

# ISAPS NEWS

Official Newsletter of the International Society of Aesthetic Plastic Surgery

## EXCITING DEVELOPMENTS FOR ISAPS EDUCATIONAL EVENTS

FIRST TIME COURSES/SYMPOSIA COMING SOON  
TO THESE CITIES

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# ISAPSNEWS

## MESSAGE FROM THE EDITOR



Welcome to this issue of *ISAPS News*.

We are well into our two-year cycle moving toward the next ISAPS Congress in Miami Beach, Florida (US), October 31 – November 4, 2018. Our great international society continues its mission of frequent educational programs across the globe, holding first and foremost the standards of excellence and patient safety that ISAPS members value so highly.

Our cover story presents the new ISAPS logo recently approved by the Board of Directors. This fresh new look enhances the image and brand of our society. I know all our ISAPS members will display this new logo proudly.

In this issue, you will see reports of ISAPS Symposia in Australia, Vietnam, and Mexico. You will also read about the very active Visiting Professor Program with visits hosted in the Czech Republic and Russia. We welcome Education Council Chairs, Vakis Kontoes from Greece (Chair, ISAPS Education Council) and Ozan Sozer, from the United States (Vice-Chair, ISAPS Education Council) and appreciate their impressive plans to expand our mission of *Aesthetic Education Worldwide*.

Our Global Perspectives Series in this issue focuses on gluteal contouring and features commentary on practice trends from ISAPS members in Egypt, the United States, and Brazil. For the first time, we have expanded the Global Perspectives section to include a featured roundtable discussion among members from Mexico, Colombia and the US on this topic of gluteal contouring. The roundtable discussion adds focused comments on technique and patient safety in a moderated panel convened by international conference call. We are eager to hear your feedback.

Also in this issue, you will read about upcoming educational events, advocacy activities by our members, and a fascinating history article on head remodeling by Denys Montandon of Switzerland.

We hope you enjoy this issue of *ISAPS News*!

J. Peter Rubin, MD, FACS  
Editor

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# MESSAGE FROM THE PRESIDENT



Dear Members, Colleagues and Friends,

In mid-January, I attended our annual Journal Retreat with our new editor Dr. Bahman Guyuron, President-Elect and Journal Operations Committee Chair, Dr. Dirk Richter, Executive Director, Catherine Foss, and the publisher's team at Springer headquarters in New York. There are many exciting developments coming for *Aesthetic Plastic Surgery* (the Blue Journal), including a new cover design that was launched with the February issue. I hope you will be as impressed with the changes as I am. Dr. Guyuron is waiting for your contribution to our journal. Please submit your article today at: <https://www.isaps.org/medical-professionals/isaps-journal>

During my New York trip, I also met with our Executive Director, Catherine Foss, to start assembling the faculty and program for the next ISAPS Biennial Congress in South Beach, Florida on October 31-November 4, 2018. If you are interested in presenting at the ISAPS Congress, please send me an email at [rsaltz@saltzplasticsurgery.com](mailto:rsaltz@saltzplasticsurgery.com) Registration is already open on our website. If you haven't registered yet, do it now and take advantage of the lower registration fees.

Immediately after the New York trip, I left for Belgium to participate as part of the faculty for the third ISAPS Aesthetic Dissection Course in Liege. It was very successful with thirty-two participants from twenty countries and an experienced group of faculty led by Ivar van Heijningen and Jean-Luc Nizet. The facilities were the best I have seen and the cadaver dissections included all aspects of facial surgery and minimally invasive facial procedures. Congratulations to the amazing faculty and course organizers for this very successful event.

Our Education Council, headed by Drs. Vakis Kotoes and Ozan Sozer, is actively planning many new courses and symposia as part of our mission of *Aesthetic Education Worldwide*. We are putting together a very comprehensive ISAPS Course in China scheduled for September this year, immediately preceding the Chinese Society of Plastic Surgery's Annual Meeting. As another ISAPS first, it is going to be a great honor to exchange education in plastic and reconstructive surgery with our Chinese colleagues. Many of our Board members have accepted the invitation to join the faculty and teach at this historic event. If you are interested in attending the ISAPS China Course, and visiting this amazing country, please email me for more details

You may have seen the recent announcement regarding *Best Practices: Breast Implant Associated Anaplastic Large Cell Lymphoma* (BIA-ALCL) – a joint initiative among ISAPS, the American Society for Aesthetic Plastic Surgery (ASAPS) and the American Society of Plastic Surgeons (ASPS). It's important that you have both the facts and best practices in case you are contacted by the media who may be inquiring about it. This information and more is available in the Member Area of our website in the Patient Safety Recommendations section that has been newly created by our Patient Safety Committee under the Chairmanship of Dr. Foad Nahai.

And finally, if you haven't participated in the 6th Annual ISAPS Global Survey, please give it to one of your staff to complete today. The world's media eagerly awaits the results each year; however, we can only include results from any country if we have statistically significant participation. Active members, you are eligible for a \$50 discount off your 2017 membership fee or a link to your practice website in your member profile on the ISAPS website (a \$100 value).



Renato Saltz, MD, FACS

# EPSTEIN ABDOMINOPLASTY RETRACTOR

As the trend in today's abdominoplasties is towards less upper lateral undermining, the upper tunnel has become narrower. During the dissection of this tunnel, it is difficult to maintain countertraction with available instrumentation. The Epstein Abdominoplasty Retractor was designed to assist in the performance of the dissection of the upper abdominal tunnel. The ergonomic handle is easily held by the surgical assistant. It is available in several blade lengths so as to best fit the anatomy of the patient: whether the tunnel is long or short, there is a retractor to provide the best mechanical advantage in yielding exposure and reducing fatigue. The widened, curved working end spreads the tissues of the upper skin flap apart as the teeth gently hold them in place without slippage. The leading edge of the dissection is easily seen and maintained, facilitating effortless cautery elevation of the skin flap from the muscle fascia. The retractor is also extremely helpful in elevating the abdominal skin flap over the narrow tunnel so that the underlying muscle fascia can be plicated.

- Designed to assist in the performance of the dissection of the upper abdominal tunnel
- The wide curved working end spreads and holds the tissue of the upper skin flap apart
- Facilitates cautery elevation of the skin flap from the muscle fascia
- Extremely helpful in elevating the skin flap over the narrow tunnel for muscle fascia plication

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# MIAMI UPDATE



Dear Members, Colleagues & Friends,

It gives me great pleasure to invite you to join me, and the ISAPS family, for the next ISAPS Global Congress in South Beach, Florida on October 31 through November 4, 2018. I promise you that this is going to be a global aesthetics meeting like none you have ever attended before.

A global gathering of the world's best faculty and programs that will provide you and your staff with the education, knowledge and cutting edge insights to take your aesthetic practice to the next level.

This is the ONLY international aesthetics forum of its kind that combines the skills, knowledge and technical abilities of the world's finest plastic surgeons, aesthetic teachers and practice management experts under one roof. We will feature a comprehensive practice management and marketing curriculum through *ISAPS Business School*. Plan to bring your office staff to learn from our experts and make your practice flourish.

We will also be launching *ISAPS Skin* with an extensive schedule of classes to help you expand your practice in this rapidly changing area of aesthetics. There will also be live injections, cadaver dissections and many other amazing learning opportunities.

The ISAPS Congress in 2018 will be five aesthetic conferences rolled into one. If there is only one aesthetic meeting you attend in 2018, then this must be it!

The best of the best aesthetic faculty and the best of the best scientific and practice management programs in one of the world's hottest destinations – the South Beach area of Miami Beach is where people from every culture go to experience its vibrant energy, glamor, nightlife and spectacular beaches. It has been voted the #1 beach resort in America by the Travel Channel.

Register now to secure your seat at the 2018 ISAPS Global Conference in Miami Beach, Florida. We fully expect this event to sell out with a waiting list, so please don't delay and register by visiting [www.ISAPSMiami2018.com](http://www.ISAPSMiami2018.com)

Follow this column in *ISAPS News*, ISAPS' E-Magazine, social media and our website. Watch our monthly updates regarding faculty, program and other important news as we plan this amazing Congress.

I look forward to seeing you in Miami Beach next year.

Best regards,

Renato Saltz, MD, FACS



# FEATURES



**Susumu Takayanagi, MD, PhD – Japan**  
Immediate Past President

## LOOKING BACK AT MY TWO YEAR EXPERIENCE AS ISAPS PRESIDENT

First of all, my thanks to all ISAPS members for your continued support and cooperation that allowed me to serve as ISAPS President for two years. My deep thanks as well to the excellent Board Members and to the Chair of each Committee for their excellent work. As I mentioned at the ISAPS Congress in Kyoto, I have had a very wonderful time these past two years.

It is true that not everything worked well during these years. I had both fun and hardship while I was the President. However, I believe that I was able to contribute to ISAPS the most during the difficult times. Now all of them are an important part of my good memories. Let me talk about some of my thoughts stemming from my experiences over these two years.

### ISAPS is an International Society

ISAPS has members in 104 countries around the world. They speak different languages and come from different cultures. The situations of doctors also differ greatly by country. We once proposed to ISAPS members that highly qualified dermatologists, ophthalmologists, otolaryngologists, and others from around the world could become ISAPS members by way of recommendation, invitation, or other selective methods and that they could participate in the activities of ISAPS. For example, I live in Japan where no dermatologists perform breast augmentation or facelifts. However, the situation is different in other countries. In South America, for example, some dermatologists do perform cosmetic surgeries, which is an unbelievable situation when compared to Japan.

When I joined the Board for the first time, I was the only Board member from Asia and this situation continued for years. After I became President, the geographic imbalance among the Board members was corrected and I think the situation has greatly improved. However, I learned that balancing the Board was not enough to reflect the global situation in the opinions of the Board.

There were many objections to our proposal, particularly from South America. The Presidents and other leaders of some countries' national societies submitted strong objections. In order to determine the direction that ISAPS should take, it is always necessary to hear the opinions of members in addition

to the opinions of the Board. I also learned that surveys of ISAPS members are a very effective method when determining the direction that ISAPS should take.

### Language Problems in ISAPS

ISAPS activities are implemented in English only, which is the official language of the organization according to our By-Laws. However, not all of our members speak English fluently or understand it well. Besides the general public, there are many surgeons in the world who do not understand English.

Today, the ISAPS website has been translated into many languages and it has become easier to understand for the general public. However, ISAPS has not yet become a well-known organization in the world and needs to be flexible in its approach to the general public and potential members – and should not insist on English only.

For example, in ISAPS courses and symposia, it is necessary to establish a policy that places the priority on languages that the participants can understand well - and to include more interpreters. I mentioned in *ISAPS News* before that I would like to request again that speakers use as many videos as possible so that it helps audiences understand their presentation even if they do not understand the language used in the presentation and that presentations in English should be spoken as slowly and clearly as possible.

### Qualifications of Board Members

During the two years when I served as the President, I worked with truly excellent Board members and I was always very proud of all of them. During the Board meetings, many opinions were always heard, discussions were intense, and many good proposals were made. Above all, the most excellent point was that once the direction for an agenda was determined, the Board started to move in the same direction with a single voice. Before anyone can join the Board, there are many checks and requirements so that a person that no one knows cannot join the Board. I think this system is wonderful. This also became an issue at the general assembly during the Kyoto Congress. It must be prevented that ISAPS members in a meeting nominate a doctor for the Board by means of recommendation, that a doctor brings many friends

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**Jean Goldsborough**  
Technology Consultant, On Top of IT

## DON'T GET HACKED: SIMPLE STEPS TO IMPROVE CYBER SECURITY

If you haven't already felt the pain of a malware infection on your computer or a hacked email account, consider yourself fortunate. Since we all rely on technology for daily productivity and communication, it is almost inevitable we will someday experience the affects of a security breach.

The cyber environment today is more active than ever before. We are dependent on an internet connection to access any of our personal and professional resources. Disconnecting from the internet is impractical, yet it might be the only reliable way to ensure protection. Everyday scams, malware and security breaches originate on the internet. The only other source of security concerns in the corporate world is the so-called "Insider Attack" - a breach caused by a trusted employee or contractor who has already been given authorization and access to internal resources. Insider attacks are not in the scope of this article.

What can you do to decrease the chances of becoming a target of cyber compromise? Let's look at some of the more common pathways that are exploited and some basic steps you can take to increase your level of protection. We'll start with definitions of terms you have likely heard and then explore some best practices to prevent the compromises.

**Phishing** – a strategy using email, websites and links to trick the recipient into trusting the source and divulging sensitive information. Phishing is a classic form of "social engineering" – essentially trickery that leverages vulnerabilities in your system and in you as a human, because you trust the source.

**Ransomware** – malware that once installed on your PC encrypts all of the data on your hard drive and connected resources and holds that data ransom. The criminals promise to restore your data once you pay a ransom fee (which does not guarantee recovery of your data!)

**Browser Hijack** – if you install a simple little program like a toolbar without knowing it (often this comes with free software downloads) then your browser settings can be modified. The result is that your browser will redirect you to sites, pages and pop-up advertising which can all lead to additional malware infection.

**Brute force attack** – a type of attack designed to crack your passwords. Password guessing can be performed by the use of algorithms to calculate every possible character combination until it breaks the password.

**Rogue Security Software** – another form of social engineering to trick you into thinking your PC is infected then paying for and downloading their fake removal tool which just installs more malware on your system.

What can you do to protect yourself from these common security threats? The answer is not as easy as you might think, but the following practices can significantly reduce your chances of becoming a victim.

- Expand your awareness and slow down! Much of the social engineering tactics are successful when the user is in a hurry and clicks before thinking. Avoid clicking on links in webpages or emails, even if the message comes from someone you know. Manually type the address of the site into your browser or if suspicious check the link or file with a URL checker like Virus Total ([www.virustotal.com](http://www.virustotal.com))
- Backup, backup, BACKUP! Storing regular backups of your data both online and locally will save you when the time comes. You can recover from ransomware easily if you have a recent backup that is NOT connected to your computer. Beware that sync services such as Dropbox and Google Sync running on your PC may not be immune to ransomware encryption.
- NEVER reuse passwords and make your passwords long. If you already have duplicate passwords, start your changes with your primary email account since that is often where password resets are sent. If a hacker gets one of your favorite passwords they will gain access quickly to other critical resources such as your primary email. Use a password manager such as LastPass or Dashlane and use 2-factor authentication on critical accounts.

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Features - Takayanagi continued

to the general assembly, and that he or she whose career is unknown suddenly joins the Board by a vote during the meeting. Currently, the Nominating Committee is operating well in this regard. I hope this will be maintained and continued.

National Secretaries

The National Secretary coordinates with ISAPS members in each country and plays an important role in our leadership. Many National Secretaries are performing excellent work and contribute well to ISAPS. However, although very few in number, it is true that there are National Secretaries who do not contribute fully to ISAPS and who are not supported by the society in their country.

Since ISAPS is a society that individuals join, it is difficult to know whether the person is supported by societies in his/her country; however, the recently created Global Aesthetic Plastic Surgery Alliance will serve to enhance the cooperation between ISAPS and Alliance member societies. This has already enabled ISAPS to contact Alliance member society Presidents directly to develop a strong connection with both the National Secretary and the President. Therefore, ISAPS activities can develop smoothly and many new possibilities can emerge, such as several societies in a specific region and ISAPS collaborating to meet their members' common needs.

In addition to conventional ISAPS activities, I think we should try new activities without hesitation if they are for the good of ISAPS members.

Industry Support

Industry support is important for ISAPS activities. As you may have understood when you saw the exhibition booths in Kyoto and at other ISAPS meetings over the past few years, most of the companies that participated in the exhibitions have been limited to companies selling breast implants, surgical instruments, and lasers. I do not think ISAPS should earn a lot of money at the congress; however, operation of an international society requires supporting funds. ISAPS needs to be prepared with sufficient funding. Support from industry will become more important as our educational activities increase. The number of companies that support ISAPS will become necessary for the sound development of ISAPS in the future.

Today, wonderful people have joined the Board again and a very hard worker, Renato Saltz, has become our new ISAPS President. I remain one of the Board members and am happy to work with these wonderful Board members and the excellent new President.

My thanks again to all ISAPS members in the world for giving me this opportunity. I am very proud of being a member of our big ISAPS family. 

Features - Goldsborough continued

- Never share passwords by email. If you must share a password, give it to them over the phone or separate the messages if you must use texting. Avoid putting the username and password in the same message or thread. Use two or more different methods of sending each.
- Keep your PC software updated. Ignoring updates to Windows (Mac OS X, too!), Java and Adobe products is especially risky. Install software updates as quickly as they are made available if possible. You can also use two user accounts: change your primary account to have limited powers (Standard User) and create an administrator account to install updates and approved software.

This article is far from comprehensive. Today's threats are increasingly advanced and prolific. As the threat landscape changes, so will security strategies change. If you can act to protect yourself in any of the ways mentioned, it will be a good start to hardening your shield against the everyday hacking tactics currently being used. 



Professor Stephen Cannon, Vice President of the Royal College of Surgeons of England, Miss Clare Marx, President of the Royal College, Foad Nahai and Nigel Mercer, former President of BAPRAS and BAAPS.

It gives the ISAPS Board of Directors and me great pleasure to congratulate Foad Nahai, MD for becoming an honorary fellow of the Royal College of Surgeons of England.

Foad is past-President of ISAPS and the current Chair of the Patient Safety Committee.

