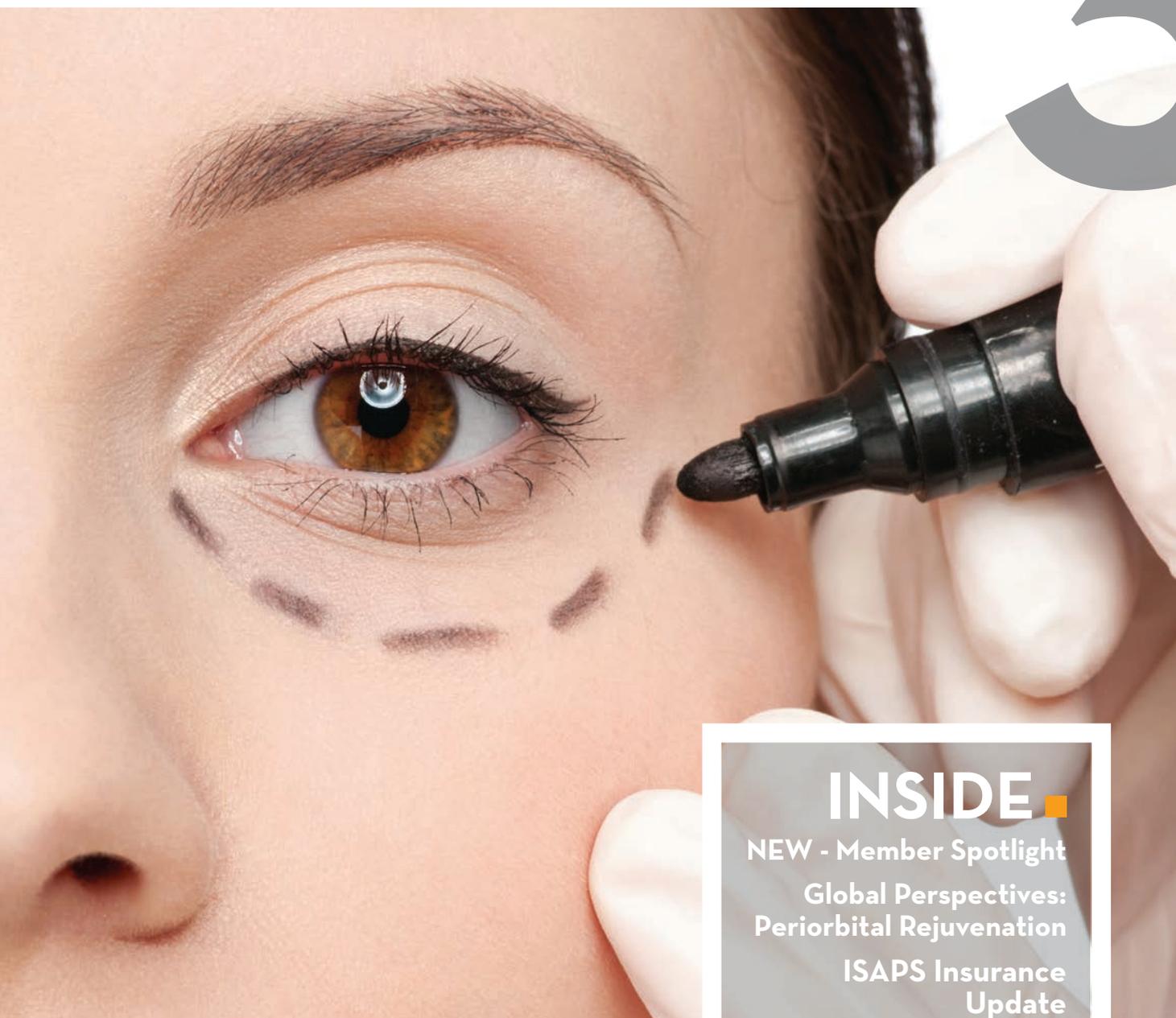


ISAPS NEWS

OFFICIAL NEWS OF THE INTERNATIONAL
SOCIETY OF AESTHETIC PLASTIC SURGERY

3

Volume 13 | Number 3



INSIDE ■
NEW - Member Spotlight
Global Perspectives:
Periorbital Rejuvenation
ISAPS Insurance
Update

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ISAPS

VOLUME 13

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MESSAGE FROM the Editor

Dear Colleagues,

Welcome to the third issue of Volume 13 of *ISAPS News*. Our focus topic is periorbital rejuvenation and we include outstanding articles detailing not only surgical techniques, but also adjuvant treatments including the use of lipofilling, hyaluronic acid, and chemical peels to optimize outcomes in this most delicate region of the face. Thank you to our contributing authors for their detailed and thoughtful submissions. Congratulations on your outstanding results.

We all know how physically demanding surgery is as a profession, for our hands, feet, backs, and eyes. Dr. Tyler Green has written an educational guest article on the effects of light color on eye strain. I encourage you to read his review which discusses the brightness measurement of various light sources with suggestions to help reduce eye strain and fatigue.

Dr. Adriana Pozzi has written another moving article on her humanitarian work with the Italian Association of Aesthetic Plastic Surgery (AICPE) in Togo. She notes that the real strength of a mission lies in being able to share daily life and tasks equally – an important message to remember for every case we perform regardless of location. AICPE Onlus is the non-profit satellite of AICPE and is open to ISAPS members who wish to join them on humanitarian missions. For more information, please visit the ISAPS website at: <https://www.isaps.org/medical-professionals/humanitarian-programs/>

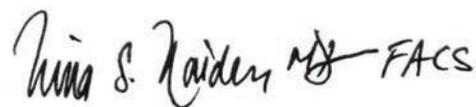
We are introducing in this issue a Member Spotlight article in which we will speak with some of our members who have significant side interests. For this inaugural article,



I interviewed our Associate Editor for the History of Medicine, Dr. Riccardo Mazzola, who owns the largest known collection of plastic surgery textbooks and art, including works by Vesalius, Da Vinci, and Tagliacozzi. Many thanks to Dr. Mazzola for his frank answers to my many questions and for his many wonderful articles on the history of plastic surgery.

The focus of our next issue will be non-invasive fat reduction. Tell us what you have been using in your practice, how you have been using it, what has worked, and what has simply been a waste of money. To contribute an article of 500-750 words, please forward it to ISAPS@isaps.org with the subject line: ISAPS NL Series. This should be a non-referenced opinion piece of several paragraphs giving your observations and perspectives on the topic. Photos are welcome, but must be high resolution JPG files attached, not embedded in your article. Please include photo captions.

We pride ourselves that *ISAPS News* is one of the most unique society newsletters in the world, but we can make it even better. Are there additional columns that you would like to see? Specific topics that you feel should be discussed? Let me know: drnaidu@naiduplasticsurgery.com.

A handwritten signature in black ink that reads "Nina S. Naidu MD FACS".

Nina Naidu, MD, FACS - United States
Editor-in-Chief



IT IS AND REMAINS A SERIOUS TOPIC:
GLUTEAL FAT GRAFTING. TIME AND
AGAIN, PATIENTS DIE AFTER SUCH
AN INTERVENTION FROM THE
CONSEQUENCES OF A MACRO- OR
MICRO-FAT EMBOLISM.



MESSAGE FROM the President

Dear friends, Dear members,

I hope you all had a wonderful holiday with great experiences and pleasant visits with family and friends.

I am happy to present to you again a nice edition of *ISAPS News* with many interesting articles, information and news about our society.

It is and remains a serious topic: **Gluteal Fat Grafting**. Time and again, patients die after such an intervention from the consequences of a macro- or micro-fat embolism.

We have been actively discussing this issue with our American friends and colleagues at ASAPS and ASPS as well as the fat societies IFATS and ISPRES. Should we advise our members not to carry out these procedures at all? Should we even get bans? We believe not!

Even if all plastic surgeons followed this recommendation or even a ban, others would not do so and the best trained plastic surgeons would no longer be available and would free up space for less trained or untrained colleagues. The only way is to educate our members comprehensively and

soundly on how such procedures can be performed as safely as possible and what needs to be considered. We are working intensively on online training modules that we want to make available to interested members. We think this is the right way.

Also, **BIA-ALCL** remains a big topic. Now that Allergan has recalled its textured Biocell implants worldwide, patients are becoming increasingly worried. The first lawsuits have already been filed and business-minded lawyers are offering their services. We can only suggest that you inform your patients comprehensively about this rare but treatable risk. Recommend regular checks to your patients and inform them about possible symptoms. Implant removal cannot be officially or scientifically recommended.

We have drafted a patient letter that you can download from our website and adapt and use according to your needs. A service from us for you. And for patient safety. Find it in the **About ISAPS** section under [Public Education](#).

Our Video Library is constantly evolving. New contributions are added almost weekly. From our many courses and webinars around the world, we

PLASTIC SURGERY

have provided you with the best selected materials to make digital learning possible for you anytime, anywhere. Take a look again!

There are some new books and videos available in our e-learning platform **MedOne**. This wonderful library is also growing continuously with the best new books from Thieme. At the moment you can upgrade your membership for \$350 and enjoy the most lightweight library available.

It is only one year until our **25th World Congress in Vienna** at the beginning of September 2020. It will be our 50th birthday, which we would like to celebrate with you extensively. We have invited over 500 of the world's best speakers to offer you a grandiose scientific and

social program in Vienna. September is beautiful in this extraordinary city – an ideal location to spend a few extra days in Austria. We are already looking forward to seeing you there!

I hope you enjoy the rest of the summer as well as reading, and browsing through this beautiful edition.

Sincerely,



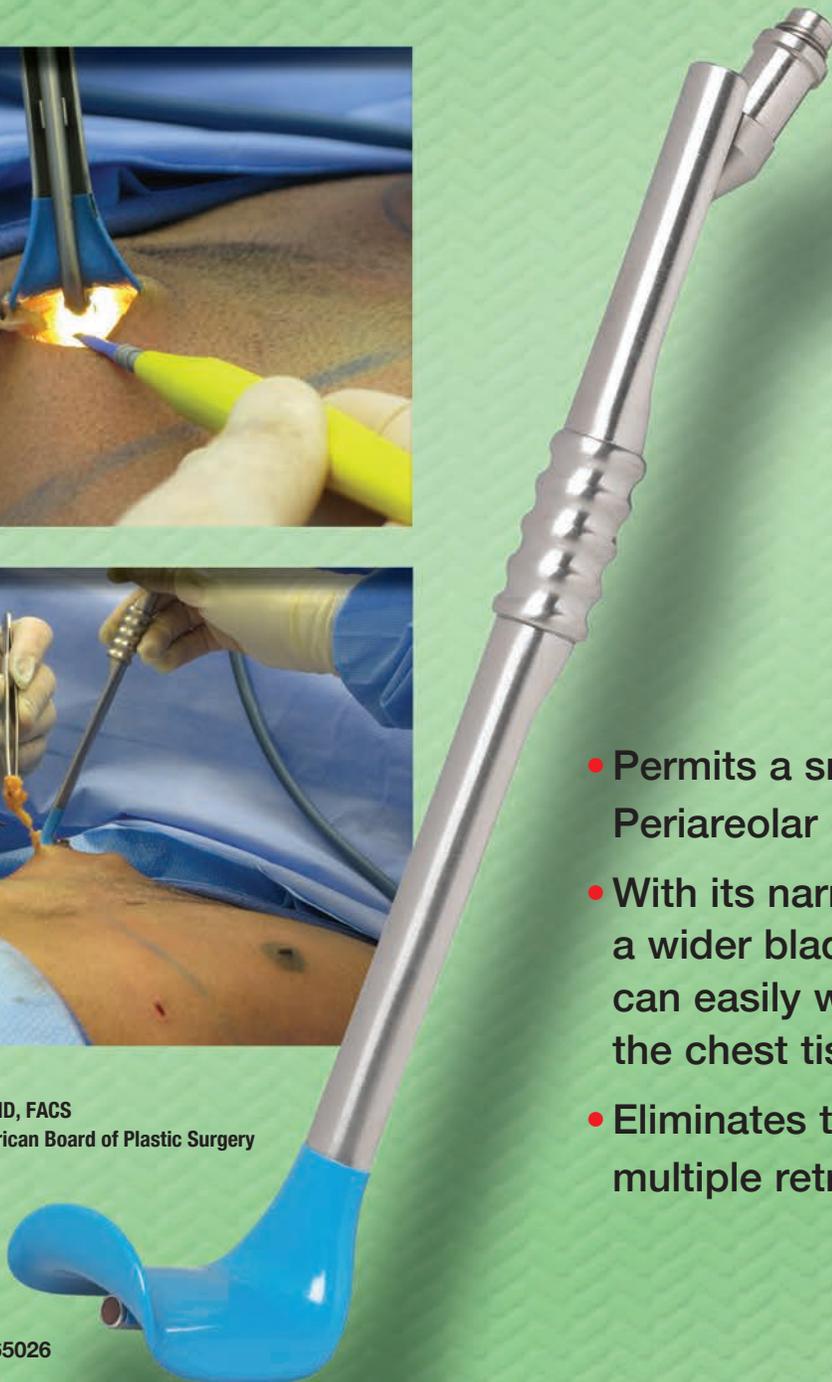
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2. **AUSTRALIA**
Australasian Society of Aesthetic Plastic Surgeons (ASAPS)
3. **AUSTRIA**
Österreichische Gesellschaft für Plastische, Ästhetische und Rekonstruktive Chirurgie (ÖGPÄRC)
4. **AZERBAIJAN**
Society of Plastic Surgery Azerbaijan (SPSA)
5. **BELGIUM**
Royal Belgian Society for Plastic Surgery (RBSPS)
6. **BOLIVIA**
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7. **BRAZIL**
Sociedade Brasileira de Cirurgia Plástica (SBCP)
8. **BULGARIA**
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9. **CANADA**
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11. **CHINA**
Chinese Society of Plastic Surgery (CSPS)
12. **CHINESE TAIPEI**
Taiwan Society of Plastic Surgery (TSPS)
13. **COLOMBIA**
Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)
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15. **CZECH REPUBLIC**
Czech Society of Aesthetic Surgery (CSAS)
16. **CZECH REPUBLIC**
Czech Society of Plastic Surgery (CSPS)
17. **DENMARK**
Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)
18. **DOMINICAN REPUBLIC**
Sociedad Dominicana de Cirugía Plástica Reconstructiva y Estética (SODOCIPRE)
19. **EASAPS**
European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
20. **ECUADOR**
Sociedad Ecuatoriana de Cirugía Plástica, Reconstructiva y Estética (SECPRE)
21. **EGYPT**
Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)
22. **ESAPS**
European Society of Aesthetic Plastic Surgery (ESAPS)
23. **FINLAND**
Suomen Esteettiset Plastiikkakirurgit ry. (SEP)
24. **FRANCE**
Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
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Georgian Society of Plastic Reconstructive and Aesthetic Surgery (GEOPRAS)
26. **GERMANY**
Vereinigung der Deutschen Ästhetisch Plastischen Chirurgen (VDAPC)
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35. **ITALY**
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37. **JORDAN**
Jordanian Society for Plastic and Reconstructive Surgeons (JSPRS)
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54. **RUSSIA**
Russian Society of Plastic, Reconstructive and Aesthetic Surgery (RSPRAS)
55. **SAUDI ARABIA**
Saudi Plastic Surgery Care Society (SPSCS)
56. **SERBIA**
Serbian Society of Aesthetic Plastic Surgeons (SRBSAPS)
57. **SERBIA**
Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPRAS)
58. **SINGAPORE**
Singapore Association of Plastic Surgeons (SAPS)
59. **SOUTH AFRICA**
Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
60. **SOUTH KOREA**
Korean Society of Aesthetic Plastic Surgery (KSAPS)
61. **SPAIN**
Asociación Española de Cirugía Estética Plástica (AECEP)
62. **SPAIN**
Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)
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66. **THAILAND**
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68. **UKRAINE**
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69. **UKRAINE**
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72. **UNITED KINGDOM**
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Vietnamese Society of Aesthetic and Plastic Surgery (VSAPS)

