



ISAPS[®] NEWS

OFFICIAL NEWS OF THE INTERNATIONAL
SOCIETY OF AESTHETIC PLASTIC SURGERY

4

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How I Do It

ISAPS Course Reports: AESURG
ISAPS Symposium 2023

Concepts of Beauty:
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Shoulders of Giants:
Prof. Ulrich T. Hinderer

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2024

VOLUME 17

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COMMUNICATION UPDATES:

Welcome to the December 2023 issue of the *ISAPS News*!

We hope you enjoy the refreshed look!

In this section, we review the latest ISAPS communications and updates to keep you current on our latest happenings.



Message from the
Editor-in-Chief

Fabian Cortiñas

Message from the
Co-Editor

Dirk Richter

Message from the
ISAPS President

Lina Triana

Message from the
Education Council
Chair

Ozan Sozer

Journal Update from
the Editor-in-Chief

Lee Pu

MESSAGE FROM

the *ISAPS News* Editor-in-Chief



FABIAN CORTIÑAS, MD - ARGENTINA
Editor-in-Chief, *ISAPS News*

Dear Colleagues,

The end of the year represents an opportune moment for reflection, a time to take stock of our progress, and a time to show appreciation to all who participated and helped to improve communication among us as members and within the *ISAPS News*. I want to extend a big thank you to all of you - authors and readers.

This was a year full of work and plenty of progress in terms of ISAPS communications. We produced our new website full of content, more user-friendly, and strong at-a-glance educational material for our members. One extraordinary and unexpected achievement was the "**Best B2C Website of the Year**" award in October at the Global Digital Excellence Awards.

The ISAPS website provides easy access to the **APS Journal**, more than 1,500 educational videos, undoubtedly the most significant **video library** in the realm of aesthetic surgery in the world, and our e-learning library **MedOne**.

Our social media channels keep growing; this year, we made the first "lives," keeping our members and potential patients informed about the latest ISAPS activities and philosophies. Today, we have more than 37,000 followers.

During the Olympiad in Athens, we held our first press conference with several journalists who interviewed our President, Dr. Lina Triana, Co-Chair, Dr. Vakis Kontoes, and the Global Survey Editor, Dr. Gianluca Campiglio, about the trends in aesthetic surgery and the results of the **Global Survey**.

Our Global Survey also grew, showing an increase in a 30% response rate and also including more countries. The Global Survey is a unique tool to reach the media and the public, and we are working constantly to take advantage of the information it provides.

Finally, you will enjoy supplemental sections, additional content, and a new design in our *ISAPS News*.

There are still many things to accomplish, and we are committed to increasing and improving ISAPS communication at all levels, but this year showed a positive balance.

Best wishes from the Editorial Board for the Holidays and the upcoming New Year.



Fabian Cortiñas, MD
Editor-in-Chief, *ISAPS News*



MESSAGE FROM

the *ISAPS News* Co-Editor



DIRK RICHTER, MD - GERMANY
Co-Editor, *ISAPS News*

Dear Colleagues and Friends,

As we approach the year's end, it's a season of culmination and reflection for many. The exceptional growth in global procedures we witnessed last year seems a tough act to follow in 2024, given the array of global crises and financial uncertainties. However, the resilience of the aesthetic sector shines through these challenges.

The past year has seen a surge in our members' commitment to continued education. The robust attendance at conferences and webinars speaks volumes about the eagerness for real-life connections, a refreshing change from the screen-dominated interactions during the pandemic. This positive trend is set to carry into 2024, with an array of enriching training opportunities already lined up in our congress calendar. This period is ideal for mapping out next year's educational journeys. Have a close look and book your trip!

In the spirit of renewal, *ISAPS News* has also undergone a transformative face lift. This subtle and significant change echoes our commitment to staying fresh and relevant while

holding true to our core values – like a good face lift. The redesign extends beyond aesthetics as we introduce new and engaging content like the "Book Nook", showcasing excellent works from our members.

As we gear up for the festive season and a new beginning, I extend my heartfelt wishes for a joyful holiday and an invigorating start to the new year.

Let's embrace this time of change and opportunity with open arms and a renewed spirit of collaboration and growth.

Warm regards,



Dirk Richter, MD
Co-Editor, *ISAPS News* and
ISAPS Past President (2018-2020)

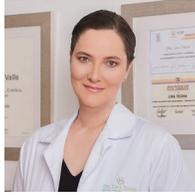
BOOK NOOK INTRO:

We're excited to introduce our new "Book Nook" feature, a special section in each issue dedicated to showcasing selected works exclusively by ISAPS members. We take pride in our highly competent members, many of whom are accomplished authors.

We aim to highlight these exceptional publications through critical reviews. If you're an ISAPS member who's an editor or co-editor of a professional book, we invite you to submit it for review by an independent reviewer appointed by us.

Please provide a complimentary copy of the book, either in hardcopy or digital format. Note that submission does not guarantee publication. We eagerly anticipate your feedback and hope you enjoy our first book review. For more information, please email isapsnews@isaps.org.





MESSAGE FROM the ISAPS President

Dear Friends and Colleagues,

As we near the year's end, ISAPS has not been resting. As well as being a time for reflecting on some of the highlights of the last year, we have also been busy planning ahead for our members for another exciting year in 2024! Together with our Scientific Program Committee in London this week, we have been finalizing our scientific program for the **ISAPS World Congress 2024 Cartagena**, and we will share it with you very soon. Our Congress is taking place earlier next year, **June 11-15**, so take a moment during the holidays if you have not already done so and register for the Super Early Bird Deadline (**before January 11, 2024**) and take advantage of our lowest rates.

It was also a great privilege for me, over this last weekend, to be able to welcome the presidents and representatives of our Global Alliance Partners (GAP) from all around the globe, who came together in person at our **First Global Alliance Forum on December 9, 2023**, in London. Our Global Alliance Partners play an essential role in our ISAPS vision for a safer aesthetic world through their work as national societies. We can only be stronger together through collaboration, and I



L.I.F.T. Program: Coaching & Mentoring Workshop



Global Alliance Forum Event



am extremely grateful' to over 40 society leaders from 38 countries, who gave their time, energy, and ideas, and in many cases also traveled great distances, to participate. This meeting began our work to cooperate more closely: to co-create and agree on core strategy goals that all GAP can commit to working towards in the coming years to promote patient safety globally and to improve our aesthetic world. We look forward to sharing our goals early next year.

Another focus for this year has been the development of our ISAPS Leadership Insights for Transformation Program (L.I.F.T.), which culminated in the second interactive face-to-face workshop in our Leadership Series, our **L.I.F.T. Program: Coaching & Mentoring Workshop**, moderated by our Program Director Andy Craggs, and our guest Leadership Coach from London Business School, Randall Peterson. The program also took place last weekend on **December 10**, allowing many of our global forum participants to attend as we



explored team building, engaging and motivating others, and maintaining the highest professional standards and performance. I invite you all to be ready for our next webinar next semester and be part of our L.I.F.T. live event at our Cartagena ISAPS World Congress June 11-15, 2024.

As we close out the year, I invite you to reflect on this leadership theme and to live through these holidays and into 2024 standing on the **four fundamental aspects of being a leader:**

- our integrity
- our authenticity
- standing for something bigger than ourselves
- being the cause in the matter

As ISAPS members we are role models, and we are leaders in our aesthetic world.

Thank you all for being part of our ISAPS Community, and I wish you all a happy holiday season.

Sincerely,



Lina Triana, MD - Colombia
ISAPS President, 2022-2024



MESSAGE FROM

the Education Council Chair



OZAN SOZER, MD - UNITED STATES
Chair, ISAPS Education Council

Dear ISAPS Members,

Since our first Olympiad in Greece, we have been busy preparing for the **ISAPS World Congress 2024**, our biannual meeting in **Cartagena, June 11-15, 2024**. Our abstract submission deadline was on November 6, 2023, and we received **more than 350 abstracts** from all over the world. Our Scientific Program Committee met just last week in London to finalize the program, which will be released soon.



Cartagena's high-quality, prestigious **program** will include a pre-Congress live surgery, a Residents' and Women's Symposium, a video cadaver dissection course, and a full-face sculpture workshop.

As part of our ongoing educational initiatives, we recently participated in seven **endorsed meetings, Residents' Webinars, and Journal Clubs**. To stay up-to-date on upcoming events, visit the online **Events Calendar**.

ISAPS also participated in the **Brazilian Congress of Plastic Surgery**, the annual meeting of the Brazilian Plastic Surgery Society, with a successful Regenerative Medicine Symposium (**Figure 1**) organized by Dr. Katarina Antjelkov.

As we finish up the year and prepare for 2024, the ISAPS Education Council is already looking forward to bringing you continued learning and networking opportunities.

Please mark your calendars for the ISAPS World Congress 2024 - see you there!

Sincerely,

Ozan Sozer, MD
Chair, ISAPS Education Council



ISAPS JOURNAL

MESSAGE FROM THE EDITOR-IN-CHIEF



LEE PU, MD, PHD - UNITED STATES

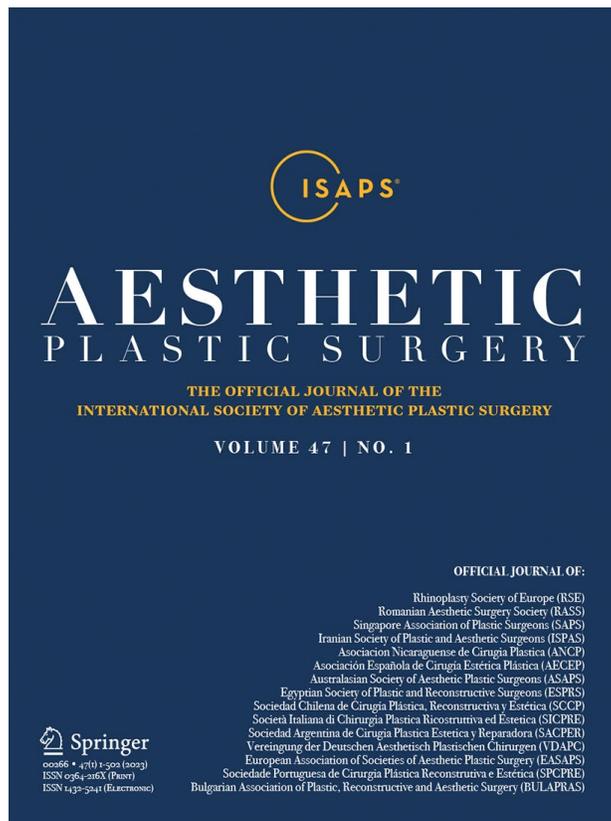
Editor-in-Chief, *Aesthetic Plastic Surgery*

Dear ISAPS Members,

Since I have resumed the role of Editor-in-Chief of the Journal I'm happy to report that the Journal, has continued receiving many submitted manuscripts with high quality from our worldwide aesthetic plastic surgeon community. Those manuscripts include excellent systematic reviews of particular topics in aesthetic plastic surgery or medicine, innovative surgical techniques, more extensive case series with longer follow-ups for some established aesthetic surgical or non-surgical procedures, and many remarkable experimental studies in our specialty.

I'm happy to report that, starting in January 2024, the Journal will become a monthly publication. Each issue will include both printed and online published articles. This way, high-quality articles can be viewed monthly, and the Journal indeed becomes a top-ranked and more reputable international plastic surgery journal.

For the past several months, I have worked with several members ISAPS' Journal Operations Committee, the



managing team of the Journal, and the publisher to possibly make some good changes to the Journal. These include the table of contents, article layout, reference style, and adding academic degrees for each author. All these potential changes were discussed during the recent Editorial Board meeting in Athens. In addition, a new design for the cover page has been created and is awaiting approval by the ISAPS Board of Directors and the publisher.

We have actively been working on restructuring the Journal's peer review system and three very capable associate editors have been appointed by ISAPS. They are Drs. Fabio Nahas (Brazil), Moustapha Hamdi (Belgium), and Woffles Wu (Singapore). We will be adding a significant number

of section editors and broadly expanding our editorial boards. If any of you would like to contribute to the Journal by serving as an Editorial Board member or a reviewer, please write to me at llpu@ucdavis.edu. We are always seeking many capable individuals for peer review to meet the increased workload.



Although the Journal has been facing some obstacles in terms of the length of time to complete a peer review for each submitted manuscript, I'm very optimistic that once the restructure of the Journal's peer-review system is complete, we will be able to overcome this difficulty and meet an increased demand of more submitted manuscripts. Soon after that, I will work with associate editors and section editors to improve scientific content and the readership

of the Journal. We will continue making improvements so that the "Blue Journal" can become an even more reputable international journal of aesthetic plastic surgery and medicine. Thank you for your continued support!

Happy holidays to you and yours!



Lee Pu, MD, PhD
Editor-in-Chief, *Aesthetic Plastic Surgery*



NEXT ISSUE

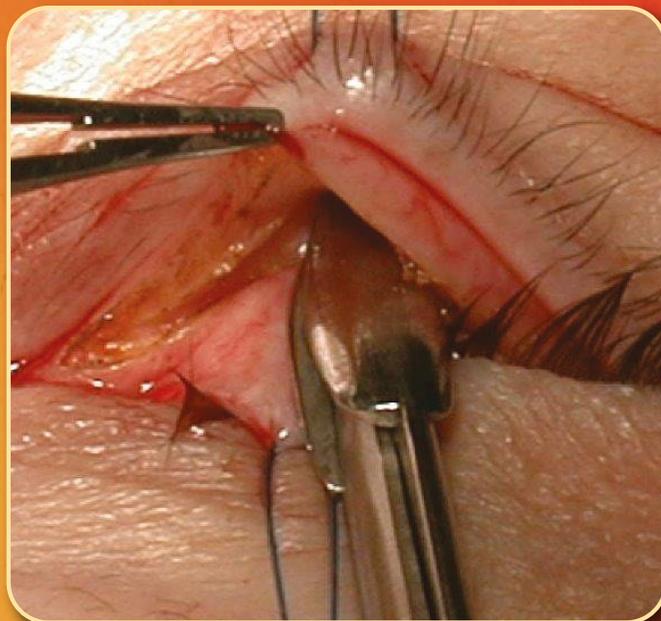
HOW I DO IT:

**BREAST
ASYMMETRIES**

To submit an article or for questions,
email: isapsnews@isaps.org.

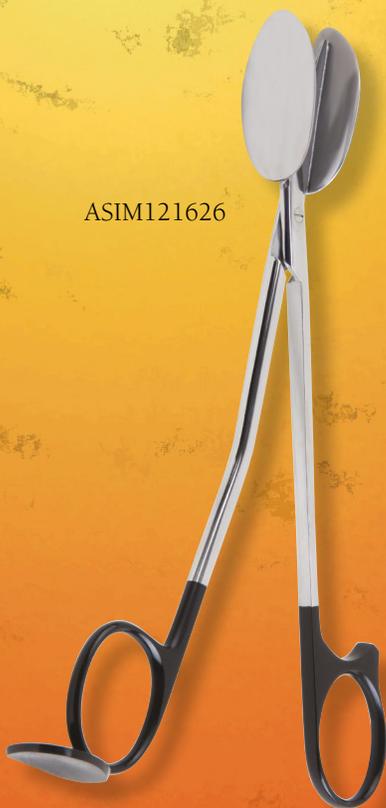


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93. **VIETNAM**
Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)



COMMITTEE BULLETIN:

ISAPS' various committees support the Board of Directors, who work together to organize and deliver the many ISAPS projects and activities.

Stay updated on what they are doing for ISAPS.



ISAPS Governance
Committee Report
Ivar van Heijningen
Sarah Johnson

ISAPS Ethics
Committee Report
Kai Kaye

ISAPS Course
Report
Karishma Kagodu

Congress Report
Vakis Kontoes

Kick-Off Meeting
for Establishment of
a Breast Centre in
Burkina Faso and Mali
Volker Wedler

**Click here to
submit a Course or
Congress Report.**

COMMITTEE REPORT

ISAPS Governance Committee



IVAR VAN HEIJNINGEN, MD - BELGIUM
Chair, ISAPS Corporate Governance and Policy, and Certification Committees



SARAH JOHNSON - UNITED KINGDOM
ISAPS Executive Director

GOVERNANCE AND THE OFFICE

For this 11th article on Governance in the ISAPS quarterly newsletter, Sarah Johnson, ISAPS Executive Director, was kind enough to join me in explaining what Governance principles apply regarding the office and to introduce our ISAPS team.

THE OFFICE: WE CANNOT DO WITHOUT THEM

ISAPS would not be ISAPS as it is today if it were not for the professional support of the office! Membership organizations are unlike commercial businesses in that we benefit from a wealth of working resources from all our volunteer committees. However, none of the Board of Directors, committee chairs, or committee members can dedicate themselves full-time to working for ISAPS. For them, this is a voluntary job they choose to do because they believe in our cause of education and patient safety, but it is a full-time job to take care of all the day-to-day work. Our Board makes decisions on the direction the Society will take. It is then the purpose of the office to plan and implement the work towards our strategic plan and to make sure this is done in the best possible way.

FOR MEMBERS, BOARD, AND COMMITTEES!

The office makes sure that all systems are in place to serve ISAPS as an organization and all involved: the membership, the Executive Committee (EXCO), the Board, and committees, in addition to everybody else that we work with, including the media, general public, other societies, sponsors, congress

organizers, IT-system operators, and so forth – basically, everybody and every entity that ISAPS interacts with. To help facilitate these interactions, we have specific consultants such as the Talley Management Group in the US who manage our US office; Boeld Communications who take care of our marketing, Springer who provides the editorial office for our *APS Journal*, as well as many committees who focus on specific areas of our strategic plan. The office coordinates our work with all our stakeholders to ensure that relevant information is shared and forwarded correctly, resulting in the desired actions.

We must communicate consistently and professionally with all involved, respecting everybody's needs.

WHO MAKES UP THE ISAPS STAFF AND OFFICE TEAM? WHAT ARE THEIR ROLES, AND RESPONSIBILITIES?

To make sure that our office itself works efficiently, we need someone looking after all the administrative aspects, which the Executive Team shares: our Executive Assistant and Office Manager, together with our Administration Officer, Christina Baber. They also coordinate all the external communications that flow into ISAPS, ensuring these reach the appropriate people and get actioned appropriately. Accounting is essential for all organizations, and Sean Finnell, based in the US, ensures we are in line with all applicable laws as our Accounting Manager.



The office focuses on all topics related to membership subscriptions, including answering questions, helping members pay dues and fees, verifying credentials, and communicating with our "army" of national secretaries to share membership updates around the globe. This is an arduous job managed by Richard Guy, Head of Membership Services, now with assistance from Precious Akpoviroro.

Digital education is at the heart of our work to ensure access to Aesthetic Education Worldwide®, and Laura Lundy, Digital Project Manager, has overseen the work to design an award-winning website that is modern, easy to navigate, and helps both members and the general public understand our mission and vision. Members can find all educational content, videos, webinars, and upcoming events online. Lundy and her team, Daniah Hagul and Kelly-Anne Searyoh, care for all our digital and resident education projects. Joanne Joham, Operations and Business Development Consultant in the US, provides a first port of call to our North American office, represents ISAPS at our US partner events, and coordinates partnership projects in education.

Alex Ceriu, our Customer Relationship Coordinator, handles all of our customer relationship management for our ISAPS events and manages our X-CD registration and abstract systems. Monica Martins, Niki Cripps, and Gemma Boyd are our Event Managers, responsible for ensuring and maintaining year-on-year continuity and quality for our World Congress and ISAPS event programs.

Internal and external communications are managed by Gemma Moreno, our Communications Consultant, who works with Boeld Communications and the membership team; this includes projects like our Global Survey, developing our social media campaigns, and membership communications.

Sarah Johnson oversees our team, and all their work. As Executive Director, she makes sure all cogs connect and provides the connection between our Board of Directors' strategy and the operational work of the team, assisted by her Executive Assistant, Pippa Waller, who also keeps our governance work on track and takes care of our agendas.

HOW DOES THE "OFFICE" DO THE JOB?

A not-for-profit organization founded in the US, ISAPS maintains its official office base there. At the same time, as an international organization, we have elected to work primarily within a virtual office environment, allowing us

to recruit team members from around the world and also to attract more part-time staff so that we can provide the breadth of skills that an international membership organization needs while still working most efficiently.

Our teams are primarily based in the UK and US, but we also have staff members in Romania and Spain and our marketing team in Germany.

Keeping in close communication is paramount in managing a global team. As for many people working in the post-COVID environment, Microsoft Teams has become the primary "office" environment, where team members discuss day-to-day projects or reach out to a colleague for a 'face-to-face chat. The whole team gets together weekly in Teams to connect on priorities and progress, but meeting face-to-face when possible remains important. This happens periodically at numerous ISAPS events and through meetings at our satellite office at the Royal College of Surgeons in London.

EFFICIENCY AND EFFECTIVENESS

The ISAPS team is still relatively small and is growing gradually based on specific needs that must be covered or are overloaded. One of the advantages of a small team is the ability to focus together on our mission, even at a time when the organization is growing. We see our structure as a "matrix," meaning that while each staff member has a clear job description for their specific area of responsibility, descriptions are still flexible to include aspects of cross-team working on larger projects (such as our Congress or our new website), which further supports close teamwork and collaboration.

For new projects, specific plans are made with timelines so that it is clear what is expected of all parties involved, and we work closely with the ISAPS Corporate Governance and Policy Committee to describe all aspects of our work with other ISAPS committees in our policies and Terms of Reference.

