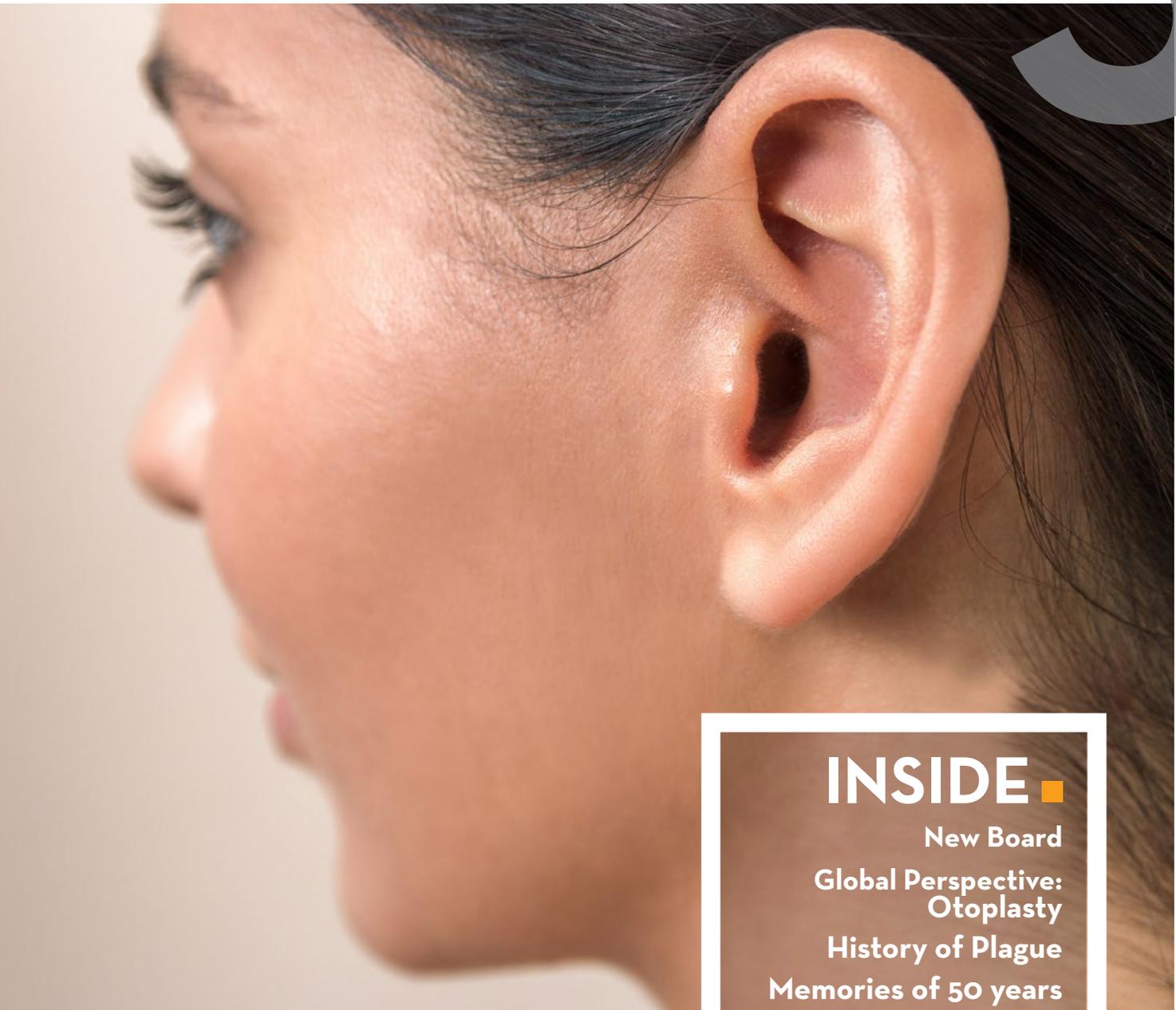


# ISAP S<sup>®</sup> NEWS

OFFICIAL NEWS OF THE INTERNATIONAL  
SOCIETY OF AESTHETIC PLASTIC SURGERY

# 3

Volume 14 | Number 3



## INSIDE ■

New Board

Global Perspective:  
Otoplasty

History of Plague

Memories of 50 years

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## **NOTICE OF NEW ADDRESS**

ISAPS has moved administration to virtual offices.

Please make a note of our new address:

International Society of Aesthetic Plastic Surgery (ISAPS)

**10 Benning Street, Suite 160 #264**

**West Lebanon, New Hampshire 03784-3402 USA**

# MESSAGE FROM the Editor

---

Dear Colleagues,

I hope that this issue finds you, your families, and your staff in good health. We continue to struggle with the Coronavirus pandemic worldwide and will likely continue to see its effects on our lives for many months.

As you know, Lebanon has been facing extraordinary economic challenges in the past several years. These have been exacerbated by the Coronavirus pandemic, and now the terrible explosion in the port of Beirut which to date has claimed at least 137 lives and wounded over 5,000. The Board of Directors of ISAPS in conjunction with the Humanitarian Committee has donated \$40,000 from our humanitarian account to a dedicated bank account in Beirut for medical supplies. We urge you to consider a donation to the same fund according to the recent email we sent, or to one of the charities currently providing service to the population, including Médecins Sans Frontières (Doctors Without Borders), UNICEF, and the Red Cross.

This issue's focus topic is otoplasty and we once again received a number of remarkable articles on this challenging procedure. We present a truly global perspective on this topic, with articles from the Middle East, South Asia, the United States, and the United Kingdom. The majority of the articles are beautifully illustrated with hand-drawn diagrams illustrating the authors' technical as well as



surgical artistry. I greatly enjoyed reviewing this section and I hope that you will find it as fascinating as I did.

Dr. Riccardo Mazzola's (Italy) extensive history of plagues is concluded in this issue and I trust that you will find it enlightening. It is beautifully illustrated with images from his own collection, and includes a depiction

of the frightening masque worn by physicians of that era to protect themselves from contamination. Also, in this issue, Dr. Bouraoui Kotti (Tunisia) unveils his new book, *The Hidden Stories of the Breast*, which he completed during his lockdown due to COVID-19. Few of us were so productive during this time!

Our next issue will feature rhinoplasty, and I look forward to your innovations and observations on this highly technical and core procedure of our specialty. Please send them to: [ISAPSNews@isaps.org](mailto:ISAPSNews@isaps.org)

I welcome your feedback and suggestions as we continue to improve upon your newsletter. Thank you for all you do for ISAPS.

A handwritten signature in black ink that reads "Nina S. Naidu MD FACS". The signature is written in a cursive, flowing style.

Nina S. Naidu, MD, FACS, Editor-in-Chief (United States)



# MESSAGE FROM

## the new ISAPS President

---

Dear Friends and Colleagues,

It is a great honor and pleasure for me to be President of ISAPS for the next two years.

I was first involved in ISAPS leadership as a member of the Education Council in 2008. I served as Chair of the Education Council from 2010-2014. I was then 2nd Vice President (2014-2016), 1st Vice President (2016-2018), and President-Elect (2018-2020) under President Dirk Richter.

I must confess to you that ISAPS had a significant influence in my personal and scientific life. I have learned a lot from the ISAPS leaders, particularly the servant mentality. I had the opportunity to meet many plastic surgeons from different parts of the world; I learned from them and also shared my knowledge with them. ISAPS provided me with so many dear friends from all over the world which is invaluable to me.

Since the beginning of the year, we are all having difficult times due to the COVID-19 pandemic. Most of us had to stop our practices, our businesses have been affected, meetings were cancelled all over the globe, and travel has been banned or restricted. Unfortunately, we had to postpone our 25th Biennial Congress and many other ISAPS educational events. Due to the postponement of the Vienna Congress, we had to make a change in the ISAPS By-Laws to allow election of the new Board of Directors using online voting and a virtual ISAPS General Assembly due to these extraordinary circumstances. After the first ISAPS virtual General Assembly on September 5th, the Board of Directors for 2020-2022 will start to work. The newly elected officers of the Board of Directors are true servants and I am sure that they will work hard to bring ISAPS to another level. I am very happy and looking forward to working with this great new team.

Since the onset of the COVID-19 pandemic, ISAPS has been supporting our members and non-member plastic surgeons all around the world through COVID-19 webinars and weekly Master Classes by world masters - a unique feature of ISAPS. Our Master Class Series is scheduled to the end of the year and will continue next year. During the 2020-2022 term, Aesthetic Education Worldwide™ and patient safety will be our primary missions again. Our Education Council Co-Chairs Ozan Sozer (USA) and Francisco Bravo (Spain) and the Education Council team from all continents will prepare a comprehensive education program to teach the most recent innovative techniques in aesthetic plastic surgery.

COVID-19 has caused significant changes in traditional teaching methods. Virtual meetings and webinars will be important tools for education in the future. As leaders in aesthetic education, in this new era ISAPS will provide different teaching modalities to educate plastic surgeons. However, I believe that virtual meetings will never completely substitute for in-person, face-to-face meetings. That's why we have already planned in-person ISAPS Courses and Symposia combined with virtual participation.

Our residents are our future. We will focus more on educating our residents in this term. We are currently developing teaching modules and fellowship programs to reshape their careers.

COVID-19 taught us the importance of minimally invasive applications in our practices. We will give more opportunities for teaching non-surgical procedures in our meetings and all educational activities.

The previous two presidents, Dr. Saltz and Dr. Richter, have made a great effort to grow the ISAPS Global Alliance. We have now reached 84 National Societies in the Alliance.

We will advance our collaboration with our Global Alliance Partners on international issues and in developing new strategies for safe aesthetic surgery, education and global accreditation to protect our specialty. To increase joint activities with Global Alliance Societies is another goal of mine.

After the last modification of the By-Laws, the Membership Chair is now a Board position charged specifically with growing our membership. I am sure that our new Membership Chair, Dr. Vakis Kontoes, will work hard to fulfill the needs and demands of our members, and facilitate membership procedures.

Our National Secretary army has an essential role in connecting the Board with the members. I am planning to do a conference call with National Secretaries every three months to listen to their opinions and requests.

Expanding industry partnerships and enhancing our cooperation with our current partners, increasing visibility of ISAPS in social media, improving the ISAPS website and ISAPS video library are also important goals during my Presidency.

In recent years, through the efforts of ISAPS leaders, the financial status of ISAPS has grown significantly. I am proud to say that ISAPS is still holding strong with a good investment strategy for our treasury spite of the COVID pandemic state.

Recently, we have launched initial insurance programs of a wider range with special benefits for ISAPS members. We will further develop these insurance programs with additional benefits for our members.

I am so pleased to see that our journal, Aesthetic Plastic Surgery, has improved under the leadership of Editor-in-Chief Bahman Guyuron, and is now attracting more readers with a significantly increased Impact Factor.

At the end of the year, our Executive Director, Catherine Foss, will retire after 22 years of service. Catherine has done

a lot for ISAPS. On behalf of the ISAPS Board of Directors, I express our gratitude for her service and dedication for all these years.

Our new Executive Director, Sarah Johnson, and her team is already working hard for ISAPS. She is an energetic and motivated woman who will make great contributions to our beloved society.

I will have a strong team of servant leaders on my Board of Directors and Committees to help me during the next two years.

Our postponed 25th Biennial Congress will be held in Vienna in September 2021. It will be a wonderful event. I hope to meet all of you in Vienna next year.

I will be delighted to welcome you to my hometown of Istanbul in September 2022 for the 26th Biennial ISAPS Congress. Istanbul is a unique city embracing eastern and western cultures with everlasting scenic beauty. We have been planning a spectacular scientific and social program for you to enjoy to the fullest.

ISAPS is a big family and gets its power from its members. Without the support of our members, it is impossible to achieve our goals. Knowing our weaknesses and strengths, diversity and differences, I urge you to give constant support to build a stronger, better society. I am honored to be part of this distinguished family. In such difficult times, our solidarity is essential. **Let's unite under the ISAPS umbrella and support each other for the better development of our speciality.**

Thank you!



Nazim Cerkes MD, PhD  
ISAPS President

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# FAREWELL FROM THE IMMEDIATE PAST PRESIDENT

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**DIRK RICHTER, MD - GERMANY**  
ISAPS President 2018-2020

It's time to say goodbye!

On Saturday, September 5th, during our Virtual Olympiad and General Assembly, I handed over the baton to my successor as President, Dr. Nazim Cerkes.

A diversified time with many journeys has come to an end, during which many new friendships, alliances, and achievements were made all over the globe.

Currently, many friends and colleagues are asking me what the best part of my Presidency was. I must say it is the many thanks from members and colleagues who appreciate the achievements we have made. Emails saying thank you for new initiatives like the reduction of membership fees by introducing à la carte fees, the immediate introduction of weekly webinars at the start of COVID-19, the e-learning platform, ISAPS MedOne, with its many resources, free membership for our residents, and new training programs like the FAST program, to name just a few.

Indeed, a lot has happened, and our members have noticed it and shown their gratitude with the highest number of members and the biggest increase in membership ever. It is nice to feel that all our work has paid off. In addition, a lot of things have happened in the background, such as installing a completely new IT system for our Central Office, finding a new Executive Director (good luck Sarah Johnson) to succeed Catherine Foss as well as a new team, switching to a completely virtual office,



and publishing the first textbook of a society for residents and fellows. All of that makes me very proud.

Of course, I would like to thank my entire team and board, especially Catherine Foss and the Executive Committee, and on a personal level, long-time ISAPS Treasurer Dr. Kai Schlaudraff, ISAPS Secretary Dr. Ivar van Heijningen, and ISAPS Parliamentarian Dr. Tim Papadopoulos. They have relieved me of a lot of work, improved the structure of ISAPS, placed their trust in me and worked diligently and selflessly for our society. I will miss the almost-daily phone calls with you guys!

Thank you also to Catherine Foss, Peter Rubin, and Nina Naidu, who have developed the ISAPS News together with the Boeld Communication team so beautifully during my presidency and made it one of the most beautiful tools of member communication.



A most beautiful farewell was of course our 50th birthday which we hope you all witnessed at our Virtual Olympiad. If not, you can still view the **exhibition booths** and have a look around as well as visit the digital World of ISAPS. If you missed our little celebration you can experience it **here**, I think it's worth it.

You can also still watch the many exciting lectures on demand.

We have received so much positive feedback about this new digital world of ISAPS and our new platform that we will continue to work on this basis and give you the opportunity to stay up to date - our new ISAppS will help with this. Get ready for more information on this soon.

Thanks to everyone's help, I could hand over the Society to my good friend and successor Dr. Nazim Cerkes in the best financial situation and with a new structure. I am confident that he will make many things even better and that ISAPS will continue to develop in a fantastic way. We can already be

proud to be the largest, most respected international society for aesthetic plastic surgery.

I thank you for the wonderful two years that you have accompanied and supported us and especially me and I am sure that we will meet again soon despite COVID-19.

**Maybe next year in Vienna at our World Congress in September? I would be very pleased.**



All the best,  
Dirk Richter, MD  
Immediate Past President

# FAREWELL FROM THE EDUCATION COUNCIL CHAIR

---



**VAKIS KONTOOS, MD, PHD - GREECE**  
Chairman, ISAPS Education Council

Dear Friends,

A beautiful and fruitful journey through ISAPS education, full of new experiences, achievements, friendships, knowledge and commitment has been duly completed.

It is four years now since two consecutive ISAPS Presidents entrusted me with the appointment as Education Council Chairman and I thank them for this trust.

The bar was already high and I had to do my best to raise it higher as ISAPS and its main mission, Aesthetic Education Worldwide™, deserved.

I was honored to be authorized by the Presidents to go ahead with innovations, new policies, and new guidelines. I was fortunate to have members of the Education Council (EC) who supported my initiatives and I could not have done it without the contributions of the outstanding ISAPS faculty who willingly supported the EC mission worldwide.

I was honored to cooperate with my Vice-Chair, Dr. Ozan Sozer, both of us having the same vision and expectations towards the new horizons for the EC and I am very happy he is going to be the next Chair for the 2020-2022 term.

In the last four years, the EC came up with new modalities and guidelines. I have been regularly updating you through our newsletter, but I cannot avoid mentioning again the impact of the new EC guidelines and rules in the high standard educational events worldwide. The different formats of educational activities

were designed to attract various levels of audiences. The new educational programs (F.A.S.T.) and Courses in underserved countries, the Global Sponsors' involvement and, of course, the recent successful COVID-19 webinars, the highly attended Master Classes and the virtual meeting on September 5th this year are examples.

Our world is changing. The unprecedented pandemic has affected our usual course and plans, but ISAPS and the EC were strongly present during these difficult times to support, update and educate our members!

I, with all my gratitude, would like to thank the local organizers around the world for their commitment and amazing cooperation, the members of the EC for their precious help, and all those who supported my efforts of striving for excellence, kindly hoping that I have met their expectations - efforts which soon will go on, in the capable hands of Dr. Sozer, the next EC Chairman.

I want to reassure everyone who joined, entrusted and cooperated with me during this amazing journey, as well as the new EC, that I will be again here to support the goals of ISAPS' education mission, sharing with pleasure the experience I have gained from my honorable position as the Chairman of the Education Council for the years 2016-2020.

**Stay strong, stay safe, stay ISAPS! THANK YOU!**

# COURSE REPORT

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## 1<sup>ST</sup> WORLD AESTHETIC MEDICINE AND PLASTIC SURGERY ONLINE



KIRILL PSHENISNOV  
Russian Federation



**2020** has become a challenge to almost every human on Earth. Plastic Surgery was not an exception.

In 2011, ISAPS Courses entered the Russian Federation and have become the platform of sharing knowledge, new surgery techniques, communication, exchange of opinions and making good friends with colleagues from many countries.

St. Petersburg, Russia has become the city which hosted plastic surgeons for international course-training for plastic surgeons from all over the world to teach and learn and to enjoy the architecture and culture of the Russia's Northern Gem.

Since the first ISAPS project in Russia in 2011, all organization was done by BIO Concept company with their General Director Igor Bogoroditskiy. The Course became one of the largest and most important events in plastic surgery in Russia.

We had planned to mark the 10th Anniversary of the ISAPS Courses in Russia in 2020 and scheduled this event well in

advance. The scientific program was organized in friendly collaboration among ISAPS EC Chairman, Vakis Kontoes (Greece), EC Regional Chair, Apostolos Mandrekas (Greece) and myself. But in the beginning of the year, COVID-19 shocked the world and stopped travel by quarantine measures.

The organizers decided to change the format of the event and integrated the ISAPS Course to the **1st World Aesthetic Medicine and Plastic Surgery ONLINE (WAMPS ONLINE)**.

It has been probably the biggest challenge in the local organizer's - BIO Concept company - practice within just a couple of months since travel was suspended. The Organizing Council created an online platform allowing the faculty to lecture, share presentations, and show videos of surgeries and procedures. All the content had simultaneous two-way translation (English-Russian), including all Q&A sessions and discussions. Several days were spent just to test the technical side with every presenter.

**IN 2020, THE MAJOR TOPICS OF THE MEETING WERE:**

**Day 1:** Facial aesthetics and surgery - face anatomy, brow lift, periorbital rejuvenation, rejuvenation of the face and neck. Great contributors to the sessions were Gianluca Campiglio (Italy), Apostolos Mandrekas (Greece), Mike Nayak (US), Fausto Viterbo (Brazil), Sami Saad (Lebanon), Cemal Senyuva (Turkey) and Kirill Pshenisnov (Russia). At the end of the day, Nazim Cerkes (Turkey) presented his Master Class on Rhinoplasty.

**Day 2:** The second day was devoted to Rhinoplasty with great speakers sharing their knowledge in almost all aspects of correction and beatification. Suleyman Tas (Turkey), Gianluca Campiglio (Italy), Dario Rochira (UK), Tunc Tiryaki (Turkey) and Kirill Pshenisnov (Russia) shared their knowledge and experience in this area. Face lifting and regenerative techniques were presented by Tunc Tiryaki (Turkey).

**Day 3:** During the final day of the Course, the major topics were body contouring, breast surgery and genital aesthetic procedures. Great contributors for those sessions were Gianluca Campiglio (Italy), Cemal Cenyuva (Turkey), Sami Saad (Lebanon), Francois Petit (France), Demetris Stavrou (Cyprus), Tunc Tiryaki (Turkey), Michael Scheflan (Israel), Mario Mendahna (Portugal), Paulo Montemuro (Sweden), Alexandre Munhoz (Brazil), Dmitry Batyukov (Belarus), Tatiana Mavrodi (Russia).

The first World Aesthetic Medicine and Plastic Surgery Online meeting drew the attention of over 200 aesthetic plastic surgeons from many countries. We received lots of positive feedback from the participants, and would like to share some with you to show the scale and relevance of the Course.