GLOBAL ALLIANCE

SPOTLIGHT ON MOROCCO



SOUAD TERRAB, MD - MOROCCO
ISAPS National Secretary for Morocco

The Moroccan Society of Aesthetic and Plastic Surgeons (SOMCEP) is a non-profit plastic surgery organization founded in March 2013. The members are exclusively board-certified plastic surgeons, practicing mostly Aesthetic surgery.

Our society is committed to several goals. First, to promote and uphold plastic surgery by contributing to the legal development of its practice by qualified practitioners. Second, to organize scientific meetings and encounters concerning plastic surgery, the promotion and the diffusion of its members' work and experience. Third, to secure the profession's compliance with international standards by ensuring continuous medical training for its growing scientific community. Fourth, to collaborate with other scientific societies – Pan Arab Society of Plastic and Reconstructive Surgery, IMCAS and the prestigious ISAPS.

Before the creation of SOMCEP, only three Moroccan plastic surgeons were ISAPS members. Immediately after, we submitted a fast track group registration, raising the percentage of ISAPS members to 25% of Moroccan plastic surgeons. SOMCEP is now an ISAPS Global Alliance member.

Our Society is the contact point with health authorities in our country. We were the privileged touch point during the



breast implants gate. The health authorities got in touch with us to take part to a public debate and we are proud of the very satisfying outcome that is compliant with ISAPS and ASAPS guidelines.

Our aim is to ensure that plastic surgeons continue medical training for junior as well as senior practitioners, sharing friendly plastic surgery tips and tricks among members, and developing the latest and most important topics concerning both invasive and non-invasive techniques.

THE HEALTH AUTHORITIES GOT IN TOUCH WITH US TO TAKE PART TO A PUBLIC DEBATE AND WE ARE PROUD OF THE VERY SATISFYING OUTCOME THAT IS COMPLIANT WITH ISAPS AND ASAPS GUIDELINES.

Since its creation, many medical meetings, workshops and hands-on activities have been organized by SOMCEP.

On September 28th and 29th, 2018 our first congress was held in Marrakech, with the participation of many Moroccan colleagues and some distinguished international lecturers. We tackled four main topics and conducted nine workshops. This first edition boasted 200 colleagues and 20 sponsors and was presented in French. Our strategy is to make our congress international; hence, the official language for the second edition is English. This meeting will be held in Marrakech on September 26th to 28th, 2019, providing live surgery as well as conferences and workshops. Faculty and speakers are renowned plastic surgeons from all around the world.

All the members of SOMCEP are looking forward to a fruitful collaboration with ISAPS by promoting international plastic surgery standards and hosting ISAPS courses.



Global Alliance

One of the first things I did as President of ESAPS was to sign the global alliance agreement with ISAPS on July 1, 2019. The Global Alliance is the perfect contact among regional and national societies and ISAPS. All organizations need to worry about patient safety and ethics. As a regional Society, ESAPS will concentrate on supporting these global goals. An example of this is the joint event we have organized in Bruges on the 17th to the 19th of October 2019 to include [the EASAPS/ESAPS congress on facial rejuvenation](http://www.easaps.org/bruges) while ISAPS organizes [the First ISAPS Resident and Fellow Congress](#). A fantastic educational event specifically for residents and young colleagues, with an outstanding faculty.

We hope to welcome many plastic surgeons to Bruges, experienced colleagues as well as residents and fellows, European national society presidents and board members as well as plastic surgeons without society affiliation, as long as all are willing to share and contribute to the common goal of education, patient safety and friendship in our specialty.

Conflict of interest?

Some colleagues fear a conflict of interest between ISAPS and ESAPS. Since ESAPS is a society of members, European plastic surgeons could favor ESAPS over ISAPS and drop their ISAPS membership. Others, especially in Europe, worry about ISAPS' influence on ESAPS (and EASAPS). In our opinion, there is no reason for these concerns.

The global orientation of ISAPS is different from the more local orientation of ESAPS. Europe has certain peculiarities that are specific for our continent, just as Asia, South America, Africa, the Middle-East and North America have the same. It is impossible for ISAPS to cater to everybody's needs; regional societies can do that much better. On the other hand, ISAPS has a fantastic education program, that is impossible for national and continental societies to duplicate; thus, we intend to complement ISAPS' educational activities with our expertise in regional matters. ESAPS can benefit from the knowledge and organization of ISAPS on education and ISAPS can take advantage of the local orientation of ESAPS. We believe that there is a very good synergy, where there is room for both types of organizations without a conflict of interest. This has been proved by working side by side on issues such as ALCL, the possible ban of textured breast implants and the safe approach to buttock fat grafting.

Ready to serve

We are ready to serve European plastic surgeons with an interest in aesthetic procedures and their national societies. It is our intention and goal to become [the European representative organization for this group](#). We hope to welcome many of you to Bruges and look forward to working for and with you.



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1. Duteille F. et al. Aesthetic Surgery Journal Open Forum 2019; 1(2). 2. The rupture rate was calculated as an actual rate per implant in the overall cohort. 3. The reintervention and capsular contracture rates were calculated as an actual rate per implant across all cohorts. © Copyright 2019 GC Aesthetics.

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EDUCATION COUNCIL UPDATE



VAKIS KONTOES, MD, PHD - GREECE
Chair, ISAPS Education Council

Although the previous three months in many countries around the globe coincide with the vacation period, the Education Council has accomplished a lot of structured and productive work.

The organization of our World Congress in Vienna in September 2020 is progressing at full speed. We have contacted selected faculty and have received replies from the majority of invited speakers. Several issues regarding the layout of the program schedule have been decided and soon we will come back to you with more details. We are looking forward to welcoming you to this exceptional event next September.

Moreover, at their New Orleans meeting in May, the Board unanimously approved a new meeting that in the future will be filling the gap between the World Congresses in the odd years and which we have named "ISAPS Olympiad." The 1st ISAPS Olympiad, a global meeting with a different format from the World Congress of our society, will take place in Athens, in September 2021. We have already confirmed the venue, an amazing location with many facilities, and soon will sign the agreement. More information for another outstanding event of our society will be available by the end of next year, as we are now gearing up to make our Vienna World Congress one more great success.

I am happy to announce a new ISAPS member benefit – **ISAPS travel insurance**. It is offered to ISAPS members teaching as invited faculty at ISAPS Courses all over the world and ISAPS Visiting Professors and covers the ISAPS members and their families when traveling together for

twelve months, worldwide, on both business and holiday travels. Through this benefit, ISAPS wishes to recognize the tremendous efforts of its traveling faculty members and keep them and their families safe during their trips.

ISAPS travel insurance is also included as a benefit for all ISAPS First members and available at reasonable cost for other member categories. For information, contact Alison Thornberry at: isaps@sureinsurance.co.uk

Before I move on to a brief description of the EC events that took place in the last three months, I would like to point out two issues related to the organization of ISAPS educational events worldwide, very useful for the local organizers of such events. One is about our Global Sponsor Program for industry that supports our visions financially. Among the benefits to which they are entitled, our Global Sponsors can request a free exhibit booth at a certain number of educational events. The Executive Office must request the space from the local organizer on behalf of the Sponsor and I would appreciate very much their kind cooperation, in view of honoring our commitments to our Global Sponsors. Here, I have to point out that no direct negotiation between the local organizers and the Sponsor is permitted, as it would only create difficulties and organizational problems. The Sponsors must first contact the Executive Office prior to any discussion with the local organizers who, if contacted directly, must refer the Sponsor to the Office.

The other issue is waiving registration fees for members at certain membership levels to attend Courses or Symposia worldwide. Again, the Executive Office will inform the local organizers regarding the procedure and settlement as ISAPS is obliged to pay the fees for these members. Our new membership structure, which has been enthusiastically received by our members, provides this type of benefit for certain levels and I would appreciate your cooperation in this matter.

In the months of June, July and August the Education Council was happy to support and organize ten endorsed meetings, two courses (St. Petersburg, Eurasian) and three webinars. The 2nd Module of the F.A.S.T. Program on Breast Aesthetic Surgery was also organized very successfully in Moscow. All these meetings and related information can be found in our Calendar of events on our website, which apart from the upcoming programs also stores previous events. For the months of September and October, five endorsed meetings and five Official ISAPS Symposia will take place all over the world. I am happy to mention the 1st ISAPS

Residents and Fellows Symposium which will take place in Bruges, Belgium in October. Many more confirmed educational events to come in November and December including the 3rd Module of ISAPS F.A.S.T. on body contouring in Moscow. Please visit our Calendar of events for more information. Our sincere thanks to all of you for supporting our ISAPS Education Mission from any position in the ISAPS family. We urge you to keep in close contact with us for any matter regarding educational issues in aesthetic surgery. We will be very happy to support and help your initiatives.



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ISAPS is excited to have you on board! As a thank you for your commitment to ISAPS, we are happy to insure you and your family for one year on all of your travels through the ISAPS Member Travel Policy.

The ISAPS Member Travel Policy is travel insurance for Member Surgeons and their families traveling abroad for a holiday, ISAPS educational courses, consultations, training and/or to perform surgery. A family member may include a mother, father, child, sibling, spouse or partner. Family members must be traveling with the Member to be covered.

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£50 for each 24 hour period spent in hospital.



PROPERTY & MONEY

Coverage for the loss, theft or damage of your accompanied property and/or money. Covers up to £10,000 limited to £3,000 for any single item, pair or set of articles and limited to £1,000 for money.



BAGGAGE DELAY EXTENSION

Coverage for up to £250 for purchase of immediate necessities in the event that your personal baggage is temporarily lost for more than 10 hours by the carrier.



LOSS OF PASSPORT & TRAVEL DOCUMENTS

Coverage for up to £250 towards any reasonable expenses incurred in obtaining a replacement passport, tickets or other travel documents if the originals are lost or stolen.



TRAVEL DELAY

£100 for every 12 hour period you are delayed.

Subject to Terms and Conditions*
*All Terms and Conditions will be provided and explained to each member invited to join the travel scheme.

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ISAPS VISITING PROFESSOR PROGRAM

CZECH REPUBLIC



JOÃO ERFON A. RAMOS, MD - BRAZIL
ISAPS Visiting Professor

In March 2018, I was introduced to Dr. Vladimír Marik by our mutual friend Dr. Fabio Nahas during the Jornada Carioca and GBAM Course in Buzios, Brazil. After the event, Dr. Marik visited Fortaleza, my hometown, where he attended my surgery to observe how I do a mammoplasty.

At that time, he invited me to teach as an ISAPS Visiting Professor in Hluboká nad Vltavou, a beautiful city in the region of South Bohemia in the Czech Republic.

Dr. Marik is the current President of the Czech Society for Aesthetic Surgery as well as ISAPS National Secretary in this country. He is also the head of the Plastic Surgery Service at České Budějovice Hospital and the beautiful Plastic Surgery Clinic RRC Clinic Hluboká nad Vltavou where he is also the Director.

My flight was via Paris and I arrived in Prague on July 26th in the afternoon. Dr. Marik was already waiting for me at the airport. We left the suitcase at the hotel and went on a city tour of Prague. Then we had dinner at the restaurant in the beautiful Dancing House building,



Figure 1 - Dancing House, Prague.

a symbol of democracy in the Czech Republic, designed by architect Frank Owen Gehry.

The next day, we traveled to Hluboká nad Vltavou,

155 km from Prague. We stopped for a visit at Tabor and its Castle (hometown of Dr. Marik) and for a snack. We arrived in Hluboká in the afternoon and at the entrance of the hotel we met the other invited teachers for the course, Drs. Joachim von Finckenstein (from Munich), Klaus Ueberreiter (from Berlin) and Pavel Kuriál Dr. Marik's partner who organized the course with him.

The same night, we visited together, along with their wives (Vladimír and Eva, Joachim and Cristina, Klaus and Anete, Pavel and Marcela, and I) the city of Krumlov, where there is a beautiful castle. After dinner, we watched an incredible ballet performance outdoors.