CONCLUSION

Without an efficient and consistent working office, no organization can thrive. We are very proud of what has been built in recent years, but there is always more to do to improve. With an ambitious Board strategy, it will be important to continue to evaluate our staffing needs regularly, to continue to deliver on ISAPS' mission effectively,



and to be able to support our new projects, for example, in continuing to build our online learning capabilities, creating a structured certification program for aesthetic plastic surgery, and developing the newly agreed annual Congress program.

Writing during the Thanksgiving holidays provides an opportunity to extend a warm thank you to all our dedicated



Ivar van Heijningen, MD
Chair, ISAPS Corporate Governance and Policy,
and Certification Committees

ISAPS team – from our office staff to all our volunteer committee members who create the extended team needed to deliver all our work together – thank you.

Sincerely,



Sarah Johnson
ISAPS Executive Director



COMMITTEE REPORT

ISAPS Ethics Committee



KAI KAYE, MD - SPAIN
Chair, ISAPS Ethics Committee

SEXUAL MISCONDUCT WITHIN THE SURGICAL WORKFORCE – A WIDESPREAD PHENOMENON AND HOW TO DEAL WITH IT

In the wake of the #MeToo movement, which had its origin within the entertainment industry in the US, various other fields of work have been scrutinized for sexual misconduct after members of their respective workforces publicly called out these incidents.

In 2021, the first paper targeting the surgical workforce was published by Fleming and Fisher after interviewing 20 women in the surgical field, indicating the existence of a big elephant in our surgical theaters, mainly because not one of these affected women was willing to co-author their paper, even anonymously¹.

A recent publication in the *British Journal of Surgery* showed even more alarming findings on the prevalence of sexual misconduct in the surgical workforce of the UK².

According to this recent publication based on data from over 1,500 participants across the UK with weighted and unweighted analyses, women are not only approximately three times more likely to be exposed to sexual harassment at their workplace than men, but they also experience forced physical contact in the context of career opportunities in more than 10% of cases.

Furthermore, the study showed a widely perceived lack of accountability of the leadership within the affected workplaces and health-related organizations when confronted with sexual harassment.

In our continued effort to strive to forge an accountable and socially responsible leadership organization of healthcare professionals worldwide, the ISAPS leadership would like to underline in this context our strong position that sexual harassment, sexual assault, and rape, all referred to as sexual misconduct, are unacceptable within any workforce, but even more so in the medical field, where our primary goal is to help, and not to harm.

As data shows, sexual misconduct appears to often go unchecked in the surgical environment, as structures of career dependency, especially in resident training environments, and the still standard strong hierarchical structure contributes to gender and power imbalance.

The ISAPS leadership believes that challenging these behaviors needs to become more accessible, and particularly from the point of view of the Ethics Committee, we want to raise awareness amongst our members for these behaviors.



For our Resident members in particular, we want to communicate that we are aware of the significant power that superiors may have over career progression, especially in a highly sought-after specialty like plastic surgery, and we want to encourage them to step forward when they experience or witness those kinds of events.

The ISAPS Ethics Committee has a strong commitment, reflected in our newly revised ethical code, not to tolerate this behavior among our members, and we encourage our members to contact the **Committee** via the website if they experience such behavior by ISAPS members.

ISAPS' leadership believes that sharing and reporting is an essential first step to enhance awareness, and contribute to subsequent social action, and that professional societies should play a significant role in addressing this issue.

There is a social responsibility role for any surgical leadership association, and ISAPS is committed to setting the tone by being world leaders not only in aesthetics but also by being leaders in cultural change; we invite all our members to actively participate in this much-needed cultural change to create better and safer working environments for our members because safer environments lead to safer and better treatments.



Kai Kaye, MD, PhD
Chair, ISAPS Ethics Committee

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2. Christopher T Begeny, Homa Arshad, Tamzin Cuming, Daljit K Dhariwal, Rebecca A Fisher, Marieta D Franklin, Philippa M Jackson, Greta M McLachlan, Rosalind H Searle, Carrie Newlands, Sexual harassment, sexual assault and rape by colleagues in the surgical workforce, and how women and men are living different realities: observational study using NHS population-derived weights, *British Journal of Surgery*, 2023; znad242, <https://doi.org/10.1093/bjs/znad242>





KARISHMA KAGODU, MD - INDIA
ISAPS Assistant National Secretary

COURSE REPORT: AESURG ISAPS SYMPOSIUM 2023

Dear Friends and ISAPS Members,

I am delighted to write in this issue of the *ISAPS News* about my experience at the AESURG-ISAPS Congress conducted by the Indian Association of Aesthetic Plastic Surgeons (IAAPS) in Pune, India.

The AESURG ISAPS Symposium 2023 took place between March 1-5, 2023. This congress had a major league turnout of more than 400 plastic surgeons from across India, 20 international faculty, and international delegates. Out of the international faculty, six were ISAPS faculty. Dr. Ashish Davalbhakta has served the IAAPS organization for over 15 years, was elected President of IAAPS from 2022-2023, and exceeded all expectations by organizing a landmark congress event.

Our dedicated organizing committee, headed by Dr. Srirang Pandit and an enthusiastic scientific team, Drs. Milind Wagh and Viraj Tambwekar, this congress was filled with fantastic international and national faculty who graced us with their presence and enlightened us with their knowledge. This congress was a breath of fresh air up on the hillside in the beautiful city of Pune, India.

Kudos to the ISAPS Education Council Chair, Dr. Ozan Sozer, and Vice Chair Dr. Francisco Bravo, who helped AESURG-ISAPS 2023 feature the best international faculty coming to India, who covered six master classes, six orations/keynote lectures, diverse trending topic panels, a focus on hair transplant, thread lifting, non-surgical procedures, business management, and transgender surgeries. There was also a special session on "Aesthetics in Reconstruction," and for the first time, we also conducted a very lively debate on hair transplant (FUE VS. FUT).

This AESURG 2023 Congress featured a series of live surgery demonstrations (**Figure 1**), including live surgery on hair transplants by Drs. Viral Desai and Anastasios Vekris. There was also a live demo of a gliding brow lift by Dr. Jerry O'Daniel and a renuvion skin tightening demonstration by Dr. Aris Sterodimas. There was also a focus on many new emerging surgical and non-surgical technologies, with parallel sessions running in four halls throughout the five days.

The first day of the congress kicked off with sessions in association with the IMCAS Society (for the first time in AESURG), with Dr. Benjamin Ascher giving us updates on blepharoplasty and orbital injections on cadaver from the IMCAS Meeting. This was followed by extensive rhinoplasty sessions by our national faculty and the masters of rhinoplasty Drs. Enrico Robotti and Wolfgang Gubisch shared their extensive experience with rhinoplasty and an intriguing panel discussion on the preservation of rhinoplasty.

The ISAPS Symposium covered the next two days, with extensive lectures on breast, face and neck, periorbital rejuvenation, and body contouring by eminent national and ISAPS international faculty (**Figures 2-4**).

It was an amazing experience to watch plastic surgeons from across the globe showcasing their work. It inspired me to think new and think differently. Almost every aesthetic surgical topic was covered with new innovations and techniques. The congress featured not only an extensive aesthetic surgical program, but also witnessed good attention on emerging technologies, lasers, the latest in fat grafting, a hands-on workshop on fillers, a thread lift workshop and lastly, business strategies in cosmetic surgery practice - which featured digital marketing strategies, focus on how to set up your



own practice and social media approach, which is extremely important in the new age of social media.

Let's not forget, that as doctors, we want the best for our patients - things done correctly under safe conditions. Patient safety should be our foremost concern, which was well highlighted during the conference. Focused sessions were presented along with complications associated with surgeries and how to tackle them. All lectures were very interactive, and we could use the AESURG Congress App to communicate with surgeons and ask questions.

Seeing numerous young plastic surgeons and residents in attendance was very pleasing. ISAPS has taken an excellent initiative to provide free membership for plastic surgery residents and provide them with access to the ISAPS scientific journals. So, residents from India were exposed to the ISAPS community and what they have to offer.

The congress was well represented by senior IAAPS members, colleagues, and Indian residents, and it was a joy to be part of the great Indian brigade headed by our ISAPS National Secretary, Dr. Manoj Khanna, and IAAPS President, Dr. Ashish Davalbhakta.

The social program brought the whole society together, and it was amazing to meet old friends and colleagues. From the traditional gala dinner (Figures 5 and 6) to the house talent show and a beautiful night of Indian dance (Figure 7) and music performance along the riverside of the beautiful Aamby Valley Resort nestled between mountains, the social events were a big hit. The AESURG organizing team made every night a "night to remember".

It was the perfect amalgamation of good educational content with extravagant cultural programs. The ISAPS international faculty constantly interacted with all our Indian delegates, sharing their knowledge, and let's not forget - were also shaking a leg in full "Hindustani style" at the social events.

As a proud ISAPS and IAAPS member, I loved being part of this fantastic congress and being part of the national faculty. Currently, as part of the ISAPS Website Committee and Residents Committee under the guidance of our current ISAPS President, Lina Triana, my responsibility of spreading the word about the work ISAPS does to Indian residents was key during this AESURG event.



Figure 1: Live surgery demonstration.

Figure 2: Drs. Kunal Sayani, Jerry O'Daniel, Ozan Sozer, and Ashish Davalbhakta (left to right).



Figure 3: Drs. Ozan Sozer and Karishma Kagodu.



Figure 4: ISAPS international faculty.



Figure 5: Traditional gala dinner.



Figure 6: Traditional gala dinner.

Figure 7: House talent show and night of Indian dance.



The AESURG-ISAPS Symposium 2023 was a great success, and a large part of this was due to the organization offered by Dr. Ashish Davalbhakta, who proved to be a great IAAPS leader, a dedicated organizer and excellent host in the beautiful and heartwarming city of Pune, India. I left Pune feeling fulfilled, beaming enthusiastically of all the new things I learned and enjoying five days with my national and international plastic surgery friends.



CONGRESS REPORT

THANK YOU #ISAPSFAMILY: ISAPS OLYMPIAD ATHENS WORLD CONGRESS 2023



VAKIS KONTOES, MD - GREECE

Board of Director
Co-Chair, ISAPS Olympiad Athens World Congress

The first live **ISAPS Olympiad Athens World Congress** was held in Athens, Greece from August 31-September 2, 2023, at a superb venue, the Megaron Athens International Conference Centre.

It was a great pleasure and honor for me to welcome you all to this long overdue first live ISAPS Olympiad World Congress, in our home and mother city of the Olympic games. The first Olympiad was supposed to take place in 2021, but due to Covid-19 it was postponed to 2023.

It was decided that the ISAPS Olympiad Athens World Congress was to be presented in a different format than the usual Biennial Congresses of ISAPS, with the intention to offer the podium to all of you, our members, to present your work, and to compete for awards like in the Olympics.

Complimented by the higher ranked faculty speakers during the last three years of ISAPS' major educational events, the virtual Olympiad in 2020, the ISAPS World Congresses in Vienna (2021), and Istanbul (2022), which of course were not included in the competition, this format is going to be continued in the future ISAPS Olympiads

A lot of hard work, with my Co-Chair Dr. Apostolos Mandrekas, ISAPS National Secretary for Greece (**Figures 1 and 2**), who I wholeheartedly thank for his immense support and cooperation, the Education Council, and our staff team who put together such a new and different meeting format. So many new things, new procedures, many details, and small and big things that had to be aligned!

More than 500 paper submissions had to be peer reviewed, and my extended thanks to the Scientific Program Committee for their great support in reviewing the submissions.

After these hard and continuous efforts, Athens, like the stage of the modern Olympic games, also witnessed the champions in aesthetic plastic surgery getting together in the world-leading event in aesthetic plastic surgery in a healthy environment competing for the medal awards to the best abstracts.

The Congress attracted 1,234 delegates (including 1,099 plastic surgeons onsite, and 135 attending virtually) and achieved a truly global reach with 91 countries onsite with the top ones being: Greece, Germany, Brazil, US, and Mexico.

An additional 298 exhibitors attended from a total of 51 exhibiting companies, nine of which were our Global Sponsors and Olympiad Sponsors, and 71 accompanying persons providing a total attendance of 1,603 (1,468 onsite).

So, the first gold medal goes to...**the attendance!**

Also deserving of a gold medal is the **scientific program** that included 67 keynote talks, 14 master classes, and a total of 374 presentations from submitted abstracts: 99% of delegates rated the program and the quality of speakers fair to very good. This was your meeting, your program: our initial invited faculty of 60 speakers were chosen as your 'best rated' speakers across all ISAPS events of the last three years, according to the speaker



ratings. The rest of the speakers were selected from a competitive peer-reviewed abstract submission process.

For this first Olympiad we also introduced the rapid-fire presentations which, despite some reactions in the beginning, proved to be very well accepted by the delegates and offered the opportunity to presenters to showcase their teaching abilities, consolidate messages to the attendees, and provide high efficiency of presentations' structure. All abstracts presented during the Olympiad are published as an abstract supplement of the *Aesthetic Plastic Surgery Journal (APS)* that is now available to [view online](#).

The ISAPS Olympiad Athens World Congress 2023 also offered the first **Leadership Insights For Transformation (L.I.F.T.)** in-person workshop (*Figures 3 and 4*). If you missed that session, watch it on the virtual platform and get ready for the challenge and building of your personal

power. We also held a Pre-Congress Residents' Symposium, live video surgeries, "Debates" with very high attendance and excellent video presentations on surgical techniques with different approaches by two different surgeons on the same topic, with time to discuss each one, a Women's Symposium and multiple Board, National Secretaries and Committee meetings behind the scenes. Another gold here!

During the Athens Olympiad, we had our own ISAPS podium: the first Award Ceremony at an ISAPS congress, with a total of 70 award winners in all presentation categories of the Congress: gold, silver, and bronze medals were awarded in each subject area as well as a special prize for the best presentation from an early career surgeon (*Figures 5 and 6*). Overall winners in each subject area have been invited as faculty to our next **ISAPS World Congress 2024 Cartagena, Colombia**.



Figure 1: Holding the torch.

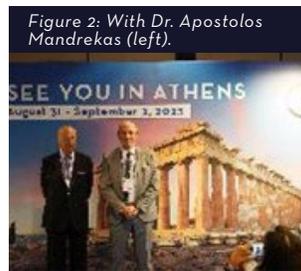


Figure 2: With Dr. Apostolos Mandrekas (left).



Figure 5: Awards Ceremony.

Figures 9,10,11, and 12: Gala Dinner and dancing at the Zappeion.



Figure 3: Leadership Insights For Transformation (L.I.F.T.) in-person workshop.



Figure 4: Leadership Insights For Transformation (L.I.F.T.) in-person workshop.



Figure 6: 2023 Award winners.



Figure 7: With ISAPS President, Dr. Lina Triana and Dr. Gianluca Campiglio, during the press conference.



Figure 8: Opening Ceremony 2023, Athens.



Figure 13 and 14: #ISAPSFAMILY in Athens.



Also, another "winner" was the first **press conference** held at an ISAPS Congress: 19 journalists attended the release of the **Global Survey** results in Athens and showed a lot of interest in our specialty and society, with multiple publications and broadcasts in the press (**Figure 7**).

A gold medal is also going to the Opening Ceremony (**Figure 8**) of the Olympiad where delegates had the opportunity to attend the Ohmori Lecture and Presidential address followed by an amazing performance of the legendary composer Thanassis Polycandriotis with his group, playing worldwide Greek music with 25 bouzouki performers on the stage.

One more gold medal goes to the Gala Dinner, where there was an opportunity for the #ISAPSFamily to meet, engage, celebrate, and dance in the iconic location of the **Zappeion**, built in 1894 as the place to be used for the

hospitality of the athletes of the first modern Olympic Games in Athens in 1896, and the headquarters of the games (**Figures 9-12**)!

A warm thank you to the 51 exhibitors and specifically to our Global Sponsors and Olympiad Sponsors that contributed to the success of the event.

And to the #ISAPSFamily (**Figures 13 and 14**), stronger, champions of aesthetic plastic surgery; 97% of the delegates have said that they would recommend the event to a colleague and 98% would be likely to attend another similar event in the future.

It was an honor to welcome you all in Athens! I hope you keep up the Olympic flame which was lit in Athens and take it with you to Cartagena World Congress next year and of course to future Olympiads. See you all there!



HUMANITARIAN WORK

KICK-OFF MEETING FOR ESTABLISHMENT OF A BREAST CENTRE IN BURKINA FASO AND MALI



VOLKER WEDLER, MD - SWITZERLAND

Interplast-Switzerland was founded 20 years ago by me and six colleagues. Since then, we have conducted regular operations in Ghana, Ethiopia, Cameroon, Uganda, Mali, Burkina Faso, Jordan and Palestine. On the first day of my missions, during patient screening which included the addition of the entire spectrum of plastic, reconstructive, and hand surgeries, I regularly saw women who had undergone radical mastectomies.

Some of the surgeries took place one year or more years prior, and research confirmed that oncology colleagues in Bamako/Mali and Ouagadougou/Burkina Faso performed the unilateral or partially bilateral mastectomy due to infections, trauma or the diagnosis of breast cancer.

For women in Mali and Burkina Faso who receive a mastectomy due to breast cancer or other medical problems, their access to advanced diagnostics and reconstructive surgery as well as adjuvant therapy, is severely limited in comparison with breast centers in Europe. So, our idea was to bring all colleagues with breast cancer patients to a table, similar to gynecologists, general surgeons, and oncology surgeons, with one plastic surgeon, pathologists, radiologists, and oncologists, all in one place.

Interplast-Switzerland sought cooperation with local hospitals to enable women with suspected breast cancer to receive both preoperative diagnosis, restorative

operations, and correct histology, as well as necessary radiotherapy/chemotherapy and aftercare.

It is important for us to train medical personnel in Mali and Burkina Faso for the long term in reconstructive surgery and to provide the necessary resources, including medical devices, implants, and expertise. That's why we started with the following techniques: expander- and silicone prostheses implantation, pedicled musculocutaneous latissimus dorsi, and the transverse rectus abdominis myocutaneous flap (TRAM).

Our objective was to improve the infrastructure of microsurgery as much as possible to offer the deep inferior epigastric artery perforator flap (DIEP) and transverse musculocutaneous gracilis flap (TMG) as quickly as possible.

In most cases, women in Mali and Burkina Faso are unable to cover the costs of comprehensive diagnostics and surgery out of their own pockets. Interplast-Switzerland, together with the local hospitals, contributes to the costs in the form of a flat rate per case. Aftercare treatment is especially important for reconstructive breast surgery and is crucial for the success of an operation and for the health of female patients. It is important to ensure that women receive the necessary long-term care and aftercare, which can be provided in a breast center.



That's why I was able to organize the first "Breast Centre Meeting" in Bamako/Mali and Ouagadougou/Burkina Faso in October 2022, with the participation of the respective Ministry of Health (*Figures 1-3*). Since then, two humanitarian operations have been carried out under our leadership, and with the affected colleagues on the ground, diagnostics and treatment have been coordinated in advance.

Despite geopolitical, financial, personnel, and administrative hurdles, we must not lose sight of the objective, because there is no difference in breast cancer, whether it happens in Europe or Africa. We all deserve the same care.



Figure 1: First Breast Center Meeting in Bamako/Mali.



Figure 3: First Breast Center Meeting in Ouagadougou/Burkina Faso.



The ISAPS Olympiad Awards Ceremony was a culmination of the ISAPS Olympiad Athens World Congress 2023, where we came together to recognize and celebrate the contributions made by our free communication authors and presenters to the scientific development of our field and acknowledge contributions to Aesthetic Education Worldwide®.

Congratulations to all the award winners in all presentation categories of the Congress: Gold, silver, and bronze medals were awarded in each subject area and a special prize for the best presentation from an early career surgeon.