**«Thank you! Three days of immersion in aesthetic plastic surgery! Immersion to the nuances of our specialty, to our colleagues' experience, to their knowledge and experience! Super transmission of the presentations, video, fantastic moderation! Great simultaneous translation!»** D. Buzov, Plastic Surgeon, Russia.

**«Many thanks! Once again, I'm grateful to such an efficient congress! You have done a great job to prepare the event and it happened at the highest level!»**

S. Kolodiychik, Plastic Surgeon, Russia.

**«Let me express the gratitude for the WAMPS ONLINE ISAPS Course in this unique format! The organization was on the highest level! The deep scientific program and the professionalism of the faculty stimulates us to the further work and evolution. Many thanks to all speakers, moderators, and all those who made the congress happen!»** I. Shakirova, Plastic Surgeon, Russia.

**«I'd like to express the gratitude to the wonderful tandem of BIO Concept - the organizer of the congress and Clovermed - the general sponsor for the fantastic organization and conduct of the WAMPS -2020. Many thanks to Olga Zaseeva and Igor Bogorodiskiy for the interesting forum and their love to plastic and aesthetic surgery! Thanks to the ISAPS Education Council, Course Directors Yakis Kontoes and Apostolos Mandrekas and Kirill Pshenisnov!»** Y. Przhedetskiy, Professor, Plastic Surgeon.

Due to the multifunctional platform interesting presentations of the faculty, disputes with the participants and speakers' comments, lots of questions and discussions of clinical cases we felt ourselves united after several months of quarantine. Three days of the intensive program of WAMPS ONLINE-2020 passed quickly and we hope the event will have a great future!

The sponsors of the meeting were CLOVERMED (distributor of plastic surgery supplies: Mentor breast implants, PAL Liposculptor, Endotine, Marena post-surgical and compression garments, Spring Threads, MINT lift, NITHYA injectable Collagen), Polytech Health and Aesthetics, Motiva.

We are moving forward! We did not cancel our plans to mark the 10th Anniversary of ISAPS Courses in Russia - we just moved it to 2021!

**We invite you to the 10th Anniversary ICTPS- ISAPS Course in June 2021!**



*Kirill Pshenishov (Russia), Fausto Viterbo (Brazil), Gianluca Campiglio (Italy)*



*Dario Rochira (UK), Kirill Pshenishov (Russia), Cemal Cenyuva (Turkey), Gianluca Campiglio (Italy), Suleyman Tas (Turkey)*



*Mike Nayak (US) and Kirill Pshenishov (Russia)*



*Francois Petit (France), Cemal Cenyuva (Turkey), Sami Saad (Lebanon)*



*Cemal Cenyuva (Turkey) and Tatyana Mavrody (Russia)*



*Tunc Tiryaki (Turkey)*



*Suleyman Tas (Turkey)*

# FEATURE

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## WELCOME TO OUR NEW BOARD OF DIRECTORS

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Member-at-Large:	<b>Ivar van Heijningen</b> (Belgium) - Corporate Governance and Policies, Global Alliance
National Secretaries Chair:	<b>Michel Rouif</b> (France)
Education Council Chair:	<b>Ozan Sozer</b> (US)
Trustee:	<b>Renato Saltz</b> (US)
Parliamentarian:	<b>Sanguan Kunaporn</b> (Thailand) - NON-VOTING
Education Council Vice Chair:	<b>Francisco Bravo</b> (Spain) - NON-VOTING
Executive Director:	<b>Catherine Foss</b> (US-to Dec 31); <b>Sarah Johnson</b> (UK-after Dec 31) - <i>Ex Officio</i>

# FEATURE

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## RETIREMENT



**THOMAS M. BIGGS - UNITED STATES**  
ISAPS President, 2002-2004

### HURRAH . . .

Free at last from the burden of going to work every day, standing and working at an operating table on someone who may or may not be appreciative, dealing with unusual bleeding or swelling, and managing a variety of other temporary but unexpected problems.

Now one can play golf all day, take romantic trips, read all the books they have always wanted to read, and participate in innumerable pleasures which our busy schedules have denied us.

But . . . wait a minute. There's more to retirement than freedom from previous responsibilities. Don't be too hasty.

Several decades past, I took a two-year course on the Bible at my church, and afterwards also taught the course. It was broad and complete and covered both testaments - the underlying theme being "we are blessed to be a blessing."

When asked to consider the matter of plastic surgeons retiring, some description is necessary about exactly from WHAT is a plastic surgeon retiring and what does it mean. A plastic surgeon is one who has undergone an extensive educational process and has satisfied the requirement of their national board, one who has spent 40-50 years exercising the skills of this profession. In so doing, they are known not by an anatomical parameter (ENT, Cardio, Vascular, Bone, Joint), but for their innovative skills, which means the entirety of the human body. The purpose of this surgery has been to satisfy the needs of the patient, whether it be for functional

or appearance purposes or both. This satisfaction has the ultimate purpose of making the patient's life better.

When a plastic surgeon encounters a former patient in a grocery store, restaurant or any place where people gather, and is greeted with "Oh, Doctor. I'm so happy to see you. You operated on me thirty years ago and it made my life so much better," - they feel a burst of joy. The thought of retirement and the ending of thousands of these circumstances of joy creates a feeling of discontent. This is a loss of identity.

A plastic surgeon is an artist. The definition of ART being the taking of a medium and altering, molding or changing it in some way to replicate the vision the artist (in this case the plastic surgeon, with the patient's approval) has beforehand using specific skills. Plastic surgeons have the artist's genetic inclinations, which tug and pull at those in its possession.

When a plastic surgeon retires, they must have some way to use their talents to pursue excellence and provide a better feeling of a person toward themselves. In other words, seek a new identity which includes the expression of their art.

Whereas I've had the good fortune to pass on my experiences to the next generation through lecturing and writing, while keeping my physical skills optimal, each person going into retirement needs to find a way to maintain the feeling of well-being. Of great significance is a change of focus in our approach to daily activities.

Perhaps the most important change should be the recognition of the existence of one's own family members. These people may, or may not, have recognized a scarcity of the surgeon's involvement or interest in their lives. This should be a primary goal for correction.

In addition to this focus should be the pursuit of something creative and publicly benefiting.

## « ONE WHO HAS SERVED NEEDS TO CONTINUE TO SERVE. »

A second factor of retiring is that with retirement comes aging, and with aging comes impairment of any or all the body parts. In the years after retirement, one is guaranteed that the loss of physical and mental capacities will appear and probably progress, depending upon the number of years lived post retirement. This will include, from the author's point of view, lessening in optimal function of the skin, eyes, ears, teeth, heart, intestinal tract, genito-urinary system, hips, shoulders, hands and worst of all - the BRAIN.

These deficiencies will make the retiree a frequent visitor to physicians' and dentists' clinics . . . and many may require

operative intervention. All these problems require help in dealing with them, with family members being the front line of support.

As the years move on, this support becomes more and more necessary, intruding on the supporter's life in an increasing fashion. The retiree is certainly sensitive to the burden they are causing and this realization is a heavy burden in itself. Having described the problem, a solution is required. The disorders rarely go away. At best they don't progress very fast. What can the retiree do?

The author suggests that one recall that they have been blessed to have been given superb skills (physical, intellectual and creative), extensive training, opportunities to express their skills - all for the purpose of making someone's life better. This is itself a blessing for the retiree.

Now, as agism continues to creep, one should find ways to continue to give. Understanding that "old age" is when one spends more of one's time looking back on one's life whereas "youth" is a time of solely looking forward. Our lives' experiences give us an abundance of wisdom we can pass on. Employing these concepts, the way seems clear: invest oneself in the lives of younger people. Find ways to help them (ALL people can use help no matter their age or station). The more of oneself that is going out to others will not only be a blessing, but the giver will feel it as well thus proving that, despite our age and despite whatever infirmities we're encountering, we can still live in our retirement the admonition: We Are Blessed To Be A Blessing.

# FEATURE

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## SERVE AND THOU SHALT BE APPRECIATED (OR HOW TO BECOME A BOARD MEMBER...)



**IVAR VAN HEIJNINGEN, MD - BELGIUM**  
ISAPS Secretary

**A**NY non-profit organisation functions thanks to the efforts of a limited group of people who work diligently in the interest of the organization. Plastic surgery societies such as ISAPS are no exception to this fact. Being the president or a board member of a prestigious organization is a position many people want, but what does it take to get there? This article tries to describe what the ideal route to a board position should be and what the obstacles are.

### The ideal board

The ideal board consists of people with the qualities necessary to govern; so, you need people with organizational skills, financial skills, management skills, visionaries, educators, and executors. Of course, they should subscribe to the key values of the organization and have shown impeccable ethical behaviour since they serve as an example to the society as a whole.

The ideal board consists of a healthy mix of relatively new people, a solid group of experienced members and some senior members with institutional memory. It should have a healthy gender and age distribution and should ideally reflect the countries/continents the members of the society come from so that they feel adequately represented. They should function as a team supporting each other when and where possible.

Since these board functions are not paid it is almost impossible for any individual to do this job alone without support. The Executive Director and their team can give some support, but to run the society efficiently, a great number of committees are essential for its functioning. These committees do most of the work and the board uses their work to move the society in the desired direction. The ideal board is supported by an ideal executive team and an ideal group of committees with Chairs and members who are carefully chosen to do the job at hand.

### ISAPS SERVANT LEVEL

How do you get nominated for a position in the board or in any of the committees? What are the criteria? According to the By-Laws you must be an ISAPS member and past service to ISAPS is taken into account.

It is advisable for an organisation to write down what skill sets are most important for every board and committee member position and look for people who fill those qualities. The By-Laws are not the perfect place to describe this; it is better to do this in a policy that can be adjusted easily if needed. But following the By-Laws, how do we describe “past service to ISAPS?” Simply put, it is what you have done for ISAPS. Let’s call it ISAPS Contribution Level.

If we try to categorize this in an ISAPS Contribution Level list, that would be:

1. ISAPS member
2. Faculty of ISAPS educational events
3. National Secretaries, Standing and Ad hoc Committee members, ISAPS Educational Event Directors, (all current or past)
4. Chairs of Standing and Ad hoc Committees
5. Board members
6. Exco members and president

### NOMINATION CRITERIA

Transparency of the nomination procedure is extremely important to have the trust of the membership. Failure to do so will impact the membership in a negative way. The willingness to comply with board decisions and the coherence in the society will be threatened. If the path to leadership is clear and transparent the confidence of the membership in its leadership will follow. “Old boys’ network” and favoritism should be avoided at all times, since this sincerely undermines trust in leadership.

When looking for a candidate for a given position, the ideal procedure would be to choose these from the adjoining ISAPS Servant level.

- Thus, Board members are preferably drawn from Chairs of committees or else from National Secretaries, Standing and Ad hoc Committee members or ISAPS Educational Event Directors.
- Committee chairs are preferably drawn from the board, from the National Secretaries, Standing and Ad Hoc Committee members or ISAPS Educational Event Directors or else from faculty at ISAPS Educational events.

In order to be eligible for a leadership position, the candidate should have shown to have worked for the organization first.

**Besides this, other relevant criteria are:**

- whether the nominee's skill set and qualifications complement the needed skill set;
- previous and other directorial experience (e.g., board member in National or other societies);
- consideration of the nominee's experience as a thought leader and team player;
- the nominee's standing in the ISAPS community;
- the nominee's level of seniority as a Plastic Surgeon (e.g., a certain number of years working as a plastic surgeon are required);
- any declared or apparent conflict of interest;
- any other attributes the nominating committee believes will benefit the organization.

### NOMINATION PROCEDURE

Choosing the right people is a big responsibility that has a big impact on the integrity and future of the society. Nominations for most Committee Chairs are reserved for the future president. Committee members are chosen by the future president together with these chairs. This is essential for a president to put a team together to reach the goals put forward. The president can nominate three board positions: Education Chair, Education Vice-Chair and Parliamentarian. President and Past President are automatically elected. The Chair of National Secretaries has a separate election by all National Secretaries.

The nominations for the board are done by the Nominating Committee consisting of the President, President-Elect and Past President with two members elected from and by the general membership. The Executive Director is a non-voting member of the Nominating Committee. They come up with a proposal of suitable candidates for board positions based on the above-mentioned criteria.

The By-Laws allow the membership to propose additional candidates for specific board positions. These candidates must be vetted by the Nominating Committee against the above-mentioned criteria before putting them on the ballot.

### THE OBSTACLES

The recent By-Laws change, where some positions have been modified into four Member-at-Large positions, have produced a surprising impact on the membership. While we hardly ever had proposals from the membership for a board position, we now received many proposals. Some of these more valid according to the above-mentioned criteria, others less. The Nominating Committee will have the difficult task to judge these candidacies. If they allow all, the above-mentioned balance for a coherent team can be disturbed. If they allow none, the membership will feel unappreciated. That will be a challenge. The second big obstacle is the continental distribution. Although as mentioned above, the ideal board is represented equally among the continents, but the number of candidates from the different continents for any position has been very different. Many candidates from Europe, few from Asia. It is not always easy to get valid candidates from every continent, if only because the language is an obstacle for some. Continental distribution should be strived for, but should not be a key reason to select a candidate over a more qualified candidate.

The last obstacle is even more controversial. Do big countries with many members have more "rights" to a board member than smaller member countries? Can these countries "claim" a board member? This sounds reasonable, but actually is not! Since they have so many members, they should be able to easily find more suitable candidates to work for ISAPS compared to countries with only a few members. If they "use" this advantage, the Nominating Committee would have a big number of candidates from these countries in categories 3 and 4 to choose from which gives them more chance to be in leadership positions.

### CANDIDACY

The interest in board positions is much appreciated and shows that the growth of our membership has resulted in more interest for what has been done by the board. The most important skill to be eligible for a board position is the willingness to work for the society. There is no direct route to the board for anybody, but those helping ISAPS to become the leader in aesthetics by promoting education and patient safety have a big chance to work in any of the many committees and thus be spotted for a leadership position.



# ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

1. **ALGERIA**  
Algerian College of Plastic and Aesthetic Surgery (CACPRE)
2. **ARGENTINA**  
Sociedad Argentina de Cirugía Plástica Estética y Reparadora (SACPER)
3. **AUSTRALIA**  
Australasian Society of Aesthetic Plastic Surgeons (ASAPS)
4. **AUSTRIA**  
Österreichische Gesellschaft für Plastische, Ästhetische und Rekonstruktive Chirurgie (ÖGPÄRC)
5. **AZERBAIJAN**  
Society of Plastic Surgery Azerbaijan (SPSA)
6. **BANGLADESH**  
Bangladesh Society of Aesthetic Plastic Surgeons (BSAPS)
7. **BELGIUM**  
Royal Belgian Society for Plastic Surgery (RBSPS)
8. **BOLIVIA**  
Sociedad Boliviana de Cirugía Plástica Estética y Reparadora (SBCPER)
9. **BRAZIL**  
Sociedade Brasileira de Cirurgia Plástica (SBCP)
10. **BULGARIA**  
Bulgarian Association of Plastic, Reconstructive and Aesthetic Surgery (BULAPRAS)
11. **CANADA**  
Canadian Society for Aesthetic Plastic Surgery (CSAPS)
12. **CHILE**  
Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)
13. **CHINA**  
Chinese Society of Plastic Surgery (CSPS)
14. **COLOMBIA**  
Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)
15. **CYPRUS**  
Cyprus Society of Plastic, Reconstructive and Aesthetic Surgery (CySPRAS)
16. **CZECH REPUBLIC**  
Czech Society of Aesthetic Surgery (CSAS)
17. **CZECH REPUBLIC**  
Czech Society of Plastic Surgery (CSPS)
18. **DENMARK**  
Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)
19. **DOMINICAN REPUBLIC**  
Sociedad Dominicana de Cirugía Plástica Reconstructiva y Estética (SODOCIPRE)
20. **EASAPS**  
European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
21. **ECUADOR**  
Sociedad Ecuatoriana de Cirugía Plástica, Reconstructiva y Estética (SECPRE)
22. **EGYPT**  
Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)
23. **ESAPS**  
European Society of Aesthetic Plastic Surgery (ESAPS)
24. **ESPRAS**  
European Society of Plastic, Reconstructive and Aesthetic Surgery (ESPRAS)
25. **FINLAND**  
Suomen Esteettiset Plastikkirurgit ry. (SEP)
26. **FRANCE**  
Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
27. **GEORGIA**  
Georgian Society of Plastic Reconstructive and Aesthetic Surgery (GEOPRAS)
28. **GERMANY**  
Deutsche Gesellschaft der Plastische, Rekonstruktive und Aesthetische Chirurgie, e.V. (DGPRÄC)
29. **GERMANY**  
Vereinigung der Deutschen Aesthetisch Plastischen Chirurgen (VDAPC)
30. **GREECE**  
Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)
31. **GUATEMALA**  
Asociación Guatemalteca de Cirugía Plástica Estética y Reconstructiva (AGCOPER)
32. **HUNGARY**  
Hungarian Society for Plastic, Reconstructive and Aesthetic Surgery (HSPRAS)
33. **INDIA**  
Indian Association of Aesthetic Plastic Surgeons (IAAPS)
34. **INDONESIA**  
Indonesian Association of Plastic Reconstructive and Aesthetic Surgeons (InaPRAS)
35. **IRAN**  
Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)
36. **IRELAND**  
Irish Association of Plastic Surgeons (IAPS)
37. **ISAPS**  
International Society of Aesthetic Plastic Surgery (ISAPS)
38. **ITALY**  
Associazione Italiana di Chirurgia Plastica Estetica (AICPE)
39. **ITALY**  
Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)
40. **JAPAN**  
Japan Society of Aesthetic Plastic Surgery (JSAPS)
41. **JORDAN**  
Jordanian Society for Plastic and Reconstructive Surgeons (JSPRS)
42. **KAZAKHSTAN**  
Kazakhstan Society of Aesthetic and Plastic Surgery (NSAPS)
43. **KOREA**  
Korean Society of Aesthetic Plastic Surgery (KSAPS)
44. **KUWAIT**  
Kuwait Society of Plastic Surgeons (KSPS)
45. **LEBANON**  
Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)
46. **MALAYSIA**  
Malaysian Association of Plastic, Aesthetic and Craniomaxillofacial Surgeons (MAPACS)
47. **MEXICO**  
Asociación Mexicana de Cirugía Plástica Estética y Reconstructiva (AMCOPER)
48. **MOROCCO**  
Société Marocaine des Chirurgiens Esthétiques Plasticiens (SOMCEP)
49. **NETHERLANDS**  
Nederlandse Vereniging voor Esthetische Plastische Chirurgie (NVEPC)
50. **NICARAGUA**  
Asociación Nicaragüense de Cirugía Plástica (ANCP)
51. **NORWAY**  
Norwegian Society of Aesthetic Plastic Surgery (NSAP)
52. **OMAN**  
Omani Society of Plastic, Reconstructive and Aesthetic Surgery (OSPRAS)
53. **OSAPS**  
Oriental Society of Aesthetic Plastic Surgery (OSAPS)
54. **PAKISTAN**  
Pakistan Association of Plastic Surgeons (PAPS)
55. **PANAMA**  
Asociación Panameña de Cirugía Plástica, Estética y Reconstructiva (APCOPER)
56. **PERU**  
Sociedad Peruana de Cirugía Plástica (SPCP)
57. **PHILIPPINES**  
Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)
58. **POLAND**  
Polish Society of Plastic, Reconstructive and Aesthetic Surgery (PSPRAS)
59. **PORTUGAL**  
Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPRE)
60. **ROMANIA**  
Romanian Aesthetic Surgery Society (RASS)
61. **RUSSIA**  
Northeastern Society of Plastic and Reconstructive Surgeons (NESPRS)
62. **RUSSIA**  
Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS)
63. **SAUDI ARABIA**  
Saudi Plastic Surgery Care Society (SPSCS)
64. **SERBIA**  
Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)
65. **SERBIA**  
Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)
66. **SINGAPORE**  
Singapore Association of Plastic Surgeons (SAPS)
67. **SOUTH AFRICA**  
Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
68. **SPAIN**  
Asociación Española de Cirugía Estética Plástica (AECEP)
69. **SPAIN**  
Asociación Española de Cirugía Plástica Reparadora y Estética (SECPRE)
70. **SWEDEN**  
Svensk Förening för Estetisk Plastikkirurgi (SFEF)
71. **SWITZERLAND**  
Schweizerische Gesellschaft für Aesthetische Chirurgie (SGAC)
72. **SWITZERLAND**  
Swiss Society of Plastic, Reconstructive and Aesthetic Surgery (SSPRAS)
73. **TAIWAN**  
Taiwan Society of Aesthetic Plastic Surgery (TSAPS)
74. **TAIWAN**  
Taiwan Society of Plastic Surgery (TSPS)
75. **THAILAND**  
Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)
76. **TURKEY**  
Turkish Society of Aesthetic Plastic Surgery (TSAPS)
77. **UKRAINE**  
Ukrainian Association of Plastic, Reconstructive and Aesthetic Surgeons (UAPRAS)
78. **UKRAINE**  
Ukrainian Society of Aesthetic Plastic Surgeons (USAPS)
79. **UNITED ARAB EMIRATES**  
Emirates Plastic Surgery Society (EPSS)
80. **UNITED KINGDOM**  
British Association of Aesthetic Plastic Surgeons (BAAPS)
81. **UNITED KINGDOM**  
United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
82. **UNITED STATES**  
American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
83. **VENEZUELA**  
Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)
84. **VIETNAM**  
Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)

# IN MEMORIAM

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## PROFESSOR ALBERT DE MEY (1950 - 2020)



ALBERT DE MEY  
BELGIUM

With great sadness we learned of the death of our esteemed colleague and friend, Professor Albert De Mey, who passed away far too early and unexpectedly. Words are not enough to express this loss.