The 4th Castle Beauty Conference, organized by Drs. Marik and Kuriál, started at 9:00 am on July 28th at the RRC Hluboká nad Vltavou Clinic with three surgical demonstrations: 1) Reduction Mammoplasty - Dr. Klaus Ueberreiter aided by Dr. Marik; 2) Reduction Mammoplasty - me, assisted by Dr. Marik and Dr. Hedvika Janouškova, and 3) Fat Graft - Dr. Joachim Finckenstein, aided by Dr. Kuriál.



Figure 2 - 4TH Castle Beauty Conference - ISAPS Course, Hluboká nad Vltavou

The nurses, Radka Kozakova and Iveta Zeniskova, instrumented and organized the operating rooms. Also present were other members of Dr. Marik's team and Residents Drs. Tomas Votruba, Petr Polak and Jan Kasper. 48 plastic surgeons from the Czech Republic attended the course. All surgeries went well and met everyone's expectations with great results.

The next day, discussions of the previous day's surgeries and additional lectures were presented all day, including presentation of edited videos. My presentations included: Mammoplasty Reduction in a Single Central Block, Lipoabdominoplasty and Temporal Fascia Flap in Rhytidectomy, as well as discussion of the edited video of the surgery I performed. The other lectures were given by the Professors: Drs. Ueberreiter, von Finkenstein and Marik, and moderated by Drs. Marik and Kurial with plenty of time for discussion with all present.

The Course concluded with a wonderful dinner at the event hotel. I would like to draw your attention to the perfect organization by Drs. Marik and Kurial. I spent another two days in Hluboká visiting the sights, always accompanied by my hosts, including the incredible Hluboká Castle, the second most visited in the Czech

Republic. I also had the opportunity to see them both operating and prove that they are two excellent surgeons.

My trip to the Czech Republic was wonderful and I'm sure we made new and great friends. Sharing the Course with Klaus, Joachim, Vladimir and Pavel was a great honor for me. That's why I feel deeply honored to participate in this important ISAPS Visiting Professor program, led by Dr. Renato Saltz.



Figure 4 - The faculty: Drs. Marik, me, Ueberreiter, von Finkenstein and Kurial.



Figure 3 - The group that performed breast reduction: Drs. Janouskova, Erfon, Marik and the Nurse Kozakova.



Figure 5 - My visit to Hluboka Castle with my guide, Dr. Kurial.

FEATURE

PROBLEMS USING A HEADLIGHT IN THE BLUE SPECTRUM



R. TYLER GREEN, DDS - UNITED STATES
White Oak Dental Care, Conroe, Texas

We have known for many years that using high intensity blue light can cause fatigue and possible damage to the eyes. (Ref 2014 article).

With the increased use of headlights in surgical procedures – used to avoid shadows and improve the visual acuity of the surgeon – the blue light issues are again becoming a discussion of increasing concern. In response to the demand for brighter light, both LED and headlight manufacturers are moving the spectrum towards blue light. This causes our eyes to perceive it as a brighter viewing area.

In order to fully appreciate the critical nature of an increase in the blue spectrum, we need to explore properties of light that is defined as the photons striking an object and reflecting back to our eyes. There are two terms generally used to describe the brightness of light – lumens and lux.

Lumens, the more commonly recognized term, relates to the overall ambient light in your operating room which includes all overhead light sources in addition to the focused source light. In general, lumens are used as a measure of light for most consumer and industrial applications. In a typical room in your office or home, there may be 5,000 lumens. In a surgical suite setting, the lumens may be in the range of 10,000 - 15,000. A headlight in this instance would also be producing increased lumens when combined with the other light in the surgical suite.

Lux, on the other hand, is a very specific unit used to measure the amount of light that is shed on a specific object. With the advent of LED lighting, lux has become the standard for most surgical settings. Specifically, lux is the number of lumens in a square meter (1 lux = 1 lumen/m²). It is used to describe the power of the beam coming from a headlight; its measurement is not in relation to other light sources in the area. The measurement of lux (or brightness number) is so precise that its measurement is directly related to the distance at which the measurement is taken. For example, perhaps you have eaten at a restaurant where the ambient light was so dim you could not read the menu. As a result, you pulled out your cell phone to turn the flashlight on in order to see. If you held the flashlight over the menu, it would



Figure 1 - Blue spectrum.

increase the overall brightness of the area, and you could see the menu better. If, however, you were to move the light closer to the menu, you would notice it getting brighter.

In other words, the closer the light is to the object, the less the light diffuses, making the light appear brighter. As a result, the measurement of lux is taken at a specific distance and at a specific point to accurately determine its brightness number (i.e., the amount of light on a 3" circle at 16").

Since each light manufacturer uses different distances to measure their light output, it is important for you to consider your own working distance when choosing what type of light to use for surgery. For example, if a plastic surgeon is performing a rhinoplasty, his or her working distance may be around 12-16 inches. However, when doing deeper cavity surgery, the working distance can be as much as 20-28 inches.

Since most surgeons are performing various types of surgeries, it is important to consider the brightness measurement at various working distances. A single headlight should be able to shed enough illumination onto the working field at various distances to accommodate for the variety of surgeries you are performing.

With a better understanding of how light is measured, let's further explore the questions regarding blue spectrum headlights as originally set forth in this article.

Over the last 25 years in practice working with head mounted lights, I have been exposed to different light sources and wavelengths. I have used metal halide (typically brighter and bluer) and xenon lamps (typically warmer and yellower) with fiber optic cables along with LED headlights which, depending on the LED used, can have a cool (blue) or warm (yellow) wavelength.

From my experience, although the halide lights produce a large amount of bright light, having my head tethered to the wall was cumbersome and forced me to work within the limitations of the cord instead of what would allow me to best work for my patient. In addition, these fiber optic lights were so bright that I often had to "dial them down" to have an image I felt comfortable using. Furthermore, at the end of a two to four-hour procedure, my eyes hurt, and were so fatigued, it was difficult to focus. After years of wearing these lights, and my eye fatigue getting worse, I made the connection that repetitive use of the haloid light was causing irreversible excessive strain to the eyes.

In an effort to protect my deteriorating eye sight, and reduce the strain on my eyes, I started to research using LED lights. I bought a head mounted LED battery powered headlight and have never looked back! I saw an immediate reduction in both my neck and eye fatigue at the end of my day and was no longer tethered to the wall. However, over time, as my headlight needed replacing, I noticed that with the newer lights, the manufacturers were increasing the output of their headlights to match the older fiber optic box lights. With these brighter lights, I started to experience eye fatigue once again. When I switched to a warmer more color corrected headlight, the strain on my eyes was significantly reduced and I was able to focus on the treatment I was providing instead of fighting the strain.

I encourage you to try a "warm" version of your current headlight with blue light reduction and see if you notice a difference with regards to your eye strain.

Reference

Kaul, Rachna, et al. "Usage of Protective Eye Wear among the Dental Practitioners of Bengaluru City: A Survey with Review of Literature." *World Journal of Dentistry*, vol. 5, no. 1, 2014, pp. 17-20., doi:10.5005/jp-journals-10015-1251.

Dr. Green has been a consultant and lecturer for many loupe/light companies including Orascoptic, SurgiTel and Enova Illumination since 1993.



Figure 2 - Warm spectrum with blue filtered out.

1st Annual
SESPRS/ISAPS
**Periorbital & Facial
Symposium**

Best Practices on Video



January 23, 2020

Intercontinental Hotel, Atlanta, Georgia



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TOPICS

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- LOWER BLEPHAROPLASTY
- TREATMENT OF COMPLICATED PERIORBITAL CASES
- BROWLIFT
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GLOBAL PERSPECTIVES: FUTURE THEMES

December 2019: Non-Invasive Fat Reduction
Deadline: October 15

March 2020: Abdominoplasty
Deadline: January 15

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

Articles must be submitted as WORD documents.

HUMANITARIAN

APRIL 2019: MY FOURTH MISSION IN TOGO



ADRIANA POZZI, MD - ITALY
ISAPS National Secretary for Italy

During my last mission to Togo, I realized from the beginning that my companions were special people. Dr. Enzo Facciuto, a maxillo-facial surgeon from Naples, a member of the Italian Association of Functional and Aesthetic Surgery of the Face (AICEFF) on his second mission to Togo; Dr. Francesco Bellezza, a plastic and reconstructive surgeon from Rome, an Italian Association of Aesthetic Plastic Surgery (AICPE) member on his second mission to Togo; Marie Christine Laporte, our irreplaceable AICPE Onlus Secretary, with great experience in the humanitarian field, who teaches French to the children of Afagnan Hospital School and looks after diplomatic relations of our Charity; Valerio Santarelli, expert plumber, IT expert, expert cook, a really eclectic person; and Anna Maniero, Enzo's wife, a very enthusiastic person, ready to lend a hand in various situations. Last but not least, me on my fourth mission.

I would like to take this opportunity to underline how much the enthusiasm and good feeling among the participants of the mission is fundamental in order to face the daily work load with serenity. The real strength of a mission is sharing daily life and tasks equally, discussing clinical cases, and planning the best surgical approach.

Before our missions arrive, the monks usually send a notice to the population in the surrounding villages, and so many of them travel to the hospital to be examined by the visiting doctors. This mission was, from a surgical point of view, mainly oncological and reconstructive.



Figure 1 - The team socializing.



Figure 2 - And the team at work.

We had 15 cases of face surgery, 8 cases of lower and upper limb burn sequelae (most of them were children under 10 years) and 12 cases of minor surgery.

At the end of a day's surgery, when we thought we had finished, Sister Simona, who was still examining people, sent in more patients for minor surgery to keep us busy. In Afagnan, patients do not often have enough money to cover the cost of histological tests, so we help them and the costs are often covered by our charity.

As always, Sister Simona was a great help in patient planning and on our arrival, she introduced us to many patients on whom we would operate in the following days. She continues to be present, following up patients, updating us with the information and photos of the patients' conditions.

A few weeks after our return on April 10, we had some good news about the results of histological tests of a patient operated on for parotid cancer and simultaneous reconstruction with pectoral skin fascial flap. The tumor was completely removed.



AICPE Onlus is a non-profit association and a satellite of AICPE, the Italian Association of Aesthetic Plastic Surgery. It was founded with the aim of carrying out charitable activities to help disadvantaged people with particular attention to

developing countries. AICPE Onlus is included on the list of organizations that welcome ISAPS Members to join their missions on our website at: <https://www.isaps.org/medical-professionals/humanitarian-programs/>



Figure 3 - Five days post-op photo of our patient operated on for parotid cancer and simultaneous reconstruction with pectoral skin-fascial flap.



Figure 4 - The author operating on a little patient with a malar mass.

HUMANITARIAN

NEW HUMANITARIAN PROGRAMS



NINA NAIDU, MD - UNITED STATES
Chair, ISAPS Humanitarian Committee

Three more very special programs that combine surgery and training have been added to our list of humanitarian missions open to ISAPS members who wish to participate. There are now eleven such programs on our website at:

<https://www.isaps.org/medical-professionals/humanitarian-programs/>

The description of these three programs was provided by Dr. Naveen Cavale, the ISAPS National Secretary for the UK.

GAZA - Limb Reconstruction, post conflict trauma, mainly gunshots. Teams of six for short visits (entering via Israel), involving ortho and plastic surgeons, and undertaking complex limb reconstruction, using Taylor Spatial Frames and non-microsurgery based soft tissue reconstruction. This combines two charities who work together MAP (Medical Aid for Palestinians) and IDEALS (International Disaster & Emergency Aid with Long-term Support).

Gaza Plastic Surgery Curriculum Development and Board Certification Program - Connected to the above, to help

them set up their own Board Certification program, starting with up-skilling existing ortho and general surgeons. They only have one surgeon who is 'Board Certified' in Plastic Surgery, so they don't have enough trainers to produce more surgeons. This includes extra visits for plastics training, every two months, for one week at a time, of intensive training.

Tanzania - Limb Trauma Reconstruction (domestic trauma, mainly RTAs) and Pediatric Hand Burns Contractures (in association with the British Society for Surgery of the Hand). We have been once with the British Foundation for International Reconstructive Surgery and Training (BFIRST), the charity arm of BAPRAS, the UK reconstructive society. We hope to run regular one-week visits with ortho and plastic surgeons working together.

Contacts:

Dr. Naveen Cavale (UK) - naveen.cavale@nhs.net

Catherine Wilson - catherine@realplasticsurgery.co.uk

COMMITTEE REPORT

RESIDENTS AND FELLOWS



MARIA WIEDNER, MD - GERMANY
Chair, Residents and Fellows Committee

This time I want to give some more detailed information about two of our new babies. The first one is the ISAPS fellowship program, which we took over from DAFPRAS in June. We received more than ninety applications for 2020 and will send the invitation now to the 56 fellows who were selected. For more information on the **ISAPS fellowship program**, and how to download the fellowship application forms for 2021, please visit our website:

www.isapsresidentsandfellows.org

Our second new baby is the **1st Residents and Fellows Congress** in Bruges, Belgium on October 17th this year. This will be a whole day of basics in aesthetic surgery and tips on how to start an aesthetic plastic surgery office from

the business and legal side. Many members of our very experienced ISAPS faculty will teach you their favorite easy surgical techniques that they would recommend to a beginner in an aesthetic plastic surgery office. Have a look at the program and join us in this beautiful Belgian city!

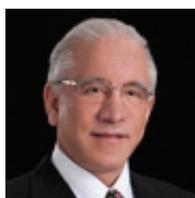
For more experienced colleagues, the EASAPS meeting will be interesting also. You can combine basic and advanced education on this trip. I hope to see you there and especially many of your younger colleagues from the plastic surgery training hospitals.

Find more information about both of these meetings at: www.easaps.org



ISAPS JOURNAL

MESSAGE FROM THE EDITOR-IN-CHIEF



BAHMAN GUYURON, MD - UNITED STATES

Thanks to many of you, submissions to the journal have increased significantly and the quality has been improving every year. You will read more discussions by the experts related to most articles and I am deeply grateful to these experts who take the time to review these articles and write meaningful discussions.

As the submissions increase, our need for reviewers rises as well. Those of you who wish to be involved and have the expertise to review articles, please send me an e-mail and we will register your name under the topic of your interest and seek your assistance in reviewing articles soon.