Renato Saltz, MD, FACS

# PATIENT SAFETY



**James Fernau, MD, FACS**  
Member, ISAPS Patient Safety Committee



## PATIENT SAFETY COMMITTEE UPDATE

ISAPS is actively and aggressively pursuing international patient safety. The Patient Safety Committee has introduced a webpage solely dedicated to patient safety recommendations. There are new protocols and important, current information in the Member Area that can be easily accessed and immediately viewed.

For example, the protocols include:

- an excellent summary of BIA-ALCL including a brief summary and frequently asked questions;
- due to the increasing use of oral benzodiazepines for office liposuction, we include a treatment protocol for benzodiazepine and opioid overdose;
- a decontamination protocol for patients to start four days before surgery to decrease the chance of infection and specifically the chance of acquiring methicillin resistant staphylococcus;
- help in making decisions for the use of compression stockings, intermittent pneumatic compression intraoperatively, postoperative aspirin use and using subcutaneous heparin;
- a practical approach to manage the cosmetic chronic pain patient is included.

ISAPS is indebted to ASAPS and Dr. Lorne Rosenfield, Chair of its Patient Safety Committee, for sharing these excellent, practical protocols. This is just the beginning. Currently, there are many other protocols being constructed and they will be included on our website page as soon as they are available. Where possible, the use of the latest evidenced-based information will be provided and updates on former protocols will also be provided. Additionally, Dr. Foad Nahai and Dr. Robert Singer are advocating the importance of practicing in a AAAASF certified surgical center.

At ISAPS, we are striving for a new era of patient safety and will continue to dedicate our time and effort on this important and critical issue. We encourage feedback and recommendations from our international community. Patient safety first!



### Patient Safety Recommendations

Visit the Member Area of [www.isaps.org](http://www.isaps.org) to access new Patient Safety Recommendations including:

- **ASPS-ASAPS Update BIA-ALCL Summary and Quick Facts**
- **Benzodiazepine Rescue & Opioid Rescue**
- **Filler Crash Kit**
- **Recommended Preoperative Decolonization Protocol**
- **DVT Protocols**
- **Managing Chronic Pain Cosmetic Patients & Prevention of Opioid Overdosing**

The Patient Safety Committee will periodically post new information on this site so check back regularly.

Meet outstanding international experts in an open and friendly atmosphere!

Learn how to treat your patients in a simple, safe and long-term stable way!

New York 7–9:00 a.m. | Rio de Janeiro 8–10:00h | Tokyo 20–22:00h | Sydney 22–0:00h

**Date**

20 March 2017

Bucharest 14–16:00h | Berlin 13–15:00h



Raul Gonzalez



Constantin Stan



François Petit

— GLUTEAL SURGERY —

**AGENDA**

Constantin Stan &  
Vivian Thompson

Welcome

François Petit

Gluteal Surgery – the Present and the Future

Raul Gonzales

Gluteal Lifting – the Brazilian Point of View

Raul Gonzales

Gluteal Augmentation – Fat or Implant, a Question of Indication

François Petit

Gluteal Surgery – How to Avoid Complications and Bad Results

Constantin Stan  
(Moderator)

Questions & Answers

Raul Gonzales  
François Petit  
Constantin Stan

**LIVE SURGERY**

**DIAL-IN INFORMATION**

Please use this link to access our webinar:

[sclinic.ro/webinar-march](https://sclinic.ro/webinar-march)

Join the Expert Experience!

## A little geography lesson

The 2018 ISAPS Congress will be held in Miami, Florida. South Beach is a neighborhood in the city of Miami Beach, Florida which is located due east of Miami City proper. The airport is Miami International - in Miami, Florida



# WHERE IN THE WORLD?



# ISAPS EDUCATION



**Vakis Kontoes, MD, PhD – Greece**  
Chair, ISAPS Education Council



**Ozan Sozer, MD – United States**  
Vice-Chair, ISAPS Education Council

## MESSAGE FROM THE EDUCATION COUNCIL CHAIRS

Although it has been just a few months since we took over the Education Council (EC), we are happy to report that there are multiple exciting developments for future ISAPS events.

*All approved Courses and Symposia, with dates and additional details, are listed at the end of this newsletter, in each issue of our journal, and on the ISAPS website.*

**North America:** There will be a half-day ISAPS/ASAPS symposium on Buttock Contouring the day before the Annual ASAPS meeting in San Diego in April 2017. The Aesthetic Cruise this year will for the first time be an ASAPS/ISAPS collaboration beginning on July 21 to include a dynamic education program including ISAPS members on the faculty and visits to Scotland and Norway.

After communication with Dr. Eric Bensimon, the President of the Canadian Society of Aesthetic Plastic Surgery (CSAPS), we are very excited to organize the first ISAPS Symposium in Canada in collaboration with CSAPS on October 12, 2017, the day before the CSAPS Annual Meeting. The symposium will include a half day on rhinoplasty and a half day on facial aesthetics and fillers.

**South America:** Recently, the EC approved courses in Santiago, Chile; La Plata, Argentina; Guayaquil, Ecuador; and Santa Cruz, Bolivia.

Argentinean National Secretary and EC Regional Representative for South America, Fabian Cortinas, is working with us to plan an oculoplastic and periorbital aesthetic rejuvenation course in Patagonia, Argentina at the end of the year.

We are pleased to report that we have started organizing the first ISAPS Course in Cuba by the end of 2017 or in 2018.

**Asia Pacific:** President Renato Saltz's visit to China in November was a very fruitful trip. We are excited to announce the first ISAPS Course in China in September. Dr. Lee Pu, EC Regional Representative for Asia, has been very instrumental and very helpful in working with us to organize this important event in China.

A new confirmed Symposium will be held in conjunction with the Korean Society of Aesthetic Plastic Surgery (KSAPS) annual meeting in April, 2018.

**Europe:** The now annual ISAPS Symposium preceding the SOFCEP meeting will be held in Marseille, France in June followed later that month by an ISAPS Course in Romania. Later in the year, another ISAPS Symposium is scheduled in Lisbon, Portugal, preceding the Portuguese Plastic Surgery Society meeting in September. For the first time, we will have a Symposium in the UK and a course in Barcelona, Spain.

**Middle East:** Two courses will be held in May and October in Cairo, Egypt and Amman, Jordan.

As your EC Chair and Vice Chair, with the support of our President and the Board of Directors, we have the mission to open new doors and develop new relationships in the world for the next two years. We are trying our best to achieve this target and we count on the support of our National Secretaries who should contact us to exchange ideas regarding the organization of ISAPS educational events in their countries to enforce our aim of ISAPS *Aesthetic Education Worldwide*. 



**Morris Ritz, MD – Australia**  
ISAPS National Secretary for Australia

## ISAPS SYMPOSIUM - GOLD COAST

This meeting was held just before the Australian Society of Aesthetic Plastic Surgeons (ASAPS) annual meeting as a one-day Symposium on Thursday 6th October. The topic was: *Facial implants and their role as an adjunct in aesthetic and reconstructive facial surgery and rhinoplasty.*

The main focus was facial anatomy, facial ageing, assessment and selection of facial implants, contemporary surgical techniques, the role of pre-formed and custom-designed facial implants and the use of Hydroxy apatite as a permanent filler. Given the role 3D printing now plays with custom-made implants, this area was also discussed and demonstrated.

The three main guests for this Symposium were our local Mr. Bryan Mendelson from Melbourne, once again talking on facial anatomy and the use of Hydroxy Apatite as a permanent filler, and Michael Yaremchuk from Boston in the United States, who gave excellent talks on technique and the use of facial implants in all types of cases. He also introduced us to custom-made 3D

implants. The third speaker was William Binder from California who was also very knowledgeable about facial implants and their use in all types of facial surgery including Rhinoplasty.

We included a local panel of Terrence Scamp, Warwick Nettle, and Paul O’Keefe. The meeting was attended by thirty plastic surgeons and ISAPS members and was considered to be a boutique, informative and instructive day with many excellent comments, a lot of interaction with the guests, and supported by industry partners. Once again, the event was successfully managed by ‘The Production House Events’. We are hoping to run an ISAPS Symposium on a yearly basis close to the annual ASAPS meeting as it has been a useful addition to our yearly program. 





**Sanguan Kunaporn, MD - Thailand**

## ISAPS COURSE – VIETNAM

### Background

There is no truly National Society of Plastic Aesthetic Surgery in Vietnam - until now. There are two societies, one in the capital of the country, Hanoi in the North, and the other, HoChiMinh City (or Saigon in the past) in the South. The dominant and active society is the latter led by current President, Prof. Le Hanh.

A year ago, as a member of the Educational Council of ISAPS, I got permission from our President Dr. Susumu Takayanagi, EC Chair Dr. Lina Triana and the Membership Chair, Dr. Ivar van Heijningen, to endorse Dr. Le Hanh to be the first Vietnamese ISAPS member and Vietnam became the 100th country to join ISAPS.

The first ISAPS course in Vietnam was planned in order to introduce the international standard of aesthetic plastic surgery and the patient safety principle to the country. The other reason was that ISAPS would be a good catalyst for the unification of plastic surgery societies in the North and South to be the National Society of this 100 million-population country.

### The Course

The first ISAPS Course in Vietnam was held in HoChiMinh City (HCMC) on December 9-11, 2016. It was the main academic activity that was organized together with the 14th Annual International Scientific Congress of The HCMC Society of Plastic & Aesthetic Surgery.

I served as the Course Director under the supervision of EC Chair, Dr. Lina Triana. Dr. Susumu Takayanagi was the key leader of ISAPS at this course. Dr. Vakis Kontoes, the current EC Chair, also joined the course. The local Course Director was Prof. Dr. Le Hanh and the Local Chairman of the conference was Dr. Pham Trinh Quoc. There were ten ISAPS speakers and another five international speakers.

More than 300 doctors from all around the country attended this course composed of two days of lectures and presentations by ISAPS speakers and local speakers at New World Saigon Hotel, HCMC. There were totally 39 topics presented by international speakers in the fields of Breast, Facial and Periorbital,

Rhinoplasty, Body Contouring, and Genital surgery. Local speakers shared 14 topics on the second day.

The third day featured live surgery held at Trung Vuong Hospital, HCMC. There was a total of four cases of Rhinoplasty, Breast Implants, Face Lift and Facial and Hand Lipofilling. Dr. Takayanagi gave a presentation about ISAPS and its Patient Safety mission. Dr. Le Hanh summarized a history of plastic surgery in Vietnam.

The Vietnamese doctors were very eager and enthusiastic during the whole course. Very few doctors left the conference room during the presentations. There was simultaneous translation between Vietnamese and English during the whole course. Even though there was no formal post course survey, the feedback from the attendees showed very high satisfaction. There are many requests asking ISAPS to organize the next course soon including a Visiting Professor Program.

The organizing committee worked very well, all AV equipment ran quite well, with no trouble during any presentation. All attendees received a certificate of attendance from the organizing committee. Dr. Takayanagi, Dr. Triana, Dr. Le Hanh, Dr. Pham and I signed our names on every certificate.

The accommodations, meals, hospitality, welcome reception, gala dinner and a post course tour to the Hot Spring and the Beach were also organized very well and impressive. Every ISAPS speaker was very happy and impressed with this first ISAPS Course in Vietnam.

Dr. Takayanagi and I also had an opportunity to visit two prominent aesthetic plastic surgery hospitals in HCMC those work is at a high standard. It was eye-witness evidence showing the situation of aesthetic plastic surgery in Vietnam.

### Conclusion

As the Course Director, I would like to express that this course was very successful and ISAPS got very high respect and recognition by Vietnamese doctors and both Aesthetic Plastic Surgery Societies. Dr. Le Hanh informed me that there was a special meeting between both societies during the conference about the roadmap of unification.





**Bertha Torres, MD - Mexico**  
National Secretary for Mexico



**Arturo Ramirez Montañana, MD - Mexico**  
ISAPS Parliamentarian

## ISAPS COURSE – CANCUN

On December 9-10, a world-class academic event was held on the beautiful Mayan Riviera in Mexico at the Hotel Resort Paradisus at Playa del Carmen, thanks to the support of ISAPS' Education Council.

The second official Mexican ISAPS Course was planned and produced by Dr. Lina Triana (Education Council Chair) and Dr. Arturo Ramirez Montañana (ISAPS National Secretary for Mexico) in collaboration with Dr. Bertha Torres (ISAPS Assistant National Secretary for Mexico), Dr. Maximiliano Martinez and many Mexican friends and colleagues.



Drs. Gustavo Jimenez, Arturo Ramirez-Montanana, Bertha Torres, Renato Saltz, and Maximino Martinez

these great plastic surgeons: Thomas Biggs, Renato Saltz, Dirk Richter, Nazim Cerkes, Ozan Sozer, Alfonso Barrera, Mario Pelle Ceravolo and Gerald O'Daniel and for the marketing topics Dana Fox and Tami Vileta who shared with us their knowledge with their high academic level lectures.

For the first time, three professors from different medical specialties were invited to participate and complement the program with their experience. We invited Hector Marines, MD (Oculoplastic), Jorge Ocampo, MD (Dermatologist) and Alejandro Martinez, MD (Oral Facial Surgery). Also, eighteen national plastic surgeons made very interesting and enriching presentations: Manuel Almaguer, Carmen Arjona, Silvia Espinoza, Martin Iglesias, Bertha Torres, Raul Lopez Infante, Jorge Ocampo, Jose Luis Haddad, Jose Luis Romero Zarate, Eduardo Gongora, Angel Papadopolus, Lazaro Cardenas Camarena, Eduardo Santos Cañamar, Jose Abel de la Peña, Adrian Manjarrez, Arturo Regalado Briz, Juan Carlos Fuente Amescua and David Ramirez Chavez.

In addition, we had great moderators including Alejandro Duarte y Sanchez, Laura Carmina Cardenas, Maximiliano Martinez and Sergio Ayuso. With the participation of 200 registrants, including several plastic surgery residents and, for first time in ISAPS history, a Cuban delegation of plastic surgeons, the event's expectations were surpassed. With the support of ISAPS Executive Director, Catherine Foss, twenty-nine new members joined this great family. It was two days of intense

academic activity, beginning at seven o'clock in the morning for twelve hours straight, with a total of 50 lectures and a very special presentation titled "58 Years' Evolution of Facial Aesthetic Surgery and Other Aspects of My Personal Journey" by Dr. Tom Biggs to whom we offered homage for his outstanding life achievements. Furthermore, plans for ISAPS' biennial Congress in Miami were presented and Dr. Renato Saltz shared an emotional historic tribute about two former ISAPS Presidents, Dr. Jose Guerrero Santos and Dr. Thomas Biggs, handing them each a recognition plaque.



Drs. Renato Saltz, Arturo Ramirez-Montanana, Lazaro Cardenas, Jose Guerrerosantos (seated), Alejandro Duarte y Sanchez, Bertha Torres and Tom Biggs.

During the meeting, voting was going on behind the scenes to elect the new ISAPS National Secretary and Assistant National Secretary for Mexico and Dr. Bertha Torres and Dr. Gustavo Jimenez Muñoz Ledo, respectively, were elected to these two positions.

Social events were carried out in exclusive and pleasant places, beginning with a golf tournament sponsored by Merz at the Grand Coral Golf Club Riviera Maya, organized by Dr. Raul Lopez Infante and Dr. Armando Flores. Crislix and Motiva sponsored the welcome cocktail reception. This was followed by a three-part dinner with an exceptional gastronomic taste at the resort restaurant Passion. The closing event was the "All in White" party, which was livened up with music and fluorescent accessories giving it a casual but fun feeling.



We are very pleased with the confidence and the opportunity we were granted to plan this meeting, continuing the ISAPS mission of *Aesthetic Education Worldwide* choosing to stay with international quality education as a motor for the scientific development of plastic surgeons in Mexico and around the world, strengthening the security and satisfaction of our patients. We send a big hug and we hope to see you at our next ISAPS Course in Mexico.

# VISITING PROFESSOR PROGRAM



**Vladimír Mařík, MD – Czech Republic**  
ISAPS National Secretary for Czech Republic

## ISAPS VISITING PROFESSOR PROGRAM CZECH REPUBLIC

On August 15-16 last year, an ISAPS Visiting Professor Program (VPP) took place in Hluboká nad Vltavou. It was the first VPP to be held in Czech Republic. I invited Prof. Fabio Nahas MD, PhD, FACS, MBA from Brazil and expectations were high. The audience was filled with residents as well as some leading Czech plastic surgeons. Capacity was completely full as nearly one third of all Czech plastic surgeons found time to attend.

The first day was devoted to live operations conducted by Prof. Nahas. Two main procedures were presented: abdominoplasty and mastopexy. Prof. Nahas pointed out important new techniques during each operation. Only a small group of surgeons was in the operating theater, so video was captured and edited for the others.



Figure 1 - Prof. Nahas (center) with the OR team.

Lectures started early in the morning of the second day. I opened the program by introducing Prof. Nahas and the ISAPS Visiting Professor Program to the audience. Then Prof. Nahas took the floor for nearly the whole day. He gave excellent lectures on these themes: Treatment of excess skin and fat of the abdomen, Treatment of the myoaponeurotic layer of the abdomen – recent trends, Abdominoplasty versus lipoabdominoplasty – what is the best technique?, Secondary abdominoplasty and atypical cases, Limits of liposuction, The internal bra technique for breast reduction, and Breast augmentation – some technical considerations.