BEST PRESENTATION BY AN EARLY CAREER SURGEON

Gold: Milind Kachare - An Update on Optimizing Results in Circumferential Lipoabdominoplasty Procedures

BODY: ORAL COMMUNICATIONS

Gold: Ahmad Saad - From Liposuction to High-Definition Liposculpture: A Spectrum of Options

Silver: Milind Kachare - Refinement to the Split Gluteus Maximus Muscle Autologous Buttock Augmentation and Lift

Bronze: Rieka Taghizadeh - Application of Aesthetic Abdominoplasty Techniques in DIEP Flap Donor Site Closure: Improving Outcomes and Reducing Complications

BODY: RAPID FIRE

Gold: Alexandros Dionyssopoulos - Delving Into Waterjet-Assisted Liposuction and Autologous Fat Transfer

Silver: Malcolm Linsell - Drainless, Day Procedure, Abdominoplasty

Bronze: James Kanjoor - Avulsionplasty: A Physiologically Sound Excision Method in Body Contouring

BODY: POSTER DISCUSSION

Gold: Juan Esteban Sierra Mejia - Simplified Gluteoplasty

Silver: Monisha Kapoor - Butt Augmentation in Android Pelvis: Difficult Problem, New Solution

Bronze: Cetin Duygu - My Tummy Tuck Technique and My Experiences

BREAST: ORAL COMMUNICATIONS

Gold: Gustavo Abrile - Treatment Options in Poland Syndrome

Silver: Andre Cervantes - Split Muscle Support: A Predictable Technique for Secondary Augmentation-Mastopexy

Bronze: Evangelos Keramidis - A Simple Classification and a One-Stage Correction of Hypoplastic Tuberous Breast With the Muscle Splitting Dual Plane Breast Augmentation Technique, Round Silicone Implants and the Northwood Index

BREAST: RAPID FIRE

Gold: Michelle Andrea Itao - Quality of Life of Patients Who Underwent Mastectomy Alone Without Breast Reconstruction Versus Patients Who Underwent Mastectomy With Immediate Breast Reconstruction in a Tertiary Hospital from 2020-2021

Silver: Yawel Lai - The Vacuum-Assisted Breast Biopsy System With Power Assistant Liposuction Is an Effective Strategy for the Treatment of Gynecomastia

Bronze: Sarah Alkhorizy - Risk of Arm Lymphedema and Arm Morbidity After Breast Reconstruction: A Meta-Analysis

BREAST: POSTER DISCUSSION

Gold: Thomas Rappl - Abscess Formation After Lipoaugmentation of the Breast: A Rare Complication

Silver: Federica Grieco - Breast Implant-Associated Squamous Cell Carcinoma: An Evidence-Based Systematic Review

Bronze: Agatha Koutsouveli - Is There a Relation Between Anatomical and Biometric Characteristics and Ideal Reduction Mammoplasty Technique? A Prospective Comparison Study

FACE: ORAL COMMUNICATIONS

Gold: Gerald O'Daniel - Demystifying Defining Safe Steps for Submandibular Gland Reduction

Silver: Ozan Sozer - Strategies in Neck Lift

Bronze: Saulius Viksraitis - Triplanar Face Lift Technique

FACE: RAPID FIRE

Gold: Melinda Lacerna - No More Ectropion! Lower Eyelid Rejuvenation With Helium RF Plasma and Fat Grafting

Silver: Kai Kaye - Multilayer Facial Rejuvenation: From Skin to Bone

Bronze: Daniel Kalbermatten - Hybrid Face Lift: Combining Superficial and Deep Approach

FACE: POSTER DISCUSSION

Gold: Omid Amiri - Usefulness of a Cadaver Dissection Course for Plastic Surgery Residents in Facial Aesthetic Surgery

Silver: Parthena Deskoulidi - Gummy Smile Correction Using Lip Repositioning Surgery and Botulinum Toxin Injection

Bronze: Adrian Manjarrez - Long-Term Results in Periorbital Rejuvenation

MINIMALLY INVASIVE: ORAL COMMUNICATIONS

Gold: Felmont Eaves - Tension Offloading With Force Modulating Tissue Bridges Improves Wound Healing in Elective Breast Surgery

Silver: Arthur Yu - A Novel Nose Tip Filler Injection Technique for Effective Nose Tip Lifting and Elongation

Bronze: Julia Real - Minimally Invasive Incisionless Otoplasty With an Anterior Approach

MINIMALLY INVASIVE: RAPID FIRE

Gold: Abeer Abdulshakoor - Retrograde Versus Spot Botulinum Toxin Facial Injection

Silver: Julia Real - Kissability Technique: Functional and Aesthetic Approach of the Lips

Bronze: Mazen Bdour - Nose Lift Revisited

MINIMALLY INVASIVE: POSTER DISCUSSION

Gold: Ahmet Demir - An Experimental Study: Botox and Nicotine - How Effective Can It Be in Flap Surgery?

Silver: Smriti Nathani - Medical Protocol for Hair Restoration in Androgenic Alopecia/Patterned Hair Loss: Tamira Medical Protocol

Bronze: Monisha Kapoor - Dimpleplasty: New Simplified Technique

OTHER SURGICAL: ORAL COMMUNICATIONS

Gold: Kamol Pansritum - Rare Complications in Neovaginoplasty for Trans Female

Silver: James Kanjoor - Modified Subfascial Pocket in Trans Women Breast Augmentation

Bronze: Richard Fakin - Comparison of Two Different Male-to-Female Penile Skin Inversion Vaginoplasty Techniques and Their 5.5-Year Outcomes

OTHER SURGICAL: RAPID FIRE

Gold: Giulia Lo Russo - Masculine Chest-Wall Contouring in Trans AFAB Patients: A Personal Approach and a New Algorithm

Silver: Huizi Song - Primary Reconstruction of Abdominal Wall and Vulva Defect With the Tensor Fascia Lata Myocutaneous Flap in the Gynecologic Malignancies

Bronze: Kamol Pansritum - Metoidioplasty Using Combined Labial Ring Flap and Martius Flap Interposition in Trans Male

OTHER SURGICAL: POSTER DISCUSSION

Gold: Anmol Chugh - Intraoral Silicone Chin Augmentation: Safe and Secure

Silver: Manoj Khanna - Innovations to Improve Scars in Plastic Aesthetic Surgery

Bronze: Federica Grieco - Prevention of Breast Cancer-Related Lymphedema: An Up-to-Date Systematic Review of Different Surgical Approaches

PRACTICE MANAGEMENT/PATIENT SAFETY: ORAL COMMUNICATIONS

Gold: Austin Chen - Demystifying Public Understanding, Interest and the Search Process for Aesthetic Procedures

Silver: Georgios Karamitros - Human Capital and Productivity in Plastic Surgery Research During COVID-19: An Artificial Intelligence Approach

Bronze: Pepe Delgado - How to Succeed in Instagram Without Posting Before and After Pictures

PRACTICE MANAGEMENT/PATIENT SAFETY: RAPID FIRE

Gold: Marie Jaeger - Breast Implant Rotation Assessment Using Ultrasound: A Case Series From the International Breast Implant Check Clinic

Silver: Sarah Alkhorizy - Effect of Tranexamic Acid on the Reduction of Blood Loss in Craniostylosis Surgery: A Systematic Review and Meta-Analysis of 9,739 Craniostylosis Surgeries

Bronze: Todd Dow - Does Combining Abdominoplasty With Bilateral Breast Reduction Surgery Increase the Risk of Complications: A 10-Year Retrospective Analysis

PRACTICE MANAGEMENT/PATIENT SAFETY: POSTER DISCUSSION

Gold: Pepe Delgado - The Secret Behind Selling High Ticket Plastic Surgery Services

Silver: Sebastian Nischwitz - Leadership in Healthcare: The Stepchild of Medicine

Bronze: Georgios Karamitros - The Impact of COVID-19 on Graduate Medical Education: International Evidence From Plastic Surgery

REGENERATIVE MEDICINE: ORAL COMMUNICATIONS

Gold: Afzaal Bashir - Mesenchymal Stem Cell Enriched Adipose Tissue Grafting Improves Face Hyperpigmentation

Silver: Tsai-Ming Lin - A Decade Journey of Fat Transplantation for Facial Rejuvenation

Bronze: Elena Giardini - Combined Use of Stem Cells and Two Laser Technologies: A New Minimally Invasive Frontier in Non-Surgical Rejuvenation of Face and Neck and the Key Role of Stem Cells

REGENERATIVE MEDICINE: RAPID FIRE

Gold: Manoj Khanna - Innovations to Optimize and Excel Harvest in Hair Transplantation

Silver: Richard Chaffoo - Hair Restoration Update for Plastic Surgeons in 2023

Bronze: Sebastian Nischwitz - Wound Oxygenation or Inflammation: Where Lies the Future of Scar Therapy?

RHINOPLASTY: ORAL COMMUNICATIONS

Gold: Mirza Firat - Piezoelectric Ultrasonic Rhinoplasty: More Precise Surgery, Less Revision Rates

Silver: Vladislav Ribnikar - Piezo Rhinoplasty

Bronze: Eunsoo Park - Aesthetic Nasal Lobule Correction Using a Three-Dimensional Printed PCL Implant

RHINOPLASTY: RAPID FIRE

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Silver: Yang An - Snake-Shaped ePTFE Nasal Tip Graft Combined With Conchal Cartilage in Asian Rhinoplasty: A Retrospective Cohort Study

Bronze: Kapil Agrawal - Skin Only Excision and Alar Rim Triangular Flap Technique for Ala Reduction: Preserving Natural Alar Contour, Recreating Natural Ala Base and Alar Facial Groove

RHINOPLASTY: POSTER DISCUSSION

Gold: Giray Genç - Dorsal Preservation Rhinoplasty in Patients With Long Nasal Bone

Silver: Xavier Dong - Rhinoplasty in 2021 and Beyond! OpenAI ChatGPT

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STANDING ON THE SHOULDERS OF GIANTS:

This is our newest addition featuring some of our specialties' most influential figures and their impact on what aesthetic plastic surgery is today as we know it.

It pays tribute to the many founders of our specialty and current plastic surgeon experts.

It is our way to honor those who paved the way, as well as today's leaders, and made it possible for us to practice aesthetic plastic surgery.



Prof. Ulrich T.
Hinderer: A Giant
of Aesthetic
Surgery –
Remembering a
Pioneer, Teacher,
and Visionary

Dirk Richter
Fabian Cortiñas

The "Professor" Ivo
Pitanguy

Barbara H. Barcaro
Machado

**Have a suggestion for our On the Shoulders of Giants feature?
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DIRK RICHTER, MD - GERMANY
Co-Editor, *ISAPS News*



FABIAN CORTIÑAS, MD - ARGENTINA
Editor-in-Chief, *ISAPS News*

PROF. ULRICH T. HINDERER: A GIANT OF AESTHETIC SURGERY – REMEMBERING A PIONEER, TEACHER, AND VISIONARY

Prof. Ulrich T. Hinderer, born on May 21, 1924, in Madrid, Spain, was not only an outstanding doctor and plastic surgeon but also a significant individual. His early years were marked by turmoil; during the Spanish Civil War, his family moved to Southern Germany. Later, he fought on the Russian front in World War II, where he suffered severe frostbite, leading to a lengthy hospitalization.

After the war, Hinderer returned to Spain to begin his medical studies. He established his surgical base in Germany before specializing in plastic surgery. He played a significant role in developing the Spanish Society of Plastic and Reconstructive Surgery and was one of the 12 founding members of the International Society of Aesthetic Plastic Surgery (ISAPS).

As President of ISAPS from 1975 to 1977 and Co-Founder and Editor of the *Aesthetic Plastic Surgery Journal* (APS), Hinderer was a prominent individual who helped shape and promote aesthetic surgery. He was a central figure in the scientific community, a mentor, and a leader who impacted the careers of numerous surgeons. His ability to communicate in five languages facilitated international exchange.

As a leader in plastic and aesthetic surgery, Hinderer was recognized for his outstanding contributions and achievements, including having served as Chief Editor or Co-Editor of several renowned journals, including "Revista Española de Cirugía Plástica" and "Revista Ibero-LatinoAmericano de Cirugía Plástica." He also received notable awards, such as

the Dieffenbach Medal from the German Society of Plastic, Reconstructive and Aesthetic Surgeons, and the First-Class Federal Cross of Merit, one of the highest civilian honors in Germany.

Hinderer's publications span a broad spectrum of reconstructive, aesthetic, and urogenital surgery. He markedly contributed to medical literature with over 160 publications and book contributions. His innovative talent, coupled with tireless optimism, was contagious.

He was known for his helpfulness and indomitable spirit. Even as he battled severe illness, Hinderer exhibited remarkable resilience and affirmation of life, and he never lost his courage and remained active. This unconquerable attitude underscored his extraordinary personality and optimism, even in the face of personal challenges, which included a fight against lung cancer during the last five years of his life. One of his final goals was to make it to 2007, which he bravely achieved without complaining and without opiates as he wanted to keep a clear head in the final months as he wrote his memoirs.

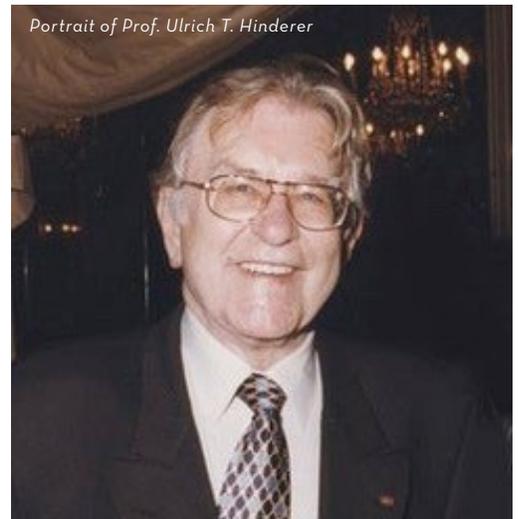
This tenacity sums up the life and character of Hinderer well; he dedicated his entire life to our field of plastic, reconstructive, and aesthetic surgery: its international organizations, its recognition, its protection, and its ethics. He was not only at the center of history, he also directed it.

In the world of plastic surgery, Hinderer is seen as a shining

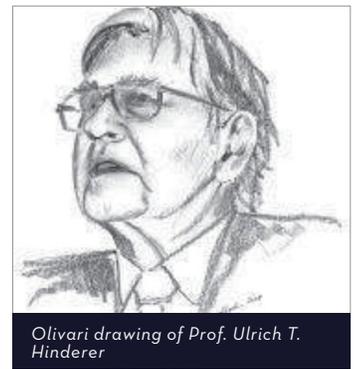




Hinderer Library, courtesy of Cirugía Plástica 8 (Suppl. 2), 2008.



Portrait of Prof. Ulrich T. Hinderer



Olivari drawing of Prof. Ulrich T. Hinderer

example of commitment, innovation, and humanity. His life and work offer valuable lessons for aspiring plastic surgeons in their careers and personal development. He encouraged young surgeons to build global networks and work together across borders. His role as a mentor and teacher, not only at ISAPS, was groundbreaking. He inspired countless surgeons, highlighting the importance of mentorship and knowledge transfer in medical education.

Hinderer was characterized by high ethical standards and deeply rooted in humanity. He taught that professional competence should go hand in hand with integrity and empathy. His multidisciplinary approach, which went beyond the boundaries of plastic surgery, emphasizes the importance of a broad understanding of medical practice.

He left his library to the German Society of Plastic, Reconstructive and Aesthetic Surgeons at the Langenbeck-Virchow-Haus in Berlin, where the study and development of plastic surgery are still promoted to this day. It offers an extensive collection of literature covering the past and current topics in this field.

This library is a symbol of his legacy and his ongoing significance for plastic surgery. It shows the importance of preserving and passing on knowledge - a lesson that is a great example to young plastic surgeons today.

The "Hinderer Library" is a lasting testament to his tireless commitment to plastic surgery and his vision of making knowledge and experience accessible to future generations. Hinderer's life and work, marked by determination, innovation, and humanity, remain an inexhaustible source of inspiration for young plastic surgeons. Hinderer left a legacy that goes far beyond his technical contributions.

He may no longer walk among the giants of today, but his life and work are reminders of his presence as a leader and a pioneer in our specialty, and his influence will always be felt by those of us aspiring to be half as great as he was...

Therefore, Ulrich Hinderer deserves a place in our Shoulders of Giants series!





BARBARA H. BARCARO MACHADO, MD, PHD - BRAZIL

THE "PROFESSOR" IVO PITANGUY

From time to time, we are presented with the opportunity to interact with human beings who impact many lives and leave a mark on history. Not because they are perfect beings but because they are unique in their way of living or understanding life. Ivo Pitanguy was one of these men with whom I had the privilege of working together with for 26 years, working as an assistant plastic surgeon or as head of the medical team in his private clinic in Botafogo, a neighborhood in the South Zone of Rio de Janeiro, Brazil.

His impact on plastic surgery can be explained by the impressive statistics of services he and his team performed over the years. By 2016, a total of 79,653 patients were treated in the 38th Infirmary at Santa Casa and more than 59,500 at Clínica Ivo Pitanguy. With these accomplishments, Pitanguy made the specialty reach first-world quality in a country where social conditions have always been a limiting factor.

Ivo Pitanguy, or "Professor" as he liked to be called, began his work in the mid-fifties when care related to deformities and traumas was limited to reconstructive procedures in Brazil. Pitanguy reported that "doctors repaired the wounds, but the scars remained." Furthermore, he understood that physical deformity and psychological discomfort could have the same impact on a patient's self-image. For this reason, he defined plastic surgery as a binomial in which aesthetics and function are inseparable.

Early in his training, he went to Cincinnati, United States, to work as a surgical resident under the service of Professor John Longacre, who had returned from World War II in England, where he served as a surgeon. Later, Pitanguy went to France by invitation of Marc Iselin, one of the creators of hand surgery and a great reference in the care of mutilated people during World War II. Pitanguy, who was very fond of literature and had a humanistic culture greatly encouraged by his mother, was introduced to notable characters such as Jean-Paul Sartre and Simone de Beauvoir during his stay in Paris, France.

Pitanguy was fascinated by art and was a curator at the Museum of Modern Art. In his Clinic, he had several works of art, including a Salvador Dalí painting dedicated to him by the painter himself. Salvador Dalí drew "Pour Monsieur Pitanguy," and the "P" in his name is a sword, and Pitanguy rides a horse. The sword is in tension, and the horse raises one leg. Dalí created a symbolic portrait of Pitanguy's art in a single stroke while performing surgeries.

Pitanguy said he was driven by a mission that became clear after the dramatic fire at the Gran Circo Norteamericano in Niterói in 1961. With a frightening number of victims (2,500 injured and 500 deceased), the accident changed his destiny. Always assisted by a team of volunteer doctors, Pitanguy attended to the victims and set up Santa Casa de Misericórdia, the 38th Ward in which the work was directed at underprivileged social classes. There, people who suffered from deformities, tumors, or burns sequels could see their dysfunctions and discomforts with their pain alleviated and were able to rediscover an existence within the social context.

However, it was through his work in his private clinic, he became known to the world. As he spoke several languages, it was possible to internationalize his techniques and receive worldwide patients. Their interaction was remarkable because Pitanguy could talk to these patients in their native language. With a very charismatic and simple approach, he used to say, "We will take care of you." Despite being in a distant country, the patient felt unique, safe, and supported.

His presence could exert an exceptional fascination in everyone as if he were a great magnet. Young doctors and residents always wanted a photograph or the master's attention. Although he was used to artists and personalities, Pitanguy was uncomfortable mentioning famous patients or highlighting those who entrusted him. He understood that he should serve patients regardless of their financial condition, "What made me famous is the combination



of everything I did. All icons are temporary. For every known person I operated on, 20 strangers passed through me."

He was authoritarian, a necessary characteristic for a leader, but he always valued teamwork. He used to delegate tasks to the team but emphasized that it was necessary to be aware of diluted responsibility and he demanded perfection because, "In Medicine, there is no room for mistakes." Assisting him in surgical procedures required unique attention. "Any inappropriate movement disrupts reasoning," he said. We didn't talk, question, or interrupt the surgery. And it was very beautiful to see him operating. An orchestra... The movements were all thought out and followed a logical sequence, eliminating unnecessary repetitions and aggression.

His conservative behavior, keeping the greatest principle of medicine: "Primo non nocere" (first do no harm), did not prevent Pitanguy from having an open mind to technological innovations. But he never allowed the patient to be the target of tests with new devices.

When asked about the concept of beauty, he quoted Stendhal, "Beauty is nothing but a promise of happiness." In his interpretation, beauty has its own structure. "It invades and penetrates, like good music. And it occupies the moment in such an unexpected way that you respect it. There is something impressive about a very beautiful being. It exudes joy just by looking at it; it's a life force ". And Pitanguy definitively left a beautiful story that deserves to be perpetuated!



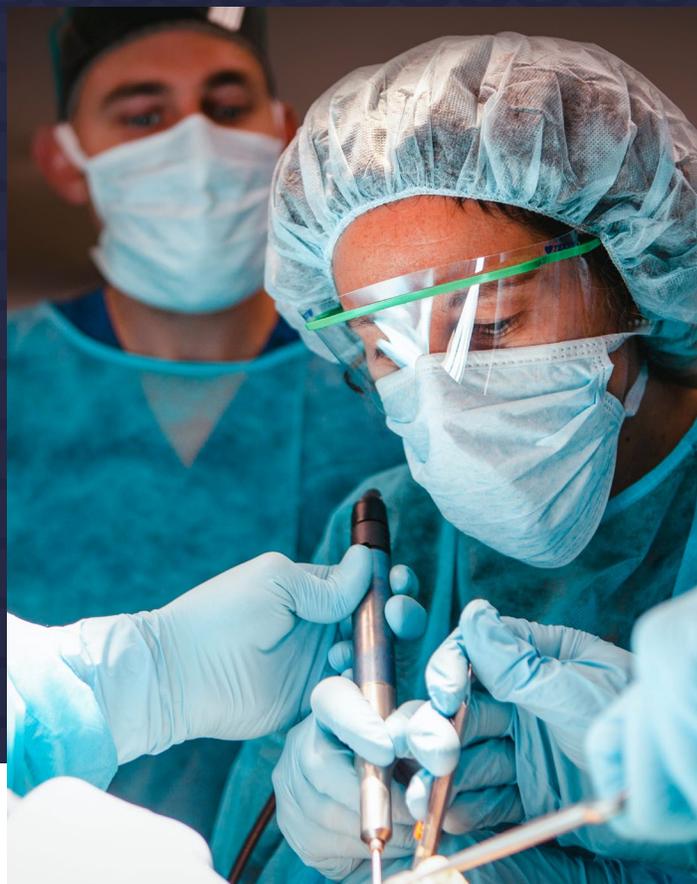
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SMAS Plication Face Lift

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The Question of Adequate Ligament Release for SMAS Mobilization:

Gerald O'Daniel

SMAS Undermining:
How Do I Do It

Sandip Jain

Extra High SMAS Flap For Deep Support In Face And Neck Lift

Juan C. Fuentes-Amezcu

A Hybrid Approach with SMAS Undermining and Plication in Secondary face lift

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GERALD O'DANIEL, MD - UNITED STATES
ISAPS Education Council

THE QUESTION OF ADEQUATE LIGAMENT RELEASE FOR SMAS MOBILIZATION

It is an honor to be invited to provide the lead article in this edition dedicated to "SMAS" undermining. The release of ligaments in sub-SMAS surgery has become the hallmark of deep plane procedures, however, in reality, releasing of the ligamentous fixation of the facial soft tissues is nothing more than a technical exercise. Whether a surgeon uses a supra- or sub-SMAS technique, the art and outcome of any selected face lift procedure is mostly related to how all the components of the mobile tissues in the anterior face are sculpted and repositioned. To properly address the question of "how much ligamentous release do I do" and to assist the reader in understanding the answer, the history of deep plane face lift and the origin of the associated anatomical terms with update of the latest anatomical findings will bring clarity to my explanations. There is a current surge in popularity for "deep plane face lift" techniques by surgeons and patients alike. The concept

of releasing the lateral fixed facial tissues (fixed SMAS) with the mobile central facial tissues (mobile SMAS) to lift the face was described 50 years ago by Tord Skoog¹. The operation was adopted by various plastic surgeons in the ensuing years but popularity was still far behind other techniques as shown in various polls and publications where it was estimated that until recently, 95% of the world's plastic surgeons preferred techniques that did not enter the deep plane. It has only been with the advent of social media and plastic surgeon influencers that the popularity of the term "deep plane" face lift has surged. When the term deep plane face lift is searched on Google it returns 68 million results in 0.2 seconds as compared to SMAS plication which returns 21,000 results. With the high visibility of the "Instafamous" face lift surgeons who have added gimmicky names to sub-SMAS procedures, more prospective patients now seek surgeons who perform a



deep plane face lift. Anyone who has attended a recent plastic surgery conference will see that some variation of a "deep plane" face lift is dominating the programs.