For those of you who are interested in learning about the review process, here is what happens. Each article needs a minimum of three reviewers. After the article goes through the initial process to assure that the submission meets the journal's standards, it reaches my queue. I then assign four reviewers and four alternate reviewers to each article. The invitations go out immediately and provide a specific deadline by which the reviewers must respond. When the reviewers decline the invitation or fail to respond within the allotted time, their name is removed and replaced with an alternate reviewer until at least three reviewers accept the invitation.

The reviewers are given two weeks to review the article. At the end of the two weeks, if at least three reviewers complete the process and submit their recommendations, I submit my decision based on the reviewers' recommendations. Should the allocated time elapse and a reviewer fails to submit their suggestion, the reviewer will be uninvited. My decision can be accepted after the first review, which is extremely unlikely as almost always the reviewers make some suggestions to improve the article.

The recommendation could be to reject. As much as I dislike doing so, I must follow the recommendations of the reviewers.

However, most articles are sent for a revision. The revised article is then sent for additional review by the same reviewers, except for the reviewer who recommends acceptance on the first review. If the reviewers are comfortable with the implementation of suggested changes and they recommend acceptance, the article will be accepted. In some instances, the article will be sent for additional revision, especially if the reviewers' recommended changes are not implemented by the authors after the initial review. Very rarely, the article is sent for a third revision, often because of the author's failure to comply. After the article is accepted, it is sent to production, galley proof reading, publication online, and then publication in print.

When a reviewer suggests a rejection, I look into the reasons and the reviewer's background to make sure that the rejection has compelling and valid reasons and the reviewer is not unnecessarily harsh. We make every effort to mend every article that has a meaningful message, but is written poorly enough to be rejected, so that it may become an article meritorious of publication.

We understand and appreciate the enormous time that the authors devote to conducting research, collecting and analyzing the data, preparing the manuscript, tables, and photographs, and submitting the article, and we are undoubtedly aware how disappointing it is to receive a rejection letter. We make every effort to minimize this negative outcome as much as possible, if the article has scientific merit.



MARKETING

SOCIAL MEDIA CULTURE IN PLASTIC SURGERY



SHEILA S. NAZARIAN, MD, MMM - UNITED STATES

It's a whole new era and the whole world, it seems, is on social media. Everyone is posting their before and after photos, glimpses into the operating room, and photos of their staff, but there are only a handful of social media stars in the aesthetic realm. What sets these physicians apart? What is so attractive about their online presence? And how do we, as colleagues, perceive them (and what does that say about us)?



I have been asked to write this article because of my success on social media, but instead of giving you tips and tricks, I want to give you a glimpse into my world instead. I spend about an hour and a half on social media daily. Instead of checking stocks, taking a lunch break, or watching TV, I do social media instead. I record every morning, before I start seeing patients, how many followers I have on each page and what influenced any stark increases in engagement or followership. Was the influencer (someone with influence on social media) who came in yesterday effective? Will the TV show that airs today be effective? I schedule a monthly photo/video shoot to have content for the upcoming 30-45 days. I show my interests, other than my job, to attract people into my office who are like-minded.

I will perform and show treatments on myself because that helps build trust and educate more effectively. Those videos get the most engagement because they are real and people want to see what I do. It can be a procedure, a meal, a vitamin, or a pilates routine. People want to know

your real life and the real you. I think this is one aspect of super-successful physicians on social media. Opening up your life and being that public is not for everyone, but in my experience, this is what sets me apart. It's me.

While social media success brings a lot of support and encouragement into my life, it has also brought about a fair share of resentment from my colleagues. While discussions happen behind closed doors, they always get back to me somehow. Colleagues will comment that I use "unfair tactics" to promote myself. I am assuming this means showing myself in an evening gown or on a vacation. Colleagues have said that I don't even operate anymore - that I just take photos of myself. Clearly, that is not true, but the real point is: why do we dislike some of our successful or cutting-edge colleagues? Why do we take the very people who are the most influential and can further the mission statements of our societies and shun them or ridicule them? Is it jealousy shrouded behind an ethical argument? Five years ago, many surgeons were above social media or billboard advertising, but I have seen the same surgeons on billboards and putting lots of effort into their marketing on social media since!

With this elephant in the room addressed, I would like to encourage everyone to support one another and remember that we have a common goal: remaining the experts that patients look to for advice and help. We have depended on our societies for so long to do this for us with political and social advocacy, but with social media, we all have influence - and a voice. If we band together and support one another, we can reach the masses and educate globally much more effectively and rapidly than ever before.

MARKETING

USING INFLUENCER MARKETING TO PROMOTE YOUR PRACTICE



WENDY LEWIS - UNITED STATES

The principle behind influencer marketing is fairly straightforward. When someone who is trusted by many people expresses a favorable opinion about a service or business, there is a reasonable chance that at least some of those people will take notice and become a customer.

In its infancy, influencer marketing was a relatively affordable way of getting the word out about a product or business, especially when compared to the cost of celebrity endorsements, TV spots, or print ads in glossy magazines. The explosion of social media, in particular the popularity of Instagram, has taken this marketing tactic to a whole new level. Being an ‘influencer’ is lining the pockets of high-profile people who are enlisted to convey a sponsored message to millions of their followers in seconds. Celebrities and reality stars are the largest group of influencers online. For example, the Kardashians have built their fortunes on it. Kylie Jenner is said to get paid a whopping \$1.26M for a single sponsored Instagram post to her 140M followers, while big sister Kim only commands a modest \$910,000 to broadcast to her 143M followers. Beyoncé gets \$785,000 in case you were wondering.¹

Social influence has shifted from brands to individuals, which has opened numerous possibilities for plastic surgery practices to engage with authentic social ambassadors to raise their online profiles. Today’s influencers are not necessarily supermodels, TV stars or even famous. They can just be real people who are active on the social channels that matter

to your practice and have developed a loyal audience. Their followers, who can range from a minimum of tens of thousands to hundreds of thousands, give them influence over others. Once you get up to the million mark, the fees for working with these influencers are cost prohibitive.

Choosing Brand Ambassadors

Influencer marketing has become intertwined with medical marketing in recent years. Just as companies have capitalized on the advantage of seeking out medical experts that carry weight in their fields, individuals who are willing to share their own experiences having a laser or a filler treatment with their followers can take your practice to the next level.

Consumers are flexing their own muscles through their social media accounts, primarily Instagram and YouTube. Many practices have seized the opportunity to network and collaborate with relevant individuals in their markets who can shape consumer opinions. These relationships may prove to be an invaluable component of comprehensive digital marketing strategy, if they are managed well.

The digital influence of ‘micro-influencers’ or ‘nano-influencers’ can drive awareness of the experience in a plastic surgeon’s practice, and thus boost new patient consultations and increased procedures. These ‘brand ambassadors’ have the ability to create compelling content to blast out to their own communities online and offline. Their ‘in real life’ experiences resonate with followers by adding a personal touch.



Consumers tend to trust the people they follow on social media.

With the current state of increasing competition for aesthetics patients worldwide, many plastic surgeons are experimenting with ways to forge valuable connections online. The way to do this is to seek out potential influencers who are local to your practice and share your values and aesthetics, with a following of greater than 10,000 as a starting point. Check out their profile, followers, and engagement (how many comments, shares, and questions each post gets). An account that has many thousands of followers yet low engagement (only a handful of interactions) can be a sign that the followers are fake and have no value. Take notice of any posts that are relevant, such as a plug for a skincare brand or a video of a spa experience. Initiate contact by engaging with the influencer in their platform of choice.

Think of it this way; influencer marketing can be compared to the digital version of word-of-mouth. When I started out in plastic surgery managing an elite practice on New York's Fifth Avenue in the 1980s, word of mouth was the only marketing we needed to have a crowded waiting room and full surgical schedule. Having someone talk about you to their circle of friends is still a powerful tool; however, as social media has become immersed in every aspect of our lives, it has naturally evolved as the method of choice. Influencers can be very effective as defacto salespeople because consumers tend to trust the people they follow on social media. We self-identify more with our friends and peers than with footballer's wives or stars on 'Strictly Come Dancing.'

For many practices, their influencers of choice may range from a loyal patient who is killing it on Instagram, the owner

of a popular salon, spa, or gym that refers clients to you, an in-demand makeup artist, or minor celebrity in the community. The type of influencers that are most attainable for plastic surgeons tend to be normal people who are switched on about aesthetic treatments and live within a 60-mile/92-kilometer radius. In the Middle East, for example, a single Instagram post from a model or a singer can put an aesthetic practice on the map.

Legalities of Influencer Engagement

When working with influencers, there are rules that need to be adhered to by both parties, and it is best to have it in writing at the outset. A contract should itemize exactly what is expected from the influencer and the time frame; for example, two Instagram posts, one Instagram story, two tweets, or one YouTube video. This will also require the usual consent forms and local regulations on patient privacy that are to be adhered to. The influencer is responsible to disclose any monetary, product/treatment compensation or both, as in free lip filler or a non-invasive fat reducing laser treatment. Social media audiences appreciate authenticity and being honest up front will make them more likely to believe the influencer's content. This is typically done in the form of adding hashtags to their posts to delineate some kind of financial relationship, such as: #sponsored #spon #ad.

These rules will vary by geography, but in general, it is best practice to adhere to this policy. If you are not sure how this works, consult with a legal expert on disclosure guidelines to be safe. Influencer marketing appears to be widespread at least in some English-speaking countries, such as the US, UK, and Canada. It can be perfectly ethical as long as disclosure is clear and consistent, depending on your market.

Influencer marketing is less direct than traditional forms of marketing and advertising, but it can effectively create authentic ways of connecting with consumers who may ultimately become your patients.

Wendy Lewis is Founder/President of Wendy Lewis & Co. Ltd., a marketing communications boutique in New York City since 1997. She is the author of 13 books, a frequent contributor to many journals, textbooks and websites in the US and Europe, and her next book "Growing an Aesthetic Surgery Practice: A Modern Roadmap for Success" shall be published by Thieme.

¹HopperHQ.com



PERIORBITAL REJUVENATION



MOKHTAR ASAADI, MD - UNITED STATES

GLOBAL PERSPECTIVES

MANAGEMENT OF FAT IN LOWER BLEPHAROPLASTY

Management of the fat of the lower eyelids depends on preoperative evaluation of the fat in three compartments of the lower lids. Lateral fat pocket of the lower eyelids should be removed aggressively in every case.

Lateral fat of the lower eyelids is different from fat of the nasal and middle fat compartments. Lateral fat bulging is frequently seen in patients who had previous lower blepharoplasty. Removal of the lateral fat is done by making a small incision on the septum over the lateral fat compartment that we call the SEPTAL WINDOW. Excision or transposition of the nasal and central fat is done according to LATERAL PULL TEST (LPT).

LPT is done by pulling the lower eyelid laterally and

upward by surgeon's index finger. If fullness and bulging of the nasal and central fat goes away by LPT, no fat is removed from the nasal and central pockets. This is called NEGATIVE LPT. If there is bulging in the nasal and central pockets, some fat has to be removed from these pockets depending on the surgeon's judgment. This is called POSITIVE LPT. Hollowness of lower lids are also evaluated.

FROST SUTURE: 4/0 silk suture is applied to the lower lid margin, two bites are taken from the grey line of the lower lids, and the loop suture is kept in upward traction by mosquito clamp.

SEPTAL RESET: In order to correct nasojugal groove and lid/cheek junction, arcus marginalis is opened from lateral

ORBITAL SEPTATION

to medial direction at the level of inferior orbital rim or slightly above it. Orbital septum is thick laterally, where it is wide and becomes thin medially and is narrower. In older patients with more laxity of the orbital septum, it is opened 2 to 3 mm above the inferior orbital rim. In younger patients with less laxity of the orbital septum, it is opened right at the level of the inferior orbital rim. Since the orbital septum is narrow medially, the opening incision of the arcus marginalis medially is done very close to the orbital rim in order not to create too much tension of the septum after septal reset and prevent postoperative lid retraction.

Fat excision is done for the fat in medial (nasal) or central pockets if LPT was positive, otherwise no fat is removed from nasal and central pockets and they are transposed for correction of nasojugal grooves and lid/cheek junctions. Septum is sutured with 6/0 clear nylon suture from the medial to the lateral direction in continuous fashion. Medially superficial bites of the medial origin of the orbicularis muscle are taken and septum, from the level of the pupil, is sutured to the fat below the inferior orbital rim or SUBORBICULARIS OCULI FAT (SOOF). Suturing of the septum ends at the level of the septal window.

FROST SUTURE is keeping the lower lid in upward traction while septal reset suture is done to prevent too much tension of the septum and prevent postoperative lid retraction. After completion of septal reset, Frost suture traction is released and there should be smooth surface appearance of the septum over the fat pocket. If slight bulging is noted, the septum can be made tighter by the Colorado electrocautery tip gently touching the bulging of the septum. SEPTAL WINDOW is not closed and if any fat is bulging through it, it is removed to be sure no fat is left in the lateral fat pocket. This part of the procedure is like hernia repair where the content of the hernia, meaning the periorbital fat, is repaired with orbital septum.

Kenalog 2.5 mg is installed under the skin/muscle flap and care is taken to avoid Kenalog spilling into the eyes.

CANTHOPEXY &/or CANTHOPLASTY: posterior lamella or capsulopalpebral fascia tightening is done when indicated - when there is decrease tone of lower lids.



68-year old female - Upper/Lower Blepharoplasty



65-year old male - Upper/Lower Blepharoplasty

PERIORBITAL REJUVENATION

WITH MIXED PEELING



SERGIO CAPURRO, MD - ITALY

Periorbital rejuvenation is carried out by means of the following techniques: upper blepharoplasty and lower transconjunctival blepharoplasty; 0.5 mixed peeling and mixed peeling with de-epithelialization; subcutaneous and intradermal (crows' feet) cellular adipo-filling; malar volumetric adipo-filling; malar elastic lifting; elastic MACS lifting; elastic lifting of the eyebrows and temporal region; and elongation of the eye with elastic thread (without surgery of the external canthus). In this article, we will only deal with mixed peeling procedures. We use the term "mixed peeling" because these procedures combine physics (a programmed high-frequency current) with chemistry (a solution of resorcin in water).