We knew Professor De Mey as a charming, dynamic man and a very committed member of our society and defender of our specialty. He was a member of ISAPS since 2001 and served as our National Secretary for Belgium from 2002 to 2010. He was the president of the Royal Belgian Society for Plastic Surgery from 2003 to 2005 and was the driving

force behind the application of their society to become “royal.” Numerous publications and educational events can be credited to his name. He was always interested in educating and developing others and applying his surgical skills to the benefit of those in need.

Our thoughts are with his wife Françoise, their children and grandchildren.

*Adapted from the notice sent by the Royal Belgian Society for Plastic Surgery.*

# IN MEMORIAM

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## PAULINO MORALES (1939 - 2020)



PAULINO MORALES  
ARGENTINA

Professor Morales was a former Rawson Hospital surgeon, disciple of Doctors Finochietto, Zavaleta and Marino - a very well-formed plastic surgeon, and involved in academic education.

In 1977 in Buenos Aires City, Professor Dr. Nestor Maquieira created the Superior Course of Especialization in Plastic Surgery and constituted the second institution for training plastic surgeons in Argentina. Dr. Morales was the first Director from 1977 to 1999 and trained many plastic surgeons, not only Argentinians but also trainees from around Latin America!

### His achievements include:

- Chief of Plastic Surgery Service, Hospital Frances, 1983-1989
- Past President Buenos Aires Plastic Surgery Society (SCPBA) 1989
- Honored Member SCPBA
- Past President, Argentinian Plastic Surgery Society (SACPER) 2000
- Former Director of the Triennial Course of Plastic Surgery Training (SACPER)
- Former National Delegate to IPRAS until 2006
- Chairman, Education Council IPRAS 2006-2010
- ISAPS Life Member

We join his family in prayers. Argentinian Plastic Surgery is in mourning.

*Gustavo Abrile, ISAPS National Secretary for Argentina*

# NS CHAIR REPORT

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## WHAT DOES THE POSITION OF CHAIRMAN OF NATIONAL SECRETARIES MEAN AND WHY IS THE SPIRIT OF THE ISAPS NATIONAL SECRETARIES FAMILY SO IMPORTANT?



**MICHEL ROUIF - FRANCE**  
Chair, ISAPS National Secretaries

**A**s most of you likely know, the Chair of National Secretaries (NS) is a voting member of ISAPS Board of Directors and participates in the decisions of the Board by voting as any other board member does. However, unlike the other board members, the Chair of NSs is elected by the NSs for a two-year-term, and not by ISAPS members. This “family” has 108 members (87 NSs and 21 Assistant NSs). We could qualify as Grand Electors or College of Electors - the group of NSs who are the ones who vote to elect the Chair and Assistant Chair of NSs. This group is therefore recognized by the Board of Directors as an autonomous group (By-laws, Article 6). As stated by our By-laws, Article 6.6 “Under special circumstances, the National Secretaries as an autonomous group may authorize electronic voting for the election of the NS Chair and Assistant Chair.” That is what we did this year because of the impossibility to hold our biennial business meeting. Among 107 member countries, those with fewer than three members don’t have a NS (21 countries), some have only a NS (66 countries), and some others, with more than 50 members, also have one or two Assistant NSs (ANS).

I see different interesting points in the particularity of ISAPS governance.

### QUICK CONNECTION

First, we have with this concentration of NSs an easy way to contact all ISAPS members (over 4,470). This makes it possible to manage a WhatsApp group with all of them. Therefore, in case of urgent questions or events (COVID-19, Lebanon explosion), we can very quickly have an idea of our members’ opinions.

### NATIONAL REPRESENTATION

Every NS (or ANS) is elected by members in their country and represent the voice of ISAPS members in that country. They can inform the Chair of NS in case of any problems. Usually, the connection between the NSs and the members in the country is very good in their NATIVE LANGUAGE - they can have their own WhatsApp group - which allows for better transmission and transparency of the information, “vertically”, coming up and coming down. This is a huge point, the native language for best communication. This shows once more the importance of the NS for an international association. The spirit of members, their concerns, their answers, the specific problems due sometimes to the richness of our different cultures can be forwarded in real time to the board and can help for a quick and sharp decision at the board level. The importance of this vertical quick streaming of information is precious in case of urgent decisions, but

also for the management of issues during the two-year term of the Board. That shows the importance of the election of your NS in your country, in order to have the most precise “temperature” of the membership at any time coming to the ISAPS central administration: our Board of Directors.

#### NS MEETS BOARD WEBINAR

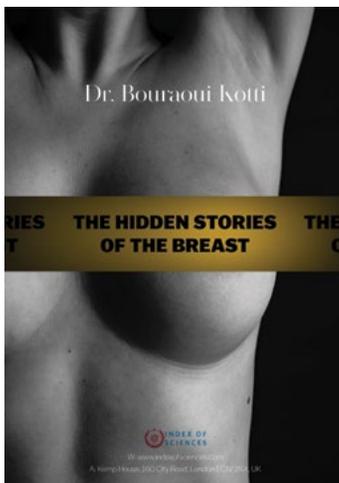
We recently had, on the 21st of August, an online “NSs meeting the Board.” It was a wonderful opportunity for sharing between the Board and the largest part of our NS family. The whole Board of Directors could explain, listen,

and answer questions coming directly from the NSs: that means actually from ISAPS members. Thanks to meetings and media tools, NSs can understand how ISAPS works and provide information to the 4,470+ members in their NATIVE LANGUAGE - and very quickly. In that way, the voice of any member, country or culture can be heard by the Board at any time.

Speak to your NS or ANS. He (or she) will be able to speak very quickly and accurately to the NS Chair (or the Assistant Chair) and your voice will be brought immediately to the Board!



## ISAPS MEMBERS WRITE

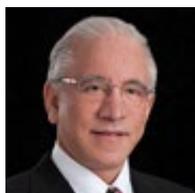


Dr. Bouraoui Kotti (Tunisia) is a former ISAPS National Secretary. Presently, Dr. Kotti is practicing in a private setting in Tunis as a consultant in plastic surgery with a visiting position to the American Academy of Cosmetic Surgery in Dubai.

**The book is available through Amazon.**

# ISAPS JOURNAL

## MESSAGE FROM THE EDITOR-IN-CHIEF



BAHMAN GUYURON, MD - UNITED STATES

I am happy to report that the journal impact factor (IF) of ISAPS' journal, Aesthetic Plastic Surgery, has gone up significantly due to higher quality article submissions. I am also delighted to see that so many of you have taken advantage of the COVID-19 situation and have used your

time effectively to produce meaningful manuscripts, which are either in the review process or have already been accepted.

Last year, our subscriptions went up by 20%. At the end of the first quarter of 2020, before the pandemic hit, subscriptions had substantially increased again. Indeed, if this trend continues, subscriptions will have increased by nearly 200% since I assumed my position as Editor-in-Chief. I am profoundly grateful to those of you who have been serving as reviewers during these very difficult times. This unprecedented increase in submissions requires a great deal of your time and energy in order to stay on schedule. However, it also offers more



selectivity and augments our ability to choose articles that are more valuable to you.

Aesthetic Plastic Surgery is the most subscribed aesthetic journal and reaches over 12,000 readers and organizations. Each article is likely to be read by over 3,500 members alone.

Unfortunately, due to the pandemic we will not be able to have an in-person Editorial Board Meeting this year. However, we will schedule a virtual meeting sometime before the end of the year.

The August issue of the journal celebrates the 50th anniversary of ISAPS by republication of the 20 most referenced and 20 most downloaded articles that have been published in our journal over the last 20 years. Additionally, the authors who are living were asked to write an update on their article. My hope is that you found this issue of the journal particularly interesting.



 Floating Hospital in Bramhaputra River

Figure 1: Map of Bangladesh showing the Bramhaputra river, where floating hospitals operate.

# HUMANITARIAN



SAYEED AHMED SIDDIKY - BANGLADESH  
ISAPS National Secretary for Bangladesh

## CLEFT AND BURN SURGERIES IN OUTREACH CAMPS OF BANGLADESH

There is nothing more satisfying than being able to work for underprivileged children in a rural setting. Bangladesh is a country of 170 million people. The population density is overwhelming. This country is crisscrossed by rivers and canals that ultimately drain south into the Bay of Bengal. Although the cities are big and bustling, most of the country is made up of villages – 68,000 of them to be exact. One of the major rivers called Bramhaputra flows vertically, in the northern part of the country (Figure 1). Within the confines of this river are numerous islands largely made up of sand. These are in fact the remotest parts of the country, with no electricity and no infrastructure. People here live a very basic life based on fishing and some cultivation. Schools and hospitals are nonexistent.

Babies born with birth defects like cleft lip and cleft palate in these remote islands do not have access to surgery. It can be mentioned here that around 7000 babies are born every year

with cleft deformities in Bangladesh. Most of them get free surgical treatment in various hospitals throughout the country by plastic surgeons supported by NGO's. However, this particular stretch of the Bramhaputra River with its numerous islands, is pretty much isolated from the rest of the country. The people living on these islands cannot afford to go to the inland hospitals for treatment – unless in dire emergencies.

I feel privileged to work for this isolated community as a plastic surgeon - moving from one island to the other on a floating hospital, thanks to the NGO called Friendship that has brought medical facilities to the doorsteps of these underserved people. When I teamed up with this NGO few years back, I experienced a whole new world. Although I have been involved in regular cleft camps in major city hospitals for more than 12 years now, this was different.

The floating hospitals are small ships with an operation theatre facility (**Figure 2**). They anchor to one of the major islands and provide medical services to that community for two to three months at a stretch. As winter approaches, the hospital floats upstream and anchors at a different island, providing treatment to a new group of people. I would stay in the floating hospital for an average of three days, operating on cleft babies. I do it several times a year. My team members include an anesthetist, an OR nurse and a documentation assistant. The travel starts from the capital city Dhaka, by train or by a local flight. The second lap of the journey is by 3-wheeler scooter - which takes about three to four hours. The final lap is an hour of travel by country boat (**Figure 3**). This takes us across the river to one of the islands where the floating hospital is anchored. The journey can be quite challenging especially in the summer time. In addition to the heat and humidity, there is always a chance of being caught in a cyclone. So, we keep an eye on the weather forecast all the time. Food on the ship is something that we all look forward to - because the vegetables and fish are all so fresh.

During patient screening, we examine all the patients lined up for surgery. Some of the families have never been to a doctor before (**Figure 4**). Sometimes, I would see an elderly person coming for cleft lip repair. These people grow up with the facial deformity, never knowing that there is a remedy. I am amused to see the expression of their family members when they see the sudden change in facial appearance following the surgery (**Figure 5**). We also see a lot of burn contracture patients. They are usually children and woman who sustain burn injuries and cannot avail proper treatment.

Temporary tin sheds are constructed on land close by to accommodate all the patients and their family members coming for surgery. A make-shift kitchen serves for the cooking. Free medicines are supplied for all patients. After my first postoperative



Figure 2: Friendship floating hospital, anchored to one of the islands.



Figure 3: Crossing the mighty Brahmaputra River with my team.



Figure 4: Pre-operative interaction with the patient.



Figure 5: Cleft lip reconstruction in progress, inside the ship's OT.

check up, any further dressing is done by the medical officer and nurses on board the ship (**Figure 6**).

As much as I love to practice aesthetic plastic surgery in my city hospitals, I long to go out to these remote island people as frequently as I can - to serve them. These outreach camps have now become a habit and passion, which I would like to continue for the rest of my life.



Figure 6: The full team, and some of the patients, on the ship deck.

# FILACP HUMANITARIAN PROJECT:

## IV PLASTIC SURGERY ALTRUIST CAMPAIGN - 2019



MARIA TERESA ZAMBRANA ROJAS - BOLIVIA  
ISAPS National Secretary for BOLIVIA

The Ibero Latin American Federation of Plastic Surgery (FILACP), as an international organization of specialists in plastic surgery united by a common language, also watches over and encourages the participation of its surgeons in humanitarian work campaigns providing medical assistance with highly complex surgeries to patients from social settings or less favored regions, which can thus improve patients' quality of life and their integration into society.

In this paper, we present as an example last year's work: the activities developed by the teams enrolled in the IV Plastic Surgery Altruist Campaign - 2019.

The campaign was organized by FILACP through its website, Facebook page, and YouTube channel and through letters sent to the presidents of the National Societies of Plastic Surgery and to the delegates of the medical and social committee for dissemination to the 22 member countries. This letter was signed by the President of FILACP, Dr. Alejandro Duarte. The campaign was coordinated by the International Relations Department, headed by Dr. Alfonso Vallarta and the Medical-Social Committee, directed by me.

The surgical activities to be carried out would include: cleft lip and palate surgeries; sequelae of burns; hand and limb trauma; congenital pathologies of all kinds; and post-breast cancer reconstruction.

The surgical working days were held during July and August with teams comprised of plastic surgeons, most of them members of ISAPS, anesthesiologists and nursing staff who worked voluntarily, altruistically, and either in a personal capacity or supported by the health institutions in which they usually work or by foundations with which they collaborate.

Those interested in participating contacted the address provided by FILACP for the general coordination of the groups and the count of activities through [medicosfilacpsocial@gmail.com](mailto:medicosfilacpsocial@gmail.com) and were integrated into the final group of activities. A template was sent to collect the data.

Plastic surgeons from 11 countries participated in the IV Plastic Surgery Altruist Campaign: Argentina, Brazil, Bolivia, Colombia, Chile, Cuba, Ecuador, Mexico, Nicaragua, Paraguay and Peru. In total, 1,280 patients were seen in consultation, of which 1,008 (78.75%) finally underwent surgical treatment. By sex: 515 women (51.08%) and 493 men (49.89%). The age range was between 2 months and 76 years, with a mean of 9.6 years.

The intervened pathologies were: 313 fissured patients (31%), 172 with sequelae of burns (17%), 242 breast reconstructions (24%) and 281 in the miscellaneous group (28%).

The Medical Social Committee of FILACP, through the work published in ISAPS News, want to thank each and every one of the surgeons who participated in this IV Plastic Surgery Altruist Campaign.

The surgical activity carried out on this occasion contributes to disseminating the reconstructive aspect of the specialty and most importantly to improving the quality of life of the most disadvantaged patients.

Our objective was fulfilled by contributing to the change of the main image that plastic surgeons give us worldwide, demonstrating that not only the aesthetic side of the specialty is our focus as plastic surgeons, but also reconstructive and social activity is very important.



Team of Dra. Teresa Zambrana in Bolivia.



Team: Drs. José Antonio León, Alfonso Miranda, José Mena, Alejandro Duarte, Blas Domínguez, Héctor Lino, México City.



Team of Dr. Fernando Quintana, Ecuador.



Dr. José Herboso, Argentina



Team of Dr. Cristian Erazo, Chile.



Team of Dr. Edison Ramos, Ecuador.



Team of Dr. Hugo Barbosa, Argentina.



Team of Dr. César Kelly Villafuerte, Brazil.



Team of Dr. Carlos Vacafloor, Bolivia.



Team of Team of Dr. Marco Antonio Salazar, Colombia.



Team of Dra. Alicia Sigler, en Ensenada, Baja California, México.



Dr. Carlos Vacafloor, Bolivia.



Team of Dra. Teresa Zambrana, Bolivia.



Team of Dr. Alfredo Carballo en La Paz, Baja California Sur, México.



Team of Dr. José Manrique en Campeche, México.



Team of Drs. Miguel Viera, Ignacio Lugo, Martín Morales, David Trejo, Cynthia Euán, Arnoldo Topete, Jesús Escriva, Guillermo Castorena, Mariana Calderón and Alfonso Vallarta en Tepic, Nayarit, México.

# HISTORY

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RICCARDO F. MAZZOLA, MD - ITALY  
Associate Editor, History of Medicine

## PLAGUE: THE MOST DEVASTATING EPIDEMIC IN HISTORY. ***PART TWO***

### Summary of PART ONE

**T**hroughout millenia, numerous epidemics/pandemics have occurred, produced either by bacteria or virus. Plague is considered the most devastating infectious disease known to man. Apparently, the first epidemic reported in the literature was the plague of Athens (430 BC), fully described by the Greek historian Thucydides. It caused 100,000 deaths, around 30-50% of the whole population; however, some historians believe that it was a typhus epidemic. The first plague pandemic, or the Plague of Justinian, named after Justinian I (ca. 482-565 AD), the Eastern Roman Emperor, affected the whole Byzantine Empire in 541-542 AD. It lasted for more than two centuries until 750 AD with various waves of recurrences. The number of deaths was calculated between 25-100 million, almost half of Europe's population. The next great plague pandemic was the dramatic Black Death (1347-1353). With 50-200 million deaths, at least a quarter of the European population, the Black Death was the most devastating pandemic in history. To reduce contagion, in 1377, the city port of Ragusa (now Dubrovnik) extended the lockdown to forty days. The term quarantine (*Ital. quaranta*), was first introduced on that occasion.

### PART TWO

#### **From the Sixteenth to the Twentieth Century**

The recurrence of the plague - from the 14th to the 17th century, plague reappeared every year in Europe and in Mediterranean regions, with dramatic consequences. Plague was also constantly present between 1500 and 1850, in numerous areas of the Islamic world, repeatedly striking the

major cities of North Africa, like Algiers in 1620-1621 with an estimated loss of 30,000-50,000 people, and again in 1654-1657, 1665, 1691, 1740-1742. Constantinople was severely ravaged between 1701 and 1750 with 37 major episodes and 31 between 1751 and 1800. Also Damascus and Baghdad had dramatic plague outbreaks. Two-thirds of the population of these cities died from plague.

#### **The Great Plague of Milan (1629-31)**

After a period of more than two centuries, relatively free from recurrences, suddenly in 1629, the infected German Landsknecht mercenary troops invaded Mantua (Northern Italy), as part of the Thirty Years' War (1618-1648), bringing the bubonic plague into the city. From here the disease spread out in three directions: to the West (Milan, Lombardy), to the East (Republic of Venice) and to the North (Tyrol). Despite the preventive public health measures adopted, including quarantine, forbidden access to the Landsknecht troops, lockdown of the contaminated townspeople in a restricted area called Lazzaretto, outside the city walls, Milan suffered the consequences of a dramatic contagion between 1630 and 1631, with more than 60,000 deaths out of a total population of 130,000 (about 46%).

The disease was named the *Manzonian plague*, after the poet, philosopher and novelist Alessandro Manzoni (1785-1873), who, in 1840, wrote the most famous Italian historical novel "*I Promessi sposi*" (The Betrothed) set in Milan during the 1630 plague epidemic. Here the report of a very emotional episode of a mother, who is entrusting the cadaver of her 9-year old daughter, Cecilia, to a monatto

(the person in charge of collecting the cadavers for burial during the plague).

From *“I Promessi sposi”* (Chap. 33): “A female, whose aspect won the regards of every beholder, came out of one of the houses, and approached the cart. In her features was seen beauty, veiled and clouded, but not destroyed, by the mortal debility which seemed to oppress her; the soft and majestic beauty which shines in the Lombard blood.

Her step was feeble, but decided; she wept not, although there were traces of tears on her countenance. There was a tranquillity and profundity in her grief, which absorbed all her powers. But it was not her appearance alone which excited compassion in hearts nearly closed to every human feeling; she held in her arms a young girl about nine years of age, dead, but dressed with careful precision; her hair divided smoothly on her pale forehead, and clothed in a robe of the purest white. She was not lying, but was seated, on the arm of the lady, her head leaning on her shoulder; you would have thought she breathed, if a little white hand had not hung down with inanimate weight, and her head reposed on the shoulder of her mother, with an abandonment more decided than that of sleep. (...)