Rich discussion followed every lecture and many ideas were shared with lots of different opinions as well. The level of discussion was very high and the atmosphere respectful. Some important conclusions were made.

The next part of the programme included the video from the previous day's operations with live commentary by Prof. Nahas, once again, with many questions from the audience. Each

participant received a copy of the video on CD. At the end of day, my colleague Pavel Kurial, MD and I presented difficult cases from our practices and Prof. Nahas commented with interest on our approach.

Despite the exhaustive course programme, organizers found some time for social events. Prof. Nahas had the opportunity to experience the uniqueness of the revolving auditorium in the city theatre of Czech Krumlov. Physical health was also taken into account with a cycling trip through the Czech landscape - icing on the cake.

The response to this VPP was huge as all participants went back home satisfied and full of new ideas. Thanks go to organizers and to Prof. Nahas for this wonderful and enriching educational experience. Hopefully, this has been the beginning of new educational tradition. Everyone looks forward to the next Visiting Professor Program in the Czech Republic that has been approved for later this year. 



Figure 2 - Prof. Nahas (center) with Dr. Marik and Dr. Kurial, VPP organizers, at Hluboka Castle.



Enrico Robotti, MD - Italy

## ISAPS VISITING PROFESSOR PROGRAM RUSSIA

When Dr. Kirill Pshenisnov, ISAPS National Secretary for Russia, invited me for an ISAPS Visiting Professor Program (VPP) on the topic of difficult rhinoplasty in Moscow last September, I accepted without hesitation. My current life is overfull with work and meetings, but I had such good memories of my first ISAPS VPP with Dr. Lokesh Kumar in Delhi in 2015 that I simply could not miss repeating such a rewarding experience. I also have to say, without fearing to pay undue homage, that Kirill is an excellent plastic surgeon with a complete reconstructive background, as well as a prolific writer of papers with impressive qualifications. He is well known in our rhinoplasty meetings for his imposing stature, which well comes together with his scientific sharpness!

I arrived in Moscow on a smooth Aeroflot flight from Milan late at night on Jan 19th. Passing through customs with my visa was quick and easy, and I was transferred readily to my hotel, a cozy and perfectly run establishment in the center of Moscow, with few rooms and a lot of charm to it.

The following day, Kirill accompanied me to the European Medical Center (EMC), where a full day of lectures was planned, involving me as a guest, as well as local rhinoplasty experts. The EMC is a private multidisciplinary clinic in Moscow, one of the leading private hospitals in the city. It provides many specialties of outpatient and inpatient care, according to high international standards and involving an international, English-speaking team of doctors. I was very impressed at the state-of-the art medical equipment, perfectly run facility and cutting-edge medical technology. This is where Kirill also sees his patients, as well as doing many of the operations he performs.



There were around fifty people in the lecture room and the day was a busy one for me, with quite a few talks and videos on the topic of complex rhinoplasty such as revision rhinoplasties as well as crooked noses and truly reconstructive cases. This is indeed one of my favorite interests today, especially regarding

the use of rib. Kirill and other local colleagues (from Plastics and ENT) presented talks as well. An efficient bilingual translation was available. I was positively surprised at the interest and attentiveness of the audience. Practically nobody left the room and questions were appropriate and bountiful. You can quickly see at meetings when an audience is genuinely interested or not, and there was no doubt this one was.



During the lunch break, I was driven to the nearby facility (still part of the same EMC) where surgery would take place the following day to see the two patients on whom I would operate together with Kirill. Both cases were interesting and challenging, the first one being a complex post-traumatic saddle nose in a former boxer, and the second a complex secondary in a young girl.

When lectures ended around 6:30 PM, the time came for a riverboat cruise. Together with Kirill and five lecturers, we were driven to the Moscow River Embarkadero close to the magnificent Radisson hotel. We had time to visit the famous Hotel Hall and the incredible miniature Moscow diorama display model, created by 300 workers (!) for the 60th anniversary of the Bolshevik revolution before we boarded our boat. This 2½ hour long night cruise included a superb dinner and gave me a wonderful unobstructed view of many of Moscow's sites from our privileged closed deck.



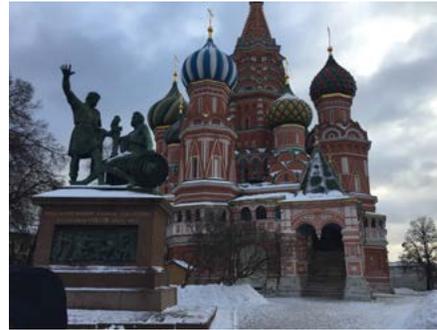
continued on page 18

VPP - Robotti continued

The following day was devoted to surgery, and everything went very smoothly. The operating facilities were superb and the personnel excellent, including OR nurses, anesthesia and my assistant. It is not always easy to operate abroad without the usual setting and the usual people to help, but I felt at ease after the first ten minutes. Connection to the lecture hall worked very well with bright and challenging moderation and a lot of questions. My case took about six hours. I guess it I would have taken five hours at home, but there was more teaching and discussion involved and I had to use rib for reconstruction. In the meanwhile, Kirill had made good progress on the second case (also taking rib) in the neighboring room, and I joined him, after finishing mine, so as to end together. We then were driven for the short ride to the lecture hall, where there was a “round up” discussion and more final questions. I was again impressed at the attentiveness of the audience and the number of people still remaining late in the evening.

At this point, the day came to an end in the best possible way: dinner with Kirill, his enchanting wife Julia and his younger daughter Angelina at the Pushkin restaurant – one of the most famous in Moscow. It is housed in a 19th century mansion that seems to come right out of the pages of a Tolstoy novel and its fame is deserved, as that dinner was indeed memorable.

On the following day, Sunday January 21, I was picked up at the hotel and went with Kirill to check on our patients who both did well. I was then privileged to take a short tour with Kirill and his wife of the Red Square, full of holiday decorations



and where a skating rink full of skaters was set up surrounded by a Christmas market, and of St. Basil's Cathedral, with its unique architecture and bountiful treasures of ancient icons. This is something I promised

myself I should come back to visit again at some point.

After a superb coffee and dessert at the famous neighboring GUM department store, and after receiving a dedicated copy of Kirill's two-volume tome on plastic surgery (in Russian, but at least I can look at the photos!) I said a final farewell to my hosts and was driven to Sheremetyevo airport.

My comments on this second VPP that I had the privilege of doing for ISAPS could not be more positive: I had a wonderful host, a wonderfully challenging time and the organization worked like a Swiss clock. The days were educational for me as well as for the audience, and the modern and vibrant city, wonderfully adorned with Christmas lights, was a discovery I would have never imagined! Thank you, Kirill. 

## ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)  
 Asociación Española de Cirugía Estética Plástica (AECEP)  
 Association of Plastic and Reconstructive Surgeons of Southern Africa (APRSSA)  
 Associazione Italiana di Chirurgia Plastica Estetica (AICPE)  
 Australasian Society of Aesthetic Plastic Surgery (ASAPS)  
 British Association of Aesthetic Plastic Surgeons (BAAPS)  
 Canadian Society for Aesthetic Plastic Surgery (CSAPS)  
 Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)  
 Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)  
 European Association of Societies of Aesthetic Plastic Surgery (EASAPS)  
 Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)  
 International Society of Aesthetic Plastic Surgery (ISAPS)  
 Indian Association of Aesthetic Plastic Surgeons (IAAPS)  
 Iranian Society of Plastic and Aesthetic Surgeons (ISPASA)  
 Japan Society of Aesthetic Plastic Surgery (JSAPS)  
 Korean Society of Aesthetic Plastic Surgery (KSAPS)  
 Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)  
 Oriental Society of Aesthetic Plastic Surgery (OSAPS)  
 Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)  
 Romanian Aesthetic Surgery Society (RASS)  
 Royal Belgian Society for Plastic Surgery (RBSPPS)

Schweizerische Gesellschaft für Aesthetische Chirurgie (SGAC)  
 Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)  
 Singapore Association of Plastic Surgeons (SAPS)  
 Sociedad Argentina de Cirugia Plastica Estetica y Reparadora (SACPER)  
 Sociedad Boliviana de Cirugia Plastica Estetica y Reparadora (SBCEPER)  
 Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)  
 Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)  
 Sociedad Dominicana de Cirugia Plastica Reconstructiva y Estética (SODOCIPRE)  
 Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)  
 Sociedad Peruana de Cirugía Plástica (SPCP)  
 Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPEP)  
 Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)  
 Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)  
 Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)  
 Society of Plastic Surgery Azerbaijan (SPSA)  
 Suomen Esteettiset Plastiikkakirurgit r.y. (SEP) - Finland  
 Svensk Förening för Estetisk Plastikkirurgi (SFEP)  
 Turkish Society of Aesthetic Plastic Surgery (TSAPS)  
 United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)  
 Vereinigung der Deutschen Aesthetisch Plastischen Chirurgen (VDAPC)

# NATIONAL SECRETARIES



**Peter Scott, MD – South Africa**

## MESSAGE FROM THE CHAIR OF NATIONAL SECRETARIES

We start the year with many new faces in our group of National and Assistant National Secretaries. I would like to thank the majority of you who were able to attend the National Secretaries' meeting in Kyoto and hope that we will have as big a turnout at the Miami Congress in two years' time.

Our enthusiastic National Secretaries have been busy at work recruiting new members and in particular Mexico has 15 new members and Russia 12. In previous months Brazil, Egypt and UAE have recruited many new members. Ivar van Heijningen, the Assistant Chair of National Secretaries and Chair of the Membership Committee, and I would like to encourage you to continue this trend.

Our new Education Council Chairs, Vakis Kontoes and Ozan Sozer, have scheduled many excellent programmes that have been circulated to your members and are available on the ISAPS website.

I attended the ABAM meeting in Park City, Utah in February and hosted an informal lunch for those National Secretaries who were present. We will have a more formal gathering during the ASAPS meeting in San Diego in April.

The only election that has been held since Kyoto was in Mexico. Arturo Ramirez-Montanana has been elected to the ISAPS Board of Directors as Parliamentarian and as a result we held elections for a new NS and ANS. We welcome Bertha Torres Gomez to the role on NS and Gustavo Jimenez Munoz Ledo to the position of ANS.

In the coming year, we will be holding elections in Cyprus, Norway and the United States as these NS terms are coming to an end. We thank Drs. Demetriou, Amland and Jewell for their valuable service over the last eight years. We will also be looking at new elections in Slovenia, Uruguay and Venezuela where the current NSs are coming to the end of their first terms. Panama and Dominican Republic also need to have elections this year especially as the Panamanian Society is in the process of adding all of their members to ISAPS through our fast track process.

We have three new countries, each with a single member: Albania, Guadeloupe and Libya and we encourage adjacent countries to include them in their activities.

Finally, it is survey time again. We need all our NSs to encourage surgeons in their country to answer the survey. We need enough members participating to make this survey statistically significant. Please work with us and with your members to make this the best response ever.

As I have stated before, you as our NSs and ANSs are our eyes and ears on the ground in your respective countries and we rely on you to give us feedback on potential applicants and courses that may be offered. 

## CHECK YOUR ADDRESS ON THE ISAPS WEBSITE



Have you looked at your listing on our website lately?

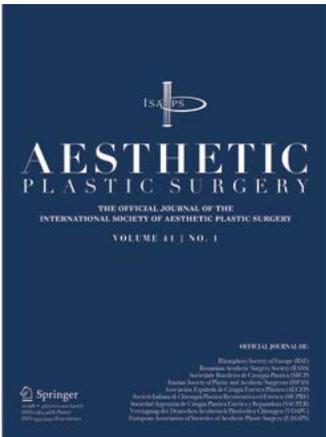
Patients will find you if your contact information is correct. Be sure the email, telephone and address are up to date. If you have not added your practice website link to your [isaps.org](http://isaps.org) profile, you can do that when you pay your dues. To update your information, send an email to [Membership@isaps.org](mailto:Membership@isaps.org)

# JOURNAL UPDATE



**Bahman Guyuron, MD – United States**  
Editor-in-Chief, *Aesthetic Plastic Surgery*

I am delighted to report that we have made significant progress with the journal. As you will notice, the cover design has been changed radically. Additionally, I am happy to report that we are going to be seeing steady improvement in the quality of the articles very soon. We have noted an increase in the number of submissions and I am deeply grateful to all of you who have been submitting articles. You will also note that the sections have been rearranged.



I want to emphasize again for those of you whose native language is not English, there are services available through Springer that can actually improve your articles before you submit them. Please note, however, that this service is not available after the article has been accepted. This helps the reviewers and me to focus on improving the scientific content of your article.

One of my most important missions is to reestablish the proper identity of this publication as a pure aesthetic journal. To that end, articles that are primarily reconstructive will be transferred to other journals within the Springer system that are more focused on the reconstructive aspect of plastic surgery. During this transition period, you may see some reconstructive articles that had been in the review process before I accepted the position of Editor. However, from here on, the articles that will be considered for review are those that will have a largely aesthetic focus, if they are not purely aesthetic.

I have been closely watching the review process to assure that articles move along as expeditiously as possible. When I look for a reviewer on our existing list, the Editorial Manager system allows me to see how many articles were assigned to a reviewer I am considering, how fast he or she reviewed them, how often he or she was uninvited because of a delay, what percentage of

the articles were suggested to be accepted and what percentage were denied. Thus, the reviewer selection process is a science and evidence-based. I choose reviewers who are fair and who respond with both alacrity and celerity.

I value the time and effort of those who review articles for the journal very much. If you are interested in being a reviewer for the journal, please send me an e-mail stating your area of expertise and the type of articles that you would like to review and I will add you to the reviewer list. [bguyuron@guyuron.com](mailto:bguyuron@guyuron.com)

Having written articles for 40 years, I am keenly aware of the time and effort that is spent for each article: conducting the study, writing the manuscript, preparing the illustrations and selecting the photographs. For that reason, no article is taken lightly or dismissed without thorough and due consideration. For articles that have significant scientific merit, but do not meet the journal's criteria for publication, rather than rejecting the article, we will make every effort to help the author revise and edit sufficiently to make it publishable and render the efforts of the author worthwhile.

I am available at any time and if I do not answer your emails or inquiries within 24 or 48 hours, it means that I am traveling without access to the internet.

You will note that the editorial board has been revised since the former board had been in place for many years. Our sincere gratitude goes to those who have been serving loyally on the editorial board of this journal for such a long time.

Finally, I am pleased to welcome three national societies who have recently affiliated with *Aesthetic Plastic Surgery* as their official journal. 

## New Affiliated Societies

- Australasian Society of Aesthetic Plastic Surgeons (ASAPS)
- Rhinoplasty Society of Europe (RSE)
- Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)
- Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)

# MARKETING



**Julie Guest – United States**  
ISAPS Chief Marketing Officer  
CEO, Premier Physician Marketing

## GROW YOUR AESTHETIC PRACTICE IN 2017 BY USING THE 80/20 RULE

How often have you said to yourself, “This is the year I’m really going to grow my practice!” – and before you know it the year has flown by and your revenue ends up being about the same as the year before?

This year can be a break-through year for you and the fastest way to ensure that is by employing the Pareto Principle, also known as the 80/20 rule, in your practice.

The 80/20 rule was discovered by its Italian inventor as a universal axiom that governs inputs and outputs. While it isn’t always an exact 80/20 ratio, this imbalance is often seen in various business cases such as:

- 20% of a company’s sales reps generate 80% of total sales.
- 20% of clients account for 80% of total profits.
- 20% of the most reported software bugs cause 80% of software crashes.
- 20% of patients account for 80% of healthcare spending (and 5% of patients account for a full 50% of all expenditures!)

On a more personal note, for example, how many amazing suits do you own, but 80% of the time you reach for your 1 or 2 favorites? At last count, I own over 50 pairs of shoes, but I reach for the same 5 pairs with alarming regularity! So how can you grow your practice this year by employing the 80/20 rule?

- 1) Find out who are your top 20% of patients (those who generate the most revenue for you). It’s highly likely that 20% of your patients generate around 80% of your practice revenue. If you want to grow your practice, identify who

these patients are, get to know them, their habits, likes and dislikes, and then find out how you can attract more patients just like them.

- 2) Once you’ve identified your top 20% of patients, brainstorm with your staff about how you can take better care of them such as scheduling special events. They are already your most loyal patients – and many would be willing to invest more money with you if you were to offer them the opportunity.
- 3) Find out who are your top referrers. Again, it’s likely that 20% of patients who refer friends and family do so repeatedly and account for 80% of your referral rate. Take better care of this group of patients and it’s a simple way to double your rate of referrals.
- 4) Take an audit of your marketing. Which 20% of your marketing tools are generating 80% of your leads? In any practice, there are usually 2 to 3 key ways that new business is generated, dwarfing all others. Find out what these are and then expand these campaigns. For example, if you’re getting the majority of your patients from Facebook, referrals and doing a radio show, then double your Facebook advertising budget, see point 3 above about taking care of your champion referrers, and offer to do another radio show for the same station on a different subject to double your airtime.

2017 has only just started! Forget any New Year’s resolutions that you might not have kept, and resolve to make this year your most profitable one ever! 

**ISAPS News** has moved to quarterly publication. We ask that submissions for each issue follow the copy deadline schedule and invite readers to send articles to the Managing Editor at this address: [ISAPS@isaps.org](mailto:ISAPS@isaps.org)

Kindly include all graphics and photos as attached high resolution JPG files, not photos imbedded in the email, and be sure to send head shots of all authors.