0.5 Mixed Peeling of the Upper Eyelid with Permeabilization

In selected cases, the upper eyelids can be rejuvenated by means of 0.5 timed surgical mixed peeling. This safe, new, strong peeling technique has the advantage of conserving the volume of the eyelid and yielding natural results after only one treatment session. Unlike traditional blepharoplasty, this non-surgical blepharoplasty avoids the risks of surgery: scars and asymmetry. Moreover, in medium-sized and large orbits, 0.5 mixed peeling does not result in "doll's eyes" or scrawny eyelids which contrast with true rejuvenation. Although 0.5 mixed peeling is a strong peeling technique, it does not carry the risks of strong peeling.

Technique

The specific pulsed programmed emission of the programmable diathermocautery makes the epidermis permeable. Program data: Direct Pulsed 0.5/24.5 hundredths of a second, Coag, 38 Watts, EM15 (1.5 mm diameter).

Permeabilization is carried out on the entire surface of the eyelid, from the eyebrow to 1 mm from the eyelashes (**Fig.1**). This physical phase, in which the Timed apparatus



Figure 1 - The specific pulsed emission makes the epidermis permeable.

(Korpo) is used, is followed by a chemical phase. A saturated solution of resorcin is applied to the eyelids for 4-6 minutes, until a uniform layer of intense frosting forms (**Fig.2**); it is then washed off with physiological solution. Resorcin has no effect on intact skin but is extremely effective on areas where the epidermis has been made

permeable. After 4 - 8 weeks, the eyelids appear naturally rejuvenated and without artifacts (Fig.3).

Mixed Peeling of the Lower Eyelid with De-Epithelization

Mixed peeling with de-epithelialization can be used to eliminate the effects of aging on the skin of the lower eyelids; these effects may range from slight roughness to evident wrinkles and large folds. The effects of skin aging in the palpebral region are difficult to correct by means of surgical techniques. However, if the overall appearance of the face is to be successfully rejuvenated, skin aging of the eyelids needs to be treated. Mixed peeling also eliminates dark circles under the eyes.

Technique

Program data: Direct Pulsed 4/9 hundredths of a second, Coag, 2 Watts, EM10 Yellow (1.5 mm diameter).

De-epithelialization is carried out with the edge of the angle of an EM 10 Yellow electromaniple (0.20 mm diameter). The operator bends the electrode in order to obtain a suitable surface. The angle of the electrode brushes the skin in small circular movements. The specific current of the timed apparatus detaches the epidermis from the dermis, while preserving the integrity of the dermal papillae and of the capillary-papillary complex (Fig.4).

On completion of de-epithelialization, a saturated solution of 50% resorcin is applied. After about 30 seconds, "frosting" will be seen (Fig.5). The resorcin is then removed by means of a gauze soaked in physiological solution. A thin crust forms after a few hours. Creams and other substances must not be applied.

Conclusion

Mixed peeling helps to restore the natural youthful appearance of the eyes (Fig. 6). Timed surgery is a section of CRPUB.ORG Open access Medical Video Journal.

At the end of the 1970s, programmed diathermosurgery was invented and the first programmable diathermocautery was made (Capurro 1979, USA patent US4352357). The author is a shareholder in the Korpo Society that produces the Timed apparatus.



Figure 2 - A saturated solution of resorcin is applied to the eyelids for 5 minutes.



Figure 3 - Result of non-surgical upper blepharoplasty in only one session of 0.5 timed surgical mixed peeling



Figure 4 - De-epithelialization preserves the integrity of the dermal papillae.



Figure 5 - A saturated solution of 50% resorcin is applied for about 20 seconds. The frost is perfectly uniform.



Figure 6 - Result of mixed peeling.

BROW PTOSIS VS BROW LAXITY:

THE RELEVANCE OF BROW FIXATION IN UPPER BLEPHAROPLASTY



GIANLUCA CAMPIGLIO, MD, PHD - ITALY
ISAPS Second Vice President

Introduction

Eyebrow shape and position are of primary importance to orbital youthfulness and attractiveness. In the past, many scientific papers described brow aesthetics in detail including gender differences, namely that the brow is usually lower and less arcuate in males.

In my opinion, we can differentiate two clinical conditions: brow ptosis and brow laxity.

In brow ptosis, the position of this anatomical structure is lower than the ideal and contributes to skin excess in the upper lid. Treatment can be non-surgical as in the case of Botox® injections and threads, or surgical using an open or closed (endoscopic) brow lift, or performing a direct skin excision.



Figure 1 - Supero-lateral brow fat pad.

In brow laxity, the position of the brow is still aesthetically acceptable, but can be worsened following an upper blepharoplasty. This negative consequence can occur as a result of 1) the tension on the wound



Figure 2 - Preoperative test showing the laxity of the eyebrow.

after skin resection, 2) the contraction of the hyperactive depressors, 3) the relaxation of the frontalis muscle following the resolution of the blepharochalasis and 4) gravity. Two factors can predispose to this downward brow displacement: a congenital weakness of the suspending orbital ligaments and an excessive brow heaviness due to the presence of a hypertrophied supero-lateral eyebrow fat pad.

Treatment for brow ptosis is brow lift while correction of brow laxity is brow pexy. Indeed, in medical terminology the suffix “pexy” means surgical fixation.

I perform my browpexy using the transpalpebral technique originally described by McCord and Doxanas in 1990.¹



Figure 3a - Dissection of the soft tissue at the level of the superolateral orbit in a suborbicularis plane.

Surgical Technique

Upper blepharoplasty is marked with the patient standing in front of the surgeon. A slight upward traction of the brow with the non-dominant hand eliminates the effect of the brow laxity and helps to plan a correct skin resection. On the operating table, upper lid surgery is performed removing conservatively the medial and central retroseptal fat pads and preserving the bulk of the orbicularis muscle.

Holding the upper margin of the wound with a double hook, the sub-orbicularis space beneath the lateral half of the brow is dissected. Usually one or two big veins (sentinel veins) must be coagulated laterally. The ideal position of the brow is marked being for female patients up to 1.0-1.5 cm above the orbital ridge with the lateral extension of the brow a little higher.

A resorbable stitch is passed from outside the lower row of hairs of the brow and is recuperated inside, thus indicating on the deep surface of the flap the exact position of the brow. The needle is passed again through the soft tissues where it emerges and the tail of the stitch is recuperated. The suture catches the orbital soft tissues in correspondence of the marking and the knot is closed. Usually two or three sutures are used to block the position of the brow and prevent its inferior displacement. Differently from the upper blepharoplasty without browpexy, the wound has to be closed with a significant tension so one or two subdermal resorbable sutures are used to prevent the dehiscence of the scar especially in its lateral part. A compressive elastic dressing is used for 24 hours to reduce the risk of hematoma. Sutures must be removed 48 hours later than usually done for a traditional blepharoplasty. Browpexy can be

associated to transpalpebral corrugator resection or lateral canthopexy. Apart from asymmetries of brow shape and/or position, another common complication is the presence of a skin dimple that usually resolves spontaneously once the internal stitches are resorbed.

Conclusion

Eyebrow and upper eyelid aesthetics are intimately related as the ones of the lower lid and the cheek. Laxity and heaviness of the brow must always be carefully evaluated preoperatively along with its shape and position. In younger patients, mainly female, a standard upper blepharoplasty is enough to obtain satisfying and stable results. If the patient requires also an elevation of brow position, a browlift is the procedure to be selected. On the other hand, if brow laxity is preoperatively evidenced, as happens often in older and male patients, a traspalpebral browpexy is useful to prevent the descent of the brow in the postoperative period and persistency of lateral hooding.

Reference

McCord C. and Doxanas M. BROWPLASTY AND BROWPEXY: AN ADJUNCT TO BLEPHAROPLASTY. *Plast Reconstr Surg*, 86:248-254; 1990



Figure 3b - The resorbable stitch is passed from the outer surface of the skin at level of the lower row of brow hairs.



Figure 3c - The stitch is passed again on the deep layer of the flap and its tail is recuperated.



Figure 3d - The suture catches the orbital soft tissues over the orbit at the level previously marked.



Figure 4 - Browpexy can be associated with transpalpebral corrugator resection.



Figure 5 - A skin dimple, due to a too superficial fixation, can temporarily complicate the procedure.



Figure 6 - Lower blepharoplasty and upper blepharoplasty with browpexy in case of a heavy and lax eyebrow.

UPPER EYELID BLEPHAROPLASTY REVISITED



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ALAN MATARASSO, MD - UNITED STATES

Periorbital aging is a common presenting complaint of the aging population. Typically, this may include a combination of the upper and lower eyelid, as well as brow changes. The upper eyelid blepharoplasty remains a workhorse operation for plastic surgeons. The straight forwardness of this procedure, combined with its low risk profile, produces effective results in patients seeking periorbital rejuvenation. Although assessment of the whole eye and brow complex is vital when speaking of periorbital rejuvenation, we will focus here on the upper eyelid.

Patient History and Physical Exam

A thorough history and physical exam are required for each patient. Specific areas to note include; the brow (asymmetry and ptosis), upper eyelid dermatochalasis, and eyelid ptosis. Further aspects of the upper eyelid to assess include fat pad pseudo herniation and lacrimal gland ptosis.

To assess whether a brow ptosis is present, one may perform a lifting test (Figure 1). Here, the examiner blocks the frontalis muscle with their hand or elevates the brow. If the brow is in a lower position in relation to the supraorbital rim with the frontalis blocked, then brow ptosis is present as the muscle is unable to compensate for brow descent, or elevate the brow to the desired position.

In males, the brow should be at the level of the supraorbital rim, whereas in females, the location of an unadorned eyebrow should be approximately 1cm above the rim. Other factors to look for include static rhytids in the forehead, which also points to compensated brow ptosis. Brow ptosis should be pointed out to the patient preoperatively as upper eyelid blepharoplasty alone may not satisfy their goals of improving lateral eyelid hooding or aspects related to brow descent. This is particularly evident when, in conversation, patients push up their eyebrow stating what they want eyelid surgery to accomplish.

Eyelid ptosis should be assessed with all upper eyelid evaluations. If ptosis is present, this can be corrected at the time of surgery.

Technique

Markings are performed with the patient in the upright position. A dot is placed on the medial and lateral ends of the skin crease on each side. The supratarsal fold is identified. One can take note as to where the skin becomes thicker or changes color, which is the junction of the eyelid and eyebrow skin, and is where the upper skin excision is demarcated. Skin resection is then verified via a pinch technique with a pair of smooth forceps by asking the patient to open and close their eyes. The area is then injected with 1% lidocaine with epinephrine,

which aids in vasoconstriction, pain relief, as well as hydrodissection. After waiting for the vasoconstrictive effect of epinephrine to take place, the initial incision is made, and the excision proceeds from lateral to medial. After the skin is removed, a small cuff of orbicularis is removed (approximately 0.5cm) at the medial aspect, in order to expose the post septal medial fat pad. A judicious amount of fat is removed based on the patient's anatomy. If a herniated lacrimal gland, which has a grey color compared to the post septal fat, can be addressed with a "pexy" to the underlying orbital periosteum with a 6-0 Ethibond.

After one side is completed, a sponge soaked in epinephrine is placed on the wound and the other side is addressed. The surgeon applies electrocautery to a Colorado tip or Jewlers forceps to create a deeper crease on the supratarsal fold. The wounds are then closed either in a subcuticular manner or running fashion with a 6-0 nylon. Steri strips are placed over the wound.

Post-Operative Care

Patients are asked to elevate their head and apply cold compresses to minimize bruising and edema. Typically this will last up to a week. Sutures are removed at 3-5 days.

Complications

Complications are uncommon, but can include asymmetry, residual lateral hooding, hollowed appearance of the orbit, scar contracture, hypertrophy of the scar, particularly medially, and lagophthalmos. This scar formation medially can be addressed with early and aggressive massaging. Rarely, a retrobulbar hematoma may develop, and this is considered a surgical emergency. A thorough preoperative evaluation and discussion with the patient as well as meticulous surgical planning and technique will obviate the many potential problems.

Conclusion

The upper blepharoplasty is a safe, effective technique with low risk and a high degree of patient satisfaction. It is valuable to incorporate this as a component to periorbital rejuvenation and to take into consideration the brow aesthetics in order to achieve optimal results.

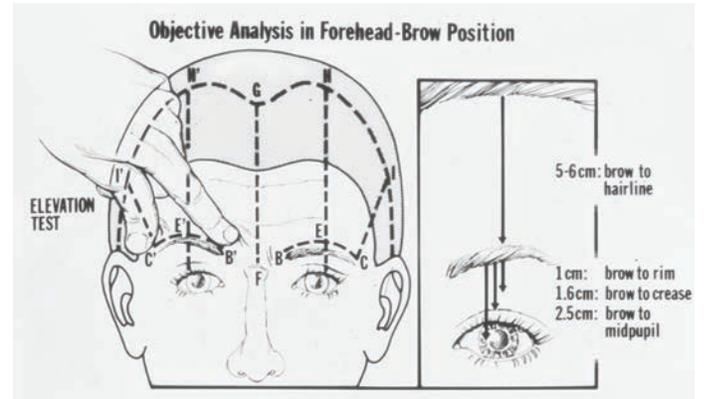


Figure 1 - Elevation Test



Figure 2a - 69-year-old female shown here 1-year post operatively from an upper blepharoplasty and short scar face lift. AP View.



Figure 2b - 69-year-old female shown here 1-year post operatively from an upper blepharoplasty and short scar face lift. Lateral view.

PERIORBITAL REJUVENATION

SURGICAL AND MINIMALLY INVASIVE APPROACHES FOR THE AGING PERIORBITA



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Periorbital rejuvenation demand has increased over the years and includes minimal access approaches, but also deeper dissections. Periorbital aging presents as volume loss, skin laxity and fine rhytides.

The most ideal approach would be the one to offer the longest lasting results with the fewest complications and achieve high patient satisfaction.