A hideous monatto approached the lady, and with unusual respect offered to relieve her of her burthen. “No,” - said she, with an appearance neither of anger nor disgust - “do not touch her yet; it is I who must place her on the cart. (Figure 1). Take this,” and she dropped a purse into the



Figure 1: The cart collecting plague corpses during the Great Milan plague (1630). From Manzoni A. *I Promessi sposi*. Milan, 1840.

hands of the monatto; “promise me not to touch a hair of her head, nor to let others do it, and bury her thus.” The monatto placed his hand on his heart, and respectfully prepared a place on the cart for the infant dead. The lady, after having kissed her forehead, placed her on it, as carefully as if it were a couch, spread over her a white cloth, and took a last look; “Farewell! Cecilia! rest in peace! Tonight we will come to you, and then we shall be separated no more!” Turning again to the monatto, “As you pass tonight,” - said she - “you will come for me; and not for me only!”



Figure 2: The Church S. Maria della Salute in Venice, built in 1631 for deliverance from the plague.

### The plague in Venice

- East of Lombardy, the Republic of Venice experienced a dramatic outbreak in 1630. The disease ravaged Verona (the city of Romeo and Juliet) and Venice severely, with a reported 33,000 and 46,000 deaths respectively, out of a population of 54,000 and 140,000 (about 61% and 33%). However, due to the preventive

measures adopted, the epidemic was relatively short. The following year, in mercy to the Madonna della Salute (Our Lady of Health) for the deliverance of the city from the plague, the Venetians built the church Della Salute, a masterpiece of baroque architecture with a spectacular dome, facing the Canal Grande, often reproduced in paintings by famous artists (Figure 2).

**The plague in Naples** - Later outbreaks of the great bubonic plague of Northern Italy included the city of Naples, where it caused 240,000 deaths out of 450,000 inhabitants (about 50%). The poor hygienic local conditions favored the diffusion of the disease.

### The Great Plague of London (1665-66)

A new tragic plague epidemic spread out rapidly in London in April 1665 after a period of relative quietness which lasted about a hundred and 165 years (the last reliably reported episode occurred in 1499). Rodents carrying infected fleas on their backs were considered

responsible for transmission. However, one of the the main causes was undoubtedly the poor hygienic condition, the absence of sanitation, and the mass of rubbish and waste filling the suburban areas particularly. Finally, the heat of the summer months favored the diffusion of the disease. Official dog- and cat-catchers were hired with the specific task to eliminate these animals, supposed as the origin of the infection, whereas flea-bearing rats were left undisturbed. The Royal College of Physicians, requested to provide a plan to counter the diffusion of the disease, was only able to supply the same measures adopted in the 14th century.

As soon as someone caught the infection, he was immediately quarantined, secluded at home with the rest of the family, the windows locked to avoid diffusion of the, “*miasmatic air*”, instead of isolating him outside the city. There was no treatment available. The whole family, the healthy, the infected and the dead, were locked down in the same home. If one caught the disease, he had roughly two weeks to live. People were desperate. The city of London had become a “vast mortuary.” Only a restricted number of practitioners visited the patient. To protect themselves from contagion, doctors had developed a new type of gown.



Figure 3: A 17th century plague-doctor with his typical apparel. The beak contained aromas and a sponge with vinegar. From Bartholinus T. *Historiarum Anatomicarum... Centuria V.* Copenhagen, 1661.

### The apparel of the plague doctor

- The physician wore a typical over-clothing long garment with pants, gloves and a hat, all made of waxed leather or canvas (Figure 3). The face was covered by a mask, with spectacles opening on the eyes and a curved beak, similar to a bird's beak, with straps that held it in position in front of the nose. The beak, with two holes for breathing, held aromatic essences, like dried flowers, herbs (including mint), spices, camphor, or a vinegar sponge. Finally, the plague doctor used a wooden cane for indicating the areas requiring special

attention, for examining patients without touching them, and for clothing removal.

Interestingly, one of the most popular masks worn during the Carnival of Venice mimics the facial mask of the plague doctor. (Figure 4)



Figure 4: The popular plague doctor mask, worn during the Carnival of Venice.

By the time the plague ended, about 100,000 people, or 15% of London's population, were dead. Fortunately, an unexpected though dramatic event suddenly blocked the diffusion of the disease. On September 2, 1666, the Great Fire of London began. It lasted four days and burned a large part of the city, including the suburban areas, filled with garbage and trash.

After the two-year plague outbreak, London has remained free from major epidemics ever since.

### The Plague of Marseille (1720-23)

The Great Plague of Marseille started when the ship called Grand-Saint-Antoine coming from Lebanon, Turkey and Cyprus, docked in the port of Marseille, France in May 1720 with precious merchandise of silk and cotton goods. Sanitary legislation was very strict in Marseille regarding arrivals from plague-endemic areas. Sailors and visitors would not be admitted into the city until they had first quarantined. Despite this, the plague spread rapidly. Early disembarkment of the precious, but contaminated goods, and the presence of rats carrying infected fleas, were the most likely explanation.

Not only Marseille, but also the surrounding areas of Provence (Southern France) were ravaged over the next three years. Until 1723, as many as 100,000 people died, about 30% of the population. This was the last major outbreak of bubonic plague in Western Europe.

### **The Plague of Moscow (1771 -72)**

This bubonic epidemic originated in Moldova during the Turkish-Russian war (1768-74).

In January 1770, it moved northward through Ukraine and central Russia, reaching Moscow in September 1771. It was also known as the plague of 1771, the last massive outbreak of plague in Central Russia.

The disease was so aggressive that it killed about 1,000 Muscovites per day (20,401 confirmed dead by the end of September). To escape the contagion, three quarters of the population fled the city.

Moscow sanitary inspectors declared a state of emergency, locking down shops, inns, taverns, factories and even churches; the city was placed under quarantine. The terror of quarantined inhabitants, denied of their trade and recreation habits, exploded into violence. Riots spread through the city and culminated in the murder of the Archbishop Ambrosius, who was supporting the avoidance of crowds during religious ceremonies.

The Empress Catherine II (also called Catherine the Great) tried to restore public order with considerable difficulties. By the end of September, the riot was sedated. The plague killed between 52,000 and 100,000 people. At that time, Moscow had a population of about 250,000.

### **The Third Pandemic (1855-1960)**

The third great plague pandemic started probably in Yunnan province (Southwestern China) in 1855. It reached Guangzhou (Canton) and Hong Kong in 1894. All these port cities were potential plague spreading centers due to the cargoes, shipping goods all over the world. The disease arrived in Bombay (now Mumbai) in 1896 and in Calcutta in 1898. It appeared in Cape Town (South Africa) and San Francisco (USA) in 1900, in Bangkok in 1904, in Guayaquil (Equador) in 1908, in Colombo (Sri Lanka) in 1914 and in Pensacola (USA) in 1922. These port cities were struck severely, but of all the areas, India suffered the most, with more than 10 million deaths.

According to the World Health Organization (WHO), the pandemic was considered active until 1960.

The good news was that the third plague pandemic was the last one, for it coincided with a series of important scientific achievements in the understanding and controlling of the disease.

### **The Bacterium of the Plague: A Crucial Discovery (1894)**

In 1894, during the Hong Kong epidemic, the bacterium causing plague was isolated independently by two bacteriologists, the Swiss-French Alexander Yersin (1863-1943) working for the Pasteur Institute, and the Japanese Kitasato Shibasaburo (1853-1931), a former associate of Koch. Both researchers found bacteria in fluid samples taken from plague victims. Yersin then injected them into rats and observed that rats died quickly of plague. He called the new bacillus *Pasteurella pestis*, as a tribute to his mentor Louis Pasteur (1822-1895). However, in honour of Yersin himself, the bacterium was renamed *Yersinia pestis* in 1970. Yersin was also able to show for the first time that the same bacillus was present either in the rats or in the human beings, demonstrating the potential way of transmission of the disease. In 1894, during the Hong Kong epidemic, he prepared the first anti-plague serum. The results were not particularly promising (4). A vaccine was discovered, but its efficacy was questioned. At present, no licensed vaccine is available. However, serum and vaccine are used in preventing or counteracting the consequences of a variety of plague clinical forms caused by *Yersinia pestis*.

Fortunately, the various forms of plague are highly responsive to antibiotic therapy. After two millenia and almost 300 million deaths, bubonic plague, the most devastating acute infectious disease known to man, has almost completely disappeared, thanks to Alexander Yersin. The world should be greatly indebted to him!

Nowadays, about 600 cases a year are reported by the WHO, in the Democratic Republic of Congo, Madagascar and Peru.

### **Conclusion**

Both plague and Covid-19 are infectious diseases, the first one caused by the bacterium *Yersinia pestis*, whereas the second by severe acute respiratory syndrome Coronavirus 2 (SARS-Cov-2). Despite the different origin, plague and coronavirus have numerous similarities.

1) The beginning of the outbreak - Most plague epidemics started in Asia and particularly in China, the third plague pandemic in the Yunnan province in 1860. Coronavirus pandemic originated in Wuhan, Hubei province (China).

2) Wave of recurrences - Plague constantly recurred over the centuries. Coronavirus has already returned in China, South Korea, and Japan. A second wave of coronavirus pandemic might be expected also in Europe. For this, prevention and sticking to the rules is essential.

3) Transmission - Bubonic and septicemic plague are transmitted by flea bites or infected animals, whereas the pneumonic form diffuses generally between people through the air, via infectious droplets (coughing or sneezing on another person). Coronavirus is transmitted through the air or by direct physical contact.

4) Prevention - In both cases, hygienic rules, lockdown, social distancing and quarantine remain the gold standard to prevent the spreading of the disease and individuals living in areas at high risk of exposure should be extremely strict in observing these guidelines to avoid unpleasant consequences. Historically, the rapid diffusion of the plague in Marseille, in 1720, with its 100,000 deaths should remain as an example of bad management of sanitary legislation and at the same time a warning to stick to the rules.

5) Medical treatment - Plague medical treatment was unavailable for millenia. As we have seen, theriac, based on a supposed miraculous remedy, was the only possibility, until the advent of antibiotic therapy. For Coronavirus, despite the multiple clinical trials running all over the world, the numerous drugs proposed from hydroxychloroquine, to antiviral therapies, to survivors' plasma, are ineffective. The discovery of a vaccine to protect against infection rather than treating it, looks promising. The entire world's population is anxiously awaiting it.

Finally, before concluding this overview about the plague and Coronavirus, we would like to raise a thought-provoking question. May asters influence the onset of the disease? For centuries the tails of comets were considered responsible for bad omens (**Figure 5**).

Seven comets were seen between 1298 and 1314 and numerous others between 1500 and 1543. All of them were associated with dramatic plague outbreaks. On December 28, 2019, ten days after the first cases of the new Coronavirus infectious disease were reported in Wuhan, the C/2019 Y4 (ATLAS) comet was discovered. Is there any possible relationship between comets and Covid-19? (5). The question is left open, unanswered for personal considerations.



Figure 5: An astronomer scans a comet. From Mezzavacca F. Bologna, 1701.

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# 50th ANNIVERSARY

## HISTORY OF ISAPS



# HISTORY OF ISAPS

## THE FOUNDING

ISAPS can look back with pride on a 50-year history since the first draft of the Constitution and By-Laws was presented in São Paulo on October 1-4, 1969, and on the accomplishment of the goals as summarized in the Act of Organization on February 12, 1970, at the Headquarters of the United Nations in New York. This site was chosen to reaffirm the international scope of the Society. The Founding and following EXCO Members, always backed by the General Assemblies, guided the Society in a straight direction overcoming birth pains and resisting human temptations.

[Click here](#) to read our history.



*The Founders*

THE FOUNDERS
Salvador Castanares - USA
Perseu Castro de Lemos - Brazil
Mario Gonzalez-Ulloa - Mexico
Ulrich T. Hinderer - Spain
John R. Lewis, Jr. - USA
Ernesto F. Malbec - Argentina
Hector Marino - Argentina
Rodolphe Meyer - Switzerland
John C. Mustarde - United Kingdom
Guillermo Nieto Cano - Colombia
David Serson Neto - Brazil
Jose C. Vinas - Argentina

THE CHARTER MEMBERS	
Leo A. Bornstein - Israel	Seiichi Ohmori - Japan
Ernestor Caronni - Italy	Jack P. Penn - South Africa
Jack Edward David - Argentina	Darrel Shaw - USA
Claude Dufourmental - France	Joseph Tamerin - USA
Simon Fredricks - USA	
William A. Lange - USA	
Gordon Letterman - USA	
William R.N. Lindsay - Canada	
David Napier Matthews - United Kingdom	
D. Ralph Millard Jr. - USA	
Lorenzo Mir Y Mir - Spain	
Roger Mouly - France	

## ISAPS PAST PRESIDENTS



**2018-2020**  
**Dirk Richter, MD**  
Germany



**2002-2004**  
**Thomas BIGGS, MD**  
US



**1985-1987**  
**James SMITH, MD**  
US



**2016-2018**  
**Renato Saltz, MD**  
USA



**2000-2002**  
**K. Guler GURSU, MD**  
Turkey



**1983-1985**  
**Benito VILAR-SANCHO, MD**  
Spain



**2014-2016**  
**Susumu TAKAYANAGI,**  
MD, PhD  
Japan



**1997-2000**  
**Kiyotaka WATANABE, MD**  
Japan



**1981-1983**  
**Seiichi OHMORI, MD**  
Japan



**2012-2014**  
**Carlos UEBEL, MD, PhD**  
Brazil



**1995-1997**  
**Ricardo BAROUDI, MD**  
Brazil



**1979-1981**  
**Sanford GLANZ, MD**  
US



**2010-2012**  
**Jan POELL, MD**  
Switzerland



**1993-1995**  
**Blair ROGERS, MD**  
US



**1977-1979**  
**Jack DAVIS, MD**  
Argentina



**2008-2010**  
**Foad NAHAI, MD, FACS**  
US



**1992-1993**  
**Guy JOST, MD**  
France



**1975-1977**  
**Ulrich HINDERER, MD**  
Spain



**2006-2008**  
**Bryan C. MENDELSON,**  
FRACS, FACS  
Australia



**1989-1992**  
**Jose GUERREROSANTOS, MD**  
Mexico



**1973-1975**  
**Mario GONZALEZ-ULLOA, MD**  
Mexico



**2004-2006**  
**Joao Carlos SAMPAIO GOES,**  
MD, PhD  
Brazil



**1987-1989**  
**Rodolphe MEYER, MD**  
Switzerland



**1970-1973**  
**John LEWIS, Jr., MD**  
US

# REMEMBRANCE

## WHAT ISAPS HAS MEANT TO ME



**THOMAS M. BIGGS - UNITED STATES**  
ISAPS President, 2002-2004

**T**wenty-two years after finishing my residency, where I had had excellent training in all aspects of plastic surgery (head and neck, burns, hand, urogenital, general reconstruction with grafts and flaps, and aesthetic surgery), taught me primarily by Dr. Mel Spira and others, I realized that my practice was primarily aesthetic. This was not so much by intent on my part, but simply the way referrals flowed. I was an active member of ASPRS and the AAPS. ASAPS was young and I participated, but I was never invited to be part of the executive branch whereas I was delighted to see all the contributions coming in from plastic surgeons across the border from the US and thus was led to join ISAPS.

Joining ISAPS was pleasantly revealing. I saw that many things were evolving around the world that were quiescent in the US. This realization led me to coin the phrase “ISAPS is where the world and new ideas come together.” I was recognized by Dr. Jose Guerrerosantos as someone who could contribute and he invited me to be a participant in his annual congress.

In 1972, I had been invited by the Brazilian Society to lecture at their annual meeting in San Jose Do Rio Preto where I was astounded by the quality of work being done in Brazil. That same trip took me to Rio de Janeiro where I started a

life-long relationship with Ivo Pitanguy – and the same thing occurred in Campinas/Sao Paulo with Ricardo Baroudi. From that trip, I realized that excellent plastic surgery was going on strongly in places beyond US shores. Then, in 1987, I met Ruth Graf which began a lifelong companionship through a commonality being the search for excellence. 45 trips to Brazil followed that fortunate experience in 1972.

In 1989, at the biennial ISAPS Congress in Zurich where Jose Guerrerosantos was elected president, he invited me to be the program chairman for his meeting the next year in Guadalajara, and thus began my rise in the executive branch of the organization. I was appointed National Secretary for the US and then Chairman the next year. In 1999, in San Francisco, I met Sergey Nudelman who at that time was the most recognized plastic surgeon in Russia and who, the next year at the ISAPS biennial meeting in Tokyo, invited me to Ekaterinburg, Russia, which began my ultimate (to date) 12 trips to Russia for extensive educational experiences, and where I learned of the depth of the Russian culture and the strength of its people. The same thing occurred with ten trips to India with Neeta Patel and Satish Arolkar. My ascent in office in ISAPS continued and in Tokyo in 2000, I was elected as President-Elect and in 2004 conducted the ISAPS biennial Congress in Houston as the ISAPS President.

From 2002 to 2010, I served as Editor-in-Chief of our journal, *Aesthetic Plastic Surgery*, where I experienced a flood of intellectual material coming from outside the US, increasing even more my conviction that the world's great ideas come through ISAPS. The sum of all this is that whereas I was busy at home operating, writing, lecturing and participating in the education of more than 100 residents (most of whom have exceeded me in the quality of their work - which is as it should be) I was not forgotten and was named an Icon of Plastic Surgery by the American Association of Plastic Surgeons.

My journey in plastic surgery has included lecturing in 63 countries and performing surgery in many of those. I've met many, many people whom I've come to love and respect. I don't have the space to name them all, hundreds, maybe thousands, and I've come to appreciate even more one of my "sayings." I've come to realize that all of us, especially

those of us in ISAPS, live similar lives. We see patients, we operate on patients, we experience the joy of the pursuit of excellence on our patients' behalves, we experience the misery of cases that don't go as well as we'd expected, we're introduced to new things - some of which we try and some of which we wait until later to try, and we have families that need our nurture. ALL of us in ISAPS live these kinds of lives. I've often said in my lectures to my attendees that "I actually have more in common with YOU than I do with my next-door neighbor." Which all leads us to the point of what ISAPS has meant to me - the conclusion that:

*THE BONDS THAT UNITE US ARE GREATER THAN THE BORDERS, BOUNDARIES AND LANGUAGES THAT DIVIDE US.*

To the readers of this remembrance, I am driven to say, without hesitation, I love you all.

## ISAPS - MY FAMILY

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**SUSUMU TAKAYANAGI - JAPAN**  
ISAPS President, 2014-2016

It was an ISAPS course in Paris in 1997 when I was invited as a member of the faculty for the first time. The course director was Yann Levet. On that occasion, I found a lot of great plastic surgeons including Tom Biggs and Foad Nahai very active in ISAPS.

After that, I was pleased to be invited to many ISAPS courses and symposia. When Bryan Mendelson, Foad Nahai and Tom Biggs encouraged me to join the Education Council,

I immediately accepted. It was a great honor to organize lots of ISAPS courses and symposia all over the world as a course director. I invited excellent plastic surgeons as faculty members and worked with them and their families. Every course and symposium left pleasant memories.

I was named the Program Chair of the ISAPS Congress in Melbourne in 2008 by Bryan Mendelson who was the President at that time. I am deeply grateful for his advice

and support leading me to the board of ISAPS. Bryan Mendelson is one of the people who has had the most important influence on my life.

My happiest memory is the ISAPS Congress in Kyoto, that I held as the President in 2016. I was really delighted to help so many members of ISAPS enjoy my hometown of Kyoto. The two years after I succeeded Carlos Uebel in 2014 and until I was succeeded by Renato Saltz was the best time in

my life. I was very impressed by Catherine Foss, one of the most capable people I have ever worked with. Everybody on the board was professionally and personally excellent. I am proud that I was on such a wonderful team. I express my gratitude to all ISAPS families in the world for giving me the happiest two years.

Thank you, ISAPS.

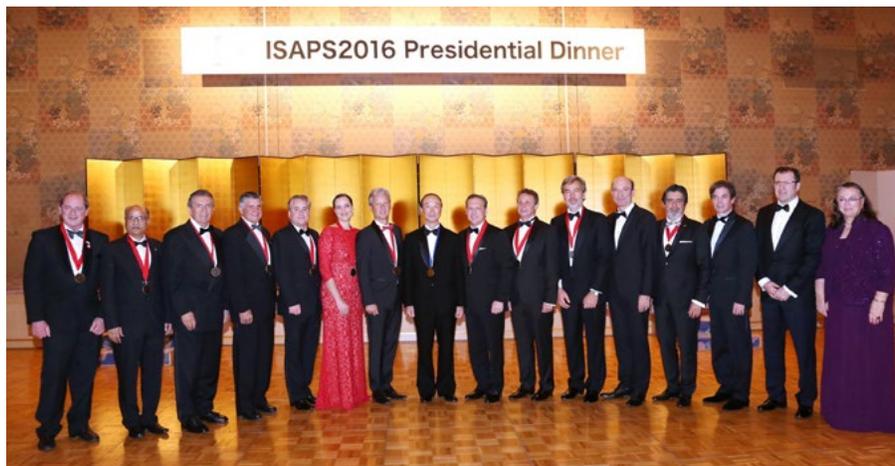


Figure 1: ISAPS Board members at Kyoto Congress Presidential Dinner in 2016.