To adequately discuss ligament release to achieve full mobilization of the mobile facial tissues, it is important we have a thorough understanding of the layered anatomy of the face. A review of the history of deep plane face lift surgery starts in 1974 with Tord Skoogs original discussion of the anatomy of the deep planes of the face and this should be mandatory reading for anyone operating in the deep planes of the face. He beautifully describes how the lateral face *"superficial fascia is fixed to the dense, deep fascia by fibrous adhesions. At the anterior border of the masseter muscle this close anatomical relationship ceases. Anteriorly, over the expansile buccinator, an areolar space exists just beneath the subcutaneous fascia, extending as far as the nasolabial fold"*. Shortly after the Skoog rhytidectomy publication, the presence of a superficial musculoaponeurotic system (SMAS) was proposed by Mitz and Peyronie² in 1976 and described as a distinct musculo-aponeurotic layer between the superficial fat and the deep fat connecting the facial muscles. Since then the term SMAS has become ingrained in plastic surgery lexicon and used in some way in nearly every face lift technique described. Furnas³ was the first author to propose the presence of "retaining ligaments" of the cheek that fixate the overlying skin to the deeper structures that prevent sagging. He suggested that the sagging occurred in the face anterior to these ligaments.

Since these early publications related to the SMAS and retaining ligaments there have been too many subsequent publications to mention. However, all along there has been debate about the existence of such a structure as a true aponeurosis in the central face. Certainly, in my 30+ years of performing sub-SMAS face lifts I have questioned the existence of a robust layer of soft tissue anterior to the masseter that would correspond to the suggested presence of an aponeurosis, which is defined as a condensation of connective tissue organized in sheets that connects the OOM and platysma. These questions about the existence of a such thing as an aponeurosis may finally be answered with a recent scientifically rigorous study published by Lennert Minelli⁴, working as Bryan Mendelson's fellow. Using fresh cadaver dissections, coupled with large scale

histology and plastination sections, he and his team's work confirm that anterior to the masseter there is not a horizontal tissue layer that corresponds to any connection between the mimetic muscles. Instead they demonstrated that only retinacula cutis superficiales run perpendicular to the skin and attaches to the deep fat within the deep fascia. Interestingly their findings correspond to Skoogs' original clinical observations that there is a transition from the deep fascia of the lateral face into the subcutaneous tissue of the mobile anterior face.

If we accept that there is no evidence of the presence of a histological defined layer that is an aponeurosis that we have affectionately called the SMAS for nearly the last 50 years, then where do we go from there. Certainly, we have successfully created operations that are performed in a deep plane. The lateral facial soft tissue is raised within the deep fascia of the lateral face and the transitions through this deep fascia into the deep subcutaneous plane. It is now important to understand that the thick flap of soft tissue anterior to the masseter lacks a true aponeurosis and that the strength of the flap to maintain fixation is achieved with the retinacula cutis superficiales.

Additional publications coming from Mendelson's lab have recently been published by Minelli⁵ that update the ligaments of the face and neck using similar methods of cadaver dissections with histology and plastination studies. They describe the ligaments encountered on a deep plane dissection as true anatomical retaining ligaments, adhesion zones and pseudo ligaments. The true retaining ligaments are dense deep connective tissue that are easily identifiable such as the zygomatic, orbital retaining, upper and lower masseteric ligaments. The cervical retaining ligament (CRL) is an area where the platysma fascia is adherent and fused to the fascia of the sternocleidomastoid muscle (SCM). Pseudo-ligaments are surgically created such as the masseteric ligaments appear as the deep plane dissection transitions through the deep fascia as is curves around the anterior border of the masseter muscle diving deep to the buccopharyngeal fascia (**Figure 1**).

With these new described descriptions of the anatomy of the "SMAS" and facial ligaments, I will give my rationale for the need for complete release of all tethering attachments of the of the mobile SMAS before customizing the SMAS



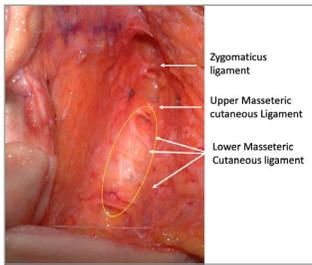


Figure 1: The zygomatic ligaments and masseteric ligaments are shown. Within the yellow circle branches of the facial nerve can be seen transitioning from deep within the deep fascia laterally to a more superficial position medially.

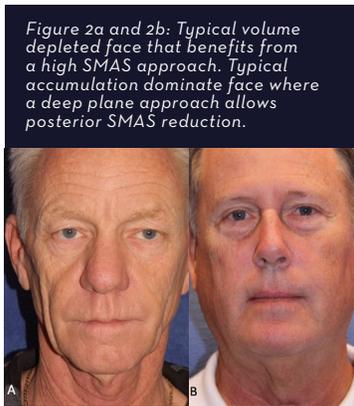


Figure 2a and 2b: Typical volume depleted face that benefits from a high SMAS approach. Typical accumulation dominant face where a deep plane approach allows posterior SMAS reduction.



Figure 3: The yellow shade represents the extent of subcutaneous undermining. The undermining includes release of the mandibular ligament. The dark yellow represents the adhesion zone of the skin to the platysma and underlying sternocleidomastoid fascia.

Figure 6: The yellow highlights the cervical retaining ligament.

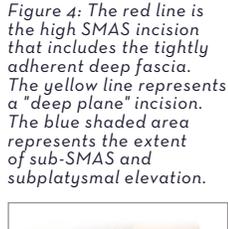


Figure 4: The red line is the high SMAS incision that includes the tightly adherent deep fascia. The yellow line represents a "deep plane" incision. The blue shaded area represents the extent of sub-SMAS and subplatysmal elevation.

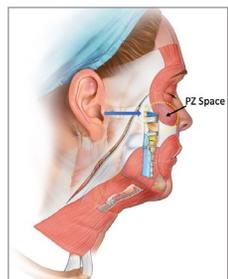


Figure 5: The red shade area is the lateral quadrant of orbicularis oculi muscle elevation.

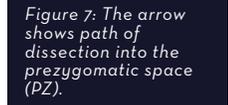


Figure 7: The arrow shows path of dissection into the prezygomatic space (PZ).

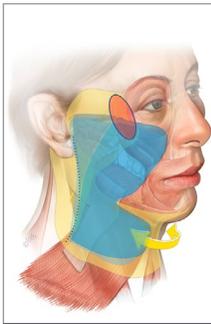
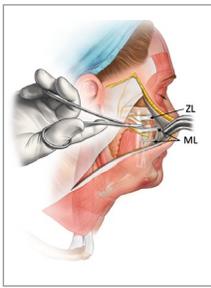


Figure 8: Blunt separation is used to identify the zygomatic ligament (ZL) and masseteric ligaments (ML).



flap. In my practice the only difference in the technical component of SMAS elevation is my chosen entry point to the sub-SMAS plane. I will outline: 1) a brief algorithm for procedure choice, 2) skin undermining to access the SMAS, 3) SMAS incision placement, 4) technical pearls for safe ligament release and accessing the buccal fat pad and 5) customizing the "SMAS" flap and customizing inset.

In my practice the only difference in the technical component of SMAS elevation is my chosen entry point to the sub-SMAS plane. A 100% of my face lift patients

undergo concomitant microfat grafting to the central face. I choose this entry point based on facial shape and volume depleted or accumulation dominant patterns. When the face is predominately deflated I use a high SMAS incision (Figures 2a and 2b). The incorporation of the fixed SMAS as part of the flap that allows me to use this vascularized flap to augment the most deflated area including the zygomatic arch, preauricular hollowing, or the gonial angle. In heavier accumulation dominant face, I use a more anterior, oblique SMAS incision that allows a closer suspension of these heavier tissues. In addition, the lower facial thickness can be reduced with a SMASectomy performed prior to SMAS inset.

The skin undermining is performed to allow access to the SMAS and ultimately redrape the skin over the final inset SMAS flap without tension. Over the previous 30 years of sub-SMAS experience my skin undermining has evolved from wide face lift skin flap undermining to currently limited skin separation from the SMAS flap. This limited undermining corresponded to my observation that the anterior soft tissue lacked enough substance in the way of connective tissue to allow reliable SMAS flap creation. In contrast, my neck skin elevation has taken an opposite path. Early in my experience I performed a composite elevation of the neck skin-platysma with wide subplatysmal elevation and limited skin release. However, the central neck skin and medial platysma outcomes were quite unpredictable and I have evolved to a dual plane neck management with wide subplatysmal and wider subcutaneous undermining (Figure 3).

The SMAS incision placement is the only real difference in a "high SMAS" and a "deep plane" face lift. The incision choice will determine the amount of deep fascia that is elevated from the parotid and masseter and incorporated into the SMAS flap elevation. The area of anterior sub-SMAS and subplatysmal elevation are the same for either a high SMAS or deep plane face lift (Figure 4).

My SMAS elevation within the lateral deep fascia is performed with needle tip cautery. Injection of local anesthetic into the lateral SMAS layer will hydro-dissect the fascial layers and assist in creating separation of the multilayered deep fascia sheets above the parotid gland and anteriorly from deeper positioned branches of the



facial nerve and masseter. My SMAS flap always includes elevation of the outer quadrant of the OOM (**Figure 5**). Once the SMAS is elevated to expose the masseter, the dissection is directed to the CRL. Using cautery, the CRL is completely released for a distance of at least 6.5 cm below the earlobe, where the platysma crosses the SCM (**Figure 6**). The subplatysmal dissection is carried out anterior and inferiorly using Viterbo blunt dissectors separating the deep cervical fascia with the platysma from the underlying strap muscles. In the region of the submandibular gland the fascia is released with care to avoid transection of the cervical branches of the facial nerve as they emerge from deep within the deep fascia to a more superficial position within the anterior capsule of the submandibular gland. Below the cervicomandibular line the platysma and deep cervical fascia are released low into the inferior neck. When dynamic platysmal bands are present a complete platysma myotomy and deep cervical fasciotomy is performed horizontally from lateral at 6.5 cm below the earlobe to the cricoid cartilage medially.

After mobilization of the platysma, utilizing the Viterbo dissectors, the prezygomatic space is entered to separate the glide plane posterior to the orbital OOM (**Figure 7**). Inferior to the prezygomatic space I identify the zygomatic ligaments, the upper masseteric fascial attachments and the deep fascia across the body of the mandible (**Figure 8**).

All ligamentous and fascial attachments are completely released using blunt, sharp and electrocautery dissection. The transition from the deep fascia dissection into the deep anterior cheek subcutaneous tissue extends into the anterior melo fat pad. The release is considered complete when there is no impediment to full movement of the melo fat pad. Often this release is just lateral to the nasolabial fold (**Figure 9**). A pearl of information for safe separation of the retinaculum cutis from the zygomaticus muscle in the danger zone: understand that the retinaculum cutis may encircle the zygomatic muscle so that retraction of the SMAS flap will elevate the muscle making it very easy to dissect below the muscle and possibly injuring the zygomatic branch of the facial nerve.

For the last 6-7 years in every face lift I have entered the buccal space to explore the buccal fat pad (BFP) (**Figure 10**). Once in the buccal space I easily release the overlying soft tissue to the oral commissure. One distinct advantage

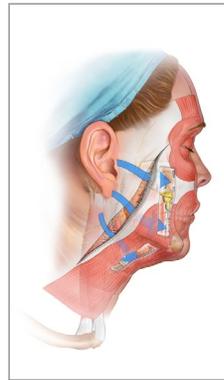


Figure 9: All true ligaments, pseudoalignments and posterior adhesion zones that impede free and easy movement of the SMAS platysma flap are completely released. The transition from the deep fascia dissection into the deep anterior cheek subcutaneous tissue extends to the oral commissure.

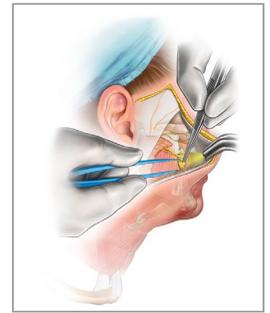


Figure 10: Buccal fat pad is accessed through the subSMAS dissection.



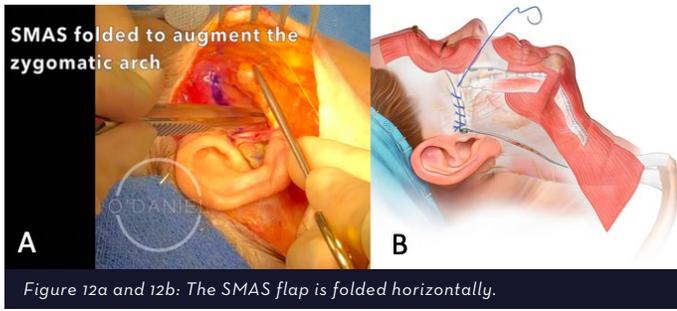
Figure 11a and 11b: Sixty-eight-year-old after deep plane face lift with SMASectomy, microfat grafting and buccal fat pad reduction.

to the subSMAS dissection is access to the BFP. In over 600 consecutive patients I have developed an algorithm that reduces, suspends, or reduces and suspends the BFP as determined by the patient's needs for volume changes to optimize facial shape.

Once the successful execution of the technical part of the face lift is completed the art of the face lift operation begins. Based on preoperative assessment of the patient's facial volume the management of the SMAS flap is undertaken. The first determination is whether the face needs volume reduction or volume enhancement. In heavy faces undergoing a deep plane approach, the determination made for the need to reduce facial volume in the case where the lower face is exceptionally full I will often preform a resection of a the SMAS flap prior to inset (**Figures 11a and 11b**). There is always retention of a flap of platysma muscle at the jawline that is used to inset into the mastoid-SCM junction where the fascia is released to deepen the angle.

The vectors for inset of the deep plane are customized. The vectors for inset of the SMAS flap is multi-directional and performed with a running 2-0 PDS suture. At the superior medial SMAS-OOM composite flap there is a totally vertical vector inset and plication of the OOM and medial SMAS flap to the deep fascia lateral to the



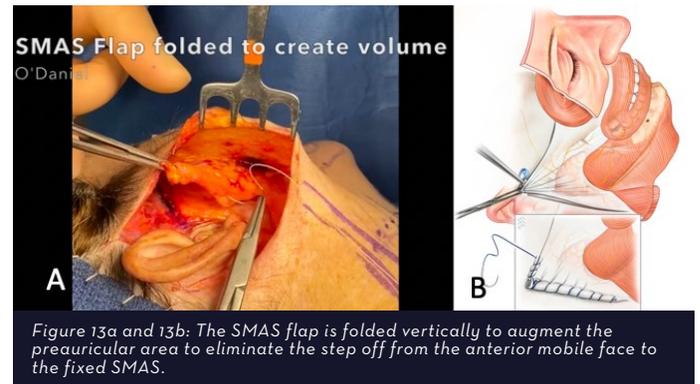


superior orbital rim. As the running suture approached the helical root of the ear the vector transitions to an oblique direction that elevated the commissure and perioral soft tissue into a natural position. The vertical SMAS is inset to redirect the preauricular tension away from the earlobe.

In thinner, volume depleted dominate faces I opt for the high SMAS incision to incorporate the fixed SMAS and lateral facial fat. This elevated deep fascial fat pad customized and inset to optimized volume restoration by creating lateral flaps that can be used to enhance malar definition, fill preauricular volume deficits or to improve gonial angle definition. When volume is needed to increase bizygomatic width and enhance malar fullness, the SMAS flap is elevated vertically and folded along the zygomatic arch (Figures 12a-f). In patients with significant volume discrepancies from the mobile SMAS to atrophic preauricular fixed SMAS I will fold the SMAS flap vertically onto itself to add volume to the preauricular region. This eliminates the step off shadowing often seen in thinner aging faces (Figures 13a-d). In aging faces there is often loss of mandibular ramus height and a deeper notched gonial angle. In these instances, I create and inferiorly based flap from the fixed SMAS deep fascial fat pad and roll it into the deficit at the mandibular angle (Figures 14a-d).

The vectors for inset of the SMAS flap are multi-directional and performed with a running 2-0 PDS suture. The inset

incorporates the created flaps in a high SMAS face lift approach. Superiorly, the medial SMAS-OOM composite flap is inset with a totally vertical vector and the OOM and medial SMAS flap are placated to the deep fascia just lateral to the superior orbital rim and anterior to the frontal branch of the facial nerve. As the running suture approaches the helical root of the ear, the vector transitions to an oblique direction that elevated the commissure and perioral soft tissue into a natural position. The vertical SMAS inset is redirected in the preauricular area to put tension on earlobe in a vertical direction to account for the inevitable inferior drift with aging to add an additional step to prevent pixie ear deformities. My management and inset of the platysma are similar for both the deep plane and high SMAS incisional face lift. I always retain a flap of platysma muscle at the jawline that is inset into the mastoid-SCM junction where the fascia is released to deepen the angle. The amount of volume for inset of the SMAS/platysma composite is customized to create a distinct mandibular angle. In both facial types, there is a



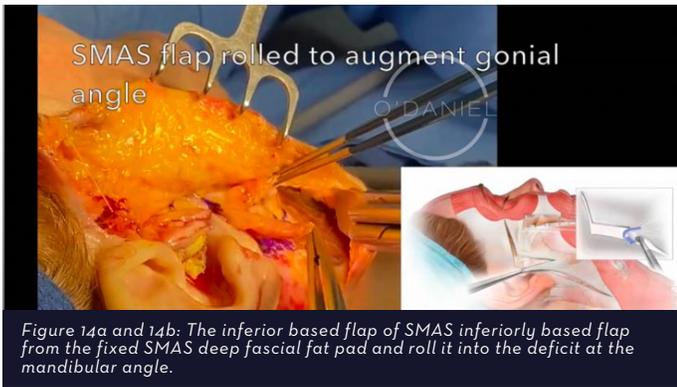


Figure 14a and 14b: The inferior based flap of SMAS inferiorly based flap from the fixed SMAS deep fascial fat pad and roll it into the deficit at the mandibular angle.



Figure 14c and 14d: Pre-op picture of 56-year-old after previous face lift and fillers to enhance mandibular definition. Same patient two years post-op from high SMAS flap augmentation of mandibular angle.

customized amount of reduction of supraplatysmal fat at the retromandibular angle to create depth just below the angle. The platysma flap is inset with a nearly horizontal vector to establish the gonial angle and place tension across the cervicomental angle. As the platysma inferior to the gonial angle is inset, the vector is transitioned to a nearly vertical direction to transmit the traction to lift the lower neck and décolletage area.

In conclusion, it is my hope that this addition to the ISAPS newsletter points out the important fact that a complete understanding of the nuances of the facial layered anatomy and associated ligaments are imperative for any type of face lift technique chosen. It is time for face lift surgeons to abandon the age-old arguments about which technique is the "best" and redirect our attention to creating algorithms that help the surgeon choose the "best" technique for each individual face that allows customization for the optimal outcomes. The true artistic outcomes in face lift surgery are achieved by the customized alterations in facial shape that take place around the ligaments that create a harmonious balance between the mobile anterior facial tissues and the fixed lateral facial tissues. If a sub-SMAS operation is chosen the complete release of the facial retaining ligaments is a technical exercise that is necessary for the successful execution of any sub-SMAS operation.

DISCLAIMER: Author has approved use of patient images.

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SMAS UNDERMINING: HOW DO I DO IT?



SANDIP JAIN, MD - INDIA

A plethora of options is available for rhytidectomy depending on the plane of the dissection and handling of SMAS. The plane of dissection can be subcutaneous or deep plane (sub SMAS). In subcutaneous dissection, SMAS manipulation can take the form of plication, suspension (MACS lift), or excision (SMASectomy). Deep plane dissection under the SMAS has also its variant in the form of high SMAS, composite flap, and extended deep plane face lift¹.

Deep plane dissection is more anatomical as it exploits the natural and bloodless sub SMAS plane akin to the subgaleal plane in the scalp. Also, the composite flap of

SMAS and skin has a more robust blood supply vis-à-vis a widely undermined skin-only flap. I more or less follow the extended deep plane face lift described by Andrew Jacono¹. However, I have introduced subtle variations in the above technique. In the original technique, the platysma is released from the anterior border of SCM by sharp dissection for 1 to 1.5 cm to divide the cervical retaining ligament. This could put the great auricular nerve or external jugular vein in jeopardy. However, I start my dissection in the cheek in the lower premassesteric space (**Figure 1**), as it is the easiest to access². Blunt dissection using the Trespat Elevator is



Figure 1: The SMAS is divided sharply along a line joining lateral canthus to gonial angle. Thereafter blunt dissection only is done under the SMAS. In this image you can see the Trespat elevator in the lower premassesteric space.