Surgical Procedures

According to the American Society for Aesthetic Plastic Surgery’s National Data Bank Statistics (2018), blepharoplasty was the 5th most common aesthetic surgical procedure, with approximately 115,000 procedures performed in the United States.

• Upper and Lower Eyelid Blepharoplasty

The techniques used in upper eyelid surgery are highly variable with a trend towards skin excision only and volume restoration recently. Markings are made with the patient in

the upright position and in neutral gaze. The tarsal crease is identified, and the inferior and superior markings are drawn. Medially, the markings end lateral to the medial canthus.

The procedure is performed in the office under local anesthesia. A clinical result of an upper eyelid blepharoplasty is shown in Figure 1.

Surgical lower eyelid rejuvenation involves addressing the redundant compartmental fat, and also the redundant skin. To prevent septal manipulation and incision, a combination of the transconjunctival approach to remove excess fat, and the pinch blepharoplasty to remove excess skin may be used with good clinical results as shown in Figure 2.

• Fat Grafting of the Upper and Lower Orbit

The areas to be grafted are marked in a topographic manner and are reviewed with the patient. Syringe liposuction is utilized for fat harvest until an appropriate amount is obtained for the fat grafting. The fat is strained for preparation, centrifuged, and placed into syringes. An 18-gauge needle is used to gain access and fat grafting is then performed using blunt tip cannulas, with micro fat grafting to the areas that had been marked. In all cases, the index finger of the nondominant hand is used to protect the globe.



Figure 1 - Preoperative frontal view of a 66-year-old female with upper eyelid dermatochalasis (above). Image obtained at 2 months follow up after bilateral upper eyelid blepharoplasty (below).

For treating the hollow upper orbit, the injection cannula is passed parallel to the globe and supraorbital rim. Typically, 2 cc of fat is injected per side in a suborbicularis and preperiosteal plane.

For treating the infraorbital area, the fat is injected in a suborbicularis and preperiosteal plane. 3 cc of fat is typically injected per side, perpendicular to the infraorbital rim.

Minimally Invasive Procedures

- **Ablative Laser Skin Resurfacing, Intense Pulsed Light (IPL) and Platelet Rich Plasma (PRP) Injections**

Facial rejuvenation and wrinkle reduction are approached with a combination of fractional Erbium ablative resurfacing (2940 nm), intense pulsed light and platelet rich injections of the periorbital region. One pass of the IPL is performed followed by at least 3 passes of the fractional Erbium laser. A very even, thorough, and complete laser skin resurfacing is performed. An appropriate amount of blood is drawn, and placed into vacuum tubes, which are centrifuged. The platelet rich portion of the plasma is then drawn up into syringes, and then injected diffusely into the face.

- **Thermi Smooth Face**

ThermiSmoothFace is performed by using radiofrequency energy and a temperature-controlled hand piece. It is performed in the office with no downtime and results in smoothing of the heated tissue.

- **Botulinum Toxin**

Lateral canthal rhytides and brow position can be improved with botulinum toxin products. The muscles commonly targeted are the lateral orbicularis oculi (lateral depressor), the glabellar complex (medial depressors), and the frontalis. Lower eyelid rhytides may also be addressed by using smaller doses for the orbicularis. These procedures are noninvasive and safe; however, the result is temporary and there is a need for repeated injections.

- **Soft Tissue Fillers**

Hyaluronic Acid (HA) was approved by the FDA in 2003. HA absorbs water and expands after injection. A choice of the desirable HA is based on degree of cross-linking of the filler product and duration of correction. Largest HA particles should be injected into the deepest layers, while midsize and smallest particles should be injected

at the middle dermis. Clinical results of fine HA injection to correct tear trough deformity are shown (Figures 3,4).

In conclusion, there are many well-described surgical and nonsurgical approaches to address periorbital aesthetics. The ultimate goal is to create beauty and balance while minimizing evidence of intervention.



Figure 2 - Preoperative frontal view of a 62-year-old female with lower eyelid dermatochalasis and redundant compartmental fat (above). Image obtained at 5 months follow up after bilateral lower eyelid blepharoplasty (below).



Figure 3 - Pretreatment frontal view of a 34-year-old female with prominent tear troughs (above). Image obtained at 1 week follow up after fine HA injection (below).



Figure 4 - Pretreatment frontal view of a 40-year-old female with prominent tear troughs (above). Image obtained at 1 week follow up after fine HA injection (below).

PERIORBITAL REJUVENATION

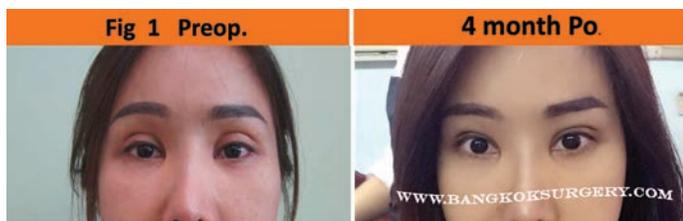


KAMOL WATTANAKRAI, MD, FACS - THAILAND
ISAPS National Secretary for Thailand

Periorbital rejuvenation is the most common procedure in my practice. There have been continuous developments in the last decade. These included the conceptual change, minimally invasive surgery and non-surgical facial rejuvenation. I have incorporated all these concepts in my current periorbital surgery.

Upper eye lid

In Asians we considered a sunken eye and too high eyelid fold as an aged and tired looking eye. The lateral hooding skin is so far unfavorable in both Asian and Caucasians. In the past, to perform an upper blepharoplasty in Asians, we routinely created the eyelid folds, removal of the periocular fat and skin excision. Too much fat removal and skin excision can cause too high a lid fold and sunken eyes that look like aged persons (Reference 1). At present there is a changing trend in the fat removal and skin excision. We will not erroneously remove too much fat in all cases, but we should selectively replace the fat back in situ to create a more youthful eye (Figures 1, 2). For the



skin excision, we try to preserve precious upper lid skin instead of too much skin removal that ends up with a short



eyelid to brow distance which is not esthetically pleasing for Asians. Moreover, with removal of the thin eyelid skin, the subsequent eye lid will look heavier because of the thicker sub brow skin show. This may mimic the bulging periocular fat.

To correct the lateral hooding skin, we will do either or both the infra brow excision (Figure 3) or lateral brow lift



using non-absorbable threads by a small incision inside the temporal hairline. Direct skin excision to correct lateral skin drooping by extending the incision outwards to the lateral orbital rim is abandoned from my practice because of the noticeable scar that is difficult to correct. If crow's feet are of significant concern to the patient, I will incorporate botulinum toxin as an adjuvant procedure either at the time of surgery or at the time stitches are removed.

Lower eye lid

The conventional lower blepharoplasty that includes skin excision, fat removal with or without muscle suspension, is rarely done in my patients. I now address the lower lid and mid-face as a single unit. As isolated procedure for lower eye lid is inadequate to improve the lid cheek junction. We should address the nasojugal groove, orbitomalar groove, mid-cheek groove and nasolabial fold at the same time during lower eyelid rejuvenation. (Figure 4). The concept of lower eyelid surgery has been changed from fat removal to fat preservation and redraping



since Loeb R. introduced his idea in 1993 (Reference 2). Hamra popularized the septal reset technique as being a preferred technique by many surgeons (Reference 3). I have developed my own fat redraping technique called "The periosteal pulley technique" (Reference 4). However, all these fat redraping procedures need more or less fat manipulation and dissection along the infraorbital rim for fat transposition. The scarred tissue between these two planes might induce lower lid retraction or ectropion (Reference 5). Since 2009, I started using lipofilling either as exclusive fat replacement or in conjunction with my fat redraping procedure to add more volume on the lid cheek junction. I have observed that the fat injection provided a long-term improvement of lid cheek junction (Figures 5, 6). However, the injected fat to soften the nasolabial fold was likely to fade over time when compared to the

Fig 5 Lipofilling : Before 5 months P.O.



Fig 6 Lipofilling: Preop. 3 month postop



lower lid area. Therefore, if the patient needs to improve the nasolabial area, I will use my own thread suspension technique to elevate the malar fat pad up. This could subsequently soften the nasolabial fold. This technique is called the K-lift technique. (Figures 7, 8, 9).

I also purposely use K-lift to improve the malar eminence instead of the popular mid-face lift or cheek implants. This technique is less invasive and does not require dissection that might create a scar along the infraorbital rim. Likewise, elevation of the malar fat pad can provide ample support to the lower eye lid. The conventional mid-face lift can elevate the malar fat pad by "pulling from above" when the K-Lift can do so by "pushing from below."

Fig 7 : K lift configuration and position



Fig 8 K-lift : Preop. 1 year postop.



Fig 9 Klift : Preop. And 1 year postop.



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WATTANAKRAI CONTINUED

In conclusion, my current lower blepharoplasty includes:

- 1) Planning a conservative skin excision in a sitting position before surgery and not relying on skin excision to improve lower lid contour.
- 2) Subciliary incision with a stair step dissection.
- 3) Preserving a few millimeters of the pre-tarsal muscle.
- 4) Removing a small amount of protruded periorbital fat (less than conventional technique).
- 5) No dissection over the infraorbital rim.
- 6) Lipofilling along nasojugal groove, lateral infraorbital rim, mid-cheek groove and medial to the nasolabial fold.
- 7) K-lift in case of flat malar and/or undesirable nasolabial fold.
- 8) Skin closure without tension.

Non-surgical rejuvenation

Energy based devices such as focus ultrasound, RF and fractional CO₂ laser are popular among dermatologists and cosmetic physicians in Thailand. Very few plastic surgeons use these devices exclusively for skin tightening. I occasionally use them as supplements to surgeries. Botulinum toxin and HA filler are adjuvant procedures or exclusively used in patients who are not candidates for surgery.

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ORBICULAR MUSCLE STRAP IN LOWER BLEPHAROPLASTY



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RAFAELA CAVACA, MD - BRAZIL

The periorbital region is one of the most important areas for facial rejuvenation. The eyes play a main role in the aging process as they are often the first to show aging signs of the face.

Over time, the adjacent skin becomes loose, hypertrophy of the muscles occurs, orbit SHAPE changes and there is weakening and stretching of the lateral canthal tendons which can result in malposition of the inferior tarsal plate, causing functional problems. There can also be aesthetic changes such as festoons, tear-trough deformity and malar bags. The search for improvement of this area is the main indication for lower blepharoplasties.

According to the latest ISAPS statistics, blepharoplasties are the third most common aesthetic surgery carried out in the world. The subciliary approach for lower eyelid described by Noel¹ has become the standard technique since its description, Adamson published the first description of the use of the inferior orbicularis oculi muscle in blepharoplasty.²

However, in the last 20 years, there has been a big controversy regarding the best surgical approach for the lower eyelid in order to prevent eyelid malposition. Jelks advocates that the orbicularis oculi muscle be kept intact to prevent denervation and recommends transconjunctival access associated with a canthopexy.³

McCord, on the other hand, recommends the subciliary incision, preserving 3 mm of the pre-tarsal orbicularis with a concomitant canthopexy.⁴ Recent publications demonstrate that the orbicularis oculi muscle is mainly innervated by the medial buccal branches of the facial nerve; keeping the medial portion of the muscle intact leads to great surgical safety.

For the last 10 years, we have been using the subciliary approach with a “strap” of inferior orbicularis oculi muscle associated with lateral canthopexy to reinforce the anterior and posterior lamella for patients with severe aesthetic changes in the periorbital area.

Surgical Technique

The lower eyelid approach begins with a subciliary dermal incision carried out with an 11-blade that extends from the lateral side up to 2 mm away from the punctus.

Preserving 4 to 5 mm of the pre-tarsal orbicularis oculi muscle, the dissection extends beneath the muscle to the edge of the inferior orbital rim. In cases with a tear-trough deformity present, the arcus marginallis attachments are released. (Figure 1)



Figure 1

Continued on page 42

The herniation of medial, central and lateral fat pads is treated with three small incisions in the orbital septum. The fat pads are exposed, and the excess is resected and cauterized. This surgical stage needs great refinement because excessive resection of the pads may create hollowness of the periorbital region and worsen a tear-trough deformity.

After meticulous hemostasis, the myocutaneous flap is positioned over the septum and the most cranial portion of the orbicularis muscle attached to the skin is marked with a fine marking pen in order to harvest a 0.5 to 1cm width flap; the detachment goes towards the pupillary line



Figure 2



Figure 3

without crossing this landmark. The length of the flap varies due to the traction needed to smooth the nasojugal groove (Figure 2)

After harvesting, this strip of muscle is sutured towards the Lockwood's eminence projection in the lateral orbital rim. We use 5-0 nylon in a "U" shape mattress. It is important to ensure that the suture is not too tight in order to prevent post-operative chemosis. The muscular flap appearance in the end of the procedure looks like an oblique strap, giving rise to our name for this technique (Figure 3)

The excess skin is removed carefully after removing the eye shield protector, with the majority of skin redundancy typically located in the lateral part of the cutaneous flap. Closure is performed with 6-0 Prolene in a continuous mattress suture.

Results

Patient 1

Pre and Post-op 12 months
Figures 4 & 5



Figure 4



Figure 5

Patient 2

Pre and Post-op 18 months
Figures 6 & 7



Figure 6



Figure 7

Patient 3

Pre and Post-op 12 months
Figures 8 & 9



Figure 8



Figure 9

Continued on page 45

THOUGHTS ON THE USE OF COMBINED HYALURONIC ACID (HA) FILLERS IN PERIORBITAL REJUVENATION



GABRIELE C. MIOTTO, MD, MED - UNITED STATES

Soft tissue augmentation using dermal fillers has resulted in a major shift in periorbital rejuvenation. Hyaluronic acid (HA) fillers are the most common soft tissue fillers used in the United States. According to ISAPS statistics, over 3.5 million facial injections using dermal fillers were performed worldwide in 2018¹. Among the available fillers, hyaluronic acid (HA) fillers are popular for periorbital rejuvenation for producing immediate, predictable and durable results with minimal recovery time and potential reversibility^{2,3}. Cumulative clinical experience and greater availability of products have fueled a paradigm shift from individual wrinkle filling to facial volumization and use of layered fillers for tissue support. One of the primary processes of periorbital aging is deflation, and the use of facial fillers for volumization can be a powerful tool to corrected volume deficiency and loss of the youthful periocular contours^{4,5}.