### ISSUE

June  
September  
December

### COPY DEADLINE

April 15  
July 15  
October 15



**Ahmed Ali Hassan, MD - Egypt**  
Professor of Plastic Surgery, Ain Shams University, Cairo

### Global Perspectives: Egypt Contouring of the Gluteal Region in Women: Enhancement and Augmentation

#### MIDDLE EAST



**EGYPT**

The shape of the gluteal region is an important aspect of the concept of physical beauty, occupying a major place in the ideal physique recognized by most cultures. What makes the buttocks beautiful? The answer to this question was the field of many anatomic, morphologic, and anthropometric studies. The norms

of beauty for the gluteal region have changed over the last decade. Women seek an aesthetic look with well-defined curves for the buttocks and breast relative to the waist and thighs. The beauty of the buttocks includes visual and tactile parameters. Visual aesthetics include a well-projected gluteal region with a uniform line that on front view makes a natural curve from the waist to the knee. Tactile aesthetic includes softness of the buttocks' mass with good skin elasticity.

Liposuction has emerged as the most popular body contouring technique. Liposuction was successfully applied to the flanks and back, and the surrounding aesthetic units of the gluteal region. The success of these interventions in improving buttock contouring quickly led to its adoption as the primary form of contouring this region. The shape of the gluteal region is enhanced by liposculpture of the excess fat within and around its aesthetic units. Increasing reports of success with autologous fat transfer techniques and the popularity of liposuction led to the adoption of aesthetic gluteal contouring with fat injections. While liposuction enhances the shape of the gluteal region, lipoinjection improves the lateral projection.

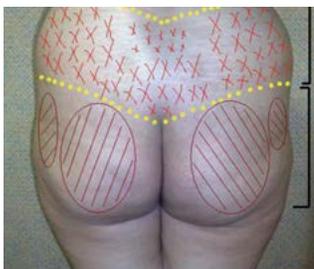


Figure 1 - The marked areas for liposuction located at the lower back, flanks, and supragluteal region. The lipoaspirate is injected into the buttocks proper.

The philosophy of this work is to enhance the buttock by liposuction of the buttocks' fat at the lower back, posterior flanks, and trochantric areas, while augmenting the size and projection by lipoinjection. Liposuction of the fat deposits at the central lower back enhances the sacral triangle.

Furthermore, removal of excess fat at the lower trunk enhances the appearance of supragluteal lines with a natural transition from lower back to buttocks.

The problem of contouring of the buttocks among slim women is the lack of donor fat for injection. However, these women usually need lower amount of fat with obvious results.

In conclusion, the aesthetics of the gluteal region include the shape, volume, and projection. The shape of the buttocks could be enhanced by liposuction of excess fat around the buttocks. The volume and projection can be achieved by lipoinjection. In most of women seeking for gluteal contouring, the surgeon needs to perform both suction and augmentation.

ISAPS NEWS



Figure 2 - (A and B) preoperative, (C and D) one year post liposuction of around buttocks' fat and fat injection (500 cc to each side).



Figure 3 - (A and B) preoperative, (C and D) three months post liposuction of around buttocks' fat and fat injection (550 cc to each side).



Figure 4 - (A and B) preoperative, (C and D) one year post liposuction of around buttocks' fat and fat injection (350 cc to each side).



**Ozan Sozer, MD – United States**  
ISAPS Education Council Vice-Chair

## Global Perspectives: United States

### N. AMERICA



### UNITED STATES

According to the 2015 statistics of the American Society for Aesthetic Plastic Surgery (ASAPS), gluteal augmentation ranked at number sixteen with a 20.7% increase compared to 2014. Buttock lift ranked at number twenty-two with a 32.3% increase compared to the previous year. When I look at my own practice,

I see that almost 70 % of the liposuctions I perform receive fat grafting to the buttocks and 50 % of the abdominoplasties have fat grafting to the buttocks. Looking at these numbers in my practice, breast augmentation is number one, liposuction is number two and fat grafting to the buttocks is number three. I certainly believe when we see the 2016 statistics we will see a big jump in buttock procedures.

With the increasing popularity comes the question of safety. There are multiple reports of sudden deaths throughout the world during fat grafting procedure. We have a task force led by Drs. Arturo Ramirez-Montanana, Mark Mofid and Constantino Mendietta investigating these fatalities and trying to make the procedure safer.

In my daily practice, I try to keep fat grafting to the buttocks as simple as possible. Certainly, the most important component of fat grafting to the buttocks is liposuction which usually gives 50% of the result. Shaping the upper portion of the buttocks and creating the waist line by suctioning the superficial and deep fat is crucial. The patient in Figure 1 did not have any fat grafting and clearly demonstrates the importance of liposuction.



Figure 1a, b - No fat grafting was done.

Although I have both Vaser® and Smartlipo in my office, I use the regular liposuction machine to obtain fat. I believe the quality of non-energy exposed fat is better quality for grafting. As far as processing the fat, I use a simple salad bowl and strainer from a department store, Figure 2. I wash the fat with saline if the aspirate is bloody.



Figure 2

I use a luer lock 60cc syringe and 2mm Coleman cannulas for injection. Years ago, I used to inject with an infuser, but I believe

I have better control and results when I inject with a hand-held syringe.



Figure 3

I always start injecting from the supine position. I believe this results in better contouring around the hips, Figure 3.

I usually inject around 400-700cc into each buttock. I do inject in a subcutaneous plane and if I get into the muscle, I make sure it is the superficial portion of the muscle. My stab incisions



Figure 4

Figure 5

continued on page 24

Global Perspectives - Sozer continued

are in the upper portion of the buttocks and if I inject through the infra-gluteal sulcus, I inject laterally never upwards. Patients can sit on their buttocks immediately after surgery. Results have been consistent with high patient satisfaction rate, Figures 4 and 5.

Regarding buttock implants, I have never been comfortable performing buttock augmentation with implants. I am aware of the fact that there are quite a few reputable plastic surgeons performing them with a great degree of success, but I did hear Dr. Constantino Mendieta during the recent ISAPS Congress in Japan admitting that he stopped using implants after so many years because he had to remove 35% of the implants he had placed. This encouraged my hesitation in using implants, at least for now.

For buttock lift and augmentation, I use the split gluteus maximus myocutaneous flap for auto-augmenting the buttock, Figures 6 and 7.

The technique is slightly more complicated compared to similar operations described. It does bring versatility that the other techniques do not offer. The incision can be placed anywhere the patient desires and does not violate the aesthetic unit of the buttocks, Figure 8 and can accommodate previous scars such as an extended abdominoplasty scar, Figure 9. It affectively brings tissue from the neighboring areas if there is significant deficiency in the buttock area, Figure 10.



Figure 6

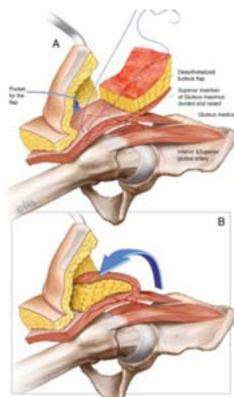


Figure 7



Figure 8



Figure 9



Figure 10

Reference  
 Sozer SO, MD and Erhan E, MD Chapter 567 Split Gluteal Muscle Flap Autoprosthesis Buttock Augmentation, Grab's Encyclopedia of Flaps



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## Global Perspectives: United States

### A Comprehensive Approach to Gluteal Contouring Procedures

#### N. AMERICA



#### UNITED STATES

The gluteal region is an important aesthetic symbol of the body and represents a major component of sexual attraction. Buttocks descent and atrophy are common presenting complaints for patients seeking elective improvement of their body. Gluteal surgery has a recent history of technique evolution, with various reported methods and refinements, including autologous tissue and alloplastic materials. Gluteal rejuvenation must address both gluteal atrophy and ptosis. Gluteal implants can give a rounded and enhanced appearance to the buttocks while lifting in the form of excisional techniques can address the ptosis. We present our approach to improve gluteal aesthetics.

#### Surgical Procedures

According to the American Society for Aesthetic Plastic Surgery National Data Bank Statistics, there were over 12 million surgical and nonsurgical aesthetic procedures performed in the United States in 2015. There has also been an exponential increase in demand for gluteoplasty, with an increase in number by 32% for buttocks lift procedures.

Many patients are simply dissatisfied with their gluteal volume. The aging process can also result in gluteal atrophy and ptosis. Additionally, massive weight gain and subsequent loss cause ptotic skin and subcutaneous fat but also loss of volume. Procedures to fulfill these goals include gluteal fat injections, gluteal implants, gluteal lifting, and hybrid procedures.

#### • Autologous Options

##### ► Buttocks lift with pursestring gluteoplasty

Pursestring gluteoplasty addresses both the gluteal atrophy and ptosis seen with aging and weight loss. It is a form of central mound autologous gluteal augmentation. Preoperative markings begin by marking final scar location. Bimanual palpation defines the redundant tissue. The upper and lower incisions are marked and the central tissue within these marks is used for the pursestring gluteoplasty. The upper and lower incision lines as well

as the incision line surrounding the central mound are dissected through the fascia. The skin of the central mound is deepithelialized. Purse-string suture is placed in the superficial fascial system (SFS) of the central mound and tightened (Figure 1). A clinical result of pursestring gluteoplasty is shown (Figure 2).



Figure 1 - Preoperative posterior and oblique views of a 41-year-old female with buttock deflation and ptosis (above). Image obtained at 6 months follow up after pursestring gluteoplasty (below).

Figure 2 - Intraoperative view of the central oblique view of the central mound used for pursestring gluteoplasty. Dissection is carried down to fascia and the overlying skin is deepithelialized. The pursestring suture is placed and tied to achieve the desired projection.

##### ► Fat Grafting

Fat grafting of the buttocks is best suited for patients with excess trunk adiposity. Markings for suctioning and grafting are made. Fat grafting is performed with 60 ml syringes. The fat is prepared for grafting by using the REVOLVE™ system (LifeCell), and is injected into bilateral buttocks using a 4mm cannula attached to a 60ml syringe. The fat is placed in bilateral buttocks, in the subcutaneous layer and intramuscular, while withdrawing with the syringe, improving the contour of each (Figure 3). End point is firmness of the tissue.



Figure 3 - Intraoperative lateral view of the buttocks before and after injection of 700 ml of fat.

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Global Perspectives - Rammos continued

• *Alloplastic Options*

► Gluteal Implants

Gluteal implants provide the advantage of achieving a desired round shape through a concentrated projection, and increasing the projection in a more definitive way. The Gonzalez XYZ technique for buttock augmentation is utilized. A 7cm long thin ellipse is incised and the intervening skin is de-epithelialized. Dissection is continued at a 45-degree angle away from the incision until the gluteal fascia is reached. Dissection is continued supra-fascially over an area of 7cm in the shape of an inverted heart for proper muscle exposure. The gluteus maximus muscle is then incised over 5cm with a scalpel in the direction of the fibers. A blunt dissector is then introduced at the halfway depth of the gluteus muscle and dissection continued bluntly toward the superior muscle origin. The dissection then continues inferiorly maintaining an intramuscular pocket until an adequate pocket dimension is created. A “duck bill” dissector is then introduced into the pocket to break up the smaller muscle fibers. Using a lighted retractor, the pocket is inspected and verified to be completely intramuscular on all sides. A JP drain is placed in the pocket, brought out through the skin, and secured. The gluteal implants are then placed and unfurled in the intramuscular pocket. The muscle pocket with the fascia is closed with 0 PDS (Ethicon) with minimal tension. Quilting sutures are placed to reduce the supra-fascial dead space. A clinical result of gluteal implantation is shown (Figure 4).



Figure 4 - Preoperative posterior and oblique views of a 34-year-old female with buttock deflation (above). Image obtained at 5 months follow up after placement of gluteal implants (below).

• *“Hybrid Options” (Autologous with implants)*

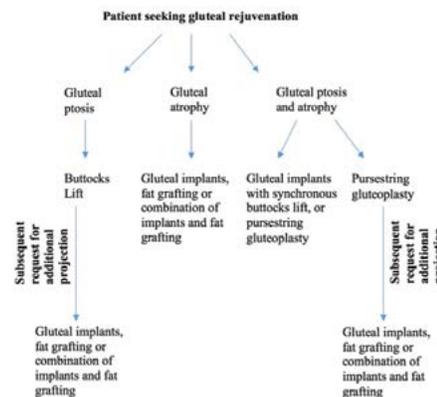
► Gluteal implants and fat grafting

In some cases, no single technique is sufficient to achieve the optimum result. Volumetric enhancement of the gluteal region may be achieved with synchronous placement of gluteal implants and fat grafting by combining the two techniques that were previously described. A clinical result of gluteal implantation with fat grafting is shown (Figure 5).



Figure 5 - Preoperative posterior and oblique views of a 37-year-old female with buttock deflation (above). Image obtained at 3 months follow up after placement of gluteal implants with synchronous fat grafting (below).

The gluteal region is a symbol of beauty. Atrophy and ptosis of this region over time can be addressed and improved with lifting and volume enhancing techniques. These techniques can be performed safely achieving patient satisfaction. A proposed algorithm, to assist with decision making, based on the gluteal deformity encountered, is shown in Table 1.



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



Rodrigo Rosique, MD, PhD – Brazil

## Global Perspectives: South America

### S. AMERICA



### BRAZIL

Over the last five years, gluteoplasty with fat graft has gained popularity all over the world, being among the fastest growing procedures according to ISAPS statistics.

Along with its widespread exposure by the general media, all kinds of situations have appeared in our offices, pushing us sometimes to educate patients about proper indications and sometimes to widen indications through the acquisition of some maneuvers to maintain high satisfaction rates.

#### 1. Appropriate Patient Selection

Almost every patient is eligible for gluteal fat graft, but excellent results depend on proper characteristics:

- First is the body's percentage of fat to lean tissue: when it is low (under 20%) patients don't have enough fat. If the fat percentage is high (above 30%), patients need to lose weight and increase the amount of muscle through exercise. Between 20 and 30%, excellent results can be achieved just with fat.
- Second is the amount of fat available, the BMI. If it is under 20 kg/m<sup>2</sup> there is not enough fat. If above 30 kg/m<sup>2</sup>, the patient has too much fat. Due to security in Brazil, by law, the liposuctioned volume is limited to 7% of the ideal weight. So, for a good result, the patient needs to lose weight. If the BMI is between 20 and 30, the excess fat can be safely removed and we can build an excellent result.
- Bodies are sculptured with fat hanging on a bony framework, so if it is too flat, it will not have the support to build curves, like in "banana" or "apple" body shapes. In these situations, patients' expectations should be prepared pre-operatively.
- Lastly, all this fat will be covered by skin, which should be in adequate amount and with good elasticity, otherwise combining a skin excision procedure like in MWL patients, is advisable.

#### 2. Ptosis

The length of infragluteal fold measures the degree of ptosis. The more lateral it goes, the more ptotic is the buttock.

Ramanadham and Rohrich showed that, in the face, there is a loss of volume letting the tissues sag down and toward the central line, producing jowls and marionette lines, which are signs of aging, but the treatment should not focus on this central and lower part, otherwise it would become even worse. On the other hand, volume should be restored toward the upper lateral regions to give a youthful appearance.

These same principles apply to ptotic buttocks. If the ptosis is mild to moderate, we can improve the appearance just restoring volume in this way (figure 1). If the ptosis degree is moderate to accentuated, like in the face, we need to associate pulling up the tissues with an excisional procedure.

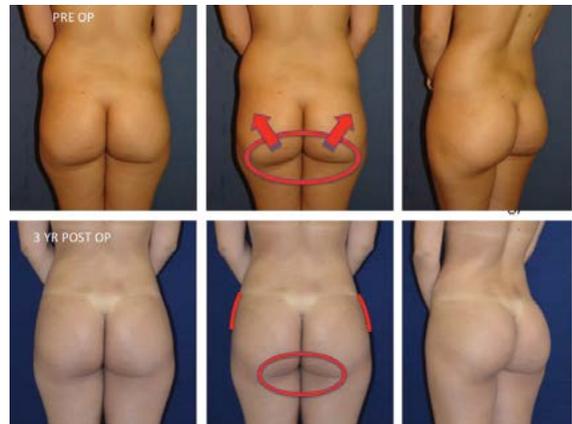


Figure 1 - 26 y. o. patient, BMI: 21.2 Kg/m<sup>2</sup>, was subjected to buttocks fat graft with 420cc each side. This case exemplifies how we can diminish the length of infragluteal fold and consequently buttocks ptosis degree by restoring volume toward the upper lateral regions, delivering a more youthful appearance.

#### 3. Fat Graft or Gluteal Implants?

Some patients can only get better results with prostheses, but for the majority, fat graft is much better.

A prosthesis, since it is placed inside the gluteus maximus muscle, gives volume mainly to the medial part leaving other areas empty. That's why prosthesis boundaries are sometimes visible with an unnatural look, even when placed inside the muscle. On the other hand, with fat you are not restricted to muscle anatomy and you can use it wherever it is needed, especially on lateral depressions.

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Global Perspectives - Rosique continued

Gluteal implants continue to be a good choice when there is no fat to harvest, like in low BMI and low fat % patients, or when there is not enough fat to receive all the grafted volume like in male patients or patients with scars that promoted fat resorption and fibrosis.