Figure 2: Bryan Mendelson selected me as Program Chair for ISAPS Melbourne. It was really a great honor for me.



Figure 3: Tom Biggs always supported me to serve ISAPS. He is one of my excellent mentors.



Figure 4: I succeeded Carlos Uebel in ISAPS Rio. He did a great job for ISAPS.



Figure 5: I was so happy to work together with Catherine Foss.



Figure 6: I learned a lot from Foad Nahai how to work as an ISAPS President.



Figure 7: Renato Saltz is a really hard worker and true servant for ISAPS.

## REMEMBRANCE

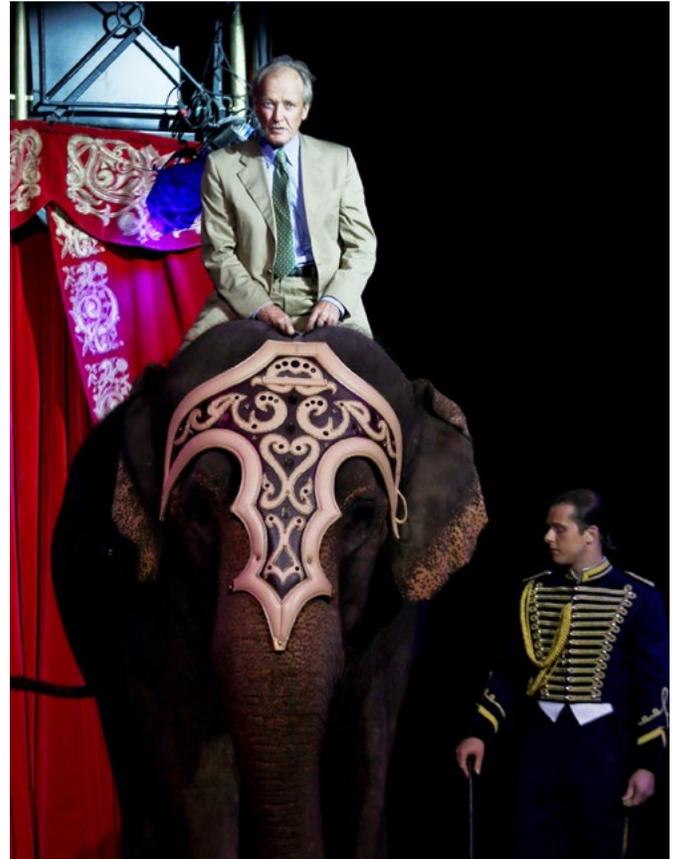


**JAN POELL - SWITZERLAND**  
ISAPS President, 2010-2012

**M**y time on the Board of Directors of ISAPS was like riding on an elephant - especially during my two years as the President. I was surrounded by knowledge, passion to serve the Society, perfect organization and very good friends of mine.

I got help wherever it was needed. I met a lot of interesting people who taught me a lot of new things about aesthetic plastic surgery. I got to know a lot of new countries and places.

Since I have retired, it is a pleasure to see how ISAPS is developing and growing, predicting a great future. I wish the society all the best. Being part of the board for 16 years and the President of the society for two was a great experience that I would not have liked to miss.



*Dr. Poell's triumphant arrival at the Circus Gala during the 2012 Congress in Geneva, Switzerland.*

## ISAPS: A PERSONAL REMEMBRANCE

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### THOMAS S. DAVIS - UNITED STATES

Past ISAPS Secretary General, Trustee, Historian,  
Parliamentarian and Chair of the By-Laws Committee

The pathway to my experience as a member of the ISAPS Board was unique.

I attended my first ISAPS Biennial Congress in 1989. Rodolphe Meyer was President.

The Congress was in Zurich, Switzerland. At the following Congress in Guadalajara, Mexico (1992), I was elected General Secretary of ISAPS. This most unusual selection was accomplished through the efforts of Blair Rogers, Nick Georgiade, and Trudy Vogt. I truly had no idea of the extent of my role/duties as Secretary General as I was a relatively new member of ISAPS.

At this time, the “central office” of ISAPS was the office of the Secretary General who was the functional head of the Society, not the President, reflecting the Society’s formation at the United Nations. Management of incoming membership applications; correspondence with members and the National Secretaries; scheduling and chairing Board meetings; recording minutes; and organizing the biennial business meeting were the responsibilities of the Secretary General. I was truly fortunate to have the full support and encouragement of the Board.

Apparently I succeeded, as I was re-elected to serve as Secretary General under Blair Rogers (1993-95) and for a third term with Ricardo Baroudi (1995-97). During this time, I had the complete cooperation and assistance from leaders in plastic surgery worldwide: Guy Jost, Ulrich Hinderer, Freddie Nicolle, Blair Rogers, Ricardo Baroudi, and Trudy Vogt, to name a few.

Fortunately for the growth of ISAPS, Catherine Foss was hired in 1998 as Executive “Secretary” and soon after Executive Director. Freddie Nicolle, a Trustee on the Board, suggested in 1995 the need to establish a permanent office to replace the usual change of address for the ISAPS office corresponding to that of the Secretary General every two to four years.

I have served on the Board for approximately 28 years as Secretary General, Trustee, Historian, Parliamentarian and Chair of the By-Laws Committee. ISAPS has provided a wonderful opportunity to work with surgeons from around the world and to establish life-long friendships. I have been fortunate through ISAPS to have experienced visits to many cities throughout the world and to have been hosted by accomplished surgeons who have contributed to the successful 50 years of ISAPS.

## ISAPS: A DYNAMIC ENTITY

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JOÃO CARLOS SAMPAIO GÓES - BRAZIL  
ISAPS President, 2004-2006

I joined ISAPS in 1989, at the Zurich Congress. I remember with great pleasure the welcome I received from Rudolph Meyer, then-President Rudolph Meyer, and unavoidably we became great friends. It was when I presented, for the first time, my previously published technique, periareolar mammoplasty, a concept that had a great impact on breast surgery at that time.

The enthusiasm led me to growing involvement in ISAPS and during 20 years I helped the society, acting on several committees and on the board.

It was a fertile period of personal growth thanks to the fraternal interaction with leaders of that time such as Bill Little, Guler Gursu, Ricardo Baroudi, Tom Biggs, Thomas Davis and others.

ISAPS was always considered a society of the “scientific elite” with great restrictions to new members, in a scenario carried out by IPRAS as a confederation of national societies. ISAPS was one of five coopted organizations of IPRAS - which now no longer exists.

As membership chair, I had the chance to observe the need for growth and international projection of ISAPS, as a vital action for its survival and development.

In 2004, I had the honor of taking over the presidency of ISAPS and I brought along my strong belief in this objective. Globalization and the great advance in communications at that time opened a fertile field for this accomplishment.

The project was strongly supported by the board and there was an easy connection to form a cohesive group of great leadership such as Renato Saltz, Rolf Gemperli, Foad Nahai, Bryan Mendelson and Jan Poel, that allowed the establishment of a reliable plan for these objectives.

A professional technical structure was created, led by Catherine Foss, for international action and a marketing plan for ISAPS with the development of branding and the objective of placing ISAPS as “the international reference in plastic surgery,” stimulating global interest in the growth of its membership.

It was the democratization of ISAPS. This project was crowned with the congress “Meeting by the Sea” held in Rio de Janeiro in 2006, an event that, although facing difficulties in local infrastructures, was a unique success at the time, leading to the desired international projection of ISAPS and opening the doors for its continuous growth and international influence. Even my early suggestion of creating a Global Alliance of national societies has been achieved with 84 members, which is very gratifying to see.

Now, I am proud of my contribution and that of my colleagues and see with great happiness the success of ISAPS that shines like the sun, the greatest star in the area of plastic surgery.



# OTOPLASTY

GLOBAL PERSPECTIVES



MARIAM T. ISMAIL  
EGYPT



SANDERENE ADEL YOUSEF ABDELNOR  
EGYPT

# OTOPLASTY: 30 CASE SERIES

**P**rominent ears are considered an aesthetic variant. Although it isn't accepted in certain cultures, it is preferable in others. From 2017 to 2020, we performed 30 otoplasty operations adopting Firmin's technique.

## PRE-OPERATIVE EVALUATION

During the pre-operative visit, analysis of the four factors of prominent ear deformity was done. Posterior root of the antihelix was examined for unfolding which is the main feature of prominent ears.

- The conchal bowl was examined for the angle of contact between it and the mastoid (valgus of the concha).
- Conchal hypertrophy was assessed after the valgus of the conchal bowl has been corrected by pressing the auricle against the mastoid.
- The lobule was checked for prominence.
- Pre-operative photos were captured: anterior (**Figure 1a**), posterior (**Figure 1b**) and two lateral views (**Figure 1c, 1d**).



Figure 1a: Frontal view of a male patient, 20 years old, bilateral prominent ears (preoperative photo).



Figure 1b: Posterior view of a male patient, 20 years old, bilateral prominent ears (preoperative photo).



Figure 1c: Right lateral view of a male patient, 20 years old, bilateral prominent ears (preoperative photo).



Figure 1d: Left lateral view of a male patient, 20 years old, bilateral prominent ears (preoperative photo).

## SURGICAL TECHNIQUE

- Posterior approach with excision of a narrow ellipse of skin anterior to the posterior sulcus leaving the soft tissue underneath it intact with no exposure of the cartilage.
- Undermining of the rest of the posterior skin to allow for smooth closure of the skin.
- Scoring of the posterior surface of the cartilage was done using blade no.11. No scoring of the anterior surface of the cartilage was done.
- Plication of the fold using non-absorbable sutures within the soft tissue covering the antihelix. Four to five stitches are placed; one in the middle of the antihelix, one at the root of the anterior branch and two to three sutures in between.

- Repositioning of the tail of the antihelix to fix the malposition of the lobule.
- Dissection of the deep surface of the conchal bowl to free its deep attachments. Two or three permanent sutures are placed transversely from the posterior wall of the conchal bowl directed posteriorly into the subcutaneous tissue to correct the valgus of the concha.
- An ellipse of cartilage is removed posteriorly measuring 0.8 to 1 cm to correct conchal hypertrophy.

## RESULTS

Aged 20 to 35 years old, 30 patients presented with bilateral prominent ear deformity. Follow-up was from six months through two years post-operative (**Figure 2a,2b,2c,2d**). No complications were reported, even recurrence, which is the most common one.



Figure 2a: Frontal view of a male patient, 20 years old, bilateral prominent ears (Follow-up six months after otoplasty).



Figure 2b: Posterior view of a male patient, 20 years old, bilateral prominent ears (Follow-up six months after otoplasty).



Figure 2c: Right lateral view of a male patient, 20 years old, bilateral prominent ears (Follow-up six months after otoplasty).



Figure 2d: Left lateral view of a male patient, 20 years old, bilateral prominent ears (Follow-up six months after otoplasty).

Another example of pre- and late post-operative photos of another case (**Figure 3, Figure 4**). Good analysis of the causes of the prominent ear is the key to satisfying results. All patients included in this study had unfolded antihelix, valgus of the concha and prominent lobules. Five of them had true conchal hypertrophy. Otoplasty helps to improve the patient's self-confidence and ability to live a normal life.



Figure 3a: Frontal view of a male patient, 35 years old, bilateral prominent ears (preoperative photo).



Figure 3b: Posterior view of a male patient, 35 years old, bilateral prominent ears (preoperative photo).



Figure 3c: Right lateral view of a male patient, 35 years old, bilateral prominent ears (preoperative photo).



Figure 3d: Left lateral view of a male patient, 35 years old, bilateral prominent ears (preoperative photo).



Figure 4a: Frontal view of a male patient, 35 years old, bilateral prominent ears (Follow-up six months after otoplasty).



Figure 4b: Posterior view of a male patient, 35 years old, bilateral prominent ears (Follow-up one year after otoplasty).



Figure 4c: Right lateral view of a male patient, 35 years old, bilateral prominent ears (Follow-up one year after otoplasty).



Figure 4d: Left lateral view of a male patient, 35 years old, bilateral prominent ears (Follow-up one year after otoplasty).

# A MODIFIED SCORING TECHNIQUE FOR PROMINENT EAR CORRECTION

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MOHAMMED BRESAM HATIF  
IRAQ



ARWA KASIM ALMAJIDY  
IRAQ



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IRAQ

## ABSTRACT

The prominent ear is the most common congenital ear deformity affecting 5% of children in the western world and has profound psychological effects on the bearer. The most common causes of the protruded external ear are an underdeveloped or flat antihelix, an overdeveloped deep concha, or a combination of both of these features.

This study aims to evaluate the clinical outcome of otoplasty in prominent ears by two parallel interrupted full-thickness cartilage incisions.

From February 2015 to November 2019, a prospective study was accomplished on 41 patients (76 ears) including 32 males and nine females. The condition was bilateral in 35 patients and unilateral in six patients. Surgery was done by a modification of combined methods of Mustarde and Furnas with partial resection of conchal cartilage.

The preoperative helical rim to the temporo-mastoid surface distance was 28-40 mm (mean 34.6 mm) and 10-15 mm

postoperatively (mean 12.1 mm). The preoperative cephaloauricular angle was 50-90 degrees (mean 75.4 degrees) and was kept at 20-25 degrees (mean 22.5 degrees) postoperatively.

Good aesthetic and satisfaction results were noted by the patients and their families. No complications had occurred and no patient required surgical revision. In conclusion, the procedure was found to be simple, easily applied with good aesthetic and satisfaction results.

## INTRODUCTION

The prominent ear is a common congenital deformity and may be a source of psychological distress in both sexes and at any age. Otoplasty techniques can be divided into three broad categories: cartilage-cutting, cartilage-sparing, and incisionless techniques. The goals of otoplasty should be to create individually normal-appearing auricles by maintaining the angle between the mastoid plane and upper helical rim at less than 40 degrees and a distance from the helical rim to the skull of 15-20 mm with creating symmetry between the two auricles.

## PATIENTS AND METHODS

From February 2015 to November 2019, a prospective study was accomplished in Al-Wasity Plastic and Reconstructive Surgery Teaching Hospital and Al-Karama General Teaching Hospital in Baghdad, Iraq, on 41 patients (32 males and nine females) (76 ears), with prominent ear deformities which had been measured at the outermost point of the ear rim at the most prominent part. Data are shown in *Table I*.

**Table I: Demographic data of the patients**

Variables	Number of patients	Percentage
<b>Age:</b>		
Children up to 18 years	29	70.73%
Adults	12	29.26%
<b>Gender:</b>		
Males	32	78.04%
Females	9	21.9%
Bilaterally affected ears	36	85%
Right ear alone	5	12.5%
Left ear alone	1	2.5%
Preoperative cephaloauricular distance	28-40 mm (mean 34.6 mm)	
Preoperative cephaloauricular angle	50-90 degrees (mean 75.4 degrees)	

In this study, we applied a modification of the Mustarde technique to correct the prominent ears by two parallel full-thickness cartilage incision lines, which aid in folding the antihelices while giving a smooth and natural shape; in addition to a conchal elliptic excision as needed, and correction of the prominent ear lobe as required.

A preoperative evaluation was done to ascertain the fitness of the patients to surgery under general anesthesia. Evaluation of the ear deformity (the site, severity, and etiology) and of the prominence of the ears was completed.

## SURGICAL PROCEDURE STEPS

With the patient in the supine position, preparation of the ear and surrounding area with 10% povidone-iodine solution was done. Planning and marking with methylene blue solution and needle tattooing to delineate the proposed antihelix and the skin ellipse that will be excised. Local infiltration of the posterior aspect of the ear and the postauricular sulcus with 2% xylocaine and 1/200,000 adrenaline solution is performed. Then the planned incision on the posterior ear is made with undermining of the skin flap and the perichondrium; to expose the cartilage. Two parallel interrupted incision lines are made on the ear cartilage 3-5 millimeters in length on both sides of the supposed antihelix lines with 3-5 mm gaps between each incision line and the other. Incisions involved full thickness of the cartilage preserving the anterior skin of the ear. Nylon 4/0 mattress sutures were used to create the fold, usually 3-4 mattress sutures were needed for each antihelix. This technique has enabled us to get an easy and smooth bending and folding of the cartilage resulting in a fine and natural antithetical fold.

Conchal hypertrophy and its severity were assessed preoperatively for marking a suitable amount of cartilage to be resected, then mattress suturing of the edges with 4/0 Nylon about 2-3 sutures usually were needed, after a limited undermining of the skin from the cartilage anteriorly then using the same ends of the sutures to fix it to the periosteum of the mastoid. Closure of the wound was completed with subcutaneous 4/0 Polyglactin (vicryl) followed by 4/0 Nylon sutures for the skin as an interrupted or continuous intradermal suture. The correction of the ear lobe was done by the suitable technique of excision and closure. Fucidin

skin ointment was applied to the wound, followed by dressing with dry gauze, cotton, and crepe bandage. **Figure 1** shows the technique used in this study.

The patients were discharged on the same day of surgery to be seen after three days to assess the operation site and change dressings. The stitches were usually removed 10-14 days postoperatively, and the patients were kept on crepe bandage for about one month. The patients were instructed to use elastic bands or crepe bandage at night for another month, to be seen in six months and one year postoperatively or as needed.

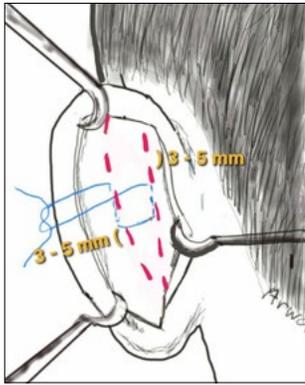


Figure 1 - A diagram showing the modified scoring technique.

### RESULTS

In a total of 41 patients (76 ears) with prominent ears, preoperative ear protrusion distance from the mastoid which was 28-40 mm (mean 34.6 mm) is changed to 10-15 mm (mean 12.1 mm) postoperatively.

The preoperative cephalo-auricular angle was 50-90 degrees (mean 75.4 degrees) and is 20-25 degrees (mean 22.5 degrees) postoperatively as demonstrated in **Table II**.

**Table II: The results of postoperative measurement changes**

	Preoperative measurements	Postoperative measurements
<b>Ear protrusion distance</b>	28-40 mm (mean 34.6 mm)	10-15 mm (mean 12.1)
Cephalo-auricular angle	50-90° (mean 75.4°)	20-25° (mean 22.5°)
<b>Total no. of ears</b>	76 ears	76 ears

No major complications were encountered. One patient asked for a mild limited upper pole correction of one ear which was not needed and we offered only reassurance.

One patient was concerned about intra-conchal skin folding at the first postoperative visit which was fading with time. Good satisfaction and expression of happiness of the patients and their families with no surgical revision. An example of preoperative and postoperative photos are shown in **Figure 2**.



Figure 2. A series of frontal, right & left lateral; preoperative and postoperative views of the ears of a 25-year-old patient.

### DISCUSSION

Surgical techniques are always aiming at more natural-looking and lasting results. The ideal results are ears with a certain symmetry that does not appear to have undergone surgery. Because of the numerous problems leading to the protruding ear, no appropriate single procedure has been described for correcting all deformities.

The three most common causes of prominent ears (underdeveloped antihelical fold, prominent concha, protruding ear lobe) were found all together in all cases of this study; they were corrected simultaneously by a combination of different procedures to achieve the pleasant appearance.

We corrected the cephalo-auricular distance and the concho-scapal angles as well as the protrusion of the ear lobe simultaneously by the application of a modification of Mustarde technique.

The postoperative cephalo-auricular distance was 10-15 mm (mean 12.1 mm). The post-operative cephalo-auricular angle was 20-25 degrees (mean 22.5 degrees) which coincides with the results obtained by multiple studies.

No complications such as hematoma, infection, wound dehiscence, skin necrosis, hypertrophic or keloid scars, or recurrence have been met in this study. The vast majority of patients and their families were satisfied with the results since they gained accepted and pleasing ear position and configuration.