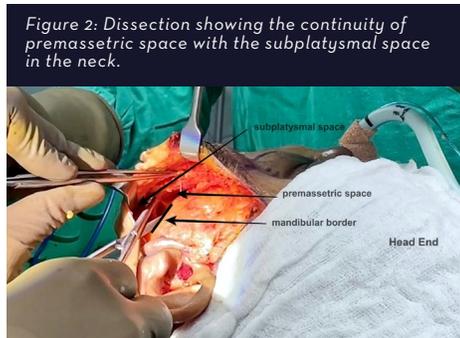


Figure 2: Dissection showing the continuity of premassesteric space with the subplatysmal space in the neck.

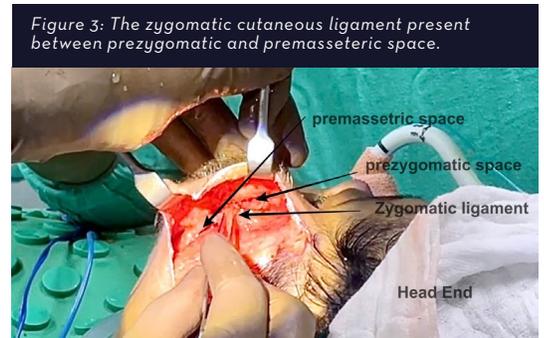


Figure 3: The zygomatic cutaneous ligament present between prezygomatic and premassesteric space.



Figure 4: A patient before face neck lift with periorbital fat grafting.



Figure 5: The same patient right oblique view.



Figure 6: A 43-year-old following face neck lift with periorbital fat grafting.



Figure 7: The same patient from left oblique view.



used to access this space. Platysma forms the roof and the parotidomasseteric fascia, covering the facial nerve branches and the masseter forms the floor of this space.

Therefore, the dissection is easily continued inferior to the mandibular border into the subplatysmal space in the neck (**Figure 2**). In the neck, the subplatysmal dissection is again done bluntly with a Trespat Elevator for up to 5 cm inferior to the mandible border and for 4 cm anterior to the gonial angle. Beyond this the mandibular branch of the facial nerve becomes superficial and it is not safe to continue dissection.

Now the platysma in the neck is lifted up with a retractor and 1.5 cm anterior to the sternocleidomastoid border, easily divided, from the deep aspect, vertically for 5 cm below the mandibular border. This avoids sharp dissection to release the cervical ligament. The freed platysma is then divided in a horizontal direction for 4 cm, just 1 cm inferior to the mandibular border, thereby releasing the platysma

in the neck from the cheek SMAS. This tongue of platysma is then pulled in posterosuperior direction and anchored to the mastoid fascia with a 3-0 PDS suture.

The other modification I have made to Jacono's technique is not dividing the zygomatic cutaneous ligament (**Figure 3**). The drooping of the cheek SMAS in the anteroinferior direction is due to the elongation and laxity of these very ligaments. So, releasing them is not going to add more mobility to the composite flap and at the same time avoids jeopardizing the cutaneous blood supply and the facial nerve branches. Extended deep plane face lift has a sound anatomical basis and dissection in the natural plane is bloodless and quick.

Moreover, after the advancement of the composite flap, a miniscule amount of subcutaneous dead space remains. So, one can do away with hemostatic net sutures, in turn saving precious operating room time. For reference, images of patients before and after the procedure (**Figures 4-7**).

DISCLAIMER: *Author has approved use of patient images.*

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JUAN C. FUENTES-AMEZCUA, MD - MEXICO

EXTRA HIGH SMAS FLAP FOR DEEP SUPPORT IN FACE AND NECK LIFT

A face and neck lift requires the adequate mobilization of the saggy tissues of the cheeks, along the jawline and the submental area. One of the most common surgical techniques to achieve this is the use of the SMAS flap, which provides stronger support to the deep facial tissues and longer results.

An extra high SMAS flap dissection is described, to provide support to the lateral aspect of the lower eyelids, and the medial and middle-fat compartments of the face, which also fills with more volume the lateral cheek area and will give support to the lower face and the submental area (*Figure 1*).

Dr. Hector Gonzalez-Miramontes, Mexico, described the extra high SMAS dissection in 2010, and his SMAS dissection starts just in front of the tragus, my design is different.

The SMAS flap is elevated 2.5 cm in front of the ear, to have a closer pull to the mobile SMAS and facial ligaments,

and to avoid the temporal branch of the facial nerve. The design of the flap has a reference, a point in the zygomatic arch 2.5-3 cm in front of the ear, an oblique line is drawn from that point toward the tail of the eyebrow and on average is about 3 cm above the zygomatic arch. From the zygomatic arch to the neck, a line is drawn vertically down parallel to the ear and in front of the sternocleidomastoid muscle (*Figure 2*), it finishes at the level of the cricoid cartilage, then it goes horizontally medially to include the platysma muscle lateral and medial bands if needed.

The SMAS flap dissection goes medially, it does include the lateral aspect of orbicularis oculi, the release of the zygomatic, masseteric ligaments, and lateral platysma muscle (*Figure 3*). The pull on the flap provides support to the lateral orbicularis oculi muscle, the higher part of the lateral cheek (middle and medial fat compartments), marionette folds, jawline, and the submental area. The SMAS flap is not transected, to make an even layer support on the



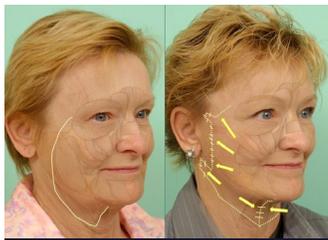


Figure 1. Schematic design of the extra high SMAS flap and suturing (patient consented use of images).

Figure 2. The design superiorly follows an oblique line from the zygomatic arch, toward the tail of the eyebrow.

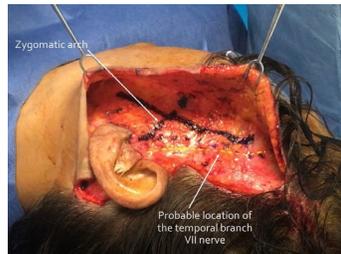


Figure 3. Extra high SMAS flap elevated 3cm above the zygomatic arch level, to include the lateral aspect of the orbicularis oculii muscle and lateral high cheek area and down to the lateral platysma below the jawline.

Figures 4: Before and 12 months after extra high SMAS flap suturing (patient consented use of images).



deep tissues and to avoid muscle action distortion. This provides a more complete rejuvenation of the midface. The excess of the SMAS on the zygomatic arch can be rotated laterally and provides more fullness in that area, without the need for fat injections over the lateral cheek area. The complications from the procedure are less common than in my previous high SMAS dissection for 20 years.

In facial rejuvenation surgery, a natural result is paramount. An even support on the periocular and upper cheek area, is desirable to achieve balance on the middle and lower third of the face, without pulling excessively on just one area, and a natural full lateral malar area is desirable (Figures 4 and 5), without adding variables like fat grafting that can eventually change over time if the patient gains or loses weight. This is an alternative for a more complete SMAS support to the lower eyelid, periocular, and upper lateral cheek area.



Figure 5: Before and 36 months after extra high SMAS flap (patient consented use of images).

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A HYBRID APPROACH WITH SMAS UNDERMINING AND PPLICATION IN SECONDARY FACE LIFT



DANIEL A. LÓPEZ FABILA, MD - MEXICO

INTRODUCTION

Every time a plastic surgeon faces a secondary face lift, it is challenging to assess the adequate surgical approach. This depends on the feasibility of the knowledge of the previous primary face lift. The weighted median rate of relapse rate outcomes after a face lift had been reported to be 2.4% on a meta-analysis without face lift technique-based comparisons¹. Actually, there are no superior face lift techniques among all of them and each case has to be individualized². There are different challenges to address in secondary face lifts in which the SMAS undermining, or SMAS-Platysma plication can be applied depending on the previous primary face lift³.

A case of a 66-year-old female patient without comorbidities arrived for consultation with aesthetic inconformity because facial and neck aging relapse after a 6-year primary SMAS plication face lift from a different surgeon. A preoperative assessment was performed addressing aesthetic patient concerns. The principal concerns of the patient were the neck relapse aging features and moderate sagging cheek. It is found the presence of bilateral jowls, lateral sweep, moderate sagging cheek, and loss of neck definition with the presence of anterior neck irregularities, neck skin pleats, and platysmal bands (*Figure 1*). As described by Rohrich et al. the previous scar bilaterally was resected with an



Figure 1: Superior preoperative row: frontal, oblique, and lateral views of patient with previous plication primary face lift. Inferior postoperative row: frontal, oblique, and lateral views of patient with hybrid (SMAS-Platysma undermine and SMAS plication) secondary face lift. Follow-up after one year of surgery and a mechanical peel.

ear posttragal preauricular incision and a postauricular incision with extension to the auricular concha skin to hide the future scar. Then the skin was undermined and correction of the abnormal SMAS vectors was assessed⁴. When it is confirmed the previously plication primary



SMAS plication, it was decided to make a secondary face lift hybrid approach (**Figure 2**). Nevertheless, the previous primary SMAS plication face lift had moderate fibrosis in the cheek sagging area.

Figure 2: Hybrid secondary face lift. SMAS plication in a one purse-string loop suture in blue. Site of cutting of the SMAS 3 cm above the angle of the jaw. Oblique arch in dotted lines site of SMAS-Platysma undermine.



Figure 3: Plication of the SMAS in only one purse-string loop suture to manage the recurrent cheek sagging.

The abnormal vector in the cheek and jowls were managed with a SMAS plication with a one purse-string loop suture bilaterally anchored to the deep temporalis muscle fascia as described in the MACS (Minimal cranial suspension lift) described by Tonnard et al. (**Figure 3**). However, as described by Hijkoop et al. the limitation of the neck improvement in the MACS lift is possible⁵. Therefore a secondary face lift hybrid approach for the neck and the lower part of the cheek was performed. The SMAS-Platysma undermine, and excision was performed as described by Althubaiti et al. with a Type B Hybrid face lift (cheek SMAS plication/ SMAS excision)⁶. The neck began with a neck liposuction. The SMAS-Platysma undermining was applied 3 cm above the angle of the mandible and extends inferiorly over the neck's platysma marking. To avoid great auricular nerve injury, the incision is angled slightly medially, about 1.5 cm anterior to the sternomastoid muscle as it goes inferiorly. This is followed by wide platysma undermining over the neck and parotid areas (**Figure 4**).

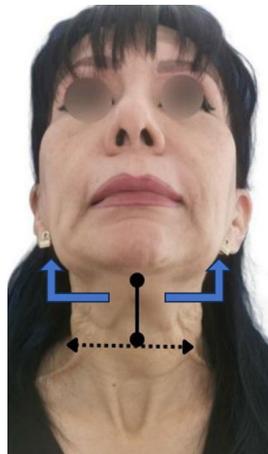


Figure 5: Secondary neck lift management. A soft neck liposuction was previously performed. Then the undermining of the SMAS-Platysma is performed down to 5 cm midline neck. The platysmal bands are horizontally cut 3 cm below the upper border of the thyroid cartilage (dotted arrows) completely to its caudal portion. Afterward, the Feldman progressive side-to-side corset platysmaplasty is performed with preplatysmal defatting (line with circles). Finally, the undermine SMAS-Platysma is cut 3 cm above the angle of the jaw superiorly to anchor it in the mastoid process (blue arrows).

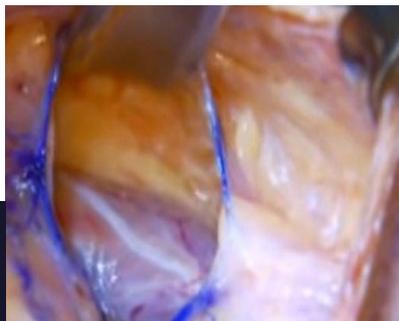


Figure 4: Window to prepare the inferior portion of SMAS and platysma undermining.

In the neck lift a horizontal cutting of the platysmal bands with complete transection of the caudal platysma is performed. Also, a submental Feldman technique on the anterior neck with pre-platysmal defatting and a 2-row plication of the platysma in the middle of the anterior neck was done⁷. SMAS in the neck is redraped and tightened, and excess tissue is excised to fashion a satisfactory neck and jawline (**Figure 5**). Because a redundant SMAS-Platysma from the undermining was present, an excision was done and the remanent was anchored in the mastoid process. Also, a micro fat infiltration grafting was performed with 5 cc bilaterally in each malar portion to volumize the face. The remanent skin was excised and redrape with placing of drains. A follow-up after one year was done without complications and adequate evolution.

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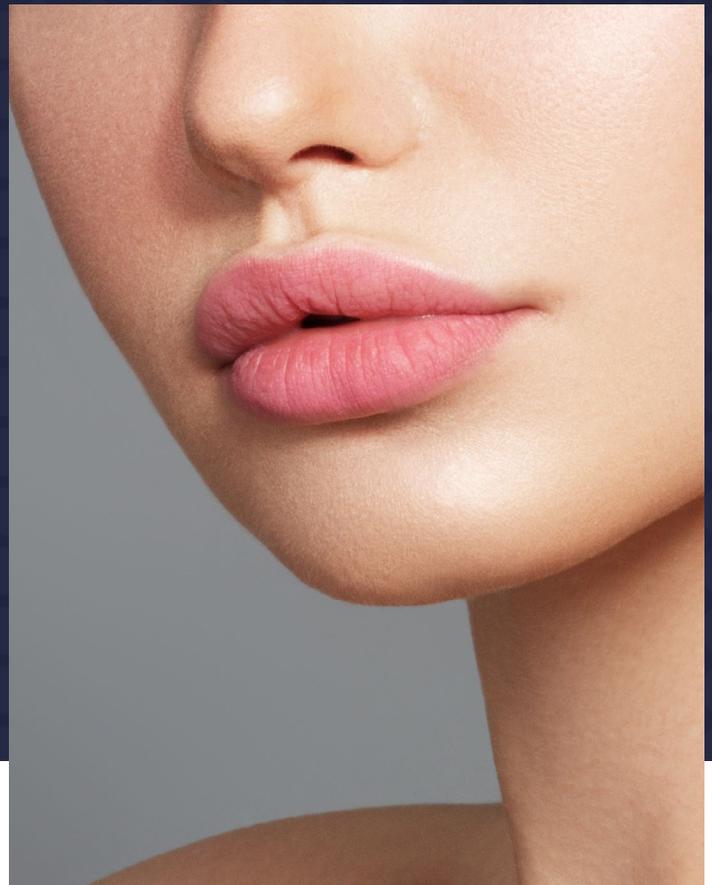
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CONCEPTS OF BEAUTY:

Lips

This section features varying perspectives from leaders who share the intricacies of the meaning of beauty worldwide.

Each issue will focus on a specific characteristic of beauty and the perceived differences between cultures.



Beauty of Lips:
a Malaysian
Perspective
Ilyasak Hussin

Concepts of Beauty
and Cultural Diversity
- the Lips: The African
Perspective
Egiehiokhin Isiwele

Concept of Beauty
and Cultural Diversity
in the European
Region: LIPS
**Smilja Tudjarova
Gjorgova**

What is a Beautiful
Lip in Latin America
**Douglas Narvae
Riera**

**Have a suggestion for our Concepts of Beauty section?
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ILYASAK HUSSIN, MD - MALAYSIA

BEAUTY OF LIPS: A MALAYSIAN PERSPECTIVE

We have all heard the saying, "Keep smiling and look for the silver lining in life." Even world-renowned supermodel Christie Brinkley has said that her smile was her ticket to the world. Without a doubt, the smile is a complex physiological process involving special muscles of expression around the mouth and has its hormonal and psychological importance by releasing our "happy" hormones: endorphins, dopamine, and serotonin. The smile is, in fact, considered to be contagious. Part of this intricate process of smiling is, of course, the lips.

The lips are an essential aspect of the human face. Besides being one of the "key players" in smiling, the lips also play a critical role in other facial expressions, as well as phonation, sensation, mastication, physical attraction, and even intimacy. Anatomically, the upper and lower lips are identified as labium superius oris and labium inferius oris, which have mucosal membranes, vermillion, and cutaneous surfaces. Boundaries of the upper lip begin from the nasolabial folds to the inferior margin of the nose, while the lower lip starts from the lateral commissures until the labiomental crease of the chin. The intersection of the upper and lower lips is known as the oral commissure or angle of the mouth, and it is at this point that we have muscular attachments for lip movements. There are other anatomical terminology and descriptions pertaining just to the lips. These include the philtrum column, cupid's bow, tubercle, dry and wet vermillion, and lower and upper vermillion borders.

Defining the "beautiful lip" has been attempted many times over time. To define what "beauty" is per se, is not necessarily an easy task. However, it can be considered that beauty is the relative measure of balance and harmony.



Figure 1: The desirable and aesthetic lip is varied across cultures and regions. Some attributes that are found to be desirable include a defined cupid's bow, symmetrical upper and lower lip volume, supple and soft lip surface, and full lips that have not thinned with age.



Figure 2: The stunning skyline of Kuala Lumpur, the capital of Malaysia, known for its rich and colorful cultural background and commercial centers.



Figure 3: Malaysia, a multicultural and multiethnic country in Southeast Asia known for its hospitable and friendly people. The perception and concept of beauty among Malaysians varies greatly and yet the beauty and aesthetic industry continues to thrive in this peace-loving nation.

It is established that an attractive appearance strongly influences a person's daily life, as beautiful people are considered friendlier, more intelligent, interesting, and socially competent.

The lips are considered to be a vital component of facial symmetry and aesthetics of the face, and they are not excluded from the rules of facial horizontal thirds or the golden ratio. Anthropometric studies have shown that wider and fuller lips in relation to facial width and



greater vermilion height contribute to defining female attractiveness. Since the beginning of recorded history, full lips have been associated with youth, beauty, and voluptuousness of women across cultures and civilizations. In fact, robust, pouty lips are actually considered to be sexually attractive by both males and females.

These assumptions and considerations of what beautiful lips ought to be (**Figure 1**), do not escape the men and women of a nation like Malaysia (**Figure 2**). Malaysia is a developing nation in Southeast Asia with a population of 33 million people from various multiracial and multiethnic backgrounds, including Malays, Chinese, and Indians predominantly. Being a Muslim-majority country, when it comes to aesthetic or cosmetic plastic surgery, it can still be considered taboo. Even so, aesthetic and cosmetic plastic surgery services are available and thriving in Malaysia, and it benefits all without any racial or religious profiling. This includes procedures and treatment for the lips.

In 2016, a survey of over 300 Malaysians of different races and ethnic backgrounds was conducted. They unanimously agreed that full lips have a balance of the upper and lower lips, and equally, plumpness is one of the features of beauty. Pink lips are also regarded as a sign of beauty and attractiveness. Without a doubt, this has led Malaysian women and men alike to seek treatment to achieve "beautiful" lips. Common procedures include lip enhancement with injectable fillers, implants, and laser treatments.

Besides aesthetic and surgical treatments to achieve the ideal lip appearance, Malaysians (**Figure 3**) are not shy about being part of current beauty trends. This includes the "gradient lip" trend, known as "ombre lips." With this technique, blending different shades of lipstick with or without lip gloss to create a soft, diffused effect, resulting in a naturally flushed pout. This beauty trend aligns with Korean makeup artistry, with an explosion of vivid, fun color styles on one end and minimalist hues on the other.

The matte lip look is another beauty trend that has caught up with Malaysians. Matte lipsticks are generally thought to be classier and subtler, which can uplift the overall makeup look and in concordance with a more "high fashion" runway-ready feeling. Some of the more beloved colors include red, wine red, and cherry red. These shades of red are usually rich in color, fulfill all their promises on the face, and can be pulled off by most, if not all, women.

Furthermore, another beauty trend for lips is "latex lips." The idea is to recreate the high-shine effect of latex by using particular products, including gloss. This trend results in lustrous and luminous lips that almost reflect the mirror-like sheen of patent leather boots or a supple latex leather coat, designed to make any glossy pout the star of any show.

Lastly, a not-so-common trend of lips in Malaysia is the "weird girl" lip. This trend involves wearing odd-colored lipstick, from blue to black, which is not the norm. This trend has been spotted among celebrities such as Doja Cat and Gigi Hadid. Without a doubt, it gives a unique and different bold look.

Currently, there is not much data on what the "perfect" lip is considered in Malaysia. With Malaysia being a multicultural and multiethnic country, such a task might not be easy. Further studies and surveys on this matter in the future will assist in ultimately defining the perfect Malaysian lip. For now, Malaysians have not shied away from seeking treatment and following the latest beauty trends to achieve the perfect lip. The decisions Malaysians make to accomplish the ideal lip are undoubtedly influenced by both Western and Eastern beauty standards and perceptions. Until then, the market for achieving the ideal lip continues to thrive in Malaysia.

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EGIEHIOKHIN ISIWALE, MD - NIGERIA
ISAPS National Secretary

CONCEPTS OF BEAUTY AND CULTURAL DIVERSITY - THE LIPS: THE AFRICAN PERSPECTIVE

INTRODUCTION - LIPS, BEAUTY, AND CULTURE

The lips are probably the most important part of the face after the eyes, with the appearance of the lips determining, in part, the attractiveness of the face. They are considered a very significant aspect of beauty in African cultures, either enhancing or diminishing it^{1,2}. Beauty is a mostly culture-bound concept, with some cultures considering certain features as beautiful and other cultures terming those same features as undesirable³.

In African cultures, full lips that are plump are often considered desirable and sometimes artificially enhanced through lip stretching or scarification. The lips are often used in non-verbal communication in Africa, with their shape and size communicating various emotions and attitudes, including sadness, joy, or anger. In some African cultures, lip tattoos and piercings are common and are viewed as a symbol of beauty and cultural identity. The lips also significantly influence African dance and music, with the different shapes and sounds created by the lips, which contribute to the richness and diversity of African music.