A multicenter review published in PRS involving experienced gluteal augmentation surgeons reported 38.1% of total complications with prostheses. On the other hand, a meta-analysis by Conde-Green and colleagues published in 2016 showed a 7% complication rate with fat graft. Interestingly, in our practice, patients are progressively avoiding the implant option. For example, patients with low BMI or low body fat percentage are classic candidates for prosthesis, but refuse it, preferring to be subjected to two rounds of fat graft to achieve the amount of volume desired. So, first we inject between 500 and 600cc in each buttock to diminish complications related to high volume graft (fat necrosis, higher resorption rate, infection, embolism) and after at least 6 months, we do a second round, achieving the result wanted and without implants (Figures 2 and 3).

4. Male Patients

The number of male patients seeking to improve their buttock appearance is increasing. In relation to female patients, males have thinner subcutaneous tissue, jeopardizing fat survival. One possible solution would be injecting mainly inside gluteal muscles, but this is clearly linked to a higher risk of fat embolism. A second solution would be to use prostheses, but most patients dislike the appearance judging it to be unnatural. A third solution, which we prefer in our practice, is to propose two stages: one round of fat graft to expand the subcutaneous compliance to accommodate more fat and a second round of fat graft, if it is needed.

5. Scars and fibrosis

In patients who present with skin scars, these are usually accompanied by subcutaneous fibrosis which prevents graft take. If the fibrosis is extensive, it is advisable to expand gluteal volume through implants, but if it is restricted to small areas, in order

to avoid unequal resorption and post-operative asymmetry, we prefer to intraoperatively release these subcutaneous fibroses with a sharp-edge cannula and graft the fat with a blunt cannula.

Buttocks fat grafting is a very versatile procedure that can treat a broad range of patients, but, to achieve good patient satisfaction, we have to outline the characteristics that promote or prevent an excellent result, work on proper solutions and make the patient aware of what the technique can deliver to them.



Figure 2 - 21 y. o. patient, low BMI, but refusing implants, was subjected to buttocks fat graft with 660cc each side in first round and 360cc each side in the second round. Superior line: pre-op. Inferior line: 1 year after first round and 6 months after second round. Note also how fat graft diminished her buttocks ptosis degree.



Figure 3 - 22 y. o. patient, low body fat percentage, but refusing implants, was subjected to buttocks fat graft with 500cc each side in first round and 540cc each side in the second round. Superior line: pre-op. Inferior line: 5 years after first round and 2 years after second round.

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**Moderator:** J. Peter Rubin, MD, FACS – United States  
**Discussants:** Arturo Ramirez-Montanana, MD – Mexico  
 Alfredo Hoyos Ariza, MD – Colombia  
 Constantino Mendieta, MD – United States

## Global Perspectives: Buttock Fat Grafting Roundtable Discussion by the Experts

### N. AMERICA



UNITED STATES

### N. AMERICA



MEXICO

### S. AMERICA



COLOMBIA

This special feature brings practical information to *ISAPS News* readers on a very timely topic. Convened by international conference call and moderated by J. Peter Rubin, MD, *ISAPS News* Editor, this round table discussion shares tips from ISAPS expert surgeons on fat grafting to the buttock with an emphasis on technique and safety. As with all expert panels, we advise our readers that the opinions expressed in this article are solely those of the expert discussants, and not the official position of ISAPS. Surgeons are advised to consider and evaluate the information presented here in the context of their own expertise, experience, and practice.

DR. RUBIN – I would like to welcome this distinguished panel of experts. We will be discussing approaches to buttock fat grafting, including patient selection, technique, and the very important issue of patient safety. Let's talk about our current methods in buttock fat grafting. We will start with Dr. RAMIREZ-MONTANANA. Can you describe your buttock fat grafting technique?

Dr. RAMIREZ-MONTANANA – I extract fat from wherever I can find it, usually abdomen and hips; I can use fat from the back. I don't see a big difference in results based on where I take the fat. I use a multi-holed, 4mm cannula with machine driven suction. Patients are under general anesthesia or spinal block. All of my procedures are outpatient.

DR. RUBIN – Tell us about your processing method and how you inject.

Dr. RAMIREZ-MONTANANA – I use sedimentation only. I use 20cc syringes with a 3.5mm or 4mm multi-holed cannula. This cannula has very good flow. I try to avoid any kind of restriction and I try to avoid the shear factor that causes a lot of damage to the cells.

DR. RUBIN – What anatomic layers do you graft in the buttock? Do you inject just into the subcutaneous tissue, or also muscle?

Dr. RAMIREZ-MONTANANA – Now that we have more data, I prefer to stay superficial. It is very difficult to know precisely where the tip of the cannula is at all times, but I prefer to stay subcutaneous. I sometimes need to apply some fat in the superficial part of the muscles, but I prefer to avoid the deepest part.

DR. RUBIN – What would you say is the average volume that you're going to put in each hemi-buttock?

Dr. RAMIREZ-MONTANANA – On average, it's about 400-500cc per side.

DR. RUBIN – Dr. HOYOS ARIZA, same question to you. Can you walk us through your buttock fat grafting technique?

Dr. HOYOS ARIZA – I use standard infiltration of wetting solution. I select patients that I know have donor sites with enough fat to provide the volume I need. I usually harvest from flanks, lateral thighs and inner thighs. In extraction, I use low-pressure. I use a VASER device that includes infiltration and suction capabilities, so I reduce the pressure of extraction to less than 15mm of mercury. I use a 6-hole cannula that is usually between 3 and 4mm in diameter. I believe also that extraction

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## Global Perspectives - Roundtable continued

has to be with smaller holes so the fat is already in small packets. I use a 3 liter canister that is part of a closed system. For processing, I always use the VASER fat, I process the fat for extraction with VASER before, so I always wash it. I always use antibiotics.

DR. RUBIN – When you say VASER, do you use VASER ultrasonic energy?

Dr. HOYOS ARIZA – Yes, I use VASER energy. I reduce the power to 60 to 70% in those areas; typically, in the lateral thighs I use 60% and in the flanks I use 70%.

DR. RUBIN – Why do you prefer to use VASER energy? Is it because of the effect on fat or because of the contour of the donor site?

Dr. HOYOS ARIZA – I think it's both. It actually helps with contouring, but I believe the retention also depends on the size of the packets of the cells. The less cells that we have in the bundle of fat, the more pliable it is, we see more retained over time. So usually what you have to get rid of is the fat that is not viable that is usually in the infranatant. I usually wash the fat for that reason. Usually, I decant the fat, but I will use centrifugation when I need smaller amounts of fat or want to specifically have more concentrated fat. For example, when filling a small depression in the gluteal area, I try to concentrate the fat more.

DR. RUBIN – What size syringes and cannulas do you use to inject?

Dr. HOYOS ARIZA – In the gluteal area, I mostly use 60cc syringes for the intramuscular regions, for instance the upper portion of the gluteal area. I use smaller 10cc syringes for subdermal fat grafting. I start with a 4mm cannula for the intramuscular layer, in the subcutaneous tissue 3mm cannulas and even much smaller (1.2 mm) cannulas as I graft subdermal. I designed a specific cannula that has a bulb tip. It has a single hole, but the edges of the cannula, specifically in the hole, are hidden, literally the metal is inverted so it doesn't create trauma. I believe that part of the safety of the procedure is to not hit a blood vessel with these holes specifically, so the smaller the number of holes that we have, the safer it is, and the design of the hole itself can impact safety during the procedure.

DR. RUBIN – What layers do you graft? You mentioned the muscle.

Dr. HOYOS ARIZA – Yes, I graft fat intramuscular. I use it in females in the gluteus maximus. I try to stay parallel to the table at the beginning, in the superficial muscular layer, and later progress more superficial. The whole idea is that I try to touch

the iliac bone and inject the fat during the retrograde motion so we avoid the oval foramen.

DR. RUBIN – I see we have different approaches here. You treat both the muscle and the subcutaneous layer.

Dr. HOYOS ARIZA – Yes, I treat the muscle differently as well. Specifically, in the female, I inject intramuscular with a larger cannula (4mm) the gluteus maximus area, and in males I also inject the gluteus medius that is above this. I follow the ridge of the bone in the male as well. Later, at the end, as I go more superficial in the subcutaneous layer, I use smaller cannulas (3.0) and smaller syringes. In the very superficial layers, I use 20cc syringes with the 2mm cannula, and, for the subdermal layer, I use 1.2mm cannulas with 10cc syringes.

DR. RUBIN – What would you say is the average volume you are putting into each hemi-buttock?

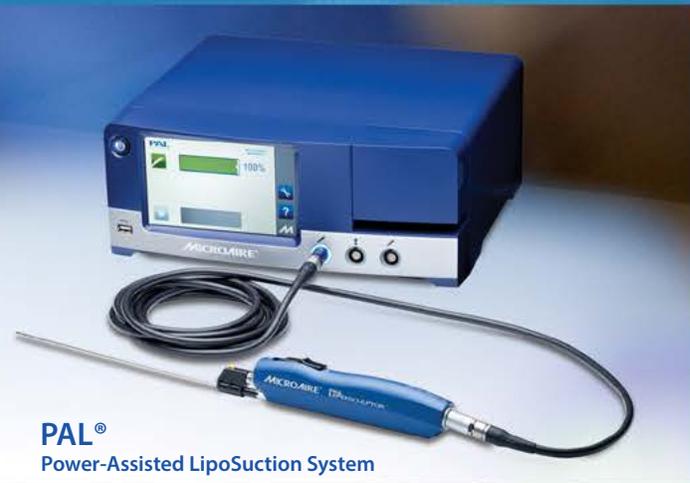
Dr. HOYOS ARIZA – I usually try and understand what the patient wants. If they just want lifting, I use between 250 and 300cc so it doesn't actually augment too much in the gluteal area. I usually graft between 300 and 800cc in each hemi-buttock when they want to have actual augmentation.

DR. RUBIN – Dr. MENDIETA, same question to you. Please walk us through your buttock fat grafting technique.

Dr. MENDIETA – We all know that there are three different processes during fat grafting: 1) harvesting, 2) collection and processing, and 3) how you're going to infiltrate the fat. My harvesting technique has not really changed over the years. I use a 5mm basket cannula with a reciprocating cannula from MicroAire. I collect the fat after infusing 4-5 liters into the body. In Florida, I am limited to a 4 liter extraction of supernatant fat. What has changed over the years for me, and I have tried a variety of methods, is the collection system and preparation. I used to prepare the fat by straining it, and that would get rid of a lot of the fluid, but it would also get rid of the small cells that would fall through the sieve of the strainer. As I progressed with my technique, I started using a different collection system by Wells Johnson which has a bottom port that allows me to extract the fluid from the aspirate, as the aspirate decants. I am therefore using a decanting technique for preparing the fat as opposed to a straining technique. The disadvantage of my decanting technique is that I retain more water in the fat that I am going to transfer, but I am keeping the smaller fat cells that I used to lose with my straining technique. The decanting method will have a false absorption rate of about 20% because that's just water in the transferred fat.

My retention rate of the grafted fat is about 50-60% of what's being injected, remembering that a lot of the retained water in

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## Global Perspectives - Roundtable continued

the graft is being absorbed. The other thing that has changed is that I use to use a 60cc syringe and 4 or 5mm cannulas, with single-holed tip, to inject into the intramuscular and subcutaneous layers. Simeon Wall and Dan Del Vecchio taught me how to use the MicroAire reciprocating cannula, 5mm basket, to reinject the fat. However, this does require a separate reinjection pump system to help inject the fat. That way the fat is not exposed to air, it's all in a closed system, and I am able to reinject much quicker. The re-injection process only takes me 10 minutes where it used to take me 30 minutes. I'm injecting into the mid-muscle, superficial muscle, and subcutaneous layers, but I stay parallel to the table. I don't angle the cannula downward because that is where you will hit the deeper muscle and the blood vessels, so my technique is staying parallel to the posterior leg so that I stay in the mid-muscle. I will use the 5mm basket cannula to inject. My average infiltrate is anywhere between 800 and 1500cc with my average being 1000cc.

DR. RUBIN – Per hemi-buttock?

Dr. MENDIETA – Per side, yes. Volumes of 2,000 to 2,500cc total, but per side it is 1,000 to 1,250cc. I've done over 3500 cases, and using the reciprocating cannula, I've done about 900 cases.

DR. RUBIN – Can you explain more about the reciprocating cannula and how you use it with the reinfusion system?

Dr. MENDIETA – There are actually two systems that are being used: one is the MicroAire reciprocating cannula that allows for the expansion vibration, which is what Simeon Wall and Dan Del Vecchio talk about, and the other is the pump system that allows me to pump the fat back through the reciprocating cannula, and that is made by Wells Johnson. (There are other systems coming onto the market soon.) It is those two different systems that are used together. They have revolutionized the way I do that procedure and it takes me about an hour and a half to do the entire case.

DR. RUBIN – This is interesting technology. What is the value of the reciprocating cannula during the injection phase? What is that device doing for you?

Dr. MENDIETA – There are two different things that it does. Through expansion and vibration, you are able to break up the fibrous tissues and loosen them up so that you can inject more fat and layer it better, and if you think about this system for a minute, in traditional syringe injections we are moving the hand back and forth performing a layering technique that Sydney Coleman taught us. If you add the vibrating cannula in addition to your hand movements, it doubles the speed and now you are laying fat even more finely. On the one hand, it expands the tissues to allow tightness to be loosened up, and on the other it

allows more fat to be injected and I believe in a more even spreading effect.

DR. RUBIN – What kind of cannula tip do you have on the end of the reciprocating cannula?

Dr. MENDIETA – A basket cannula. I use the exact same MicroAire cannula to aspirate as I do to inject, so no equipment gets changed.

DR. RUBIN – Let's talk next about post-op care and post-op regimen.

DR. RUBIN – Dr. RAMIREZ-MONTANANA, what's your post-op regimen for these patients? Do you keep them overnight? And then tell us how you manage activity and sitting.

Dr. RAMIREZ-MONTANANA – I handle all of them as an outpatient; they leave my clinic the same day. I use elastic garments and I don't allow them to lay down on the buttocks for one week.

DR. RUBIN – One week of no sitting or lying down?

Dr. RAMIREZ-MONTANANA – They can sit if they use the upper part of the thighs, but never directly on the buttocks.

DR. RUBIN – Dr. HOYOS ARIZA, same question to you. Tell us about your post-operative regimen.

Dr. HOYOS ARIZA – I start with a garment for these patients that is designed with low pressure in the buttocks, specifically. I usually have a restriction for a couple of weeks, especially sitting down on the area that has been fat grafted, so I usually tell patients to sit in a specific position.

Otherwise they have to use a special pillow, like an airplane pillow below the ischial bone. While in bed, the whole idea is to allow them to be in supine position by using two pillows, one above and the other one below the gluteal area. I usually ask them to start exercising in two weeks and ask them not to do specific exercises in the area where we did fat grafting for at least one month: squats, for instance).

DR. RUBIN – Dr. MENDIETA, what about your post-op regimen?

Dr. MENDIETA – I have them wear a garment for about three to four weeks, and after that it's just for comfort. In terms of sitting and sleeping, I have them sleep on their stomach, and whenever they sit, I have them use a pillow that goes under the back of the hamstrings. That raises the buttocks up so there is no pressure. I use two months, but as I listen to Dr. RAMIREZ-MONTANANA and Dr. HOYOS ARIZA, as well as some others, I might start to change that to three or four weeks. Right

now, I'm doing two months of no sitting and no sleeping on the buttock. They are allowed to sit using that pillow technique immediately.

DR. RUBIN – Are you OK with the patient reclining?

Dr. MENDIETA – No, I'd rather have them not recline because that will put pressure on the buttock. I want them to sit on the pillow, the pillow goes on the hamstring and they lean forward a little, so there is no pressure on the buttock whatsoever.

DR. RUBIN – Let's talk about safety. What complications do you discuss with your patients during the informed consent process?

Dr. MENDIETA – I tell everybody that there is always risk of infection. I tell everybody there is a risk of developing cellulite, which is pretty rare, or developing striae or stretchmarks, which is also pretty rare, that absorption is unpredictable and that I usually get about a 50-60% survival of the fat that I'm injecting. I've had just about every complication that you can think of, and one of the important things that people need to be aware of with fat grafting is the presentation of a *Mycobacterium* infection that occurs anywhere between three and four weeks and as late as three months after the procedure. You have to send cultures out specifically for *Mycobacterium* and if they're positive, you've got to make sure that you ask them to check sensitivities. These tests can take four to six weeks to come back. I've encountered several *Mycobacterium* infections.

DR. RUBIN – Dr. MENDIETA, what about major risks, such as hematoma, thromboembolic events, fat embolism, and other life-threatening events?

Dr. MENDIETA – I will have a discussion about possible embolisms to the lung. I've done over 3500 procedures, and thankfully haven't had a fat embolism. I do use pneumatic stocking compression during surgery, and careful fluid monitoring. Fat embolism is a big issue now and there is even a task force created by the American Society for Aesthetic Plastic Surgery (ASAPS) through ASERF to study this complication. One of the things that I'm doing is trying to avoid going deep in the muscle, and I do that by staying parallel to the leg when I'm injecting. If I'm injecting in the medial upper quadrant, I angle the cannula upwards so I'm not near the vessels at all.

DR. RUBIN – Dr. HOYOS ARIZA, tell us how you counsel patients during the informed consent. What risks and what complications do you discuss?