YOUSEF BAKIR  
QATAR

# PROMINENT EARS: MY OTOPLASTY TECHNIQUE

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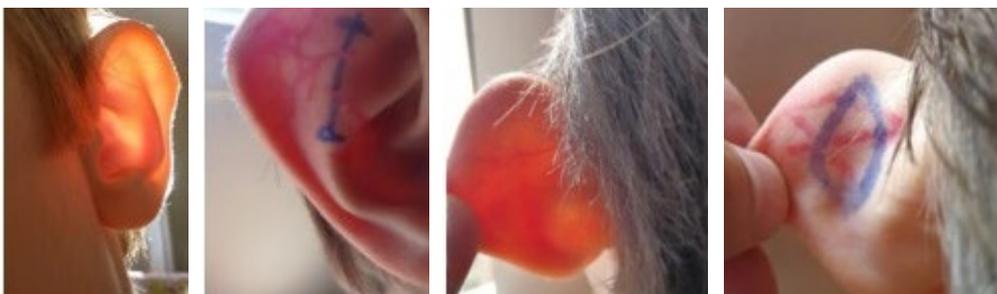
## INTRODUCTION

**P**rominent or bat ears are not uncommon. Many techniques are described to correct prominent ears (Mazeed and Bulstrode, 2019). In this article, I describe a non-cartilage scoring or breaking technique based on only bending cartilage and fixing it, with extremely low incidence of complications, no observable scars, and high patient satisfaction. The procedure is simple, of short duration, reliable and is excellent for correction of prominent ear.

## TECHNIQUE

### Preparation and measurements

Strong light is positioned behind and then in front of the ear rendering the blood vessels visible. Using a permanent marker pen, I demarcate the vessels of the external ear anteriorly and posteriorly (**Figure 1**) in order to prevent injury, bleeding or hematoma. Then I bend the ear posteriorly, and identify and mark the future antihelical fold anteriorly, and also mark the site of two small incisions to be used as entry points.



*Figure 1 Identify vessels prior to surgery, mark future antihelical fold and entry points, demarcate elliptical skin island to be excised.*

On the posterior side of the ear, I mark the elliptical skin island to be excised, and measure the distance between the helical edge and temporal scalp in the upper, medial and lower thirds of the ear. I stand behind the patient, both of us facing a big mirror, and move each ear medially to the point where it is ideal for the case and satisfying for the patient, and I then measure again the posterior distances that will be required to be achieved.

## SURGERY

Under general anaesthesia for children and local anaesthesia for most adults, the patient is in a supine position, ear exposed. On the anterior surface of the ear, I make two small incisions perpendicular to the future antihelical marking, one superior and one inferior (strictly avoiding the marked vessels) (**Figure 2**). These incisions will be for the rasping of the anterior surface of the antihelical cartilage and will help during fixation of the future sutures of the antihelical fold.

A smooth tiny dissector is used to raise the skin from the perichondrium of the anterior surface. I use a personal, curved 'Bakir' rasp (1.5 mm width) to gently and carefully tack out only the anterior perichondrium of the future antihelical fold with no damage to the cartilage (**Figure 3**). I flush the debris of the rasped perichondrium and suction it to create a smooth cartilage surface. Damage to cartilage surface leads to an unpleasant edgy surface.



Figure 2. Technique: a) rasp anterior future antihelical fold; b) excise posterior skin island and, through small superior opening using blunt forceps, rasp posterior perichondrium; c) make the stitch, only taking cartilage without damage to any tissue, to create future antihelical fold.

I then excise the posterior marked elliptical skin island (**Figure 2**), using bipolar cauterization to stop any tiny bleeding. Then

an opening is done on the superior side of the posterior tissue through which I use a blunt dissector to raise all tissues over the posterior surface of the ear cartilage. Then, parallel to the future antihelical fold, I create a shallow valley by rasping and taking away some cartilage from the posterior surface, to slightly

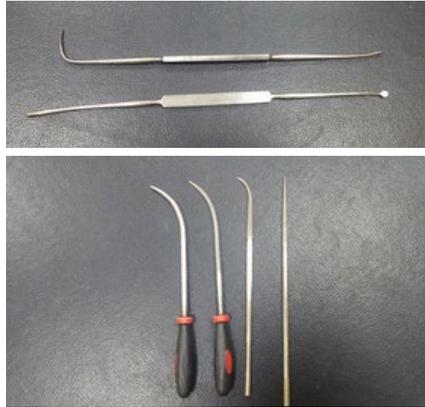


Figure 3. Smooth tiny dissectors and personal curved 'Bakir' rasps.

weaken the cartilage and facilitate bending it backwards to the intended extent. In some adults with thicker cartilages, I remove extra cartilage posteriorly. I use 4/0 PDS round needle taper to fix the future antihelical fold (2-3 stitches under the soft tissue, along the future antihelical fold, ligated posteriorly), 5/0 PDS cutting needle to close the dermis, and 6/0 PDS or nylon cutting needle for skin closure. Duration of procedure is 1-1.5 hours.

I use a personal 'Bakir' cast to secure the ear in its new position using cotton soaked in betadine, squeezed and dipped into the topographics of the new ear anteriorly and posteriorly, and covered generously with dry cotton under thick gauze (**Figure 4**). This acts as a pillow for the ear, and provides freedom to the patient while sleeping. A pressure elastic garment is then used. I leave this for 3-5 days, and then dressing and cotton are



Figure 4 'Bakir' cast to fix ear in new position using cotton soaked in betadine, squeezed, dipped into the topographics of the new ear anteriorly and posteriorly.

removed easily. There is no bleeding, and no pain within the period of the dressing as ears are fixed well. Follow-up is every five days, in which I use a thick cotton dressing covering the ears under light pressure elastic band. Stitches are removed 12 days post-op using fucidin over the posterior incision in each dressing. Oral antibiotic is prescribed (Augmentin 1000 mg once daily for seven days for adults; or 45 mg /kg/day q12h for seven days for children). I have had no cases of infection.

## ADVANTAGES

The results are excellent (**Figures 5-8**). No soft tissue damage as vessels' anatomy is identified and preserved as described earlier. No squeezing or obstruction of soft tissues of external ear as fixation stitches go over the perichondrium and underneath the full thickness of the soft tissue of the ear. No aggressive posterior dissection, rasping only. No scoring that could lead to sharp ridges. The needle's entrance and exit, and ligation of the sutures both being near the edges of the posterior valley provide the best fixation to the future antihelical fold. No excision of soft tissue, only of the elliptical posterior skin island.

## CONCLUSION

Most complications of otoplasty can be avoided and positive outcomes achieved by paying attention to anatomical details.

This cartilage-sparing otoplasty has resulted in reproducible natural correction with virtually no risk of complications. In the 40 cases I undertook, there was no haematoma, bleeding, infection, skin or wound healing or suture-related problems, scarring, or severe pain. In two cases, moderate recurrence happened (probably because both had very thick cartilages) and patients requested revision surgery that corrected the ear with no further recurrence.

This otoplasty technique can be employed with almost all prominent ears, and provides durable and excellent cosmetic results. Given the benefits, such surgery should be offered to patients pursuing correction to prominent ear-related aesthetic and psychosocial problems regardless of age.



Figure 5 Before and after photos of 30-year-old man, one-month post-otoplasty.



Figure 6 Before and after photos of 24-year-old woman, one-year post-otoplasty.



Figure 7 Before and after photos of 27-year-old man, one year post-otoplasty



Figure 8 Before and after photos of 6-year-old girl, six months post-otoplasty.

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The author has a financial interest in the rasps and casts named for him.

# THE ROLE OF EARLY NON-SURGICAL EAR MOLDING FOR THE TREATMENT OF CONGENITAL EAR DEFORMITIES



SCOTT P. BARTLETT  
UNITED STATES



VIREN PATEL  
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## INTRODUCTION

Congenital ear abnormalities are common, with some studies estimating that over half of neonates have some degree of abnormality.<sup>1</sup> These anomalies are characterized as malformations, which occur when there is a problem during embryologic development leading to missing skin or cartilage, and deformations, in which the tissue is fully present, but there is some distortion in normal ear architecture. Malformations generally require some type of reconstructive otoplasty to address the deficient tissue.

Traditionally, deformations, in which all the ear components are present but abnormally folded, pleated or crumpled, have been treated expectantly with the assumption that most of these deformations will self-correct. However, this was challenged in the 1980s, when it was recognized that many of these deformities may not self-correct, which led to the popularization of ear molding. Recent studies have also suggested that the incidence of these deformities may be increasing.<sup>2</sup>

This molding technique was first described by Japanese clinicians in the 1980s, who developed a method for shaping deformed ears using bent wires.<sup>3</sup> Since then, there have been a number of different approaches, including the use of tapes, foams and gels, with the common goal of setting the deformed ear into a normal position. While most of these techniques can lead to a satisfactory result, they can be problematic as the devices are easily dislodged by the infant. Consequently,

we developed an ear molding device that is simple to apply, but also can be secured in place. I have used the InfantEar Molding System for many years now, and have found a greater than 90% correction rate of various deformities, including helical rim deformities (*Figure 1*), Stahl's ear (*Figure 2*), lop/cup ear (*Figure 3*), cryptotia (*Figure 4*), prominent ear and mixed deformities.<sup>4,5</sup> Additionally, and importantly, in the treatment of these deformities, ear molding leads to more complete corrections when compared to reconstructive otoplasty later in a child's life.



Figure 1 A&B: Helical Rim Deformity pre and post molding.



Figure 2 A&B: Stahl's Ear Deformity pre and post molding.



Figure 3 A&B: Lop/Cup Ear Deformity pre and post molding.



Figure 4 A&B: Cryptotia pre and post molding.

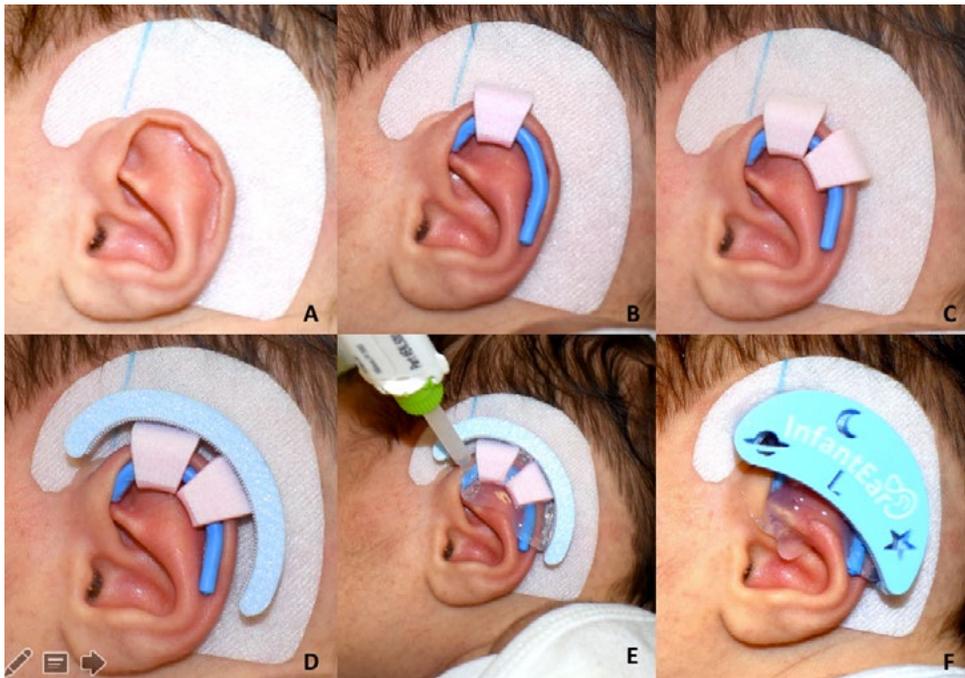


Figure 5: Application of InfantEar Neonatal Molding System.

Dr. Bartlett is Founder and part owner of TalexMedical, maker of InfantEar.

## TECHNIQUE

After a patient is deemed a suitable candidate for molding, the skin behind the ear is shaved and a precut Velcro piece is applied. If necessary, a silicone helical-rim guide can be placed, depending on the type of deformity being treated. Helical rim conformers are placed on the rim of the auricle and attached to the Velcro base, in areas that result in the most normal ear architecture. The conformers can be repositioned until the desired shape is achieved. A liquid silicone gel is then applied, and allowed to fill all the voids, fixing the device components in place, and “casting” the ear into a normal shape and position, as it dries. Finally, a plastic cover is attached to the Velcro as the gel solidifies (Figure 5). Once the device is placed, no extra care is required by parents, except to keep the area as dry as possible to prevent a moisture rash or irritation. If applied within the first few weeks of life, one or two applications (2 -3 weeks each) can often completely and lastingly correct the deformity.

## DISCUSSION

Despite the success of the InfantEar system, there is still an opportunity to improve results. Ear molding relies on the pliability of the neonatal ear cartilage, which hardens as maternal estrogen levels fall. For this reason, neonates who present within the first weeks of life achieve the best results compared to neonates who are molded after a month of life.<sup>6</sup> Therefore, the timing of referral is of paramount importance with referrals made within the first two weeks of life preferred.

The question then becomes how do we ensure that congenital ear deformities are recognized and treated promptly with ear

molding, potentially preventing surgery later in life. The obvious answer is to increase awareness about ear molding among providers on delivery floors (neonatologists and pediatricians), as they can refer to ear molding specialists within the first week of life. Therefore, plastic surgeons should reach out to acute and primary care providers in their target communities and develop early referral pathways. For example, at my institution, neonatologists follow a protocol, whereby ear deformities recognized at birth are given a week to self-correct, and then are seen in clinic the following week if the deformity persists.

## CONCLUSION

Ear molding is a safe and effective method to achieve lasting corrections of congenital ear deformities. Every effort should be made to refer these patients early, as earlier application of ear molds leads to better results.

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# IDENTIFYING DIFFERENT GRADES OF PROMINENT EAR DEFORMITY AND THEIR RELEVANCE IN DECIDING STEPS IN EACH OTOPLASTY PROCEDURE OF CONGENITAL EAR DEFORMITIES



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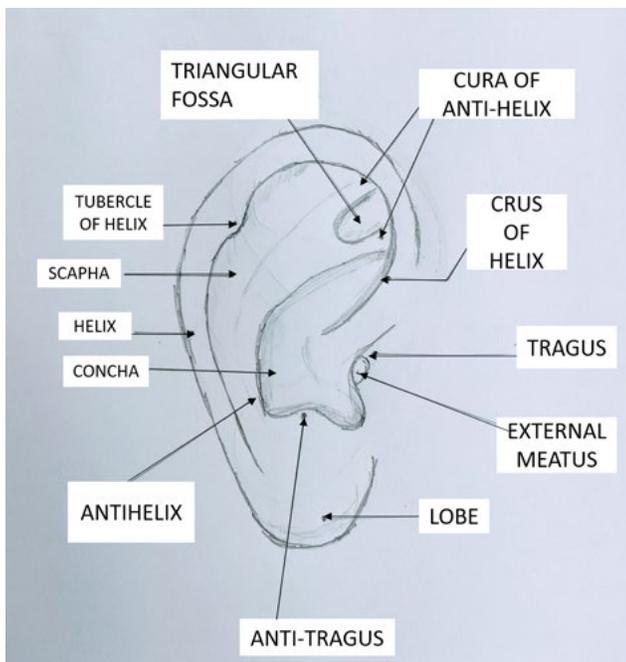


Figure 1: Anatomic landmarks of the ear.

## INTRODUCTION

The term prominent ears, otherwise known as Prominauris, refers to ears that, regardless of size, “stick out” enough to appear abnormal. The negative psychological impact of a prominent ear is the main driving factor for undergoing surgical correction, as this deformity does not cause any functional problems (Figure 1).

### Deformities accounting for prominent ears are:

1. Increased concho-mastoid angle.
2. Under-developed antihelix fold.
3. Big conchal bowl.

## IDENTIFICATION OF THE DEFORMITY

The most important thing before planning surgical correction of the prominent ear is to identify the deformity as the surgical plan will change accordingly. We propose a grading system

for a prominent ear which will help the plastic surgeon in identification of the problem and planning for surgical steps for correction of each deformity accordingly. In this system, we grade according to the deformity that the patient presents and steps of otoplasty are tailored according to each grade.

Grade	
<b>Grade 1</b>	Increased Concho-Mastoid Angle
<b>Grade 2</b>	Grade 1 +
	Absent Antihelical Fold
<b>Grade 3</b>	Grade 2 +
	Deep Conchal Bowl

Table 1: Grading of prominent ear deformity

The importance of grading is to help in planning the surgical steps, as patients with Grade 1 deformity will require only conchal set-back with concho-mastoid sutures.

Patients having Grade 2 deformity will require antihelical fold creation along with conchal set-back. We prefer the suturing technique as described by Mustarde for this as in our hands it is more predictable and with less complication.

Patients having Grade 3 deformity will require conchal cartilage excision along with the above procedures.

Along with the above procedures, in most cases it is important to correct the prominent earlobe. If not done, this will lead to unsatisfactory results.

### OUR PREFERRED TECHNIQUE

General or local anaesthesia is used for the procedure, depending on the age of the patient, as adults can be operated under local anaesthesia.

1. Incision: in most cases an elliptical incision is taken in the posterior/medial aspect of conchal cartilage, taking precautions not to include the proposed antihelical fold.

After the incision, the conchal cartilage is exposed and mastoid fascia is exposed by removing the soft tissue covering it. Marking on the anterior/lateral surface of the ear is done for the proposed antihelical fold.

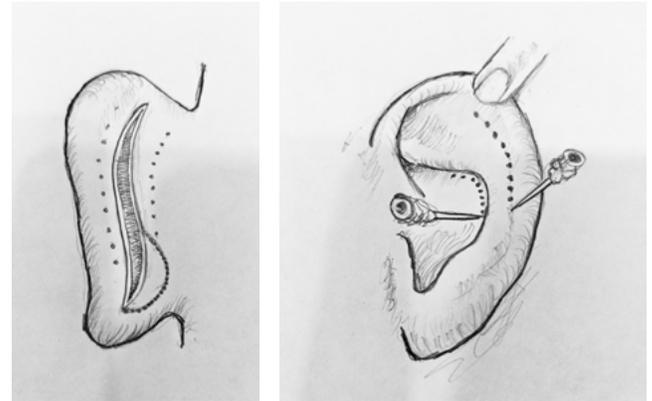


Figure 2 A & B: Marking of incision (A) and antihelical fold (B).

2. Antihelix creation: This step is done only in Grade 2 & 3 patients. It is always done before doing concho mastoid suturing. In Grade 3 patients, it should be done after conchal resection is done. The marking of the antihelix is done by pushing the helix posteriorly using the surgeon's finger until an appropriate size of antihelix is formed. Using a methylene blue dipped needle, the antihelix fold is marked by passing the needle through and through. Using 3 -4 horizontal mattress sutures with 4-0 Prolene, the antihelix is created. We prefer to keep the suture long and tie them sequentially to attain the desired antihelical fold. Care must be taken while taking these sutures to prevent taking bite of anterior dermis, which can create puckering (Figure 3).

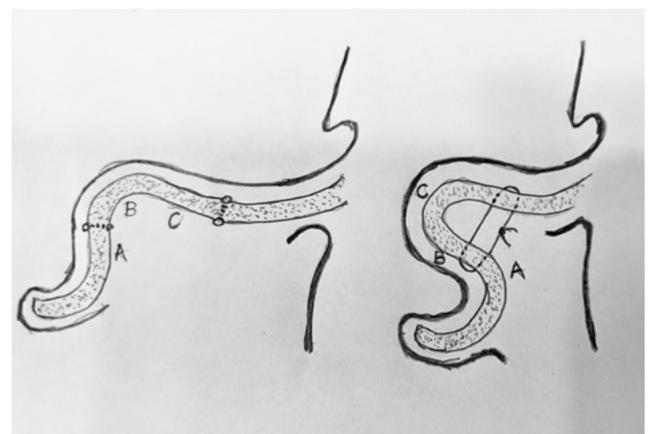


Figure 3: Creation of antihelical fold with suturing technique.

3. Conchal excision: when patients present with enlarged concha (Grade 3), then a conchal reduction should be planned before taking concho scaphal or concho-mastoid sutures. For reduction of excess conchal cartilage, a kidney shaped cartilage is excised about 1-2mm, taking precaution not to breach the anterior auricular skin. The cut ends of cartilage are sutured together with monofilament absorbable sutures; the width of excision will depend upon the excess present.
4. Conchal setback: This step is needed in all grades of prominent ear. After exposure of conchal cartilage and mastoid fascia, suture bites are taken from conchal cartilage, being careful not to breach anterior auricular skin and mastoid fascia using 3-0 nonabsorbable suture material. For the setback, 2-3 concho-mastoid sutures are taken and tied sequentially. Care must be taken with placement because it is well documented that sutures placed too far anteriorly on the mastoid or posteriorly on the conchal cartilage have the potential to exaggerate the anterior or posterior rotation of the ear and may cause narrowing of the external auditory canal. We prefer to do slight overcorrection (not too much) as there is slight loosening of the sutures seen after 3-4 months, so slight over correction at the end gives satisfactory results.
6. Closure and dressing: The incision is closed after haemostasis with continuous subcuticular sutures with 5-0 absorbable monofilament suture material. Padded dressing is given and changed after seven days when the patient is asked to wear a loose head band.