LIP IDEALS, CHANGING PARADIGMS?

Beauty standards vary widely across diverse African societies, and what is considered attractive in one culture may not be in another. Additionally, westernization has greatly modified beauty ideals and has affected the way some Africans now view their own features⁴, including their lips. Despite this, there has been a recent movement towards embracing natural African beauty and, by so doing,



Figure 1: Portrayal of ideal lips.

challenging Western beauty standards. As such, many African models and influencers have gained popularity for celebrating their unique features, including full lips. It is thought that there may be an evolutionary basis for the tendency to have fuller lips as an adaptation to Africa's hot, sunny climates. The extra fat in the lips is thought to protect against damage by UV radiation, keeping the body cool by retaining moisture. The increased melanin in the skin is protective throughout life, making dark skin less prone to solar elastosis and rarely developing radial rhytids⁵. In addition, their vermillion retains its volume even with aging. It has been noted that Caucasian patients have an upper lip to lower lip ratio of about 1:1.6, while African-American lips are generally larger in all dimensions^{1,6}.



The upper lip to lower lip length ratio obtained in a study conducted by Gerald Ikenna Isiekwe, and his colleagues⁷ in Nigeria, Africa in 2012, was 1:1.9. The mean upper lip length was 24.50 mm, and the mean lower lip length was 46.56 mm, while the mean upper lip thickness was 13.87 mm, with mean lower lip thickness being 17.07 mm. In Africa, lip volumes within this category tend to be seen as ideal, and as a result, such patients hardly seek lip enhancements (*Figure 1*).

LIP ENHANCEMENTS

Lip enhancement procedures are not commonplace in Africa, probably because most people in the populace possess lips they are satisfied with, in addition to sociocultural beliefs tending to limit aesthetic procedures, including lip surgeries.

Clients are commonly interested in correcting asymmetry and irregularities, reducing wrinkles or scars around the lips, and better defining lip shape. Ultimately, they all desire enhanced confidence and self-esteem. A few clients, however, present themselves for lip reduction because of heavy and long lips.

SOCIAL MEDIA AND LIP ENHANCEMENTS

The trend of having full lips is constantly being popularized by social media, with many people now using it as inspiration for their own lip enhancements. While this increased visibility of lip enhancement on social media can help reduce the stigma around plastic surgery and encourage people to pursue it as a personal choice, it is gradually leading to increased pressure to possess "the perfect lips." Constant comparison to those of social media influencers can lead to dissatisfaction and low self-esteem. There is also now a risk of promoting a homogenous beauty standard, which can lead to a narrow definition of beauty and unattainable beauty standards. Added to this is the rise in DIY lip enhancement procedures using sometimes unsafe "homemade" products and methods, which is potentially dangerous. A balance must be attained between risks and benefits and under the guidance of trained aesthetic surgeons.

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CONCEPT OF BEAUTY AND CULTURAL DIVERSITY IN THE EUROPEAN REGION: LIPS

WHAT IS THE CULTURAL IMPORTANCE OF THE MOUTH AND LIPS IN TERMS OF BEAUTY?

The mouth and lips are integral to European facial aesthetics, embodying cultural values, historical aesthetics, and regional traditions that define beauty standards. Southern European ideals often favor fuller, voluptuous lips, portraying a sense of sensuality, while Northern European minimalistic aesthetics lean towards a more modest, understated elegance. This cultural significance extends beyond physical features to encompass expressive communication techniques linked with the lips, contributing to a holistic concept of beauty. The enduring pursuit of beauty and youth transcends cultural boundaries, symbolized by plump, well-defined lips that are significant across diverse societies and historical periods. Individuals across cultures have explored various means, from injecting paraffin in the early 1900s to using liquid silicones in the 1960s to augment their lips, challenging age constraints in the quest for enhanced aesthetics. Despite historical shifts and concerns, the cross-cultural phenomenon of lip enhancement persists, reflecting the ever-evolving ideals of beauty and aesthetic preferences.

WHICH ARE THE MAIN COMPONENTS OF THE PERFECT LIPS TODAY?

Demography, gender, and age all influence what are considered to be the perfect lips. The main components of perfect lips in Europe encompass several factors, including shape, proportions, volume, and color (Figures 1-5). Symmetry is highly valued. Proportions that complement the individual's facial features are preferable above exaggerated fullness.

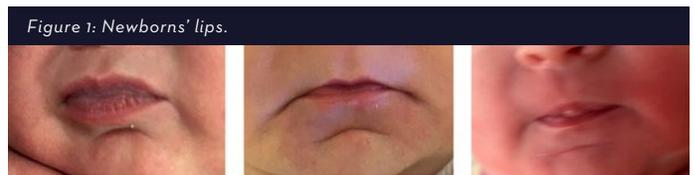
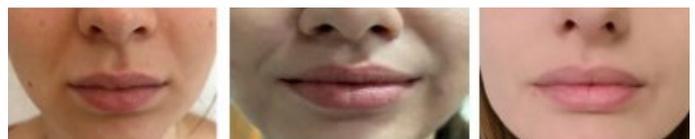


Figure 1: Newborns' lips.



Figure 2: Children's lips.



Figures 3: Naturally full female lips.

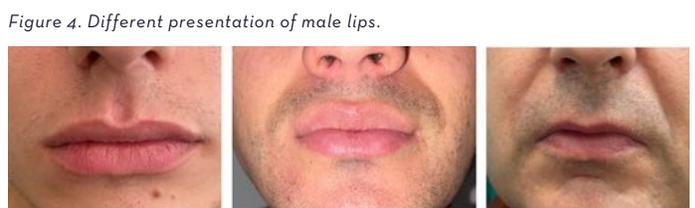


Figure 4: Different presentation of male lips.

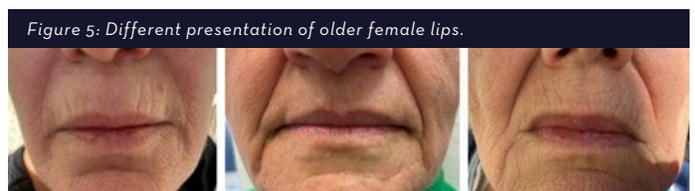


Figure 5: Different presentation of older female lips.

Specific ratios govern the aesthetic harmony of the nose, chin, and lips. The ideal ratio of the vertical height of the upper lip to that of the lower lip should fit inside the golden ratio (divine proportion), generating a value of



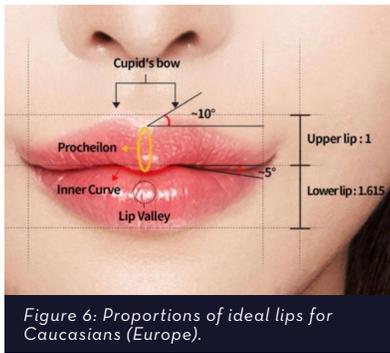


Figure 6: Proportions of ideal lips for Caucasians (Europe).

Figure 7: Burston's line.

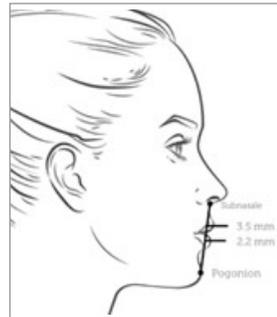


Figure 8a and 8b: Trout-pout appearance.

1:1.6 (Figure 6). This is initially seen in da Vinci's iconic lip proportions in relation to the rest of the face.

A vertical line is drawn, intersecting the midpoint of the upper lip. Ideally, the lower lip should be positioned 2 mm posterior to this vertical, and the chin, in turn, should be situated posterior to the lower lip. The horizontal line extending from the nasal tip to the junction of the nasal wings with the cheek is divided into front and back segments by the aforementioned vertical line. An optimal proportion is achieved when the front segment comprises 50-60% of the total length.

Another aesthetic ratio is defined by Burston's line (Figure 7), extending vertically from the sub-nasal area to the pogonion (the most prominent point of the chin). Ideally, the upper lip should protrude 2-5 mm and the lower lip 1-4 mm in relation to this line. Gender differences are observed, with women typically exhibiting more prominent lips, except in adolescent males, where lip protrusion exceeds that of females.

Ethnic variations in vermilion height are notable; for instance, in African American individuals, the upper lip measures 13.3 mm and the lower lip 13.2 mm in men, while in women, the measurements are 13.6 mm and 13.8 mm, respectively. Caucasians, on average, display upper lip

vermilion measurements of 8.0 mm (men) and 8.7 mm (women) and lower lip vermilion measurements of 9.3 mm (men) and 9.4 mm (women). When planning operative procedures on the lips, consideration of these ethnic nuances is paramount for achieving desired outcomes.

1. The line drawn from the corners of the lips should coincide with the center point of the pupil.
2. Fullness in the cheekbones, gradually tapering towards the ends of the lips.
3. Symmetry of both halves obtained by a line drawn through the middle of Cupid's bow.
4. The upper lip is 2/3 of the volume of the lower lip.

These fundamental artistic concepts, first practiced hundreds of years ago, are still relevant today. Natural-looking color, consistent with the person's skin tone, contributes to the perception of aesthetically pleasing lips.

WHAT TYPES OF LIP ENHANCEMENTS DOES THE AVERAGE PATIENT SEEK?

The average European patient seeking lip enhancement typically desires subtle improvements that enhance their natural beauty. Common requests include:

- Achieving fuller lips,
- Improving lip symmetry and
- Addressing signs of aging, such as fine lines and cherry lips, which are very popular.

Patients often prefer non-invasive procedures, like hyaluronic fillers, due to their minimal downtime and ability to produce natural-looking results. However, some females may want upper lip augmentation without considering the balance of their upper and lower lips. As a result, it is the physician's responsibility to educate the patient on the appropriate ratio. "Duck" lips are caused not just by overcorrection but also by a lack of awareness of the delicate curves of natural lip anatomy. An exaggeration of these proportions, or the use of the incorrect ratio, might result in a "duck-like" or "trout-pout" appearance (Figures 8a and 8b). Customization based on individual facial anatomy and preferences is gaining prominence, moving away from one-size-fits-all approaches. The emphasis is on achieving results that seamlessly integrate with the patient's unique features.



WHAT ARE CONSIDERED BEAUTIFUL LIPS IN YOUR REGION, AND WHAT PROCEDURES DO PEOPLE SELECT TO ENHANCE THEM?

Beautiful lips in Europe are subjective and influenced by regional, historical, and contemporary factors. Generally, a harmonious balance in lip proportions, symmetry, and a natural appearance is favored.

Lip enhancement (**Figures 9a and 9b**) practices include non-surgical and surgical procedures. The cosmetic landscape of the 1980s witnessed the widespread adoption of bovine collagen in cosmetic surgery, becoming a benchmark against which the outcomes of other injectable fillers were measured. However, collagen's transient nature and the need for allergy testing resulted in patients enduring a waiting period of at least three weeks for subsequent appointments and an extended timeframe to realize the full effect. In recent years, fillers incorporating hyaluronic acid, such as Restylane and Juvederm, have garnered attention from medical professionals and patients alike in Europe and North America.

Precise identification of specific areas of deficit and evaluation of the feasibility of achieving the desired augmentation necessitates a thorough preoperative physical examination. This assessment includes the patient's closed mouth and clenched teeth, maxilla-mandibular relationship, and aging patterns. Additionally, the relationship between the upper lip and incisors is scrutinized to guide the selection of the appropriate corrective method. Dr. Bahman Guyuron has proposed a comprehensive algorithm based on the preoperative physical examination for planned lip augmentation:

- Optimal presentation of the incisors - conservative augmentation with lipotransfer or dermal fat tissue graft.
- Excessive display of incisors - augmentation with lipotransfer or dermal fat tissue graft.
- Inappropriate presentation of the incisors, long lips - shortening of the lips and lifting with an incision in the area of the base of the nose, "buffalo horn," in young patients with a sharp columella-lip angle or an incision at the edge of the vermilion in older patients with perioral folds.
- Inappropriate display of incisors, normal lip length - maxillary elongation with possible lip augmentation.



Figure 9a and 9b: Lipofilling labii oris.

Figure 10. Congenital lip asymmetry, corrected with lipofilling.



Figure 11a and 11b: Surgical lip enhancement, "Cheiloplasty".

Various non-surgical and temporary methods are available for lip enlargement. These topical agents typically induce a mild inflammatory response in the lip mucosa, leading to augmentation. Common ingredients include Capsicum annuum or Capsicum frutescens (extracted from red pepper, used in the production of pepper and Tabasco). Some formulations incorporate cinnamon oil or caffeine, while more recent compositions feature palmitoyl oligopeptide and L-arginine to stimulate collagen synthesis.

For longer-lasting effects (beyond one year), hyaluronic acid mixtures with hydrogel particles, such as DermaLive, or fillers like Bioplastique (approved in the US), containing 38% biphasic polymer silicone particles dissolved in 62% biodegradable gel, offer persistent synthetic particle augmentation.

The advantages of hyaluronic fillers compared to other fillers include good control of the desired lip volume,



gradual - injections can be given over a longer period in multiple sessions until the desired volume is achieved, less bruising compared to other fillers, all unwanted lumps and bumps during the procedure can be dissolved and corrected, does not cause allergic reactions.

Autologous fat is a viable filler option, presenting a distinct advantage in its ability to yield long-lasting (sometimes permanent) results contingent upon the quantity of injected tissue and the targeted correction site. Notably, using autologous tissue-lipofilling (Figures 10a, 10b, and 11) eliminates the risk of allergic reactions. The procedure involves harvesting fat tissue from a donor site in the patient under local anesthesia. When employing appropriate techniques, up to 30%, and sometimes the entirety, of the injected adipose tissue can persist after transplantation. Less frequently used, platelet-rich plasma (PRP) may also be considered for lip augmentation.

IMPLANTS

The three most commonly used lip implants, are GORE-TEX, SoftForm, and AlloDerm. GORE-TEX® lip implants, composed of non-reactive polymer (expandable PTFE), have been employed for many years. Initially, patients may experience transient discomfort and slight tightness of the lips post-implantation. These implants feature micropores, facilitating tissue growth and integration into the lip structure.

Autologous grafts derived from the patient's own dermis, dermal fat, tendons, and fascia offer a moldable and implantable solution for lip augmentation. In some cases, grafts can be obtained from skin resected during local procedures like a lip lift, or skin may be harvested from the inner thigh, de-epithelialized, and then re-implanted. After the tissue is collected and shaped, it is inserted in the form of a thread into the lips to enhance their volume. Tabrizi et al. conducted a study treating 15 patients with a dermal fat graft, demonstrating a significant and persistent effect after one year of monitoring.

Thorough preoperative planning is imperative, given that even the slightest asymmetry becomes readily apparent to both the patient and observers. Moreover, psychological evaluation is essential to identify and address any unrealistic expectations harbored by certain patients.

TISSUE TRANSFER - SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS)

During an SMAS-ectomy face lift, residual strips of the removed SMAS are utilized for lip augmentation. For



Figure 12: Surgical "V-Y" lip enhancement.



Figure 15 and 16: The ideal, European natural lips.

Figure 13: Surgical lip enhancement - upper cheiloplasty.



| | | | | |
|---|--|---|--|--|
| | | | | |
| DLL, upper and lower lip lift (Meyer and Kessering, 1976) | ILL, bullhorn subnasal lip lift (Cardoso and Speith, 1971) | ILL, philtrum stretching, variation #1 (Austin, 1986) | ILL, philtrum stretching, variation #2 (Austin, 1986) | ILL, L-shaped philtrum lift (González-Ulloa, 1975, 1979) |
| | | | | |
| ILL, extended incision (Marques and Brenda, 1994) | ILL, Greenwald incision (Greenwald, 1987) | ILL, double duck suspension (Cardin et al., 2011) | ILL, Italian technique (Santache and Bonarigo, 2004) | ILL, non-scar suspension technique (Echo et al., 2011) |
| | | | | |
| CML, lentoid incision (Greenwald 1985) | CML, triangular incision (Austin, 1994) | CML, rhomboidal incision (Perkins, 2007) | CML, Valentine anguloplasty (Chiang and Flowers, 2005) | CML, extended incision (Parra et al 2010) |
| | | | | |
| CML, lentoid excision for correction of "sad platts" (Borges, 1989) | VYLA, transverse Y-V (Determ and Elbaz, 1975) | VYLA, double V-Y (Aiache, 1991) | VYLA, W-shaped incision (Ho, 1994) | VYLA, V-Y in V-Y incision (Mutaf, 2006) |

Figure 14: Surgical lip enhancing procedures.¹

the upper lip, the strip is tailored to be 4-6 mm wide at the center, with tapered ends, measuring approximately



4-7 cm in total length. The lower lip graft is designed to be 50-75% of the size of the upper lip graft. To minimize discomfort, a local anesthetic containing lidocaine 1% with adrenaline is administered at least 10 minutes prior to the augmentation procedure.

The process involves creating a small incision on the lateral margins of each lip near the commissures. A tendon passer is then inserted from one end to the other, and the suitable graft is placed onto the tendon grabber and pulled through the lip until the central part is positioned in the middle. Any excess graft is carefully removed, and the graft is massaged over the vermilion. Subsequently, the incision is sutured using 5-0 rapidly absorbable sutures. This meticulous technique aims to achieve balanced and natural-looking lip augmentation during the face lift procedure.

SURGICAL ADVANCEMENT OR V-Y LIP AUGMENTATION

V-Y lip augmentation is a surgical procedure designed to enhance lip volume by utilizing existing lip tissue. This technique involves a meticulous rearrangement of soft tissues on the inside of either the upper or lower lip through the creation of a V-Y flap. The initial step involves making a V-shaped incision on both sides of the frenulum, extending deep to the submucosa but remaining superficial to the underlying muscle to prevent damage to small sensory nerve branches. Following this incision, the edges are sutured together, transforming the V shape into a Y shape.

During this transformation from a V to a Y shape (*Figure 12*), excess tissue is directed upward and outward towards the oral opening, resulting in the desired enlargement of the lip. Typically, a 2:1 ratio exists between the length of the vertical arm of the Y and the achieved gain in lip volume. This surgical approach allows for a careful and controlled augmentation of the lips, using the patient's own tissue for a natural and harmonious result.

LIP LIFT

Two distinct variations of the lip lift technique are the corner lift and the upper lip lift, both aiming to restore a more youthful appearance for the patient. The upper lip lift, a more frequently employed method, involves shortening the distance between the cupid's bow and

the columella through a "seagull wing" incision. This technique emphasizes the vermilion of the upper lip, creating a highlight that contributes to increased volume and a rejuvenated look. Conversely, lifting the corners of the lips is specifically designed for patients exhibiting a "permanent frown" resulting from drooping corners. This procedure addresses the downward sagging of the lip corners, effectively imparting a more uplifting and aesthetically pleasing contour to the lips. Both techniques are tailored to enhance different aspects of lip aesthetics, contributing to an overall more youthful appearance for the patient.

Seagull-wing lips are considered to be a variant of lips that are difficult to correct with hyaluronic acid fillers. Other surgical lip techniques include heart-shaped lips, "V-Y," chestnut lips, natural ketchup lips, turtle lips surgery, and lip mucosal incision surgery (*Figure 13*).

WHAT ARE THE CURRENT TRENDS AND INFLUENCES OF SOCIAL MEDIA?

The influence of Social Media and contemporary beauty trends on lip enhancement is undeniable. With the advent of Social Media (SoMe), beauty standards have been launched into a global arena, creating a melting pot of influences that transcends regional borders. Instagram, TikTok, and other platforms have become significant propagators of beauty ideals, frequently blurring the distinctions between local customs and worldwide trends. Because the lips are such a prominent aspect of the face, they have been subjected to a plethora of trends spread by influencers and celebrities all over the world. Lip fillers, contouring techniques, and lip augmentation treatments have grown in popularity (*Figure 14*), helping to shape a new narrative of beauty that is not limited by geography. While these trends help people gain a better grasp of their alternatives, it is critical that people approach lip enhancement with a realistic mindset. Aesthetic practitioners should stress patient education and encourage educated decision-making, emphasizing the value of preserving individuality and obtaining enhancements that complement each patient's distinct facial features.

In navigating the complex tapestry of beauty within Europe, the perception of lips provides an intriguing



starting point (**Figures 15 and 16**). The concept of beauty is fluid, dynamic, and ever-changing, from regional tastes to the overarching effect of social media and aesthetic trends. Understanding these nuances promotes a better appreciation for the multidimensional nature of beauty

that binds us all while allowing individual expressions to blossom as we continue to explore and enjoy our various cultural heritage.

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WHAT IS A BEAUTIFUL LIP IN LATIN AMERICA?

In the last decade, there has been a global trend to show off more voluminous, fleshy, and hydrated lips in women and even some men. As plastic surgeons, we have a dual challenge: maintaining the appropriate proportions according to each race, skin type, and individualized patterns and, at the same time, not generating transformations that are not aesthetically consistent which can distort our anatomical and aesthetic concepts so that beauty really is shown in this area which holds sensual and proper balance in the face of each patient.

Full lips with an accentuated line have often been associated with beauty and youth. Tribal people around the world have introduced various materials through the upper and lower lips of both genders to enhance their beauty. The perceived ideal size of lips has varied over time; the current trend in Western countries is for more voluminous and defined lips. However, it is not a pattern unique to each region of the world. As I previously mentioned, it has been suggested that this is because lips occupy an important focal point in overall facial beauty. One of the effects of lip aging (**Figure 1**) is the well-known "smoker's lines" or those also called "bar codes."