Different HA fillers manifest unique biophysical characteristics (rheological properties) with distinct clinical behavior, and we can use these properties to select the best fillers for the periocular area⁴. In our experience of over 100 consecutive periocular filler injections over the last 3 years, good candidates are categorized into three main categories: the need for deep volumization, the need for line (wrinkle) or superficial contour improvement, or the need for both. When there is a need for deep volumization, a high elastic modulus or G' filler is the best option to

provide good support and lift, working as a building block for deep restructuring of the periocular deflation^{6,7}. Fillers with a low G' and high flexibility are better suited to more superficial deflation and lines⁷. HA fillers can be layered for improvement of deep and superficial contour changes and optimum aesthetic outcome^{3,8}. (Figure 1)

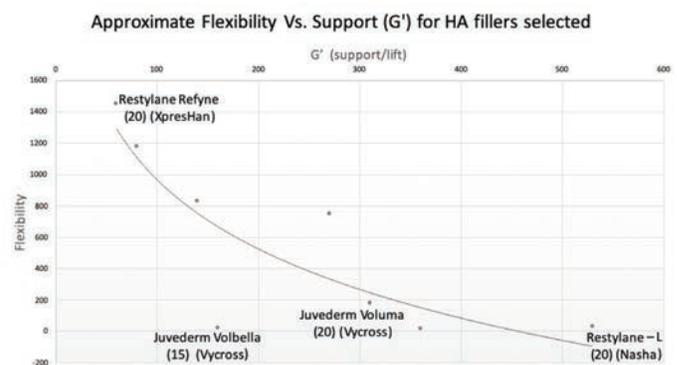


Figure 1 - Chart showing the approximate flexibility and G' of the HA fillers used. Right lower = high G' fillers, left lower = low G' fillers. Left upper = low G' high flexibility. *Adapted from Galderma's data and comparative chart of available HA fillers in the USA.

Patient examination and definition of the periorbital volume deficiency is key. Common concerns associated with periorbital deflation are hollow eyelids, dark circles, visible lower eyelid fat pads, or presence of a tired look. Understanding of the facial fat compartments that influence periorbital aging is fundamental⁹. Patients with sub-orbicularis oculi fat (SOOF) deflation, retro-orbicularis

Continued on page 44

MIOTTO CONTINUED

oculi fat (ROOF) deflation and deep malar fat compartment deflation benefit from deep volumization with high G' fillers. Deflation of the superficial medial fat compartment, the superficial inferior and superior periorbital fat compartment can benefit from use of flexible and low G' fillers. A combination of deep and superficial deflation is common, resulting in three-dimensional alterations in periorbital contour. Therefore, layered implantation of fillers is logical and has been described in Europe as a "sandwich" technique⁴. We have used a combination of fillers routinely in clinical practice for improvement of the periorbital region and the face.

Patients are consented for on-label and off-label use of hyaluronic acid fillers¹⁰. The skin is prepped with 70% isopropyl alcohol and numbed with topical anesthetic or local anesthetic. Deep injection is performed in a retrograde fashion with disposable 27G and 25G cannulas and superficial volumization done with 27G cannulas or 30G needles. Pre-periosteal bolus injection and retrograde fanning techniques are used with careful attention to high vascular areas of the face. Post-procedure instructions included icing and oral NSAIDS. Follow-up visits are scheduled in two to three weeks.

Due to its biophysical properties, NASHA and high G' Vycross are preferred for deep malar fat compartment volumization. NASHA is our selected product for SOOF and ROOF volumization and tear trough/lid cheek junction interface. For superficial injections, low G' ExpreShan and Vycross are preferred, for flexible areas such as deep crow's feet and superficial lines and for shallow lateral lid/cheek junction, respectively. Combination of different HA fillers also allows improvement of adjacent malar area and temporal recess. (Figures 2,3)

Injection safety is very important. In our review, there were no cases of intravascular injection, infection or need for filler reversion with hyaluronidase. It is important to note that lower lid and tear trough injections should fill up the area to 80-90% during the initial session, with a follow-up in 3 weeks due to the hydrophilic properties of HA fillers. Water absorption and expansion is real and can cause overcorrection. We do not use highly hydrophilic products such as Hylacross technology in the lower lid and tear troughs for that reason.



Figure 2 - Pre and post procedure pictures of a 35-year old female with early deep malar fat compartment deficiency, SOOF deficiency, superficial medial compartment deficiency and tear trough deformity. She was treated with stacking technique of 2cc of Restylane-L into deep malar/SOOF and 1cc of Restylane Silk distributed into the superficial periorbital compartments and tear troughs.



Figure 3 - Pre and post procedure pictures of a 62-year old female with deep malar fat compartment deficiency, visible orbicular retaining ligament, SOOF deficiency and superficial periorbital compartment deficiency. She was treated with stacking technique of 2cc of Juvederm Voluma XC into deep malar and 1cc of Restylane-L and 1cc of Juvederm Volbella XC distributed into the superficial periorbital compartments and visible lid/cheek junction.

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CERVANTES CONTINUED

Patient 4

Pre and post-op 18 months
Figures 10 & 11



Figure 10



Figure 11

The ideal patient for this procedure has a positive vector, festoons, and a weak inferior tarsus muscle. For those with a negative vector, lipofilling in the suborbicularis oculi fat (SOOF) region extending to the tear-trough deformity area is added.

The orbicularis muscle strap flap effectively rejuvenates the lower eyelid, does not compromise palpebral function,

reinforces the anterior lamella, and helps to maintain inferior tarsal positioning. In long-term follow-up, we have seen improvement of the orbital shape and maintenance of a more harmonious contour of the periorbital region.

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SURGICAL MARKINGS

HOW I MARK: UPPER EYELID BLEPHAROPLASTY



BABIS RAMMOS, MD, FACS - UNITED STATES



Figure 1 - The caliper is used to measure the distance between the lid margin and the tarsal crease.



Figure 2 - The inferior marking is made first.



Figure 3 - The Pitanguy grasping forceps is used to verify the amount of skin to be excised.



Figure 4 - The skin is excised.



Figure 5 - Preoperative frontal view of a 66-year-old female with upper eyelid dermatochalasis (above). Image obtained at 2 months' follow-up after bilateral upper eyelid blepharoplasty (below).

Markings

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

- The area of desired lid crease. For women it is located 8-9 mm above the lid margin and for men at 7-8 mm, at the mid-pupillary axis (**Figure 1**).
- The inferior marking does not extend beyond the medial canthus, and laterally does not extend beyond the orbital rim (**Figure 2**).
- The upper marking is at least 10 mm from the lower edge of the brow. The amount to be excised without causing lagophthalmos is verified with the Pitanguy grasping forceps (**Figure 3**).

- Depending on the skin laxity the shape of the skin excision may vary from lenticular to trapezoid (**Figure 4**).

Intraoperative, the inferior incision is made first sharply through the dermis. Using the 15 blade the skin is excised. Battery electrocautery is used to obtain hemostasis at the level of the orbicularis. The wound is closed with a running subcuticular 6-0 Prolene that is removed in 5 days.

A clinical result of an upper eyelid blepharoplasty is shown (**Figure 5**).

SHORT CASE STUDY

DOUBLE CAPSULES AND LATE SEROMA IN BREAST AUGMENTATION: A REPORT OF FOUR CASES



MAZEN BDOUR, FRCS(ED.) - JORDAN
ISAPS National Secretary for Jordan

According to the American Society of Plastic Surgeons, breast augmentation is the most common cosmetic surgery in the United States with 313,735 breast augmentation procedures performed in 2018.

The textured surface of implants is intended to enhance integration of the device with the breast tissue. Tissue ingrowth into the textured surface can disrupt the alignment of the surrounding capsule, associating it with a lower rate of capsular contracture and malposition compared to smooth surface implants.

Based on surface area characteristics and measurements, Jean-Phillipe Pirot classified textures into four groups: Smooth/nonotexture (80-100 mm²), microtexture (100 -200 mm²), macrotexture (200-300 mm²) and macrotexture-plus (730 mm²).

The surface texture of an implant's shell differs according to the manufacturer. Polytech has a polyurethane coating that creates an irregular sponge-like surface. Mentor Siltex has a texture generated by a pressure imprint stamping technique. Allergan Microcell or Biocell texturing is created by using a different lost-salt technique.

Capsular formation is a normal tissue response, but can become problematic when the capsule contracts around the implants making the breast hard and deformed, a complication known as capsular contracture.

Late seroma after primary breast augmentation is defined as mammary swelling which can occur more than one year after surgery. According to the literature, excluding other causes such as infection or ALCL, the incidence ranges from 1% to 2%. In the case of double capsules, two fibrous capsules are observed with the inner layer firmly adhered to the implants and the outer layer adherent to the breast tissue. The number of reports on late seroma and double capsules has increased with the increased use of textured breast implants.

In the period between November 2018 and June 2019, I operated on four patients who had unilateral late seroma and double capsules.

The first patient was 33 years old. She had had subpectoral breast augmentation performed by a colleague in Jordan in July 2017. The implants used were macro-textured surface Polytech 380 cc breast implants. In July 2018, she noticed enlargement of her right breast and had it aspirated by the surgeon, only to have a recurrence within two months. Last February, I replaced her old implants with smooth surface Mentor 375 cc silicone implants in the same pockets. There was a double capsule only on the right side.

The second patient, a 58-year old, had subpectoral breast augmentation performed in Saudi Arabia in 1997. The implants used were textured surface MaGhan 380cc. In October 2018, she noticed enlargement of her left

Continued on page 48

breast. Upon her request, she was treated conservatively and prescribed Singulair 10mg tablets once daily and had aspiration of her seroma. The conservative treatment failed in spite of three aspiration procedures over a period of three months. Last March, I replaced her old implants with smooth surface Mentor 375cc silicone implants in the same pockets. There were double capsules on the left side only.

The third patient was a 30-year old who'd had retromammary breast augmentation in Lebanon in November of 2016. Textured surface Allergan 325cc silicone implants had been used. She noticed enlargement of her right breast last March. In May, she had explantation without replacement. There were double capsules on both sides, but the one on the right was harder than that on the left. (Figure 1)

The fourth patient was a 33-year old who'd had subpectoral breast augmentation by the same aforementioned Jordanian surgeon using macrot textured surface Polytech 380cc implants. Last March, she noticed enlargement of her right breast (Figure 2). In June, I replaced her old implants with smooth surface Mentor 400cc silicone implants in the same pockets. There were double capsules only on the right side. (Figure 3)

Dr. Hall-Findlay in 2011 reported 14 cases of double capsules in reviewing 626 of her patients with primary breast augmentation using different kinds of implants. Three of her patients with double capsules developed late seroma. She found double capsules and double capsules with late seroma in one kind of implant - the Biocell textured surface implants.

Two of my patients with double capsules and late seroma had polyurethane macrot textured surface (Polytech) implants. The other two had Biocell textured surface implants by Allergan. Although the etiology of double capsules and late seroma is unknown in most cases, it is usually related to microtrauma due to irritation by greater contact area of the textured surface or subclinical infection.

Treatment modalities for late seroma and double capsules in literature are conservative in 24% of cases and surgical in 76%.

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

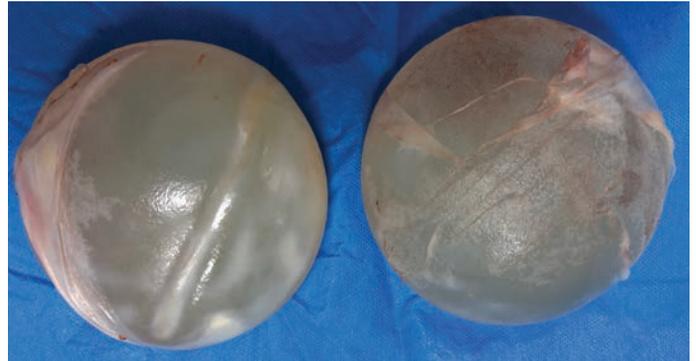


Figure 1 - Bilateral periprosthetic capsule, harder on one side than the other.



Figure 2 - Right breast late seroma.



Figure 3 - Inner capsule around implant, outer capsule lining breast tissue.

ISAPS INSURANCE UPDATE



**NIGEL MERCER, MB CHB CHM
FRCS FRCPCH FFFMLM - UNITED
KINGDOM**
Chair, ISAPS Insurance Committee

As every surgeon knows, cosmetic surgery can be stressful and all surgery carries a certain degree of risk. Although rare, complications do occur and from every type of procedure.

We are pleased to announce that our Revision Insurance* now covers over 60 procedures and over 100 diagnosed conditions. Our Insurance Committee discusses potential additions every month and we are delighted to improve our offerings based on feedback from our Members.

Of the more than 60 procedures that we cover, this list is a sample of the most popular three including the diagnosed conditions covered by the Revision Insurance:

Breast uplift with or without implants - *Adverse scarring, Bottoming Out, Dog Ears, Double Bubble, Encapsulation, Extrusion of Implant, Fat Necrosis, Haematoma, Infection, Malposition, Misshape, Nipple Malposition, Nipple Necrosis, Seroma, Significant Asymmetry, Skin Necrosis, Waterfall Effect, Wound Dehiscence.*

Face lift - *Adverse Scarring, Earlobe Malposition, Hair Loss, Infection, Late Earlobe Malposition, Late Sequelae of Haematoma, Parotid Fistula, Seroma, Skin Necrosis, Suture Extrusion, Wound Necrosis.*

Rhinoplasty/Septorhinoplasty - *Adverse Scarring, Airway Obstruction, Asymmetry, Bulky Tip, Excess Bone/Cartilage Removal, Infection, Infracture, Supra Tip Depression, Valving.*

Any current ISAPS Member is eligible to take advantage of the Revision Insurance which ensures that a patient does not have to pay the full cost of a revision should a defined complication occur.