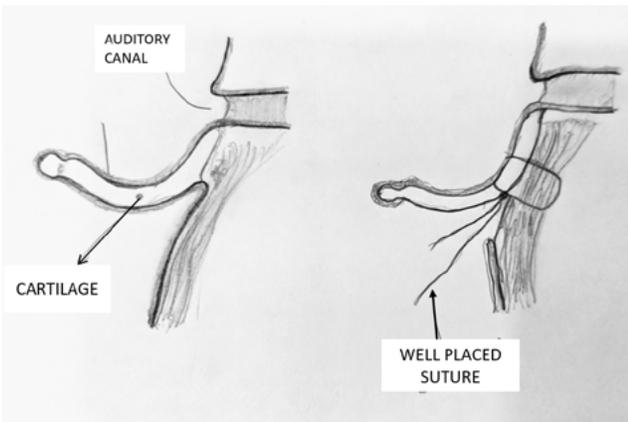


Figure 4: Concho-mastoid suturing technique.

5. Ear lobe correction: In most of our patients, we need to correct the prominent earlobe. This is done by exposing the fascia of ear lobe and suturing this to mastoid fascia.



Figure 5 A & B: Anterior view of patients with prominent ear correction.

Acknowledgement: We thank Ms. Khushi Chawda for illustrations.



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# OTOPLASTY: CORRECTION OF PROMINENT EARS WITHOUT SCAR

Regardless of the size of the ear, the term “Prominent Ears” means a birth defect in which the ears stick out enough to appear abnormal. Also, the terminology can be defined by comparing an abnormal external ear that is separated by less than 2cm from the side of the head maintaining an angle of 25 degrees or less.

**GOALS:** External ears, a beautiful masterpiece of creation, are an aesthetically and distinctly visible part of human face. After any surgical and non-surgical procedures both the ears must appear natural, soft, harmonious, not an operated look and without any surgical scar.

After the procedure is complete, if viewed from the side, the helical rim should be prominently visible and from rear view should look straight and not like a “C” or a telephone deformity.

**COMPARISON:** Other surgical procedures available for the correction of prominent ears require a long incision to expose

the cartilage. The procedure is performed by 1. Suturing anti-helical fold (*Mustarde, Photograph Ref-A*), 2. Stenstorm technique of anterior abrasion of cartilage (*Gibson, Photograph Ref-B*), 3. For full thickness incision of cartilage along the curvature of anti-helix, for creating a desired fold (*Luckett, Photograph Ref-C*).



Ref-A:  
Dr. Jack Mustarde



Ref-B:  
F. Brian Gibson



Ref-C:  
Dr. William Henry Luckett

**OTOPLASTY WITHOUT SCAR,**

a male patient, 18 years of age, (Figure 1)



Figure 1: Pre Op Both Ear

**PROCEDURE:** Done under general anesthesia

**MATERIAL USED:** Thread - Polypropylene, USP 4/0, EP 1.5, 800mm

**NEEDLE:** Diamond Cut Trocar, Double Pointed, 3/4 Curved 50 mm, DRT 50,120.

This unique Otoplasty Needle and Thread (Figure 6) is easy to maneuver in any desired direction, turning and twisting on both sharp ends, in a single point of entry and exit. The inventor is Dr. Marlen Sulamanidze (Georgia) (Photograph Ref.D).

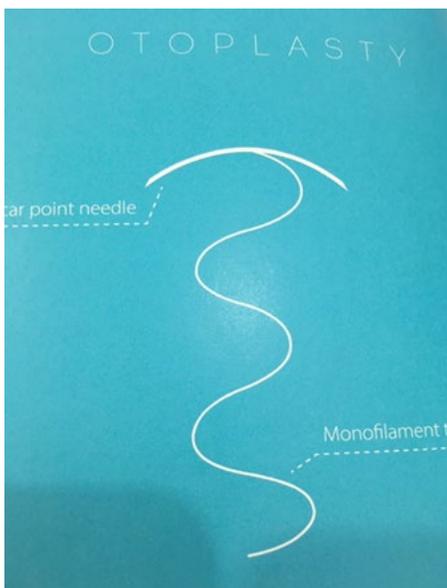
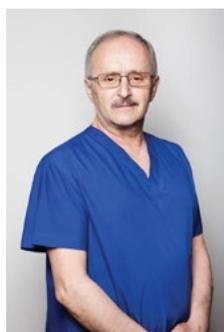


Image-6: Otoplasty Thread & Needle



Ref-D:  
Dr. Marlen Sulamanidze

**PROCEDURE:**

The assessment and marking are very important (Figure 2).

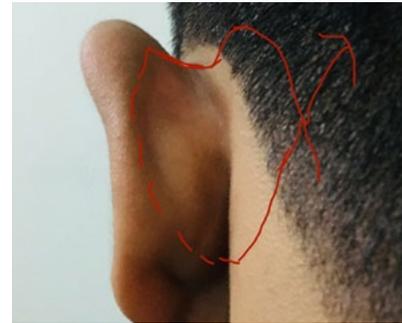


Figure 2: Pre Op Lt Ear & Marking

The needle is inserted in the middle of the mastoid area opposite the external ear. From this point, the needle is advanced subcutaneously to the upper part and never brought out completely at any point to the surface

of the skin. When the second tip remains under the skin, the needle is turned and the second tip runs ahead to continue passing the thread farther in the line of marking. From the mastoid side, the needle is passed underneath the sulcus to the upper and posterior aspect of the helix of the external ear. At this point, the needle pierces the cartilage of the helix and runs downwards along the anterior surface of cartilage, between the skin and the cartilage, to a point where it again pierces the cartilage back again. Then the needle passes through the sulcus underneath the skin to the lower mastoid area and travels up to the middle of the mastoid area to unite with the other end of the thread. Now the needle is completely brought out to the surface and the two ends are pulled to bring the scapha and helix close to the mastoid area as desired and so tied underneath the skin and buried. The procedure is completed in 30 minutes time on each side. IMMEDIATE RESULTS: Figure 3, 4 & 5.



Figure 3: Post Op Lt Ear



Figure 4: Post Op Rt Ear

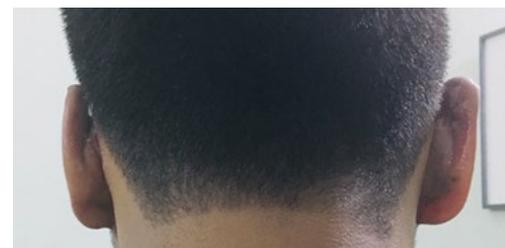


Figure 4: Post Op Both Ear

# EVOLVING TECHNIQUES IN OTOPLASTY

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## INTRODUCTION

Ear deformities not only impact self-consciousness, but also lead to psychological distress in many patients. Even though the ears can be corrected during childhood, many patients seek surgery as adults after being bullied or feeling insecure during their adolescence. According to ISAPS' International Survey on Aesthetic/Cosmetic Procedures Performed in 2018, there were 262,078 otoplasties performed worldwide in 2018. Additionally, ear surgery was among the top five aesthetic surgeries performed in men.

There are many proposed techniques to correct the complex three-dimensional nature of the deformed ear including resection, suturing, and molding. Highlighted are the keystones that have guided me in my practice in the last years and some changes which I have made to my technique.

To truly understand ear deformities, it is paramount to become facile with the normal anatomy. A large part of my non-surgical practice involves newborn ear molding. Analyzing over a thousand ears has taught me to quickly delineate normal from abnormal. Usually, a prominent ear is secondary to three factors: a missing fold (under-developed antihelix), an enlarged conchal bowl, and an obtuse angle between the ear and the scalp. A prominent ear may also have a prominent lobule. The goal of correction is therefore to create the antihelical fold, correct a hypertrophied or obtuse concha, and improve the lobule if necessary.

## TECHNIQUE

### Anesthesia

All children are given general anesthesia for the procedure. When consulting with adults, I often ask them if they would like to have the procedure performed in the office under local anesthesia or in the operating room. In addition to the advantages of not undergoing general anesthesia, when performed under local anesthesia, the patient can partake in some of the aesthetic decisions, particularly the angle between the concha and the mastoid.

### MARKINGS

The neo-antihelical fold is marked by gently pressing the ear into the correct position (*Figure 1*).

The posterior incision is also marked along the retro-auricular sulcus. Little skin is removed from the back of the ear to allow the scar to heal without tension, thus relying on changes to the cartilaginous architecture not skin resection.



*Figure 1: Marking for the neo-antihelical fold.*

## SURGERY

A narrow elliptical incision is made on the retro-auricular sulcus to remove any redundant skin and provide necessary exposure to the anatomical landmarks including the scapha, helical sulcus, and helical tail. It is important not to strip the perichondrium from the cartilage, since the sutures will not cut through the cartilage as easily with a thick perichondrium in place. As a result, this decreases the risk of recurrence. The posterior auricular muscle is resected to allow for the placement of Furnas sutures. Any protruding irregularities on the posterior surface of the concha are removed to allow for the concha to lie flatly against the mastoid.

The antihelical fold is corrected first. I used to rasp over the anterior surface of the neo-antihelical fold using the Stenson and Gibson technique in all patients. Now, rasping is reserved for older patients with thick cartilage that does not bend easily with digital manipulation. It is not necessary to weaken the cartilage with rasping in most cases. The suture placement is delineated using 30-gauge needles. Methylene-blue-dipped needles are not used as they have the potential to stain the skin and cartilage.

Instead, two needles are inserted to guide the location of suture placement. Using 4-0 clear nylon, Mustardé mattress sutures secure the antihelical fold and the superior crus of the triangular fossa. The sutures are tied with increasing tension. The first sutures are placed at the superior aspect of the pinna and continued to the middle third of the ear. Paired needles are placed along the neo-antihelix like the spokes of a wheel, forming a soft curve (*Figure 2*).



*Figure 2: Dots delineate the placement of the Mustardé sutures.*

A minimum of four sutures are necessary to form the helical fold. The sutures are then reinforced with additional sutures. It is important that the sutures are not tied too tightly or they will create a sharp antihelical fold which appears abnormal.

After the antihelix is corrected, conchal size is reassessed. When I first started my practice, I reduced the concha in most patients. With more aggressive Furnas sutures, this is not always necessary. If the concha needs to be reduced, the reduction is marked along the junction between the posterior wall and the floor of the concha from the cymba to below the anti-tragus using four 30-gauge needles to transpose the pattern to the back of the auricle. An ellipse of cartilage is removed, and the edges of the cartilage are re-approximated using 4-0 mersilene (*Figures 3a, 3b*).



*Figure 3a: 30-gauge needles transpose the proposed upper incision on the posterior surface of the concha.*

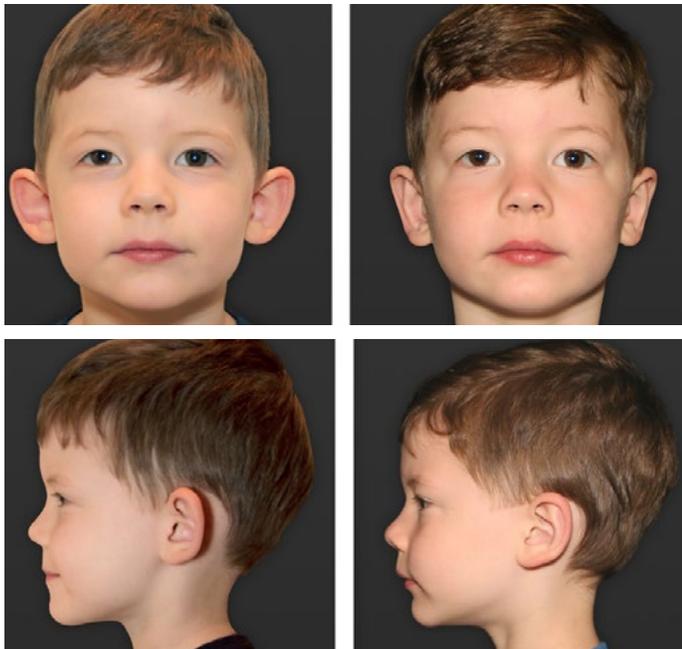


*Figure 3b: Small conchal excision which will be reapproximated with 4-0 mersilene.*

To maintain the correct temporal-helical angle, the auricular cartilage is sutured to the temporal fascia. Furnas sutures penetrate the full thickness of the conchal cartilage and then pass through the temporal fascia, anchoring the auricle. 4-0 mersilene suture is used. Sometimes, the angle between the helical root of the ear and the scalp is also obtuse. Some surgeons make an additional incision to correct this deformity. Instead, I prefer to undermine towards the origin of the helix through

the posterior incision and add an additional anchoring suture. Often the earlobe continues to project after these first major steps. Excess posterior lobular skin can be excised via a fishtail design. To reposition the earlobe medially or posteriorly, the *causa helicus* is sutured to the posterior wall of the concha. The posterior incision is closed using a running subcuticular suture (4-0 monocryl or 3-0 barbed monoderm). Mineral oil-soaked cotton is placed in the crevices of the ear to reduce hematoma formation and edema. A large bulky dressing is then secured for the next three days (Figures 4a, 4b).

### POST-OPERATIVE COURSE



Figures 4a and 4b: Five-year-old boy who underwent bilateral otoplasty. Photos were taken one year after surgery.

All patients are given antibiotics for five days. The dressing is removed in the office three days after surgery. Patients will wear an ace bandage for mild compression and extra padding during the day for a week and overnight for the next two weeks. I have abandoned headbands as a bandage as they are often too constricting and can lead to skin breakdown.

### NONOPERATIVE OTOPLASTY IN INFANTS

A special consideration should be given for ear deformities in newborns. During the first few days of infancy, the ear cartilage is abnormally plastic due to increased circulating maternal estrogen. Estrogen levels peak during the first three days of life and return to normal by six weeks. During this time, a prominent or deformed ear may be molded to correct the

anatomy. Historically, dental paste, feeding tubes and steri-strips were used. This hodgepodge of materials was difficult for mothers to maintain and not sturdy. Over the past ten years, I have used a novel device called the Becon Earwell. When applied to babies who are less than two weeks old, it can predictably correct 96 percent of ear deformities within two weeks of molding (1).

The Earwell has two pre-formed cradles, a large and medium (Figure 5). I prefer the large cradle as it is open around the lobule which prevents potential pressure sores. The cradle can be trimmed and adjusted to fit the baby's ear and address their particular deformity. At the base of the cradle is an anti-helical strut which pushes upwards on the ear while a retractor is used to push downwards on the helical rim to create a neo-antihelix. Infants are seen in the office weekly to confirm that there are no pressure sores and to adjust the mold. Most babies are molded for two to three weeks. Molding is stopped one week after correction is satisfactory. Complications consist of skin ulcerations and contact dermatitis. The correction rate for Stahl's deformities, cryptotia, lidding, and mild constricted cases are excellent (Figure 6).



Figure 5: Earwell molding system which consists of a front and posterior cradle, retractor, and conchal former.

Severely constricted ears are the most difficult to correct. As the baby ages, it becomes more difficult to correct the deformities and treatment times are longer.



Figure 6: Two-week-old baby who was born with a constricted ear deformity. Second photo shows the results after two weeks of ear molding.

### CONCLUSION

Otoplasty surgery is a common operation worldwide and leads to a high satisfaction rate among patients. With a clean technique and a good patient relationship, otoplasty has been shown to have a positive impact on quality of life with low recurrence rates. If the deformity is identified at birth, ear molding is an effective non-surgical method of correction.

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*Dr. Doft serves on the board of medical advisors for Becon Medical. Dr. Franck has no disclosures.*

# ALLERGAN EARFOLD: AN IMPLANTABLE CLIP SYSTEM FOR MINIMALLY INVASIVE CORRECTION OF PROTRUDING EARS - FIRST IMPRESSION

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## INTRODUCTION

Protruding ears are an inherited developmental anomaly of the ear that affects up to 5% of the population[1]. The dysplasia can be unilateral or bilateral and results from an absence or misplaced formation of cartilage during ear development in utero. As a consequence, the external ear has abnormal helical folds or grows laterally. Although protruding ears are viewed as a benign aesthetic problem, they can cause significant psychological distress, issues with self-esteem and reduced quality of life. The social and psychological effects of a craniofacial malformation on a patient can be so devastating that they lead them to seek correction even at a very young age.

The current gold standard of treatment for protruding ears is otoplasty. Recently, an implantable clip system, Earfold® has been proposed as an alternative treatment. Compared to traditional otoplasty, this method is considered less invasive and is associated with a shorter recovery period.

## TECHNIQUE

This article describes our experience with this new technique. Between November 2018 and February 2020, 26 patients received treatment with Earfold® implants (24 bilateral and 2 unilateral). Patients' ages ranged from 18 to 61 years old. All

of the patients returned for their final follow-up assessment at 4-12 months after treatment.

The Earfold® implantable system is composed of three main components; the implant, the introducer, and the positioner. It is not a suture, although it produces similar effects, nor is it an external splint. The main function of the implantable clip is to correct the shape of the ante helix[2, 3]. A description of the method to insert the implant has been described previously[3], but we would like to note that more than 50% of male patients required two Earfold® clips per ear.

## RESULTS

With regards to the ease of use of the clip, insertion of Earfold® is relatively fast and does not require cartilage scoring. The ability of the physician to easily and rapidly provide the treatment allows the use of local anaesthesia, thereby avoiding the risks associated with general anaesthesia.

Typical outcomes of the procedure are shown in **Figures 1-3**. As can be seen by the pre- and post-operation comparisons, correction of protrusion and reasonable symmetry can be achieved using this technique. However, the metallic implant can be visible in younger patients, especially females (**Figure 1**). This could be attributed to the reduced ear surface

and thickness of the skin. Therefore, we conclude that this treatment might be more successful in older male patients (Figure 2-3).

The main adverse effect was pain caused by the procedure, which subsided within 48 hours requiring only simple analgesia. Some swelling/bruising occurred in all patients, but this resolved within 10 days. We observed that wound healing was faster in older male patients. No other complications were reported by any of the patients.



Figure 1 A 18-year-old female, no prior otoplasty. Top: side-to-side comparison of pre- and post-operative photographs. Bottom: 5 days after the procedure. The Earfold® implant was able to correct the protrusion. However, the clip is visible under the skin especially in the right ear. Finally, with regards to patient satisfaction, our experience indicates that patients are generally satisfied with the correction of the protrusion. Although in some cases there were some concerns about the visibility of the implants under the skin, none of the patients requested their removal during follow-up.



Figure 2 A 27-year-old male, no prior otoplasty. Top: Pre-operative photographs. Bottom: 15 days after the procedure. In this case, two clips were implanted.



Figure 2 A 67-year-old male, no prior otoplasty. Top: Pre-operative photographs. Bottom: 15 days after the procedure.

## CONCLUSIONS

To conclude, the Earfold® implantable clip system is a promising alternative treatment option for the correction of protruding ears in cases where prominence can be corrected by enhancing or reshaping the antihelical fold.

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The author has no financial interest in the product mentioned in this article.

# OTOPLASTY USING CONCHAL SUTURES WITH FASCIAL FLAP UNDER LOCAL ANAESTHETICS - SAFE AND SIMPLE TECHNIQUE, 17 YEARS OF PERSONAL EXPERIENCE



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Reducing the obtuse conchomastoid angle using conchomastoid sutures

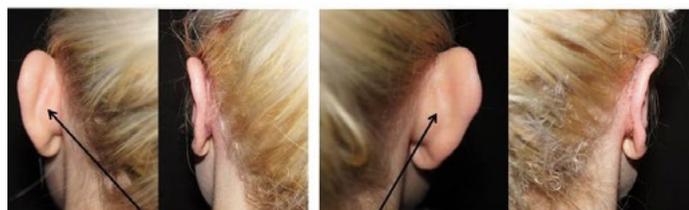


Figure 1

Poor formation of anti-helical fold

**P**rominent ear correction is one of the most common aesthetic plastic surgery procedures in my practice in the United Kingdom. I use 'suture technique' to reconstruct the poorly formed and/or absent antihelical fold and reducing the obtuse conchomastoid angle (*Figures 1 & 2*). I use braided non-absorbable sutures for better stability of the knots (during and after the procedure). The non-absorbable sutures also reduce the incidence of recurrence. The suture technique allows me to preserve the vascularity of the conchal cartilage as it requires dissection only on the posterior surface of the conchal cartilage. This also reduces the possibility of haematoma formation on both sides of conchal cartilage.

