE: 07 JUNE 2012 - 09 JUNE 2012

Meeting: Beauty Through Science
Location: Stockholm, Sweden
Venue: Stockholm Waterfront Congress Centre
Contact: Anna Eliasson
Email: bts@ak.se
Tel: + 46 8 614 54 00
Fax: + 46 8 614 54 29
Website: http://www.beautythroughscience.com

ISAPS-ENDORSED PROGRAM

DATE: 09 JUNE 2012 - 11 JUNE 2012

Meeting: VII International Plastic Surgery Course
Location: Ekaterinburg, Russia
Venue: World Trade Center
Contact: Irina Vlokh
Email: irinav@plastic-surgery.ru
Tel: 7-343-371-8802
Fax: 7-343-371-8999
Website: http://www.b-med.ru

ISAPS-ENDORSED PROGRAM

DATE: 14 JUNE 2012 - 16 JUNE 2012

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

DATE: 16 JUNE 2012 - 19 JUNE 2012

Meeting: 4th Eurasian International Aesthetic Surgery Course
Location: Istanbul, Turkey
Venue: Lutfi Kirdar Convention and Exhibition Center(ICEC)
Contact: Yagiz Tutuncuoglu
Email: yagiz@cnidus.com
Website: http://www.eurasian2012.org

ISAPS-ENDORSED PROGRAM

DATE: 21 JUNE 2012

Meeting: ISAPS Symposium: Facial Rejuvenation – Paris
Location: Paris, France
Venue: Palais des Congres
Contact: Marie Christol-Souviron
Email: sofcep@vous-et-nous.com
Website: http://www.sofcep-lecongres.info

ISAPS SYMPOSIUM

August 2012

DATE: 23 AUGUST 2012 - 26 AUGUST 2012

Meeting: 4th European Plastic Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 63 20
Fax: +49 234 325 20 80
Website: http://www.epsrc.eu

September 2012

DATE: 04 SEPTEMBER 2012 - 08 SEPTEMBER 2012

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

ISAPS OFFICIAL CONGRESS

DATE: 12 SEPTEMBER 2012 - 15 SEPTEMBER 2012

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

DATE: 26 SEPTEMBER 2012 - 28 SEPTEMBER 2012

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

DATE: 27 SEPTEMBER 2012 - 30 SEPTEMBER 2012

Meeting: ISAPS Course - Lima & Machu Pichu
Location: Lima & Machu Pichu, Peru
Contact: Julio Kirschbaum and Carlos Uebel
Email: consultas@kirschbaumplasticsurgery.com
Tel: 511-715-0808
Fax: 511-718-8849

ISAPS-OFFICIAL COURSE

October 2012

DATE: 04 OCTOBER 2012 - 07 OCTOBER 2012

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

DATE: 10 OCTOBER 2012 - 13 OCTOBER 2012

Meeting: 2nd World Congress of Plastic Surgeons of Lebanese Descent
Location: Cancun, Mexico
Contact: Jose Luis Haddad Tame
Email: hatame55@gmail.com
Tel: 52-55-5615-3191
Fax: 52-55-5615-3191
Website: http://www.congressmexico.com/lspras2012

ISAPS-ENDORSED PROGRAM

DATE: 12 OCTOBER 2012 - 14 OCTOBER 2012

Meeting: Third World Congress for Plastic Surgeons of Chinese Descent
Location: Xian, China
Contact: Dr. Wei Xia
Email: drxiawei@gmail.com
Tel: 86-29-84775512
Fax: 86-29-84775301
Website: http://www.2012wapscd.org

DATE: 26 OCTOBER 2012 - 30 OCTOBER 2012

Meeting: Plastic Surgery 2012
Location: New Orleans, LA, USA
Venue: New Orleans Convention Center
Contact: American Society of Plastic Surgeons
Email: registration@plasticsurgery.org
Tel: 1-847-228-9900
Fax: 1-847-228-9131
Website: http://www.plasticsurgery.org/

November 2012

DATE: 01 NOVEMBER 2012 - 03 NOVEMBER 2012

Meeting: ISAPS Course: Athens
Location: Athens, Greece
Contact: Vakis Kontoes
Email: myvakis@hotmail.com
Tel: +30-210-6985966
Fax: +30-210-6998731
Website: http://www.isaps2012athens.com

ISAPS-OFFICIAL COURSE



JANOS ZOLTAN, MD
Hungary

ELEAZAR FIGALLO, MD
Venezuela



This new ISAPS-LEAP collaboration results from their informal working relationship that developed following the 2010 earthquake in Haiti. LEAP, headed by CEO plastic surgeon and ISAPS member, Dr. P. Craig Hobar, was already on the scene with an established clinic in neighboring Dominican Republic, and ISAPS channeled both members' financial donations and surgical skills through LEAP's organizational infrastructure. While ISAPS members have the skills and the willingness to help, the society cannot manage global mobilization in times of urgent need.

After 21 years, LEAP is still a relatively small but active global volunteer organization working in 18 countries to provide surgical care where none is available on a non-emergency basis. In joining forces, ISAPS will encourage and enlist its member surgeons who are skilled in reconstructive plastic surgery to volunteer for short-term interventions in disaster zones, while LEAP will coordinate the mobilization they already provide through their established infrastructure. Together, they will register, help prepare and credential ISAPS volunteer surgeons to be ready when they are needed.

LEAP has already developed an informal, early interest, sign-up form on their website at www.leap-foundation.org/about/disaster-relief/ ISAPS is planning an informational lunch-time session during the Congress in Geneva in September. As the program is further structured and developed, information will be sent to ISAPS members. We are very excited about this rather unique new collaboration. We recognize that on-the-ground assistance in disaster zones is not for everyone. Thus the ISAPS-LEAP Strike Force will look for those ISAPS members with reconstructive surgical skills and a willingness to help when the need arises. 

The ISAPS-LEAP Strike Force will respond in global crises.

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