Based on the Heidekrueger et al. study, "Lip Attractiveness: a cross cultural analysis," on lips preferences, Latin American lip ideals in their study aimed to discover how demographic information affects lip size preferences (**Figure 2**). When compared with laypersons in all other demographic groups (Asian, European, and North Americans), laypersons in Latin America favored the largest, hydrated, cared for, and crack-free. North Americans favored relatively large lips, second to Asians. No other studies were identified that discussed the lip preferences in other ethnicities.

Figure 1: Comparison of young lips versus older lips.

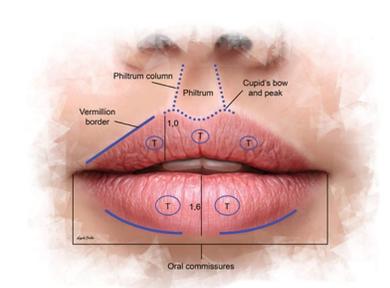
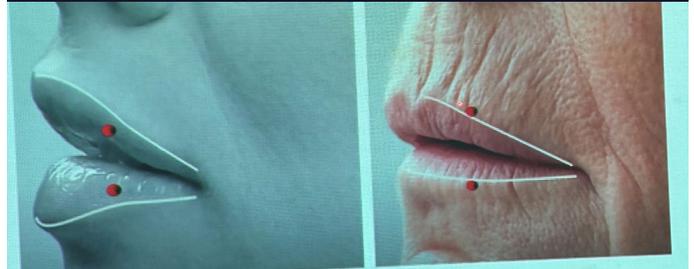


Figure 2: Ideal lips in Latin-American patient.

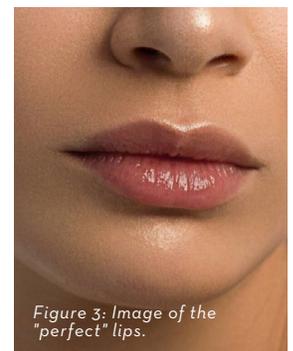


Figure 3: Image of the "perfect" lips.

Country of residence, ethnic background, and profession significantly impact individual lip shape preferences. These findings have implications for patients and surgeons because differences in aesthetic preferences can lead to dissatisfaction among patients and surgeons alike. In our increasingly global environment, cultural differences and international variability must be considered when defining new aesthetic techniques, treating patients, and reporting outcomes.

In my practice as a plastic surgeon in Venezuela with only 22 years of experience, I can mention that most of our patients who by the way are a mixture of races historically, desire a "beautiful lip" based on: volume with an adequate





Figure 4: Collage of Miss Venezuelas over the years featuring beautiful lips.

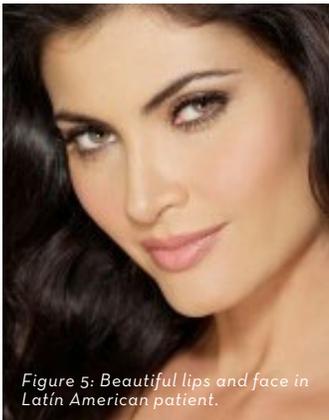


Figure 5: Beautiful lips and face in Latin American patient.



Figure 6: Beautiful lips and face in Latin American patient.

proportion, being the superior lip with a little less volume than the inferior, with a beautiful cupid arc, and philtrum with a harmonic contour and both commissures at the same level as possible (Figures 3-6).

The conclusions I reach after the impressions I take both from the study carried out, and requests in my and most Latin American plastic surgeon practices, in consultation with many mixtures of races in our offices, most patients want fuller, voluminous, and shiny lips that look natural. However, there is the so-called "ghost" of overcorrecting lips therapies offered at very low costs in dubious locations run by non-plastic surgeons who "please" patients' desires without any boundaries that become a major issue due to the fact that there are still non-absorbable substances being injected not only in lips but other anatomical areas.

I think that both aesthetic and anatomical beauty should be individualized and well evaluated and treated by those of us who are specialists and be always aware to not convince but rather properly inform our patients on what is the adequate lip proportion for each one of them.

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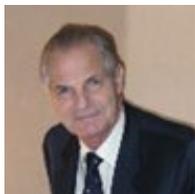
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DENYS MONTANDON, MD - SWITZERLAND

THE HERITAGE OF HIPPOLYTE MORESTIN (1869-1919)

The history of surgery, and in particular plastic surgery, has been marked by pioneers who have passed on their knowledge and, above all, their skills to succeeding generations. Prior to the 19th century, some of these pioneers did not bear the title of doctor, as they had not studied at a university and did not speak Latin; some of them, however, were given the title of master surgeon. Surgery was learned from a renowned master in small establishments where barbers and therapists rubbed shoulders.

However, for the past two centuries, all surgeons have been university-educated physicians. Learning the practice of surgery requires a personal relationship between master and pupil, which may last several years. Every trained surgeon learned their trade from tutors. Looking back, we can all remember the men and women who taught us not only surgical techniques but also how to deal with patients and the ethics of the profession. Sometimes, this tutorial goes against our own convictions, but that's part of the training, too, "I won't do it like this one!".

Among the pioneers of plastic, reconstructive, and aesthetic surgery, one of them played a very special role, not only for his commitment to the treatment of the severely mutilated during the First World War but also for his work in the field of aesthetic surgery. How did a peculiar, unruly Creole child born in Martinique, become the most respected surgeon in Paris, admired by his peers and the public alike? How can we explain the fact that this difficult, uncompromising man, who was sometimes contemptuous of his colleagues, became the inspiration for many of the greatest names in plastic surgery, neurosurgery, and even French literature (**Figure 1**)?

Hippolyte Morestin was no ordinary man^{1,2}. He had no wife and few friends. The tragedy of the eruption of the Mont Pelé

Volcano in 1902, in which he lost 21 members of his family, had affected him greatly. He was in frail health, and suffering from tuberculosis, but this did not prevent him from being a hard worker. At 28, he passed the competitive examination to become a surgeon at Paris hospitals, making him the youngest surgeon in France. At 34, he passed the aggregation in surgery and became a professor at the Paris Faculty of Medicine. He had a keen interest in anatomy, but his real passion was operating and caring for the sick, sometimes to the detriment of his own health, which he neglected.

As soon as the Great War broke out, Morestin volunteered for the French Army (**Figure 2**). A few months later, he was called upon to work at the refurbished and enlarged military hospital, Val-de-Grâce. As early as 1915, he organized the center for reconstructive surgery for facial injuries, where he obtained several hundred beds (480 in August 1919). During the four years of the war, he, and his colleagues, in collaboration with dentists, operated on hundreds of mutilated soldiers known as the "Gueules cassées" (Broken Faces). Morestin died following pulmonary complications caused by the Spanish flu on February 11, 1919, three months after the signing of the war Armistice. At his funeral, he received a vibrant tribute from the people of Paris.

During his whole career, Morestin published more than 600 articles on surgical anatomy, abdominal and head and neck surgery, and plastic surgery, such as skin expansion³ to correct extended facial naevi, application of Z-plasty for the treatment of contractures, and the use of costal cartilage grafts for the restoration of the skeletal support of the nose. He was also known among the upper-class Parisians for his successful cosmetic operations, as it was reflected in a few caricatures (**Figure 3**).



MORESTIN'S INFLUENCE AND HEIRS

GILLIES, THE FATHER OF MODERN PLASTIC SURGERY

Before settling in England, Harold D. Gillies, while in Paris in June 1915, visited the Master. As he recalled, this visit probably triggered his future specialty, "I found him (Morestin) at the huge rambling Val-de-Grâce Hospital. He was a strange and moody doctor, whose dagger-like sharpness was accentuated by his pointed mustache and tapering beard. In the space of a single moment, he could reveal the gentleness of a kitten and the savagery of a tiger. He received me kindly, and I stood spellbound as he removed half of the face distorted with horrible cancer and deftly turned a neck flap to restore not only the cheek but the side of the nose and lip in one shot. Although in the light of present-day knowledge, it seems unlikely this repair could be wholly successful, it was the most thrilling thing I had ever seen. I fell in love with the work on the spot". Asking for a second visit with Morestin, Gillies was not accepted in the operating room (*Figure 4*)!

ESSER (1877-1946), THE POLYVALENT PLASTIC SURGEON

Born in the Netherlands, Johannes Frederik Esser started his medical career as a ship's doctor and then as a general practitioner with a special interest in dentistry. Being dissatisfied professionally, he began to collect art and cultivate relationships with artists. He was also a keen chess player, becoming the Dutch chess champion. At 37, he decided to move to Paris to follow the operations of the head and neck surgeons Pierre Sebileau and Fernand Lemaître, but mainly to work with Hippolyte Morestin, with whom he remained six months during the war. Upon his return to Rotterdam, he became a very talented plastic surgeon and worked also as a military surgeon in different cities, like Brno, Budapest, Vienna, and Berlin.

MADAME NOËL (1878-1954), THE FEMINIST AESTHETIC SURGEON

Suzanne Marguerite Gros, known as Suzanne Noël (from the name of her second husband), started her training in 1908 in the service of Hippolyte Morestin and then in dermatology with Professor Brocq at Saint Louis Hospital. During the First World War, she collaborated with de Martel and Morestin to treat wounded soldiers. After having lost her daughter from the flu and her husband from suicide, she finally wrote her thesis in 1925 and started a successful career as a cosmetic surgeon. With her book published in 1926, "La Chirurgie Esthétique: Son Rôle Social" (Aesthetic Surgery, its Social Role), immediately

translated into German, she pioneered this field, describing her own methods. In 1924, she was one of the founding members of the French section of the Soroptimist Club and started to make numerous trips and conferences to promote aesthetic surgery and feminism⁴ (*Figure 5*).

During World War II, she was known to have modified the faces of opponents and Jews searched by the Gestapo. In 2018, the French Post issued a stamp for her 150th birthday to honor her memory (*Figure 6*).

DE MARTEL (1875-1940), THE PATRIOTIC PIONEER FRENCH NEUROSURGEON

Following France's entry into World War I in 1914, Thierry de Martel served on the front line and was wounded on October 3, 1914; he was then assigned as a surgeon in Val-de-Grâce Hospital, where he worked with Morestin. A year later, de Martel met Harvey Cushing at the American Hospital in Neuilly, where he was appointed Chief Surgeon in 1916. In 1917, he published a book, "Wounds of the Skull and Brain: Their Clinical Forms and Medical and Surgical Treatment," based on his experience with 5,000 soldiers with head injuries.

During the interwar period, de Martel played a central role in establishing modern neurosurgery in France and improving the management of wartime cranioencephalic injuries using his own experience. Following France's entry into World War II on September 3, 1939, de Martel took over as head of the services of the American Hospital of Paris in Neuilly and published another book, "The Treatment of Skull Injuries During Military Operations." But in June 1940, De Martel, in despair over the entry of German troops into Paris, committed suicide by ingesting strychnine.

DUFOURMENTEL (1884-1957), THE DUFOURMENTEL SCALP FLAP

Léon Dufourmentel's medical career started as an internship in the Paris hospitals, working with Morestin. During the war, he followed his master to treat the "Gueules cassées" in Val-de-Grâce Hospital and developed a method for repairing facial wounds, describing a hair-bearing pedicled flap from the temporal scalp to reconstruct the lower part of the face. He also proposed the use of ivory grafts for nasal reconstruction. His main book was published in 1939, "Chirurgie réparatrice et correctrice des téguments et des forms" (Reparative and Corrective Surgery of the Skin and Contour Defects). He also published in 1946 an essay on art and plastic surgery.



Léon was the father of Claude Dufourmentel (1915-2012), one of the leading French plastic surgeons of the 20th century.

DUHAMEL (1884-1966), WAR SURGEON, WRITER, AND PACIFIST

In the early days of WWI, Georges Duhamel decided to enlist for active service in the French Army. He wanted to give of himself and share the hardships of the men of his generation. From 1914 onwards, he spent four years as a medical officer under the supervision of Morestin, often in highly exposed situations. While practicing near the Champagne front in 1915, he decided to tell the story of the ordeals suffered by the wounded. This experience gave rise to two novels, "Vie des martyrs" (The Life of the Martyrs), published in 1917, and "Civilisation", a testimony to the ravages of war, for which he received the Prix Goncourt 1918. Once he returned to civilian life, Duhamel dedicated himself to literature and defending humanitarian civilization. In 1935, he was elected to the chair of the Académie Française. Writing numerous novels between 1930 and 1940, he traveled to conferences in France and abroad, promoting the idea of a civilization built on the human heart rather than technological progress. At the outbreak of hostilities in the Second World War, Georges Duhamel once again became a military surgeon, operating on wounded civilians in Rennes during the 1940 exodus. In 1942, his entire literary work was banned from publication by the Gestapo. After the war, his peers elected him as perpetual Secretary of the Académie Française.

PASSOT (1866-1933), THE PURE AESTHETIC SURGERY

Raymond Passot worked as an intern since 1910 in the service of Morestin. After his training, he became mainly involved in the practice of cosmetic surgery, and already in 1919, he presented to the Academy of Medicine his work on face lift. His book, "Chirurgie esthétique pure: technique et résultats" (Pure Aesthetic Surgery), published in 1931, makes a clear distinction between repair and aesthetic surgery, with new and well-illustrated methods proposed. In another book, "Sculpteurs du visage" (1933) (Face Sculptors), he justifies aesthetic surgery on a healthy body as a therapy for neuroses and prevention of suicides.

CONCLUSION

Directly or indirectly, Hippolyte Morestin had an immense influence on the surgeons who worked with him or had seen him operating. We can attribute this heritage to his dedication to the profession, tireless activity, patriotic engagement, and

multiple publications. Undoubtedly, the tragic circumstances of WWI, with its numerous wounded soldiers requiring surgical repair, played a role in the surge of vocations for reconstructive surgery. Interestingly, unlike Harold Gillies later, Morestin did not hesitate to publish several articles on aesthetic surgery, showing clearly that the two sides of our specialty are intimately linked, and encouraging Suzanne Noël and Raymond Passot to develop this field⁵.

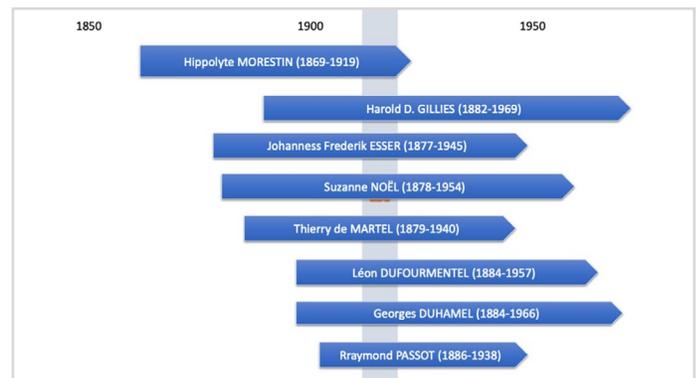


Figure 1: Chronology of the life of the surgeons in relation to WWI.

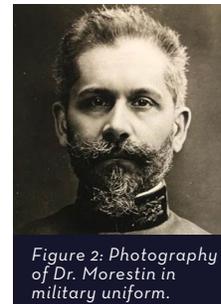


Figure 2: Photography of Dr. Morestin in military uniform.



Figure 3: Dr. Morestin: "The Modern Pygmalion."

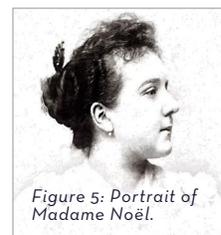


Figure 5: Portrait of Madame Noël.

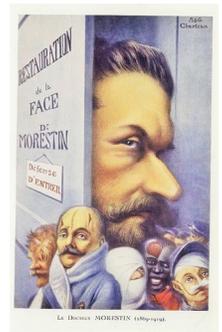


Figure 4: "Restoration of the Face, Dr. Morestin (Entry Forbidden!)."

Figure 6: 2018 post-stamp.

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Welcome to our newest section which introduces new books written or contributions made, by our prestigious members! As part of the ISAPS community, we are looking forward to sharing with you their latest accomplishments. Featured in this issue, we have an excerpt from Dr. Peter Nelligan (US) which highlights this beautiful book.



RICCARDO MAZZOLA
MD - ITALY

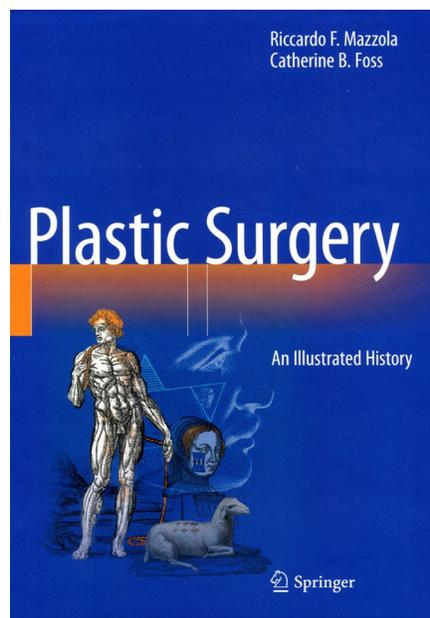


CATHERINE FOSS - UNITED STATES

BOOK REVIEW: PLASTIC SURGERY – AN ILLUSTRATED HISTORY

The very first line in the Preface of this book reads: "A comprehensive book on the history of plastic surgery would not only be complicated to write for the vast amount of material available, but also almost impossible to read." This beautiful book gives credence to the adage "A picture is worth a thousand words."

This is, in fact, a beautifully illustrated pictorial history of plastic surgery. Dr. Riccardo Mazzola owns one of the most important rare book collections specifically related to plastic surgery in the world. Started by Professor Gustavo Sanvenero Rosselli, regarded as the father of plastic surgery in Italy, he was also Dr. Mazzola's uncle and bequeathed the library to him. Dr. Mazzola has spent his lifetime adding to it. The reader is fortunate to get a glimpse of that collection in the pages of this book. Riccardo Mazzola and Catherine Foss have worked together through the International Society of Aesthetic Plastic Surgery (ISAPS) of which she was Executive Director and he was Historian. Foss carefully edited the manuscript, revised text, incorporated corrections, and reviewed dates, facts, and nomenclature.



Authors: Riccardo Mazzola (Milan, Italy) and Catherine Foss (Hanover, NH, USA) Publisher: Springer Nature Switzerland AG ISBN 978-3-031-12002-2

This book is one that can be enjoyed from start to finish. There is a comprehensive index that allows the reader the luxury of looking up and finding a particular item easily. As I went through the book to prepare this review, I found myself getting lost in fascination and marveling at the wonderful illustrations throughout.

Dr. Mazzola and Ms. Foss are to be congratulated and indeed thanked for giving this to our community. The very last sentence in the book reads: "We must be humble and recognize that nothing is new under the sun." How very true this is and how beautifully this book illustrates that fact.

Peter Nelligan, MD - US
Professor Emeritus, Division of Plastic Surgery, University of Washington, Seattle, WA, USA

The book can be ordered from Springer, Amazon, or Barnes & Noble.



COFFEE & ANECDOTES



COFFEE WITH A PERSONAL NOTE

We know Dr. Foad Nahai very well as an influential plastic surgeon, but what do we know about him from the years before he joined ISAPS?

Regarded as an innovator in the field of plastic surgery, we are honored to meet him now for Coffee & Anecdotes, on a personal level, and learn about his life before medical school, and how he came to be in his profession as we know it today.



FOAD NAHAI, MD - UNITED STATES
ISAPS Past President (2008-2010)

ISAPS: You resided in three different countries throughout the years: Iran, the United States, and the United Kingdom. What have your experiences been in these countries and how do they differ from each other?

NAHAI: I was born in Iran and was influenced by my parents who taught me right from wrong, morals, and ethics. Beyond that, I learned from them to be polite and respectful to everyone. They taught me to treat our household help with the same respect I showed to my aunts and uncles. I attended the American School in Tehran and had a private tutor at home to teach me Farsi, Persian History, and all about our Persian heritage. I lived at home and had a comfortable life surrounded by family. That ended when as a pre-teen, I was sent to boarding school in England where I spent the formative years of my life far from home and family. I enjoyed my time in boarding school, where I learned self-discipline, self-reliance, and a work ethic based on

the premise that hard work is rewarded through success. On the playing fields of my schools, I learned sportsmanship, to be modest in victory and gracious in defeat. The years in boarding school prepared me well for my future as a physician. From boarding school, I went to medical school at The University of Bristol, where I learned to treat patients as individuals and not merely a disease condition, I learned to listen to my patients as I was taught that by listening to the patient, the patient will tell you the diagnosis!

For my elective, senior year in medical school, I chose to spend a summer in the United States at the Johns Hopkins University School of Medicine in Baltimore. That was an eye-opener for me! My first time in the US and my first exposure to American medicine. After graduation from medical school and the year of required house jobs (internship) in England, I returned to Johns Hopkins to train as a surgeon. The rapid pace of work,



on-call every other night, and the competitive spirit were all new to me, but I rapidly adapted. My years in boarding school had prepared me for it all. I went from Baltimore to Atlanta and Emory University School of Medicine, which has been my academic home for fifty years, where I completed General Surgery and Plastic Surgery. My experience and the influences on me from the three continents and cultures have all shaped who I am and contributed to any measure of success I have had as a surgeon, scholar, and contributor.

ISAPS: When did you decide to join ISAPS, and why?

NAHAI: My early career was devoted to reconstructive surgery. My first position on the faculty at Emory was that of a hand surgeon, a self-taught reconstructive microsurgeon. As my practice grew and patients came to see me seeking aesthetic procedures, I joined the American Society for Aesthetic Plastic Surgery (ASAPS), now The Aesthetic Society, and learned more about aesthetic surgery. In those days at ASAPS very few international experts were on the program. I decided to join ISAPS so I could also learn from a diverse and international group of educators. That was a great decision, and to this day, I continue to benefit from my ISAPS membership.