Dr. HOYOS ARIZA – We have a very complete informed consent that usually includes emboli, trauma embolism, pulmonary embolism, death, and usually infection that has the

risk of creating an abscess. In terms of what we have seen, fortunately, we haven't seen fat embolism. For the most part, I agree with Dr. MENDIETA, and the thing we fear most is infection.

DR. RUBIN – Dr. MENDIETA mentioned *Mycobacterium*. Has that been a concern for you as well?

Dr. HOYOS ARIZA – We haven't seen any *Mycobacterium* in particular yet. We do have in our protocol to watch carefully for the early signs of infection. The main early indicator of an infection is unilateral pain alone, followed by the development of heat in the area and redness. An important indicator that it is becoming systemic is when the patient has a fever. When we have a patient with a fever after fat grafting, we treat them in the hospital. We also now use C-reactive protein and procalcitonin as indicators of a systemic infection.

DR. RUBIN – Dr. RAMIREZ-MONTANANA, what complications do you discuss with your patients during informed consent?

Dr. RAMIREZ-MONTANANA – We discuss the possibility that patients can have complications in the donor area, including irregularities. If we are talking about the recipient area, we discuss minor complications of irregularities and asymmetry, but the main complication that we have to avoid is any kind of embolism. That means, if we inject fat directly into the vessels, we can have problems. As Dr. MENDIETA said, we need to avoid big vessels, especially the big veins. We are working as part of the ASAPS task force. We need to have more data, but we believe that if we hit the vessel with the cannula we can have problems. That's why we recommend not using a small cannula, such as a 1 or 2mm cannula, when injecting fat into the buttocks. It's a different situation than when injecting the face. This is the worst complication we can have.

DR. RUBIN – Have you ever had fat embolism?

Dr. RAMIREZ-MONTANANA – Not yet! I cannot say I will never have that complication, but there are reports everywhere in Mexico, Colombia, Brazil, and Miami as reported on the news. We have to be very careful about that because we don't have enough data to say what happened precisely. We will see if Dr. MENDIETA agrees with me.

DR. RUBIN – We've been hearing a lot about deaths from buttock fat grafting. Dr. MENDIETA, why do people die from buttock augmentation?

Dr. MENDIETA – Well, I think the number one cause of that is fat embolism. We're just starting to carefully study the phenomenon. There is going to be a paper published in the

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## Global Perspectives - Roundtable continued

*Aesthetic Surgery Journal* by the ASERF task force, but the study has some limitations because it's a survey/retrospective type of study and there are a few elements that are still missing, but the bottom line is that we've found it to occur at a very high incidence.

DR. RUBIN – What do we know about fat embolism syndrome?

Dr. MENDIETA – There are two variants of fat embolism. The first is fat embolism syndrome probably caused by the lipids from the fat graft that get into the intravascular system, at the microscopic level, and irritate the lung to give an ARDS-type clinical picture. People are usually able to survive this syndrome, as opposed to having macro fat embolism where you actually have fat cells being aberrantly injected into the vessels and lodging in the pulmonary vasculature to create a deadly event. We think the incidence of death from fat embolism can be as high as 1 in 3,000. Dr. RAMIREZ-MONTANANA, is that figure correct?

Dr. RAMIREZ-MONTANANA – Yes, correct.

Dr. MENDIETA – We still don't know what the true number is, but it's definitely piqued our interest. I think you're going to see a lot more studies and this is very necessary.

DR. RUBIN – Dr. RAMIREZ-MONTANANA and Dr. HOYOS ARIZA, Dr. MENDIETA told us that the reason patients die from fat augmentation of the buttocks is fat embolism. Do you agree with that?

Dr. RAMIREZ-MONTANANA – Yes, 100%. We know that all of those events happen during the surgery. We're not talking about death two or three days after surgery, or even five hours after surgery. At least in my country, all of the fatal events occurred during the surgery at the time when the surgeon was performing the injection.

Dr. HOYOS ARIZA – I agree that what we consider fat embolism is a direct cannulation of a blood vessel, that is essentially a vein, and then it goes to the inferior vena cava and into the right ventricle and the lungs. This creates a catastrophic event that leads to death. I think the main point here is that it can be prevented by using safety measures such as attention to anatomical landmarks, selection of larger and specifically designed cannulas for the deep injection as I mentioned earlier, and especially avoiding excessive positive pressure because I think the positive pressure can actually increase the incidence of death. When we consider that fat embolism is an event that can even be created by liposuction itself, the mechanism goes beyond fat grating. What we have seen, especially in animal studies, is that every single patient undergoing liposuction has a little bit of fat emboli in the lungs. I think fat embolism is something that can happen easily and we need to be very aware of it and exercise caution.

DR. RUBIN – Dr. MENDIETA, how do you recognize fat embolism syndrome in the setting of augmentation? What should surgeons be looking for?

Dr. MENDIETA – I don't think you can differentiate the syndrome from the macro embolism other than during autopsy.

DR. RUBIN – What are the signs of fat embolism or fat embolism syndrome in the OR, and what should be the first line of treatment for those patients?

Dr. MENDIETA – I think the first thing you'll notice is an immediate desaturation, followed by potential hypotension and eventually cardiac arrhythmia. Acute desaturation can occur during the procedure, during transfer to the recovery room, or in the recovery room. I don't think you're going to see a lot of petechiae necessarily, but it's something you'd always look for. I think the biggest signs are shortness of breath and desaturation. In terms of how to treat it, people talk about alcohol drips, but we don't know how effective those are going to be. It's really more of a symptomatic treatment, so it's oxygen and supportive therapy. The use of steroids, perhaps, to try and decrease inflammation in the lungs, and monitoring fluid status, are common measures. The mainstay is really supportive care with oxygen, realizing that more than likely the patient will end up getting intubated and are going through a rough course if the injury is severe.

DR. RUBIN – It sounds like you need to get those patients to a higher level of care very quickly.

Dr. MENDIETA – Yes, there is no question. If it's a severe case, you'll see them desaturate and decompensate very, very quickly. As Dr. RAMIREZ-MONTANANA was saying, it's often observed on the table or in the recovery room. Those that are more mild will just have a difficult time oxygenating while maintaining their saturations in the low 90's or high 80's. These are patients that you do want to recognize and make sure you transfer to the hospital and observe because they tend to progress over the next day or two to more hypoxemia and more desaturation as the lungs start to react to whatever insult may have occurred. Remember that the two clinical variants are a catastrophic embolism where you have a sudden death right away, and the other is more of an indolent desaturation that tends to keep progressing to where intubation is required. While there are many people who survive this indolent form, it can also lead to death in severe cases.

DR. RUBIN – Dr. HOYOS ARIZA, anything to add?

Dr. HOYOS ARIZA – We need to recognize the symptoms and we also need to improve our skills in how to treat it. The literature talks about alcohol infusion and that it works, but most surgeons

do not know how to use it. We need better training. I think we need to design an algorithm for how to specifically diagnose and treat it. I believe the main point right now is that it needs to be treated at a higher level. Once we suspect it, we have to stabilize the patient and transfer to the appropriate center.

DR. RUBIN – Dr. RAMIREZ-MONTANANA, we are eager to hear your comments.

Dr. RAMIREZ-MONTANANA – As Dr. HOYOS ARIZA said, we are talking about two different kinds of complication; one is a pulmonary irritation syndrome that can also be caused by liposuction and on the other hand, we are talking about macro fat embolism, meaning the fat gets into the veins and goes directly to the right side of the heart and then into the lungs. Those are two different pathologies with two different kinds of treatment. If you already have macro fat embolism, there are no reports to show how to effectively treat the patient because all of those patients, as I know, arrest immediately. This is the problem with fat tissue in the blood vessels. It is very important to understand why Dr. HOYOS ARIZA and Dr. MENDIETA, and other experts, recommend a specific, larger size of cannula, and a specific tip of the cannula, with very low pressure at the time when you are applying fat. One important point is that you don't have to actually enter the vein with the cannula, you just need to lacerate the vein, because the veins in this area are very low-pressure veins and if you apply too much pressure when injecting fat, this differential of pressure between your syringe and the inner part of the vein can help move grafted fat into the vein. It's very important to avoid high pressure, avoid the larger vessels, and avoid small cannulas. As Dr. HOYOS ARIZA said, it's very important to keep in mind all of these factors.

DR. RUBIN – As we start to conclude this roundtable, the question that is on everyone's mind when we hear about deaths from buttock fat grafting is: What can we all do to decrease the risk of fat embolism in our practices when performing buttock fat grafting? I would like to ask all of you to summarize the specific technical maneuvers that you can use to avoid or minimize the risk of fat embolism. Dr. MENDIETA, let's start with you.

Dr. MENDIETA – One of the things that came out of the task force study was an appreciation for the role of cannula size. A thinner, smaller cannula has a higher incidence of puncturing and injuring vessels than a larger cannula. We were suggesting using cannulas that are larger than 3mm. We didn't address syringe sized or pressure, as that wasn't found anywhere in the literature. As Dr. RAMIREZ-MONTANANA was saying, there are two ways of getting the fat into the lung system; by direct cannulization and by accidental laceration of the vein with accompanied high-pressure to low-pressure transfer of fat into the venous system. The important factor is avoiding injection

where the vessels are the largest, which is near the piriformis, the deep muscle, and you avoid that by not angling the cannula downwards. You need to stay parallel to the leg and inject upwards. I am injecting into the middle and upper layers of the muscle. I angle the cannula slightly upwards or parallel to the table. Those are the techniques that I have used with a 5mm cannula, angling the cannula upwards or parallel to the leg, and when I get into the medial upper quadrant, I angle it upwards so that I'm in the superficial muscle and superficial subcutaneous tissues.

DR. RUBIN – Dr. MENDIETA, if people are just starting out doing buttock fat grafting, do you think it's safer to stay in the subcutaneous tissues?

Dr. MENDIETA – Well, I think you need to get familiar with the technique, so I think for safety reasons you could start there. The problem is that your retention rate is not going to be that good and you can't get that much fat into the subcutaneous tissue.

DR. RUBIN – Dr. HOYOS ARIZA, same question. Please summarize what you believe to be specific technical maneuvers that we can do to minimize the risk of fat embolism.

Dr. HOYOS ARIZA – I think we need to construct guidelines for that. The main one is the level of fat placement. If we are going intramuscular, we need to go with larger cannulas (5 or 4mm). I always insist on retrograde infiltration (injecting during cannula withdrawal), not creating high pressure, and not creating tenseness inside the muscle. I think the design of the cannula is important. We need to create less traumatic cannulas so even if we hit blood vessels they will not cause damage. The other part is the access where we are going to direct the injection so we usually use either intra on inner gluteal fold. I think for beginners I would say to access the inner gluteal fold, which has less risk. I believe we can create a protective effect if we have the patient a little hypotensive when we are going to start the fat grafting so the veins are less dilated. I usually ask the anesthesiologist to reduce the blood pressure five minutes before fat grafting. I think we need to warn surgeons about not using pumps for injection, especially intra muscularly, because we don't have control over the pressure we are injecting. I think positive pressure can create more risk than the cannula choice.

DR. RUBIN – Thank you. Before we go to Dr. RAMIREZ-MONTANANA, Dr. MENDIETA, any comments here? You mentioned earlier that you use a pump, correct?

Dr. MENDIETA – That's correct. I use a pump, but I go back and forth with the pump, so I'm not just injecting retrograde, I'm injecting both antegrade and retrograde, but it's at a fast pace.

Global Perspectives - Roundtable continued

DR. RUBIN – Dr. HOYOS ARIZA recommends not using a pump because of the pressure. So what is the key to staying safe with the pump?

Dr. MENDIETA – I think the pump actually exerts less pressure than the 60cc syringe because it’s a very constant pressure, whereas with a syringe, depending on whether you’re pushing through a fat globule that’s very large, you might end up exerting a lot more pressure. Syringe injection is not an even, constant pressure throughout the injection, but the pump tends to be more even and I think it’s less pressure. I’d say that Simeon Wall and Dan Del Vecchio would agree with that. Among all of us, we’ve got almost 3,000 cases performed with this pump system.

DR. RUBIN – Dr. RAMIREZ-MONTANANA, same question to you. Please summarize what you believe to be specific technical maneuvers that we can do to minimize the risk of fat embolism.

Dr. RAMIREZ-MONTANANA – As my colleagues said, the size of the cannula is very important, first and foremost, but it is also important to recognize that all the big vessels are in a very well-known anatomic area named the greater sciatic foramen. That includes everything around the sciatic nerve, including the superior gluteal veins, the inferior gluteal veins – all of those big veins surround the sciatic nerve. So every single time we are injecting fat we have to keep these anatomic areas in mind because it is a place where we can hit big veins. A big question is whether we can get fat embolism from injecting around superficial veins. We can draw on our experience from breast fat grafting, where veins are much smaller in the surgical zone. Based on personal communication with Dan Del Vecchio and Roger Khouri, who have performed thousands of cases of fat injection into the breast, they have not had one single case of fat embolism. Therefore, we believe that superficial veins are not sufficient to produce fat embolism. We believe very strongly,

and we still have to prove this, that we need to hit the big veins to produce serious complications. It is very important to avoid this anatomic danger area. Additionally, as Dr. MENDIETA said, the inclination of the cannula is very important, especially if we are using lateral approaches or the intra-gluteal approach. I recommend for beginners, as Dr. HOYOS ARIZA stated, using an inter-gluteal approach, generally speaking, which makes it more difficult to hit the vein. Dr. MENDIETA and Dr. Del Vecchio have thousands of cases using several approaches and they have a lot of experience and no fat embolism. For beginners, I believe it is important to follow the safety points carefully, and cannula inclination and the approach are very important.

DR. RUBIN – You said earlier that you like to stay in the subcutaneous plane when grafting.

Dr. RAMIREZ-MONTANANA – I believe that matters. I feel more comfortable applying fat in the subcutaneous layer. It’s almost impossible to know precisely where the tip of the cannula is, and I’m sure that in some cases I have unknowingly applied fat to the muscle. The big veins are in a specific part of the muscle so if we can avoid this area, we can still apply it to the muscle in a very safe way.

DR. RUBIN – We are at the end of our discussion time. *ISAPS News* is so privileged to have this wonderful panel of experts and I thank you so much for participating in this round table. I know that our readers will appreciate your insights on this very timely topic. 

**Disclosures:**  
*Dr. Hoyos Ariza is a trainer and lecturer for Valeant pharmaceuticals, the producer of VASER.*  
*Dr. Mendieta is a consultant for Wells Johnson*

**Global Perspectives - Future Theme**

June 2017	Mid-Face Rejuvenation	Deadline: April 15
September 2017	Blepharoplasty	Deadline: July 15

To contribute an article of 500-750 words, please forward it to [ISAPS@isaps.org](mailto:ISAPS@isaps.org) with the subject line: ISAPS NL Series. This should be a non-referenced opinion piece of several paragraphs giving your observations and perspectives on the topic. What do you do in your practice? What unique approaches do you use? What do you see your colleagues doing in your country or region? Photos are welcome, but must be high resolution JPG files and limited in number.

# COMMITTEE REPORTS



**Nina Naidu, MD – United States**

ISAPS Assistant National Secretary for the US

## ISAPS WOMEN SURGEONS INITIATIVE

We are pleased to announce the formation of ISAPS Women Surgeons, a committee dedicated to advocacy for women plastic surgeon members of ISAPS. Men surgeons who are members of ISAPS and Associate members of ISAPS are welcome to join us in this new initiative and participate in scheduled events.

ISAPS currently has 3435 members, of which 340 (10%) are women. Although this is a relatively small number, it includes many world-renowned surgeons who have contributed enormously to our field. As you may know, Dr. K. Guler Gursu was the first and only woman president of ISAPS from 2000-2002. Prior to this she served as the National Secretary for Turkey (1984-1992), Historian (1992-1995), 3rd Vice-President (1996-1997), and President-Elect (1997-2000). She continued to serve on the Board of Directors from 2002-2004 as Past President. Dr. Gursu's legacy also includes a long list of academic publications on the topic of craniofacial deformities.

In the spirit of Dr. Gursu's leadership, the goal of the committee is to empower women plastic surgeons at any stage in their careers to achieve their individual potential as plastic surgeons and leaders; to create an open dialogue with our men colleagues which fosters mutual respect and inclusion; and to provide networking and mentoring opportunities which can enhance our level of satisfaction with our careers.

At this time, we are actively planning our inaugural symposium to be held during the next ISAPS Congress in Miami in 2018, under the leadership of Dr. Renato Saltz. While the specific details are still to be determined, this symposium will explore the many and sometimes conflicting issues which women plastic surgeons face in both their work and personal life, and how we can resolve these more effectively. Possible topics for discussion include overcoming barriers to career success; pregnancy and the plastic surgeon; financial planning and retirement; and wellness and physician burnout.

We have been very encouraged by the enthusiasm for this project from both women and men surgeons in many of our member countries, and we hope that women plastic surgeons who are not yet members of ISAPS will be compelled to join us. We welcome any suggestions or feedback as we begin this very exciting new phase in the history of ISAPS.