I use 10 ml Xylocaine 1% with Adrenaline 1:200,000 on each side. I use 'dumbbell shaped' retroauricular skin excision preserving the fascia overlying the conchal cartilage. A posteriorly based

Formation of anti-helical fold using posterior conchal sutures



Left Before

After 6 weeks

Poor formation of anti-helical fold



Right Before

After 6 weeks

Figure 2



**Posteriorly based facial flap after dumbbell shape full thickness excision from the right retro-auricular space**

Figure 3

fascial flap is raised (Figure 3). The mastoid fascial is exposed. The posterior surface of the conchal cartilage is skeletonised. I use 3-0 Ticron or 3-0 Ethibond conchal sutures to recreate antihelical fold. The sutures are held using surgeon's knots for better stability. Conchomastoid sutures are used to reduce the obtuse conchomastoid angle. The knots are covered with posteriorly based fascial flap. The skin is closed with 5-0 Vicryl

Rapide Suture. I use 10 ml of Marcaine 0.25 % with Adrenaline 1: 200,000 on each side for long acting analgesia.

The patients are advised to take broad spectrum antibiotics and analgesics in the postoperative period. The bandage is removed in 3-5 days followed by protective head band at night for three months.

I have been using this technique for the last 17 years. The recurrence of prominent ear can be easily corrected without devascularizing the conchal cartilage from both sides avoiding the worrying serious complication of avascular necrosis of the conchal cartilage leading to irreversible 'cauliflower deformity.' Pre- and Post-op photos (Figure 5).

The ears are dressed with Gelonet, Aqueous Betadine Gauze, Cotton Wool and non-elastic soft bandage (K-band) (Figure 4).



Figure 4

**Patient camouflaging head-bandage with a smart scarf so that she could resume work from next day onwards**

The detailed technique can be viewed in the following link:

<https://www.youtube.com/watch?v=uFGgOeNOe08>

## Bilateral set back otoplasty under local anaesthetics



Figure 5

**Before**

**After 6 weeks**



# OTOPLASTY IS A MEDICAL NECESSITY

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In 1999 and 2000, I was invited by Dr. Riccardo Mazzola for microtia reconstruction with my mentor, Dr. Satoru Nagata, to Milano, Italy. I was fortunate to visit Dr. Mazzola's amazing personal medical literature library. I was stunned by the beautiful detail described and drawn by our predecessors. One of them is Tagliacozzi (1545-1599), considered the founder of plastic surgery - famous for nasal reconstruction with pedicle flap - also performed reconstructive otoplasty with flaps (*ISAPS News No.12 Vol.2, page 56*).

Since the first report of otoplasty by Ely in 1881, children with prominent ears had been the target of bullying. The child with prominent ears suffers from negative psychological impact, and this trend has never changed to date. Because of

bullying, children do not want to go to school; it causes low self-esteem and low school performance. Although insurance companies consider otoplasty cosmetic surgery in order to avoid insurance coverage, I believe that otoplasty for prominent ear correction is a medical necessity to remove children's negative psychological impact.

As a communication tool, human attention focuses on the facial triangle, including eyes, mouth, and facial expression, trying to read their mind. The auricle should not be the focus of attention in our life. When the auricle is set back, not protruded, all anatomical components are in the right dimension and harmony, with spiral helical curve, and humans do not pay attention to the shape of ear. This is exactly the purpose/



Figure 2

goal of otoplasty, either aesthetic or reconstructive. **Figure 1** is a recent case of bilateral correction of severe prominent ear. He was bullied at school because of his prominent ears. I did Mustarde sutures, skin excision, and small concha excision. The postop photo shows that the right side has projection of ear: upper; 18, middle; 18, lower; 18. Left side: upper; 20, middle; 20, lower 20. A 2 mm difference between left and right. Interestingly, the father of this child told me that when he looks at his son, his attention has changed from his ears to his facial triangle. The father no longer pays attention to the ears. The child and his father were extremely happy about the result.

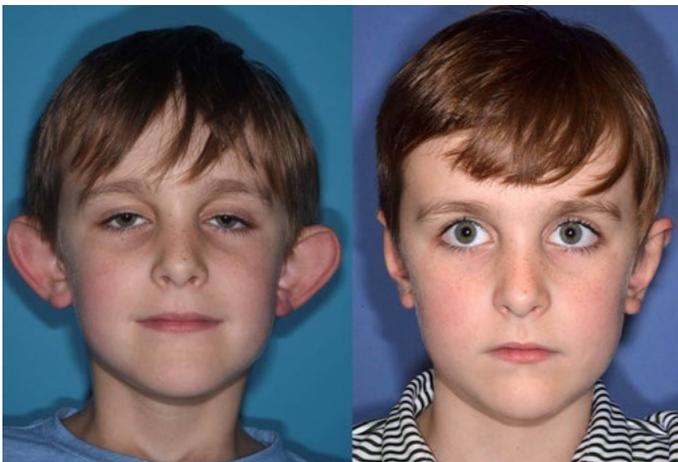


Figure 1

Totally missing auricular shape (microtia) is also the target of bullying from peers. The world of children is a reflection of our adult society: bullying, hate, and conflict. The goals of otoplasty surgeons are to protect children from bullying, to remove the psychological burden and to elevate self-esteem by creating a natural looking auricle. Total auricular construction also has functional reasons to do it. After proper surgery, children are able to wear a pair of glasses for vision, sunglasses for eye protection, and a mask for preventing infection such as COVID-19. Achieving excellent results in total auricular construction is not easy, but by working together, competing with each other, learning from each other, we must elevate the treatment level together, in order to achieve optimal results.

Thanks to the evolution of autogenous techniques over the last 60 years, started by Drs. Tanzer, Brent, and Nagata, we are getting closer to achieving a natural looking auricle (**Figure 2**).

*Guest author, Akira Yamada, MD, PhD, is Professor of Surgery in the Department of Plastic Surgery at Northwestern University's Feinberg School of Medicine and Ann & Robert H. Lurie Children's Hospital of Chicago. He has written and lectured extensively on ear reconstruction.*

#### REFERENCES

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3. Yamada A. Autologous rib microtia construction: Nagata technique. Facial Plastic Surgery Clinics for North America. Volume 26, Issue 1, Feb 2018, p 41-55, Elsevier
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## GLOBAL PERSPECTIVES: FUTURE THEMES

**December 2020: Rhinoplasty**  
**Deadline: October 15, 2020**

**March 2021: Breast Reduction**  
**Deadline: January 15, 2021**

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 attached, not embedded in your article. Please include photo captions.

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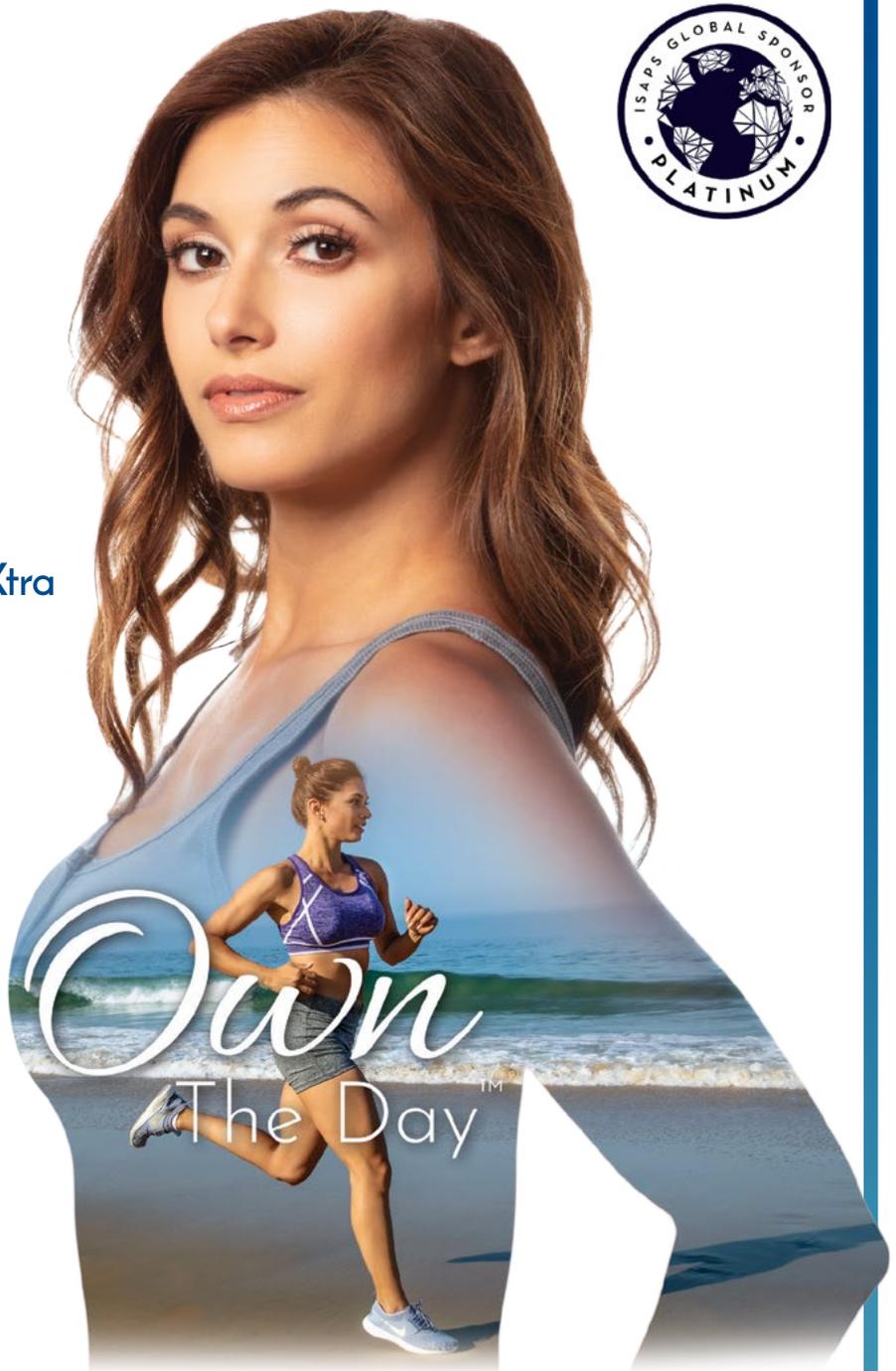
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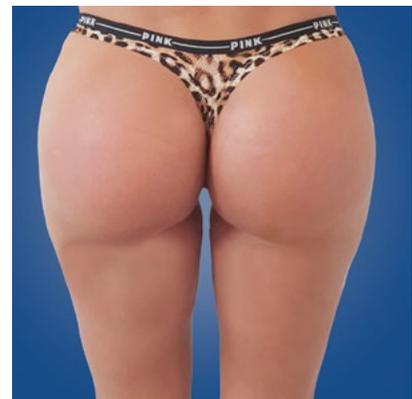
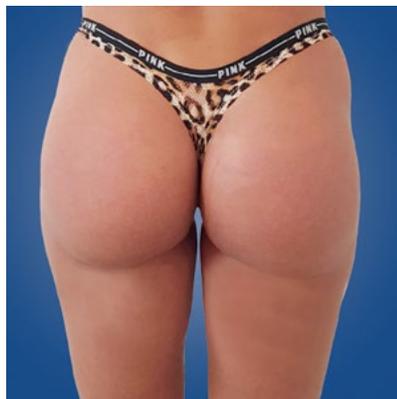
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# MEETINGS CALENDAR



Topic: Weekly topics in Aesthetic Plastic Surgery  
Origin: London, UK  
Time: 13:00 UTC  
Link to register:  
<https://www.isaps.org/webinars/master-class-webinar-series/>  
Time Zones: To find your time [click here](#)

## WEBINAR - 19 SEPTEMBER 2020

Periorbital Rejuvenation  
Vakis Kontoes & Mario Pelle  
Moderator- Ozan Sozer  
[Register here](#)

## ISAPS SYMPOSIUM – UNITED KINGDOM

Date: October 3, 2020  
Topic: Body Contouring  
Location: London, UNITED KINGDOM  
Venue: ExCel, London  
Contact: Aleiya Lonsdale  
Telephone: +44 (0) 20 3196 4375  
Email: [aleiya.lonsdale@easyfairs.com](mailto:aleiya.lonsdale@easyfairs.com)  
Website: [www.isaps-symposium.co.uk](http://www.isaps-symposium.co.uk)

## WEBINAR - 3 OCTOBER 2020

Breast Reduction  
Moustapha Hamdi & Akin Yucel  
Moderator- Ivar Van Heijningen

## WEBINAR - 17 OCTOBER 2020

MACS Lift and Periorbital Fat Grafting  
Patrick Tonnard & Alex Verpaele  
Moderator- Dirk Richter

## WEBINAR - 31 OCTOBER 2020

Secondary Rhinoplasty  
Dean Toriumi, Nazim Cerkes & Wolfgang Gubisch  
Moderator- Enrico Robotti

## TD ABS, THE MEETING – ISAPS ENDORSED

Dates: November 6 – 8, 2020  
Location: Bogota, COLOMBIA  
NOTE: This will be a virtual meeting.  
Contact: Johana Poveda/Commercial Director  
Tel: +57 310 262 8693  
Email: [info@tdabsmeeting.com](mailto:info@tdabsmeeting.com)  
Website: <https://tdabsmeeting.com>

## WEBINAR - 7 NOVEMBER 2020

Botox-Filler-Thread Applications  
Ivar Van Heijningen, Reha Yavuzer & Tunc Tiryaki  
Moderator- Francisco Bravo

## WEBINAR - 21 NOVEMBER 2020

Structural Versus Preservation Rhinoplasty  
Wolfgang Gubisch, Enrico Robotti, Olivier Gerbault, Abdulkadir Goksel, Baris Cakir & Yves Saban  
Moderator- Nazim Cerkes

## ISAPS F.A.S.T. PROGRAM - MOSCOW

Dates: November 20-22, 2020  
Location: Moscow, RUSSIAN FEDERATION  
Venue: Golden Ring Hotel, Smolenskaya str., 5  
TOPIC: Complications and Difficult Case Management Contact:  
Anna Pimenova  
Tel: +7 (495) 287-46-45  
Fax: +7 (495) 287-46-45  
Email: [orgcom@isapsfast.ru](mailto:orgcom@isapsfast.ru)  
Website: [www.isapsfast.ru](http://www.isapsfast.ru)

## CLOSED ATRAUMATIC RHINOPLASTY COURSE II – ISAPS ENDORSED

Dates: November 28 & 29, 2020  
Location: Istanbul, TURKEY  
Venue: Online  
Contact: Dr. Suleyman Tas  
Tel: +90 530 600 8271  
Email: [info@drsuleymantas.com](mailto:info@drsuleymantas.com)  
Website: [www.dr.suleymantas.com/course](http://www.dr.suleymantas.com/course)

## INTERNATIONAL FRESH CADAVER AESTHETIC DISSECTION COURSE ON FACIAL ANATOMY AND RHINOPLASTY

Dates: 21-23 January 2021  
Location: Liege, BELGIUM  
NOTE: Limited to 32 participants  
Contact: Mrs. Anne-Marie Gillain  
Tel: 32 (0)4 242-5261  
Fax: 32 (0)4 366-7061  
Email: [amgillain@chu.ulg.ac.be](mailto:amgillain@chu.ulg.ac.be)  
Website: [www.isapscourse.be](http://www.isapscourse.be)

## ISAPS SYMPOSIUM - ATLANTA

Dates: January 21, 2021  
Location: Atlanta, Georgia, USA  
Topic: 2nd Annual SESPRS/ISAPS Periorbital and Facial Symposium  
Venue: Intercontinental Hotel - Buckhead  
Contact: Susan Russell  
Tel: 1-435-901-2544  
Fax: 1-435-497-2011  
Email: [srussell@sesprs.org](mailto:srussell@sesprs.org)  
Website: <https://www.sesprs.org/page/2021PeriorbitalFacial>

### ISAPS.AESURG 2021 – ISAPS ENDORSED

Date: February 9-13, 2021  
Location: Surajkund, Delhi NCR, INDIA  
Venue: Taj Vivanta  
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### 55TH BAKER GORDON EDUCATIONAL SYMPOSIUM – ISAPS ENDORSED

Date: February 11 – 13, 2021  
Location: Miami, FL, USA  
Venue: Hyatt Regency Hotel  
Contact: Mary Felpeto  
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Email: [maryfelpeto@bellsouth.net](mailto:maryfelpeto@bellsouth.net)  
Website: [www.bakergordonsymposium.com](http://www.bakergordonsymposium.com)

### ISAPS COURSE – GREECE

Dates: April 1-3, 2021  
Location: Athens, Greece  
Venue: Radisson Blu Park Hotel  
Contact person: Vicky Delidimitriou, [vdelidimitriou@noufio.gr](mailto:vdelidimitriou@noufio.gr)  
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### BARCELONA RHINOPLASTY 2ND COURSE – ISAPS ENDORSED

Date: April 28 – May 1, 2021  
Location: Barcelona, SPAIN  
Venue: Centro Medico Teknon  
Contact: Silvia Vila  
Tel: 34 9 33933 128  
Email: [svila@vilarovira.com](mailto:svila@vilarovira.com)  
Website: <http://www.barcelonarhinoplasty.com>

### ISAPS SYMPOSIUM – CHILE

Dates: May 13, 2021  
Location: Santiago, CHILE  
Venue: Hotel Plaza El Bosque Nueva Las Condes  
Contact: Dr. Montserrat Fontbona  
Tel: 56-226-320-714  
Email: [soccpchile@gmail.com](mailto:soccpchile@gmail.com)  
Website: <http://www.sccp.cl>

### 15TH INTERNATIONAL FRESH CADAVER COURSE ON FACELIFT AND PERI-ORBITAL PROCEDURES – ISAPS ENDORSED

Dates: June 4-5, 2021  
Location: Utrecht, NETHERLANDS  
Venue: Medical University  
Contact: Jacques van der Meulen  
Tel: +31 641 461 496  
Email: [drvdMeulen@gmail.com](mailto:drvdMeulen@gmail.com)  
Website: <http://www.drvtulp.nl>

### 33RD ANNUAL CONGRESS OF SOFCEP – ISAPS ENDORSED

Dates: June 10-12, 2021  
Location: Les Sables d'Olonne, FRANCE  
Venue: Centre de Congres des Atlantes  
Contact: SOFCEP  
Tel: +33(0)53 431 0134  
Email: [sofcep@vous-et-nous.com](mailto:sofcep@vous-et-nous.com)  
Website: <http://www.chirurgiens-esthetiques-plasticiens.com/congres-sofcep-2/?lang=en>

### SECONDARY OPTIMIZING AESTHETIC SURGERY

Symposium (SOS) 2021 – ISAPS Endorsed  
Dates: September 7-8, 2021  
Location: Vienna, AUSTRIA  
Venue: Andaz Belvedere Vienna Hotel  
Contact: Barbara Boeld  
Tel: +49-89-18-90460  
Email: [Congress@bb-mc.com](mailto:Congress@bb-mc.com)  
Website: <http://www.sos2020.eu>

### SYMPOSIUM (SOS) 2021 – ISAPS ENDORSED

Dates: September 7-8, 2021  
Location: Vienna, AUSTRIA  
Venue: Andaz Belvedere Vienna Hotel  
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### ISAPS COURSE - HUNGARY

Dates: November 4-6, 2021  
Location: Debrecen, HUNGARY  
Venue: Kölcsey Convention Center Debrecen  
Contact: Dr. Csaba Molnár  
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ANNIVERSARY

**SEPTEMBER 9 - 12, 2021 | VIENNA, AUSTRIA**

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1. Duteille F, et al. Aesthet Surg J Open Forum 2019;1.(2) 1–10;

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POLYTECH

50th  
ANNIVERSARY



**NEW DATES!**  
**WORLD CONGRESS**  
Vienna | Sept. 9-12, 2021

INTERNATIONAL SOCIETY OF AESTHETIC PLASTIC SURGERY

The World Congress has been postponed to  
**SEPTEMBER 9 - 12, 2021**  
**VIENNA, AUSTRIA**

After careful thought and consideration of the ongoing situation with coronavirus (COVID-19), the ISAPS Board of Directors has decided to postpone the upcoming ISAPS World Congress in Vienna, Austria to September 9-12, 2021.

We understand that this change is an inconvenience, but we are confident that it is the right decision.

As an international organization, it is our goal to provide a stimulating environment that both features speakers from around the world and is accessible to our members from over 100+ countries. At the moment, travel bans, limits on event sizes, and social distancing measures are still in place in much of the world, and will likely remain in many regions. In light of this, we feel it is best to postpone the ISAPS World Congress for another year in order to ensure that our members will be able to join us in Vienna, no matter where they are located.

Thank you for your cooperation and understanding during these trying times. Despite this difficult situation, we appreciate your support and are working hard to ensure the 25th ISAPS World Congress is a success.

**We look forward to welcoming you in Vienna for the ISAPS World Congress in 2021!**

[www.isapsvienna2021.com](http://www.isapsvienna2021.com)