ISAPS: Throughout your career, you have shown a devotion to working for several scientific societies, including having served as President of the American Society for Aesthetic Plastic Surgery (ASAPS) and ISAPS, and being ardent to aesthetic education. How was the time you invested rewarding for you, and how has your commitment shaped you in that aspect of your life?

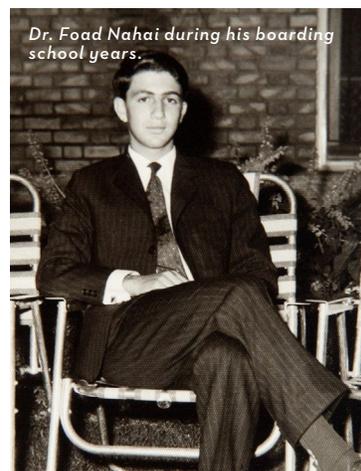
NAHAI: My several leadership positions, especially at ISAPS and ASAPS, were an opportunity to contribute to the growth and international reach of the organizations. For the 2010 Biennial Meeting of ISAPS, as president, my goal was "2,010 by 2010", meaning ISAPS membership of over 2,010 by the time of our meeting in San Francisco, a goal we almost achieved. Thirteen years later I am so pleased to see that ISAPS has become the largest organization of board-certified aesthetic plastic surgeons and a leader in aesthetic education worldwide. Leadership offers the opportunity to influence the direction and evolution of organizations in an ever-changing world. Keeping our organizations and our educational efforts relevant by embracing the rapidly developing disruptive technologies. My commitment to scholarly pursuits, education, and acceptance of technological advances has stood me in good stead in leadership positions, and dare I say, as Editor of The Aesthetic Surgery Journal. I am so grateful for the leadership positions and the opportunities to contribute.

ISAPS: Can you share a memorable anecdote or story from your time with ISAPS?

NAHAI: Throughout my career, I have simultaneously been actively involved in the leadership of multiple organizations. I flatter myself that I am able to wear many hats at once while being loyal and working hard for each entity. My most memorable moments or should I say, the many memorable months, were being president of ASAPS and ISAPS at the same time. That



Dr. Foad Nahai as a child in Tehran.



Dr. Foad Nahai during his boarding school years.



Dr. Foad Nahai at his graduation from The University of Bristol.

had not been planned! Initially, my presidency of ISAPS was to start well after the end of my term as president of ASAPS, but there were unanticipated events that led to an earlier start of my term at ISAPS. To this day I wear many hats at once, and I feel that there are benefits to it. Working with others, we brought ASAPS and ISAPS closer together through "hat sharing"!



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FRESH PERSPECTIVES:

Residents are an essential piece of what makes up ISAPS, and we invite our Resident members to contribute their views and impressions.

It is through their efforts and outlooks that our specialty will develop and remain innovative for years to come.



The Active Presence of Residents at Congresses is Paramount

Marcos Louro De Hollanda

Residents Corner
Erick Zuñiga Garz

Plastic Surgery Residency: Are We Properly Training Our Plastic Surgery Residents?

Gustavo Abrile

Calling all Residents! Click here to submit your article for an upcoming issue!



MARCOS LOURO DE HOLLANDA, MD - BRAZIL

THE ACTIVE PRESENCE OF RESIDENTS AT CONGRESSES IS PARAMOUNT

The participation of plastic surgery residents in international congresses, such as the ISAPS World Congress plays a crucial role in the development and improvement of the medical profession. These events offer a unique platform for the exchange of knowledge, updates on the latest surgical techniques, and networking opportunities. Here are some reasons why the active presence of residents at such congresses is of paramount importance:

First, international plastic surgery congresses provide a broad overview of global practices and advancements. By attending presentations by renowned surgeons from different parts of the world, residents have the chance to learn about diverse approaches and clinical experiences. This enriches their knowledge and prepares them to become more competent and informed professionals.

In addition, exposure to a variety of clinical cases during these congresses is invaluable. Residents can witness complex case studies and their resolutions, which helps them develop problem-solving and critical-thinking skills. This practical experience is difficult to replicate in a classroom environment.

Interaction with colleagues and specialists from all over the world is another significant advantage. Exchanging ideas and experiences with people from different cultures and

health systems broadens the residents' perspective. This can lead to future collaborations and a deeper understanding of the needs and challenges faced in different regions.

Attending international congresses also helps keep residents up-to-date with technological and scientific advances in their field. Plastic surgery is a constantly evolving discipline, and exposure to new technologies and research is essential for cutting-edge medical practice.

Last but not least, the active presence of residents at international congresses contributes to the reputation and credibility of their institutions and countries of origin. This demonstrates a commitment to excellence and advancement in the field of plastic surgery, which can attract international collaborations and investment.

In summary, the participation of plastic surgery residents in international congresses is a fundamental part of their training and professional development. These events offer unique opportunities for learning, networking, and exposure to global best practices.

Therefore, encouraging and supporting residents' active participation in international congresses is essential for the continued progress of plastic surgery as a medical discipline of excellence.





ERICK ZUÑIGA GARZA, MD - MEXICO

Try it...

Have you ever felt that when you conceive an idea, the most critical person is yourself?

In our academic environment, once you overcome the most demanding judge, yourself, a series of questions come from your superiors. We all have heard things like:

- ...in other places, they do it better rookie...
- ...everyone is going to question why you did it...
- ...it's not such a good idea...

And so on...

Sometimes I perceive that we live undervaluing our own ideas.

A simple and original idea can be conceived on a night out with a friend, while you get a cup of coffee with another great mind, or at seeing the results of surgery in a patient.

In my case, my idea originated from seeing the happiness associated with a postoperative result which inspired me to do the research and propose an approach to share with my colleagues.

The right people supported, helped, and motivated me in the development of this idea, which culminated in the presentation of original research at the 14th European Plastic Surgery Research Council Meeting (EPSRC) (**Figure 1**), where dozens of original ideas were presented in a friendly, stimulating and innovative environment; where the ideas of young plastic surgeons, most of them residents (**Figure 2**), were eager to contribute to improving the quality of life of patients.

After this rewarding experience, I want to invite you, who take the time to read this, to develop your idea, hold on to it, make it grow, and share it with the world, because no one else but you will do it.

The ISAPS World Congress 2024, Cartagena, Colombia is on the way, and it will be the perfect opportunity to try it and share our ideas.

I hope to hear your idea soon!

Figure 1: With a great friend, at the 14th EPSRC meeting.



Figure 2: With a great friend, at the 14th EPSRC meeting.





GUSTAVO ABRILE, MD - ARGENTINA

ISAPS Residents Education and E-Learning Committee and National Secretary

PLASTIC SURGERY RESIDENCY: ARE WE PROPERLY TRAINING OUR PLASTIC SURGERY RESIDENTS?

In Argentina, very few plastic surgery services can provide comprehensive training that enables young plastic surgeons, who recently graduated from their residency, to enter a very competitive and diverse health system in terms of the environment that will develop their future as young professionals.

When we mention training, more than 90% of accredited hospitals or university training centers have a three-year residency in general surgery or traumatology as a requirement, therefore, a residency in plastic surgery acts as post basic, and implies three years, with the option of one more year as chief of residents.

The areas involved are classically:

- Burns
- Congenital Malformations
- Cranial-Maxillo-Facial Surgery
- Reconstructive Surgery Post Exeresis Oncologica Tumors of the Skin and Breast
- Trauma Upper and Lower Members
- General Principles of Aesthetic Surgery

This last area, aesthetic surgery, is perhaps where our residents register the least amount of training and warrants a re-evaluation of our training program.

In addition, two areas that are growing rapidly are post-bariatric surgery and gender reassignment, which involve an exhaustive and detailed study incorporating them into the training program.

In terms of the vision of training centers in Latin America, with the many idiosyncrasies of each country, the the issue had been the ability to streamline and collaborate the training across the differing countries.

Thus, during 2020-21, a group of Latin American hospital and university plastic surgery service leaders from Argentina, Uruguay, Chile, Brazil, Paraguay, Bolivia, Peru, Ecuador, Colombia, Venezuela, Panama, Mexico, Nicaragua, Portugal, and Spain, began to consider paths that would lead towards horizontal training in the respective countries, with the principal idea of providing knowledge and training in each of the areas, with experts, and experiences of residents with the guidance of their tutors. This education would be reflected in the papers presented in what we now call the **International Meeting of Plastic Surgery Residents**, with more than 300 papers submitted, and the participation of more than 950 Residents of Latin America (*Figure 1*).

To give continuity to this initiative, I suggest working with a modality of virtual meetings where experts develop approaches to plastic surgery pathologies in an exhaustive 6-8-hour intense training program one Saturday per month (*Figure 2*).

In this regard, ISAPS has been working diligently in virtual training, summoning international experts in aesthetic surgery and non-invasive procedures, to member residents, and inviting residents from all over the world, as well as junior and senior plastic surgeons to participate.

Federacion Iberolatinoamericana de Cirugia Plastica (FILACP), has undertaken a similar task, involving experts and residents



of Latin America, in virtual activities covering the entire spectrum of aesthetic and reconstructive plastic surgery.

It is necessary to see that each of the situations reveals the need to standardize training criteria, and fundamentally begin to consider where we are going in the future.

What do we consider a training program in aesthetic surgery should involve?

At our discretion are:

1. Minimally Invasive Procedures
2. Regenerative Medicine
3. Lasers and Technologies
4. Artificial Intelligence
5. Post-Bariatric Surgery
6. Assisted Endoscopy
7. Aesthetic Facial And Cervical Surgery
8. Aesthetic Breast Surgery
9. Body Contour Surgery
10. Female and Male Intimate Surgery
11. Gender Reassignment Surgery
12. Bio-Statistics, Photography, Diagnosis by Images

Strengthening inter-institutional ties, linking experts, senior plastic surgeons, juniors, and residents of all latitudes of the five continents, is the current challenge.

Figure 1: International Meeting Of Plastic Surgery Residents.

1 AL 5 JUNIO
PLATAFORMA ON-LINE

Coordinadores

| | |
|---------------------|------------------------|
| GUSTAVO ABRILE | ALFREDO DONNABELLA |
| ERNESTO MORETTI | ANTONIO PINTO OLIVEIRA |
| GONZALO FOSSATI | OSVALDO AQUINO |
| MONTSERRAT FONTBONA | BRUNO BALMELLI |
| RICARDO DELGADO | FRANCISCO GOMEZ BRAVO |
| JAVIER RUIZ BAREA | TIAGO BAPTISTA |
| LINDA LORENA RINCON | MAURICIO MENDIETA |
| ERNESTO BARBOZA | SANDRA GUTIERREZ |
| CELSO BOHORQUEZ | ALICIA SIGLER |
| MARCELA YEPEZ | MONICA TRIBALDOS |

ARG/BRA/URU - 17hs. VEN/CHI - 16hs.
MEX/COL - 15hs. ESP - 22hs. POR - 21hs.

Figure 2: Example of a training module.

REUNIÓN
INTERUNIVERSITARIA DE RESIDENCIAS
DE CIRUGÍAS PLÁSTICA
LATINOAMERICANAS

1 Módulo Mensual **7** hs

Módulo 6 Parálisis Facial

Sábado 4 de Septiembre
9 a 15 hs. Bs. As./ São Paulo



IN MEMORIAM

DR. ERIC AUCLAIR (1957–2023)



DR. ERIC AUCLAIR

written by Michel Rouif, MD

Dear ISAPS Friends and Colleagues,
Our dear friend and colleague Dr. Eric Auclair passed away on Saturday, November 4, 2023.

We are deeply saddened by losing a friend and a very enthusiastic colleague. Eric was 66 years old and had been practicing at a private practice in Paris, France, for over 30 years. He completed his internship in Paris at Interne des Hôpitaux de Paris and was a post-resident at Hôpital Boucicault in Paris, where he became inspired during his training by Drs. Vladimir Mitz and Raymond Vilain.

He was a very enthusiastic surgeon, traveling extensively and promoting the "French touch" all over the world. Eric was a very creative surgeon, always looking for new ideas, and he loved teaching the younger generation. During the last few years, he developed a hybrid breast augmentation and was revered as a leader in this specialty.

Throughout his career, he was involved in national plastic surgery societies. In 2012, he served as President of the French Society of Aesthetic Plastic Surgeons (SOFCEP) and was also very active in the French Society of Aesthetic Plastic and Reconstructive Surgery (SoFCPRE) as Co-Chair of the Aesthetic Chapter during the current term. As a respected Board Member, he was involved in the

European Aesthetic Plastic Surgery Society (EASAPS). Eric also dedicated much of his time to ISAPS in different capacities, including as Assistant Treasurer (2014-16) and as a European representative for the Education Council (2012-14). He also devoted his time as Committee Chair on the Fellowship Committee (2012-16).

He was an extremely skilled surgeon who liked getting directly to the point. During discussions with Eric, you had to be straightforward as he strived for efficiency, but at the same time, he was very humorous and energetic. He enjoyed life and was very close to and proud of his family.

As a member of the ISAPS community and family, we wholeheartedly express our condolences to his family and friends.

We will not forget you, Eric.

"The real grave of the deaths is the heart of the alive"
Jean Cocteau

Michel Rouif, MD
ISAPS National Secretary, France

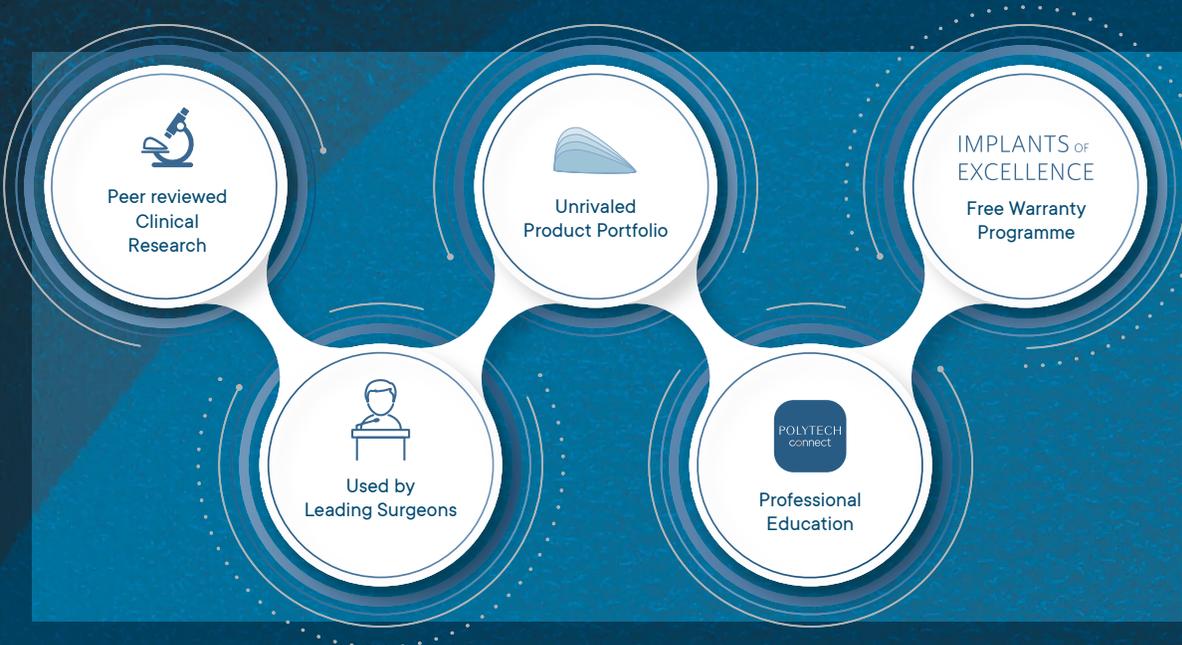


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ISAPS Welcomes New Members

October – December 2023

We would like to present our new members in a video slide show on our Instagram channel [@isapsplasticsurgeons](https://www.instagram.com/isapsplasticsurgeons). If you agree to be featured in our Instagram post, please email Monica Pucci from our social media team at media@isaps.org and send her a picture of yourself with a link to your Instagram account so we can follow and tag you.

If you have time, please send Monica a message (either in writing or in a video message) explaining why you have joined ISAPS and what you are most looking forward to. This quote will be added to the post and may be included in other marketing materials. Please confirm that you approve the publication with your name. Why not tell your followers and patients that you are a member of ISAPS? We would like to encourage you to add

[@isapsplasticsurgeons](https://www.instagram.com/isapsplasticsurgeons) to your Instagram bio.

Together, as the ISAPS Family, we are stronger. [#ISAPSFamilly](https://www.instagram.com/ISAPSFamilly)

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Dr. Gianluca Campiglio
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MEETINGS CALENDAR



Click here to see
upcoming ISAPS events!



2024

ISAPS OFFICIAL COURSE: INTERNATIONAL ISAPS FRESH CADAVER AESTHETIC SURGERY DISSECTION COURSE

Dates: January 18-20, 2024
Location: Liege, Belgium
Venue: University Hospital of Liege
Contact: Aurelie Geldhof
Email: info@isapscourse.be
Website: www.isapscourse.be

ISAPS ENDORSED: INTERNATIONAL BUTTOCKS ANATOMY MASTERCLASS (IBAM)

Dates: January 19-20, 2024
Location: Verona, Italy
Venue: ICLO Teaching and Research Center
Email: info@agora.clinic
Website: www.ibam.academy

ISAPS JOURNAL CLUB: ANATOMICAL BASIS FOR THE LOWER EYELID REJUVENATION

Date: January 27, 2024
Location: Online
Website: www.isaps.org

ISAPS ENDORSED: IMCAS LIVE AUGMENTED SURGERY & ANATOMICAL DISSECTIONS

Dates: February 2-3, 2024
Location: Paris, France
Venue: Palais de Congres
Contact: Anaelle Rajic
Email: a.rajic@gmail.com
Website: www.imcasurgery.com

ISAPS ENDORSED: 58TH BAKER GORDON EDUCATIONAL SYMPOSIUM

Dates: February 8-10, 2024
Location: Miami, United States
Venue: Hyatt Regency Hotel
Contact: Mary Felpeto
Email: maryfelpeto@bellsouth.net
Website: www.bakergordonsymposium.com

ISAPS ENDORSED: THE AMERICAN-BRAZILIAN AESTHETIC MEETING (ABAM)

Dates: February 8-12, 2024
Location: Park City, United States
Venue: Grand Summit Hotel
Contact: Grainne Gray
Email: ggray@sdevents.com
Website: www.americanbrazilianaestheticmeeting.com

ISAPS RESIDENT WEBINAR: BASICS IN HAIR TRANSPLANTS

Date: February 17, 2024
Location: Online
Website: www.isaps.org

ISAPS ENDORSED: SOS LIVE SURGERY SYMPOSIUM

Dates: March 8-9, 2024
Location: Cologne, Germany
Venue: Schloss Bensberg
Email: congress@bb-mc.com
Website: www.sos2024.eu

ISAPS JOURNAL CLUB: A NEW TECHNIQUE IN CALF VOLUMIZATION

Date: March 23, 2024
Location: Online
Website: www.isaps.org

ISAPS SYMPOSIUM: EL PASO LIVE SURGERY COURSE

Dates: April 4-6, 2024
Location: El Paso, United States
Venue: El Paso Cosmetic Surgery Center
Contact: Ozan Sozer
Email: ozansozer@gmail.com
Website: www.aesthetica.institute

ISAPS RESIDENT WEBINAR: THORAX AND ARM ANATOMY

Date: April 20, 2024
Location: Online
Website: www.isaps.org



THE AESTHETIC MEETING

Dates: May 2-5, 2024
 Location: Vancouver, Canada
 Email: registrar@theaestheticsociety.org
 Website: www.theaestheticsociety.org

ISAPS JOURNAL CLUB: A 7-STEP GUIDE TO HIGH-DEFINITION LIPOSUCTION

Date: May 18, 2024
 Location: Online
 Website: www.isaps.org

ISAPS WORLD CONGRESS 2024, CARTAGENA, COLOMBIA

Dates: June 11-15, 2024
 Location: Cartagena, Colombia
 Venue: Las Américas Convention Center
 Website: www.isapscartagena2024.com

ISAPS RESIDENT WEBINAR: BASICS IN BREAST AUGMENTATION

Date: July 6, 2024
 Location: Online
 Website: www.isaps.org

ISAPS JOURNAL CLUB: TOPIC TO BE CONFIRMED

Date: September 21, 2024
 Location: Online
 Website: www.isaps.org

ASPS PLASTIC SURGERY - THE MEETING

Dates: September 26-29, 2024
 Location: San Diego, CA
 Website: www.plasticsurgery.org

46TH ASAPS CONFERENCE

Dates: October 18-20, 2024
 Location: Brisbane, Australia
 Venue: Hotel W
 Website: <https://aestheticplasticsurgeons.org.au/event>

ISAPS RESIDENT WEBINAR: BASICS IN BREAST ASYMMETRY AND PTOSIS

Date: October 19, 2024

Location: Online
 Website: www.isaps.org

ISAPS JOURNAL CLUB: TOPIC TO BE CONFIRMED

Date: November 9, 2024
 Location: Online
 Website: www.isaps.org

ISAPS RESIDENT WEBINAR: BASICS IN BREAST REDUCTION AND POST-MWL

Date: December 7, 2024
 Location: Online
 Website: www.isaps.org

2025

AESURG 2025 SYMPOSIUM

Dates: March 5-6, 2025
 Location: Coimbatore, India
 Contact: Dr. James Roy Kanjoor
 Email: aesurg2025coimbatore@gmail.com
 Website: www.aestheticbodyclinic.org



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JANUARY 11, 2024

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