For more information or to participate, please contact Dr. Nina Naidu at [drnaidu@naiduplasticsurgery.com](mailto:drnaidu@naiduplasticsurgery.com) 

Currently, the committee includes the following members:

Nina Naidu, MD – New York, NY, USA

Lina Triana, MD – Cali, Colombia

Maria Wiedner, MD – Bonn, Germany

Dana Jianu, MD – Bucharest, Romania

Violeta Skorobac, MD – Belgrade, Serbia

Fatema Al Subhi, MD – Riyadh, Saudi Arabia

### How to pay lower annual fees:

Complete the Global Survey and we will send you a discount code worth \$50 off your 2017 dues\* or you can request a free weblink for your practice in your ISAPS website profile - a \$100 value. Or, you can donate the \$50 to our Education Fund.

*\* If you already paid your dues, and you complete the refund request you will see when you complete the survey, we will refund \$50 to you.*



**Maria Wiedner, MD – Germany**  
Chair - Residents & Fellows Committee

## ISAPS RESIDENTS & FELLOWSHIP PROGRAM

As the new chair of the Residents and Fellows Program Committee, I am proud to introduce our international team and to report about our activities and plans for the future.

When I took over the responsibility for this committee last summer as a still young ISAPS member, I realized that not many residents or students knew anything about ISAPS and that they were not addressed by our society. On the other hand, I knew there was a huge demand for aesthetic education among our residents and students. They were looking for courses and fellowship programs all over the world as they are willing to travel - but not much was available.

As one of ISAPS' missions is aesthetic education worldwide, it became clear that we should become the number one society for the younger generation and to meet their demands.

To find out the different requirements worldwide for a fellowship, we asked our National Secretaries in 104 countries to gather any kind of information and to learn about and from existing programs. We received many interesting details showing that a variety of licenses may be necessary. In some countries, a medical license is enough while other countries require also medical language tests for hands-on training.

Another aspect for the team was to identify adequate teachers so that the fellow receives a high-level education in a special field of aesthetic surgery. The already existing successful ISAPS Visiting Professor Program was of great help. We also reviewed the Master Class lecturers at the ISAPS biennial meetings.

As a first step, we are going to implement the Visit the Expert program, which is designed for a short stay with the expert from one week up to three months. This program is offered by ISAPS members who accept plastic surgeons for short periods of training for an informal and more intimate fellowship in their practices and clinics or academic settings. The intention is to improve already existing knowledge in a special field of aesthetic surgery in a short period of time at designated ISAPS experts all over the world.

As a next step, the fellowship program is going to be improved with the experience of the Visit the Expert program. The fellowship program is designed for a longer stay from three months to two years. The intention is to get intensive training in a broader field of aesthetic surgery. This format is applicable for residents as part of their training and also for young plastic surgeons after board certification. We are currently looking into funding and financial aspects.

The structure of such a teaching program is entirely up to the expert and local host.

Finally, we plan to come up with a worldwide map of different locations for the Visit the Expert and fellowship program, with all the information necessary for application at one click.

If you are interested in hosting one of the programs in the future or if you are interested in participating in one of the programs in the future, please don't hesitate to contact my team and me. You are welcome to send me an email at: [maria.wiedner@malteser.org](mailto:maria.wiedner@malteser.org)

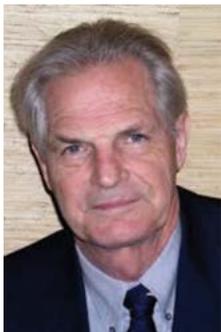


### Team members:

- Mehmet BAYRAMICLI, Turkey
- Georgios KOLIOS, Germany
- Vakis KONTOES, Greece
- Bianca OHANA, Brazil
- Peter D. SCOTT, South Africa
- Beryl Hui Hui TAN, Australia
- Bertha TORRES GOMEZ, Mexico

# HISTORY

## THE HISTORY OF HEAD REMODELING



Denys Montandon, MD - Switzerland



The Coneheads was a recurring sketch on *Saturday Night Live* (SNL) about a family of aliens with bald conical heads. It originated in 1977 and was later made into a movie. Dan

Aykroyd, its creator, said he developed the idea for the Coneheads at the sight of the Moai, the mysterious and ancient stone statues of Easter Island, which have similarly conical heads. In fact, the idea of modifying the shape of the head is very old and has been particularly developed in some populations for various reasons. Nowadays, modeling or remodeling an infant skull or parts of the face like an ear or a nostril without surgical intervention is not an uncommon therapeutic tool for a few specific deformations.

At birth, the shape of a newborn's skull is highly variable due to its inherent plasticity, intrauterine constraint, and the tortuous journey through the birth canal. Variations from the typical oval shape that usually results from the vaginal delivery process will generally return to normal in a relatively short period of time. Breech babies typically have a craniofacial shape resulting from their position in utero. They have characteristically a long, narrow head, with a prominent occipital shelf, redundant skin over the neck, overlapping lambdoidal sutures. After birth, restrictive or constrictive forces applied to a baby's head can result in more or less severe distortions. In children with positional head deformity (posterior plagiocephaly), the occiput is flattened with corresponding facial asymmetry. Positional head deformity produces more facial asymmetry than synostotic plagiocephaly, because of the forehead protruding on the side of the flattening. With early detection and intervention, most positional head deformities can be treated conservatively with physical therapy or a head orthosis ("helmet"). The skull undergoes 85 percent of its postnatal growth within the first year of life. The helmet alleviates the pressure on the flattened area of the occiput and allows the skull to grow faster in the desired directions.

Some facial anomalies may also benefit from an early remodeling. Corrections of infant ear deformities by various molding methods are used to shape the antihelix, the triangular fossa, the helical rim, and the overly prominent conchal-mastoid angle, with a good success rate when begun in the first week of the infant's life. A few malformations associated with facial clefts may also benefit from external or internal like devices to push back the premaxilla in order to alleviate the tension in very wide clefts or to remold the deformed nostrils. The recent methods of distraction osteogenesis of the maxillaries or the correction of scaphocephaly by spring expansion of the sagittal suture are other examples of progressive facial and skull remodeling. Of course, the most common facial corrections produced by conservative therapy are related to the orthodontic treatments that may sometimes enhance dramatic changes to the lower third of the face.

As said before, the idea and the custom to modify the shape of the babies' head and to enhance its beauty dates back to prehistoric times and seems to have been practiced on all continents. Early examples of intentional human cranial deformation predate written history and date back to 45,000 BC in Neanderthal



skulls from the Shanidar Cave in Iraq. The earliest known culture to bind their children's heads were the ancient Egyptians of the third millennium BC. King Tutankhamen had typically an elongated head. The earliest written record of cranial deformation dates to 400 BC in

Hippocrates' description of the Macrocephales. According to Hippocrates, the Macrocephales is a population, probably located around the Black Sea, who attached an idea of nobility in elongating their heads using bandages. He thought it could

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become hereditary: “As soon as a child is born, while his body is still supple and his head conserves its softness, it is molded with the hands and forced to elongate with bandages and suitable apparatus, that loosens its spherical form and makes it grow in length. Thanks to this custom, with time, this change of shape identifies so well with Nature that this art (molding the infant skull) became unnecessary.”

The geographer and historian Strabo (63 BC – 24 AD) mentioned that a Caucasian population called the Sigynni had the custom to elongate the heads of their children in such a way that “their foreheads were so prominent as to shadow their chin.”

During the Italian quattrocento, it was the practice in the House of Este in the 1400s to place restrictive ties known as “bandeau” at birth on the heads of the royal newborns. A portrait of a princess who underwent this process hangs in the Louvre Museum.



### Medical orthomorphosis

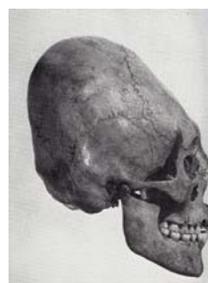
Since the 17th Century, doctors became interested in the making of beautiful children, giving advice to the parents as to how to handle their offspring.

In 1656, Claude Quillet, a French physician and cleric, wrote a long poem entitled *Callipedy* (from the Greek καλλός – beautiful / παιδι-child) or *the art to have beautiful children*. He gave advice as to how to raise them from birth with emphasis on nutrition and education, but did not give specific advice about the physical beauty. A century later, another French doctor, Nicolas Andry de Bois-Regard, wrote a book that is often considered the founding treatise of conservative orthopedic surgery, entitled *Orthopaedia or the art of correcting and preventing deformities in children*, orthopedics meaning the art of rectifying the children. It is a sort of homage to the grace and beauty of children; he wrote for example: “one must not neglect the body and let it become deformed, this would be against the intention of the Creator; this is the basic principle of orthopedics” and further “this book is aimed exclusively at fathers and mothers and all people bringing up children who must try to prevent and correct any deformed part of the child’s body”.

The purpose of Andry is to describe the organs in their “natural perfection” and teach how to maintain this state of perfection. He then proceeds in depicting deformities of the body and the face and how to rectify them. Although most corrections are aimed at the limbs and the spine, several deal with facial aesthetics. “When I speak about the ears, I do not mean to teach how to correct deafness, but how to behave to produce or conserve an ear, the external perfection that it should have, like being nicely flattened”. For him, a beautiful face can vary according to the standard of the cultural environment. The apparent flaws of a

body should never be considered as real flaws. “French people, for example, despise pug-noses and small eyes, that are praised by the Chinese”. He then proceeds in describing maneuvers to correct ears and noses. For well-flattened ears, one should use a tight bonnet from an early age and never let an earlobe escape from it. As for the flat and snub nose, considered a great deformity for the French people, it can be corrected by often bringing the two alae together with the fingers and to do it again and again every day. For the pug-nose, it is even more difficult: one should pass and re-pass with the fingers on the dorsum of the child’s nose, at every hour of the day, for several months. For the crooked nose, similar methods are advised. Most interesting is the chapter entitled *deformities of the head, in relation to the cranium*: “The head, to be well made in relation to the cranium, should be a little round, with a small forward and backward projection, and slightly flat on the sides. This is the natural figure; however, this figure might often be corrupted by the way children are handled. One should be careful with the bonnets and the bandages that we bind to the head. If these bonnets or bandages apply too much pressure on the sides, the head might elongate and look like these folks, which have been called *Macrocephales*, from the Greek word meaning long heads. If one tightens too much not only on the sides, but also in the front and in the back, it will elevate like a peak and look like the head of this known historical *Therside* whose head was a pyramid<sup>1</sup>.”

Since the beginning of the 19th century, doctors and anthropologists have been studying these intentional cranial deformations. In 1805, the Lewis and Clark expedition encountered the Chinook tribe at the mouth of the Columbia River. Infants of the tribal leaders were noted to have their heads constrained by wooden sticks and rope. These devices were placed soon after birth and kept in place for months or years to create a permanent cranial deformity that was interpreted as a mark of distinction. The most comprehensive historical and physiological reports have been published by J. Ambialet in 1893: *La déformation artificielle de la tête dans la région toulousaine* and by EJ Dingwall in 1931: *Artificial cranial deformation, a contribution to the study of ethnic mutilations*. The study of Ambialet is mostly concerned with the deformed heads found in the area of Toulouse in France, which could have been a tradition transmitted by the Huns who had settled in the country.



Hun Skull



Hun X-Ray

<sup>1</sup>Homer describes a Thersite soldier as the ugliest man to come to Troy, with a pointed head and a thin patch of fuzz growing on it. (*An ancestor of the Conehead!*)

He describes various headbands and skullcaps, which were commonly used to tighten the heads of the babies, and gives images of deformed skulls that he was able to examine. Dingwall's study not only refers to traditions in many parts of the world, but also describes the methods used to modify the skull shape and the possible reasons that the parents had to adopt this type of practice. For this author, there are six types of intentional cranial deformation:

- 1) The molding the head of the infant (Torres Straights). The molding is performed either by the mother, midwife or relative, and is often accompanied by a preparatory greasing of the child's head. At the same time, the nose, ears and limbs are often massaged or molded.
- 2) The application of boards to the head: Pieces of wood are secured to various parts of the infant's head in order to flatten those parts against which they are fixed. The boards and pads are fastened together by laces or strings and tightening is effected by tightening or by a process of twisting. The basic idea is the intention of flattening certain portion of the skull.
- 3) The application of bandages to the head (New Hebrides and Central Africa): In many parts of the world the head of the child is immediately after birth bound tightly with yards of material, thus forming a kind of tight, cone-shaped cap. This fitting is applied to the head for considerable periods of time, the result being that by way of compensation, it becomes cone-like or cylindrical.
- 4) The application of pads to the head: A pad usually made of material stuffed with some hard packing or with sand or clay, is often a supplement of a board. They are seldom used alone and secured over the child's forehead by means of bandages or linen strips.
- 5) The application of stones to the head (Polynesia). It consists broadly of putting heavy stones round the head of the child as it lies in its cradle. Three stones are usually employed, one for the top of the head and one for either side.
- 6) Cradles. Certain attachments to the cradles are used to the express purpose of deforming the head of the child (Borneo, Celebes). The cradles of the North American Indians were used for both, cradle and transport, one result of the latter being that the child was lashed tightly to the supporting board.



Mangbetu woman



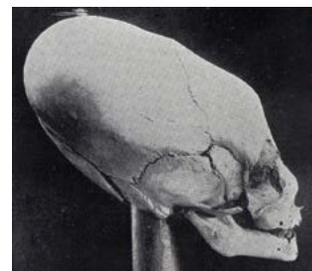
Mangbetou child



Maya head shaping



Chinook practice



Chinook skull

The rationale for these interventions was not only to make beautiful children. It was sometimes to create class and tribal distinction. Similar practices were felt to enhance intellectual and sexual abilities and to provide intimidation in battle through the imitation of beasts. Artificial cranial deformations are not always intentional. The use of tight bandages and bonnets served to keep the babies' heads warm. The application of a pad above the forehead was to protect the brain at the level of the opened fontanel before the closure of the skull bones. Maintaining the head in a stable position in a travelling cradle is another explanation.

It is interesting to note that if nowadays we have ceased to reshape the head of our children except in cases of cranial or facial deformity, many young women adopt a hairstyle that simulates an elongation of their skull. The conehead figures might still become fashionable! 

# IN MEMORIAM



**Joshafat Shulman, MD – Israel**  
1924 - 2017

It is with great sadness that I report the passing of Dr. Joshafat Shulman, plastic surgeon and Israeli Life Member of ISAPS.

Dr. Shulman was one of the fathers of the Israeli plastic surgery and was world renowned as an expert in rhinoplasty, a procedure that he performed thousands of times.

He was a member of ISAPS from its very beginnings and participated in the organization of the Second ISAPS Congress that took place in Israel in 1973.

Thanks to his involvement in ISAPS activities, he made numerous friends around the globe while spreading his professional expertise.

Dr. Shulman is survived by his wife and five children. One of them, Dr. Ori Shulman, is also a current ISAPS member following in his father's footsteps as an expert in rhinoplasty.

ISAPS NEWS

Marcos Harel, MD  
ISAPS National Secretary for Israel



**Giovanni Ponzielli, MD - Italy**  
1951 -2017

On February 15, 2017, Dr. Giovanni Ponzielli, distinguished long-time member of the Italian section of ISAPS, passed away. He was born in Trento, an ancient city located in the northeast of Italy, and graduated cum laude in medicine and surgery at the prestigious University of Siena. He completed his plastic surgery residency in Milan where he became one of the youngest and smartest assistants of Prof. Luigi Donati, a pioneer of plastic surgery in Italy.

Dr. Ponzielli worked for more than 30 years at Niguarda Hospital in Milan, one of the largest in Italy, where he treated thousands of complicated reconstructive cases, including craniofacial malformations, burn sequelae and maxillofacial traumas. He left the hospital in 2010 and since then dedicated his work totally to aesthetic surgery.

He is survived by his adorable wife Marivanna with whom he loved to spend long periods in their beautiful cottage on Lake Garda. He was a brilliant colleague with an extensive classical culture and great sense of humor. We all miss him. Ciao Giovanni

ISAPS NEWS

Gianluca Campiglio, MD, PhD  
ISAPS Secretary

## WHERE IN THE WORLD?



**Answer:** The observatory in Monte Romano, in the Appennino mountain range in Italy bordering Tuscany and Emilia Romagna. The observatory was financed by Luigi Pozzi (1932-2013), beloved father of Adriana Pozzi, Assistant National Secretary for Italy. One day he announced to his fellow amateur astronomers: "...listen guys, I think it would be better to spend the money saved for my gravestone on an observatory from where we all can gaze at the stars..."

The Antares amateur astronomers group continues to work very hard with a calendar full of events.

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# ISAPS *Calendar* of International Meetings



## MARCH 2017

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### 17 March 2017 - 19 March 2017

GLOBAL ALLIANCE - AICPE 5th National Congress

Location: Florence, ITALY

Contact: Barbara Urbani

Email: congressoaicpe@gmail.com

Tel: +39-334-686-3347

Website: <http://www.aicpe.org>

### 29 March 2017 - 01 April 2017

ISAPS SYMPOSIUM

ISAPS Symposium - Israel

Location: Eilat, ISRAEL

Contact: Einat Bar-Ilan

Email: einat@duetevents.co.il

Tel: 972-54-4304045

Website: <http://www.redseaplastics2017.com>

### 31 March 2017 - 01 April 2017

ISAPS SYMPOSIUM

ISAPS Symposium - Chile

Location: Santiago, CHILE

Contact: Dr. Montserrat Fontbona

Email: soccpchile@gmail.com

Tel: 56-2-2632-0714

Website: <http://www.sccp.cl>

## APRIL 2017

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### 01 April 2017 - 02 April 2017

GLOBAL ALLIANCE - Aesthetic Plastic Surgery 2017 -

Korean Society for Aesthetic Plastic Surgery

Location: Seoul, SOUTH KOREA

Contact: Prof. Seung-Kyu Han

Email: ksaps@ksaps.or.kr

Tel: +82-2-3472-4243

Fax: +82-2-3472-4254

Website: <http://www.aps-iae.com>

### 07 April 2017 - 08 April 2017

ISAPS ENDORSED PROGRAM

7th Body Lift Course

Location: Lyon, FRANCE

Contact: Géraldine Buffa

Email: contact@docteur-pascal.com

Tel: 33-4-7824-5927

Fax: 33-4-7824-6158

Website: <http://www.jfpascalmd.com/meetings>

### 12 April 2017 - 15 April 2017

Dr. Nazim Cerkes Open Rhinoplasty Hands-On Course

Location: Istanbul, TURKEY

ISAPS ENDORSED PROGRAM

Contact: Seven Event Company

Email: yagiz@seveneventcompany.com

Tel: 90-533-7471423

Website: <http://www.istanbulapsc.com/>

### 12 April 2017

ISAPS SYMPOSIUM

ISAPS Symposium - Japan

Location: Osaka, JAPAN

### 21 April 2017 - 23 April 2017

ISAPS ENDORSED PROGRAM

FATS 2017 featuring ISPRES - AP Bangkok

Location: Bangkok, THAILAND

Contact: Dr. Kotaro Yoshimura

Email: kotaro-yoshimura@umin.ac.jp

Tel: 6012-4889321 (Eddie Liew)

Website: <http://www.fats.my/>

### 21 April 2017 - 22 April 2017

GLOBAL ALLIANCE - Secondary Breast Surgery Course

Location: Oviedo, SPAIN

Contact: Beatriz Álvarez

Email: aecep@aecep.es

Tel: +34-91-575-5035

### 22 April 2017

GLOBAL ALLIANCE - RBSPS Spring Meeting -

Reconstructive Microsurgery: from cutting-edge  
knowledge to aesthetic refinements

Location: Brussels, BELGIUM

Contact: Aurélie Geldhof

Email: secretary@rbsps.org

Tel: +32-479-07-0788

Website: [http://bit.ly/RBSPS\\_SM17](http://bit.ly/RBSPS_SM17)

### 27 April 2017

ISAPS Symposium - USA - During the 2017 ASAPS  
Meeting

ISAPS SYMPOSIUM

Location: San Diego, California, UNITED STATES

### 27 April 2017 - 01 May 2017

GLOBAL ALLIANCE - The Aesthetic Meeting - American

Society for Aesthetic Plastic Surgery

Location: San Diego, CA, UNITED STATES

Website: <http://www.surgery.org/>

**MAY 2017****04 May 2017 - 06 May 2017**

ISAPS Course - Egypt

ISAPS OFFICIAL COURSE

Location: Cairo, EGYPT

Contact: Dr. Hussein Abulhassan

Email: husseinabulhassan@hotmail.com

Tel: 20-1-2218-9725

Fax: 20-3-420-4246

Website: <http://Isapscairo2017.org>**09 May 2017**

ISAPS Symposium - Argentina

ISAPS SYMPOSIUM

Location: La Plata, ARGENTINA

**18 May 2017 - 20 May 2017**

GLOBAL ALLIANCE - 52nd Congress of the Spanish Society of Aesthetic, Plastic and Reconstructive Surgery (SECPRE)

Location: Bilbao, SPAIN

Contact: Carlos Lázaro

Email: c.lazaro@bnyco.com

Tel: 00 34 91 571 9390 – 00 34 91 571 9210

Fax: 00 34 91 571 9206

Website: <http://www.congresosecpres.com>**JUNE 2017****01 June 2017 - 03 June 2017**

ISAPS Symposium - France - Immediately preceding SOFCEP

ISAPS SYMPOSIUM

Location: Marseille, FRANCE

Contact: SOFCEP

Email: sofcep@vous-et-nous.com

Tel: +33(0)5 3431 0134

Website: <http://www.congres-sofcep.org>**01 June 2017 - 03 June 2017**

ISAPS ENDORSED PROGRAM

Beauty Through Science 2017

Location: Stockholm, SWEDEN

Contact: Dr. Per Heden

Email: bts@ak.se

Tel: +46 8 614 5400

Fax: +46 8 614 5420

Website: <http://www.beautythroughscience.com/>**08 June 2017 - 10 June 2017**

ISAPS ENDORSED PROGRAM

13th Dr. Tulp Fresh Cadaver Dissection Course in Facial Plastic Surgery

Location: Utrecht, NETHERLANDS

Contact: Dr. Jacques van der Meulen

Email: drvdmeulen@gmail.com

Tel: 31-641461496

Website: <http://drtulp.nl/>**21 June 2017 - 23 June 2017**

Body Sculpting

Location: Panama City, PANAMA

Contact: Dr. Joseph Setton

Email: [info@bodysculptingpanama.com](mailto:info@bodysculptingpanama.com)

Tel: 507-6747-0300

Fax: 507-204-8459

Website: <http://www.bodysculptingpanama.com>**22 June 2017 - 25 June 2017**

GLOBAL ALLIANCE - Non-Surgical Symposium

Location: Gold Coast, AUSTRALIA

Contact: The Production House Events

Email: [gina@tphe.com.au](mailto:gina@tphe.com.au)Website: <http://www.asapsevents.org.au>**22 June 2017 - 24 June 2017**

ISAPS ENDORSED PROGRAM

MIPSS 2017 - Marbella International Plastic Surgery Summer School

Location: Marbella, SPAIN

Contact: Vanessa Garcia

Email: [info@oceanclinic.net](mailto:info@oceanclinic.net)

Tel: 34-951-775518

Fax: 34-952-868827

Website: <http://www.mipss.eu/>**23 June 2017 - 24 June 2017**

ISAPS OFFICIAL COURSE

ISAPS Course - Romania in conjunction with the Conference of the Romanian Aesthetic Surgery Society (RASS)

Location: Poiana Brasov, ROMANIA

Contact: Simona Raia

Email: [djianu02@gmail.com](mailto:djianu02@gmail.com)Website: <http://www.isapscourse.ro/>**30 June 2017 - 01 July 2017**

ISAPS ENDORSED PROGRAM

8th Body Lift Course

Location: Geneva, SWITZERLAND

Contact: Géraldine Buffa

Email: [contact@docteur-pascal.com](mailto:contact@docteur-pascal.com)

Tel: 33-4-7824-5927

Fax: 33-4-7824-6158

Website: <http://www.jfpascalmd.com/meetings>**JULY 2017****14 July 2017 - 15 July 2017**

ISAPS OFFICIAL COURSE

ISAPS Course - Ecuador

Location: Details Pending, ECUADOR

**21 July 2017 - 01 August 2017**

GLOBAL ALLIANCE - ASAPS-ISAPS Cruise 2017

Location: North Sea, NORWAY

ISAPS ENDORSED PROGRAM

Contact: Bob Newman

Email: [BNewman@CruiseBrothers.com](mailto:BNewman@CruiseBrothers.com)

Tel: 1-401-223-4711

Website: <http://www.surgery.org/downloads/microsite/cruise2017/index.php>

**AUGUST 2017**

**31 August 2017 - 02 September 2017**

GLOBAL ALLIANCE - XV Chilean Congress of Plastic Surgery

Location: Viña del Mar, CHILE  
 Contact: Dr. Stefan Danilla  
 Email: soccpchile@gmail.com  
 Tel: 56-2-2632-0714  
 Website: <http://www.sccp.cl>

**SEPTEMBER 2017**

**13 September 2017 - 15 September 2017**

ISAPS Course - Bolivia **ISAPS ENDORSED PROGRAM**  
 Location: Santa Cruz, BOLIVIA

**21 September 2017 - 23 September 2017**

GLOBAL ALLIANCE - 66th Congress of SICPRE and 1st Joint Meeting with the Brazilian Society of Plastic Surgery

Location: Modena, ITALY  
 Contact: nord est congressi  
 Email: [info@nordestcongressi.it](mailto:info@nordestcongressi.it)  
 Tel: 39-0432 21391  
 Fax: 39-0432 506687  
 Website: <http://www.sicpre2017.it>

**22 September 2017 - 23 September 2017**

ISAPS Course - Lebanon **ISAPS OFFICIAL COURSE**  
 Location: Beirut, LEBANON  
 Contact: Dr. Elie Abdelhak  
 Email: [elie.abdelhak@gmail.com](mailto:elie.abdelhak@gmail.com)  
 Tel: (+961) 371-6706

**28 September 2017 - 29 September 2017**

ISAPS Symposium - Portugal **ISAPS SYMPOSIUM**  
 Location: Lisbon, PORTUGAL

**OCTOBER 2017**

**05 October 2017 - 07 October 2017**

ISAPS Symposium - Romania Immediately preceding the EASAPS Congress **ISAPS SYMPOSIUM**  
 Location: Bucharest, ROMANIA

**06 October 2017 - 07 October 2017**

GLOBAL ALLIANCE - EASAPS Congress  
 Location: Bucharest, ROMANIA  
 Contact: Karen Rogerson  
 Email: [easaps@mzcongressi.com](mailto:easaps@mzcongressi.com)  
 Tel: +39 02 6680 2323 ext 933  
 Fax: +39 02 668 6699

**07 October 2017 - 07 October 2017**

ISAPS Symposium UK, in collaboration with CCR Expo 2017 and BAAPS **ISAPS SYMPOSIUM**  
 Location: London, UNITED KINGDOM  
 Contact: Alison Willis  
 Email: [alison.willis@easyfairs.com](mailto:alison.willis@easyfairs.com)  
 Tel: +44 (0)20 3196 4300  
 Fax: +44 (0)20 8892 1929

**11 October 2017 - 13 October 2017**

ISAPS Course - Jordan **ISAPS OFFICIAL COURSE**  
 Location: Amman, JORDAN

**12 October 2017**

ISAPS Symposium - Canada immediately preceding the 44th Annual Meeting of the Canadian Society for Aesthetic Plastic Surgery **ISAPS SYMPOSIUM**  
 Location: Toronto, CANADA  
 Contact: Tara Hewitt  
 Email: [csapsoffice@gmail.com](mailto:csapsoffice@gmail.com)  
 Tel: 1-(905) 655-9889  
 Fax: 1-(905) 655-7319  
 Website: <http://www.csaps.ca>

**13 October 2017 - 14 October 2017**

GLOBAL ALLIANCE - Canadian Society for Aesthetic Plastic Surgery **ISAPS OFFICIAL COURSE**  
 Location: Toronto, Ontario, CANADA  
 Contact: Tara Hewitt  
 Email: [csapsoffice@gmail.com](mailto:csapsoffice@gmail.com)  
 Tel: 1-(905) 655-9889  
 Fax: 1-(905) 655-9889  
 Website: <http://www.csaps.ca>

**19 October 2017 - 22 October 2017**

GLOBAL ALLIANCE - 40th Annual ASAPS Conference  
 Location: Melbourne, AUSTRALIA  
 Contact: The Production House Events  
 Email: [gina@tphe.com.au](mailto:gina@tphe.com.au)  
 Tel: 61 (03) 9020-7056  
 Website: <http://asapsevents.org.au>

**NOVEMBER 2017****02 November 2017 - 04 November 2017**

GLOBAL ALLIANCE - II International Congress AECEP 2017

Location: Madrid, SPAIN

Contact: Carlos Lázaro

Email: c.lazaro@bnyco.com

Tel: +34 91 571 9390

Fax: + 34 91 571 9206

**JANUARY 2018****01 January 2018**

ISAPS OFFICIAL COURSE

ISAPS-BAPRAS Joint Meeting - UK

Location: Manchester, UNITED KINGDOM

**18 January 2018 - 20 January 2018**

ISAPS Cadaver Dissection Course - Belgium

Location: Liege, BELGIUM

ISAPS OFFICIAL COURSE

**FEBRUARY 2018****01 February 2018 - 03 February 2018**

ISAPS Course - India

ISAPS OFFICIAL COURSE

Location: City and details pending, INDIA

**MARCH 2018****23 March 2018 - 25 March 2018**

ISAPS Course - South Africa

ISAPS OFFICIAL COURSE

Location: Cape Town, SOUTH AFRICA

**APRIL 2018****07 April 2018 - 08 April 2018**

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

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>

**26 April 2018 - 30 April 2018**

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

Location: New York, NY, UNITED STATES

Website: <http://www.surgery.org/>

**MAY 2018****31 May 2018 - 02 June 2018**

ISAPS Symposium - France - Immediately preceding 2018 SOFCEP meeting

ISAPS SYMPOSIUM

Location: Lyon, FRANCE

Contact: SOFCEP

Email: [sofcep@vous-et-nous.com](mailto:sofcep@vous-et-nous.com)

Tel: +33(0)5 3431-0134

Website: <http://www.congres-sofcep.org>

**OCTOBER 2018****31 October 2018 - 04 November 2018**

24th Congress of ISAPS

ISAPS CONGRESS

Location: Miami Beach, FL, UNITED STATES

Contact: Catherine Foss

Email: [isaps@isaps.org](mailto:isaps@isaps.org)

Tel: 1-603-643-2325

Fax: 1-603-643-1444

Website: <http://www.isaps.org>

# NEW ISAPS MEMBERS

## Admitted December 2016 – January 2017

### Belgium

Socorro ORTIZ, MD

### Brazil

Marcelo ASSIS, MD\*

Gustavo PADUA, MD\*\*

Douglas WESTPHAL, MD\*

### Canada

Mohammed ELAHI, MD, FRCSC

### China

Zumeng YA, MD

Jufang ZHANG, MD

Chinese Taipei

Po-Cheng HUANG, MD

Chao-Chuan WU, MD

### Chinese Taipei

Po-Cheng HUANG, MD

Chao-Chuan WU, MD

### Colombia

Jaime Roberto ARIAS GONZALEZ, MD

Maria Consuelo CARRANZA BOTIA, MD

Arturo Alejandro DENIZ MARTINEZ, MD

John GARCIA, MD

### Germany

Olaf FLEISCHER, MD\*

Branislav MATEJIC, MD

### Greece

Alexandros DIONYSOPOULOS, MD, PhD

Thanasis PAPAS, MD, PhD, FEBOPRAS

### Hungary

Peter KOVARI, MD

### India

Parag TELANG, MBBS, MS, MCh

Srinagesh VADREUVU, MBBS, MS, MCh

Vinod VIJ, MD

### Indonesia

Siti HANDAYANI, MD

Lynda HARIANI, MD

Donna SAVITRY, MD

### Iran

Mohsen FADAEI ARAGHI, MD\*

Seyed Nejat HOSSEINI, MD

### Iraq

Mahdi Hameed ABOOD, MD, MBChB

### Italy

Mariagrazia MOIO, MD\*

Guglielmo RUFOLO, MD, MRM, FHM

### Japan

Mika ISHII, MD

### Jordan

Tarek COPTY, MD, FACS

### Kuwait

Salem AL AJMI, MD

Ahdi ALBADER, MD, EPOBRAS

Ismail IBRAHIM, MD

### Malaysia

Kien Seng HENG, MD

### Mexico

Francisco Javier AMAYA BLAS, MD

Pablo ARIZTI, MD

Sergio AYUZO, MD

Jose BARRAGAN CABRAL, MD

Ana Del Carmen CHANG MANJARREZ, MD

Harold Martin DENT ALVARADO, MD

Victor GUTIERREZ URIBE, MD

Fernando HASFIELD, MD

Denisse HERNANDEZ, MD

Elsa MOREL FUENTES, MD

Arturo MUNOZ MEZA, MD

Mario NAVARRETE RIVERA, MD

Julio PALACIOS, MD

Jessica RAMIREZ, MD\*

Victor Manuel RAMIREZ HERNANDEZ, MD

Rogelio RINCON LOZANO, MD

Elizabeth del Carmen RODRIGUEZ ROJAS, MD

### Oman

Gopal MALHOTRA, MS, MD, FRCS, MCh

### Romania

Daniel POPESCU, MD

### Russian Federation

Elena N. AGANINA, MD

Tair R. ALIEV, MD

Elena BELYUSTINA, MD\*

Vladimir A. DEMCHENKO, MD

Anton KONDULUKOV, MD

Pavel E. KUPRIN, MD, PhD

Filipp A. ROMANCHISHEN, MD

Vladimir SAFRONOV, MD\*

Ilya SOKOLOV, MD\*\*

Svetlana A. VAKULA, MD

Maxim V. VENEDIKTOV, MD\*\*

### Saudi Arabia

Khalid ALZHRANI, MD\*

Loai EL-BASSIOUNY, MD

Amr IBRAHIM, MS, MRCS, EBOPRAS

### Serbia

Vesna S. RAKIC, MD

### Spain

Alexander ASLANI, MD, EBOPRAS

### United Arab Emirates

Naser AL DWAIK, MD

Faisal AMEER, MD, MCh

Mazen ARAFEH, MD

Tarek BAYAZID, MD

Dora EVANGELIDOU, MD, MSc, PhD fellow

Mohammed KHAMAS, MD, PhD

Manik MENEZES, MBBS, MS, MCh

### United Kingdom

Samuel ISAACS, MD\*\*

### United States

Scott SPIRO, MD

\* indicates Associate Member

\*\* indicates Associate Resident/Fellow Member

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