Understanding ISAPS Insurance - providing peace of mind to more patients

ISAPS insurance is one of the best ways to let your patients and colleagues know that you are committed to the very highest standards of patient care and safety.

- Once the patient is insured, you schedule surgery, and hopefully you don't need to use it, but if there are complications, you and your patient have total peace of mind knowing that all the additional costs are covered.
- You contact the dedicated claims team and provided that you have submitted pre and post photographs together with the patient notes, a decision may be made within 48 hours.

Another marketing benefit offered to you through ISAPS Insurance is that we provide you with a patient leaflet that you may pass on to your patient showing that you are part of this program.

Give your patients - and yourself - the safety net that helps deepen the crucial bond of trust between a doctor and patient. You can apply for ISAPS insurance online, or call Sure Insurance London headquarters at +44 (0) 207 374 4022 between 09:00 and 17:00 (GMT). It's one of the most beneficial things you can do for your patients and your practice.

For more information on any of our available insurances, please visit the website www.isapsinsurance.org and click on your country.

**Not available in every country.*

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MEMBER SPOTLIGHT

RICCARDO MAZZOLA, MD - ITALY MEMBER SINCE 1985



We introduce a new feature of ISAPS News and are pleased to present this brief interview with our Associate Editor for the History of Medicine.

How did you decide to become a plastic surgeon? What was your area of expertise?

I decided to become a plastic surgeon following the steps traced by my late uncle Gustavo Sanvenero Rosselli, the founder of plastic surgery in Italy. He was like a father for me, as I lost my parents in a car accident when I was six months old. My uncle was a bachelor and he proudly brought me up, taking care of my education and eventually of my training in plastic surgery. When he passed away in 1974, to preserve his memory I established a foundation for plastic surgery in Milan that bears his name. The foundation organizes courses with live surgery on a regular basis and houses his library. My area of expertise is mainly devoted to head and neck, cleft lip and palate, aesthetic surgery of the face, fat grafting and history of plastic surgery.

What led to your interest in the history of plastic surgery?

My interest in the history of plastic surgery started as soon as I inherited my late uncle's historical library. I considered it my mission to improve and expand it.

We've heard that you inherited your amazing medical library from your uncle. Can you tell us how he started it?

Sanvenero Rosselli started the plastic surgery collection in the 1930's when the supply of rare books was large and demand was limited to a few collectors. Books have never been cheap. On the contrary, they have always been very

expensive, but in the past they were available from antique dealers. Provided one had enough money, he could buy whatever he liked. Nowadays, it is difficult to find rare books, particularly in the field of medicine as the number of collectors has greatly increased. They have disappeared from the market. Most of them are in private hands or public libraries. They will seldom appear on the market again.

Please tell us about your library. How many volumes do you have, are they all plastic surgery texts, what is your most treasured volume, and do you give tours?

When my uncle passed away in 1974, I inherited about 2,000 rare books, the great majority of them on plastic surgery. Nowadays, the collection has expanded considerably with new acquisitions. It now includes more than 5,000 items. The library is divided into two parts. The rare book section going from 1480 to 1800 and the so-called "modern" section with books and pamphlets going from 1800 to World War II - about 3,000 items. The modern section is certainly the most interesting from an historical point of view, because it traces the recent evolution of plastic surgery, the development of reconstructive surgery and the birth of aesthetic surgery. The library is certainly the most complete in the field of plastic surgery with important sections on anatomy, wound healing, congenital malformations (the so-called *monsters*), and physiognomy. It is open to visitors by appointment only. What is my most treasured volume? Good question. There are several treasured books in the library. *Fabrica* (1543) by Andreas Vesalius is one of them. *Divina Proportione* (Divine



Proportion) issued in 1509 in Venice and co-authored by Luca Pacioli, a mathematician, Piero della Francesca, a painter, and Leonardo da Vinci is another example. I tell you an anecdote regarding the value of old books. When my uncle bought his first Tagliacozzi (the famous work on nasal reconstruction) he didn't dare tell his family about the purchase, as it was the price of an apartment! Nowadays, one cannot buy an apartment with a Tagliacozzi!

How do you select which surgeon to highlight in each issue of *ISAPS News*? Are all the illustrations drawn from your collection?

How I select surgeons and topics for *ISAPS News*? I try to choose either surgeons or topics directly or indirectly related with the field of aesthetic surgery or if there is evidence of great ideas in the history of our discipline. Another important point is that all the historical illustrations published in *ISAPS News* come from the library. I have no problems obtaining permission for publication!

Have you ever thought about writing a book on the history of plastic surgery? An excellent one by Sykes was just published, but I'm sure our readers are wondering this.

Writing a book on the history of plastic surgery is my future task. I have had this on my mind for a long period of time. In my opinion, the work should be organized in the following way: short text with numerous illustrations. This is what the readers are expecting. For this, I need a professional photographer. However, before that, I have to finish the reasoned catalogue of the collection. It will take a while.

Another hot point is whether I scan all the books and make them available, at a certain cost, for those interested in historical research. The question deserves special attention. Old books cannot be opened for scanning. The binding will be irreparably damaged. Therefore, a big investment is necessary to bypass this problem. At the same time, scanning will preserve this unique treasure forever. Imagine the following dramatic issues: fire, water, war, earthquake, paper corrosion. The Sykes book on the history of plastic surgery? Yes, I know it. Excellent work. The great majority of the images included in the text comes from the my library. They are acknowledged as Courtesy of *Riccardo Mazzola, MD*.

I would like to add that I am very proud of the long-lasting historical cooperation with *ISAPS News*. Once I suggested to the editorial board of the *ISAPS Journal, Aesthetic Plastic Surgery*, to gather all the articles related to history, published until now in *ISAPS News*, in a small volume which traces the development of our specialty. Perhaps it could be a good idea.

Thank you, Dr. Mazzola.

Nina Naidu, MD - Editor, ISAPS News

HISTORY



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

DUCHENNE DE BOULOGNE (1806-1875): A PIONEER IN THE STUDY OF FACIAL EXPRESSION AND MEDICAL PHOTOGRAPHY

LIFE

The son of a fisherman, Guillaume Benjamin Amand Duchenne was born in 1806 in the region of Boulogne-sur-Mer in northern France. For this reason, he is generally known as Duchenne of Boulogne. Instead of becoming a mariner, as was his father's expectation, he was mostly attracted to medicine and science. He first entered the College of Douai (France) receiving his Baccalaureate at age 19. He then moved to Paris where he studied medicine and was trained by renowned physicians and physiologists, like René Théophile Laennec (1781-1826), François Magendie (1783-1855) and Baron Guillaume Dupuytren (1777-1835). In 1831, he graduated with a thesis on burns, probably influenced by Dupuytren.

At the completion of his studies, he returned to Boulogne and began his medical practice. He devoted himself to the study of muscular action, using electropuncture, a technique recently invented by François Magendie and Jean-Baptiste Sarlandière (1787-1838), by which a mild electric shock was produced beneath the skin with sharp electrodes to stimulate the muscles. However, Duchenne discovered that there was no need to perforate the skin to stimulate the muscular activity with electric current. He developed a non-invasive technique of muscle stimulation instead. It was only necessary to add a wet sponge to the terminal electrodes on the surface of the skin.

In 1842, he moved to Paris where he worked in different hospitals, without an official appointment, and continued his medical research by studying muscular activity. He developed a portable device that produced muscular

“faradic” stimulation to determine the movements of all the voluntary muscles of the human body. Duchenne established the basis of electrophysiology, introduced electrotherapy and contributed to the description of numerous neuromuscular disorders, many of them eponymically bear his name, including Duchenne muscular dystrophy, Duchenne spinal muscular atrophy, Duchenne-Erb paralysis. He is considered one of the greatest neurologists of France.

Duchenne's most famous pupil was Jean-Marie Charcot (1825-1893) who became director of the insane asylum at Salpêtrière. In the last four years of his life, Duchenne was affected by brain arteriosclerosis and died forgotten and alone in Paris in 1875.

SCIENTIFIC WORKS AND LEGACY

Duchenne published numerous scientific works: *De l'électrisation localisée*, *Mécanisme de la Physionomie Humaine with Atlas and Physiologie des Mouvements*.

De l'électrisation localisée (On Localized Electrification) issued in 1855 (1), reports Duchenne's experience on the applications of faradic stimulation to determine the activity of voluntary muscles, in particular those involved in facial expression, studying their action in normal and pathologic conditions, with his portable electrical

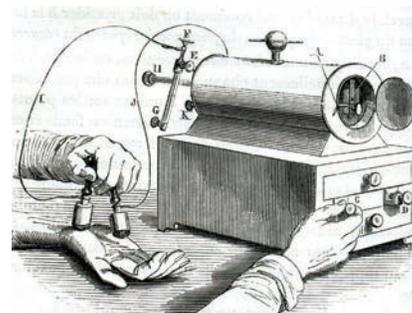


Figure 1 - Duchenne's portable device for faradic stimulation of voluntary muscles.

device illustrated in Figure 1. He gave accurate descriptions of numerous neuromuscular disorders, such as the progressive muscular atrophy (Aran-Duchenne disease), labio-glosso-laryngeal paralysis (Duchenne paralysis), and locomotor ataxia (Duchenne disease), and laid down the foundations of localized electrification treatment, the so-called electro-therapy.

Mécanisme de la Physionomie Humaine (The Mechanism of Human Physiognomy) was published in 1862 (2). Duchenne demonstrated here that each emotion visible on the face has a corresponding specific mimic muscle. To stimulate the facial musculature, the so-called selective electric stimulation, he employed faradism. Thanks to this novel method, Duchenne virtually split all the facial muscles into a number of emotional sub-entities and by masking the stimulated area, he proved that no reflex activity occurs elsewhere in the face. The concept of emotional expression as a basis for muscle classification in the face is shown to be original, although not entirely valid as a scientific basis for physiological research.

But Duchenne wanted to go further and to document each movement, not by drawing or painting, as was hitherto almost universally done, but by something comparable and conforming to a uniform pattern. To record each muscular movement, he had the brilliant idea to refer to photography, invented a few years earlier (3). He established a close relationship with the French photographer Adrien Tournachon, the younger brother of Gaspard Felix Tournachon, better known as Nadar (1820-1910), the legendary pioneer of photography. Tournachon helped Duchenne in supplying all the technical details for achieving the best possible results, but he also taught him the art of documenting his experiments by providing proper lighting. Duchenne strongly believed that medical photography was not a mere system to illustrate clinical cases, but something artistic and at the same time aesthetic. "Only photography" - he wrote - "as truthful as a mirror, could attain such desirable perfection."

Mechanism of Human Physiognomy was accompanied by an Atlas with 84 actual photographs, and from an art-historical point of view it was the first publication illustrating the expression of human emotions using photography. The text is divided into three parts: 1. General Considerations; 2. A Scientific Section; 3. An Aesthetic Section.

The typical patient for the *Scientific Section* was "the toothless old man, with a thin face" - hospitalized at Salpêtrière - "whose features, without being absolutely ugly, approached ordinary triviality" (Figure 2). Duchenne replied to criticisms of using the old man by saying that "every face could become spiritually beautiful through the accurate interpretation of his or her emotions." The patient was suffering from anesthesia of the face, thus he could support the pain produced by electric stimulation easily. Duchenne classified the mimic muscles, depending on their degree of expressiveness, the frontalis for attention, the orbicularis oculi for stupor, the procerus for anger, the corrugator for pain, the zygomatic major for joy, the levator labii superioris for crying, the compressor nasi for stupor, the depressor anguli oris for sadness (Figure 3), the depressor labii inferioris for surprise, and the risorius for happiness. Movements were recorded with the help of photography.

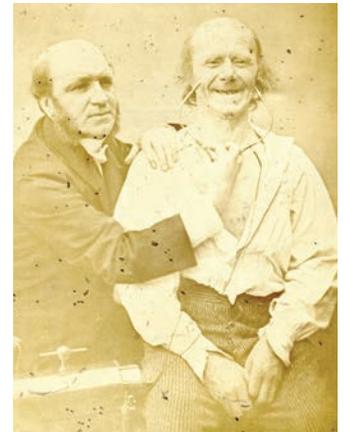


Figure 2 - Duchenne faradizing the toothless old man. At the bottom the portable device.

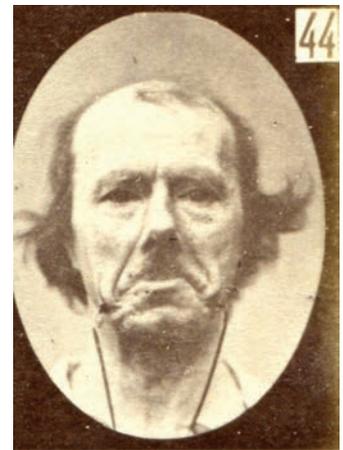


Figure 3 - The faradisation of the depressor angulis oris in the toothless old man showing sadness.



Figure 4 - Duchenne's patient playing the role of Lady Macbeth, with the expression of aggression.

In the *Aesthetic section*, he used six living models of female patients astonished, praying or smiling and an attractive young lady playing the role of Lady Macbeth with the expression of aggression (Figure 4). Through his experiments, Duchenne sought to capture and portray all the possible "conditions that aesthetically constitute

Continued on page 54

beauty” - beauty of the form associated with details of facial expression, pose and gesture. He named this the “gymnastics of the soul.”

To help him identify the facial muscles and their role, Duchenne was considerably inspired by Charles Bell’s (1774-1842) work *The Anatomy and Philosophy of Expression* (4), where the author described beauty and proportions of the human head and face, the mimic muscles and the expression of emotions in normal and psychiatric patients.

Mécanisme de la Physionomie Humaine remained completely ignored for years, until it was discovered by Charles Darwin (1808-1882) who reproduced some illustrations taken from Duchenne’s photographs for his book “*The Expression of Emotions in Man and Animals*” (1872). In the introduction to his text, Darwin noted that the work had not been given the due consideration it deserved (5).

Physiologie des Mouvements (Physiology of Movements) published in 1867 (6) is Duchenne’s last work and probably the most important contribution. The work is divided into four parts. Parts one and two are devoted to the study of movements of the thoracic and abdominal organ. “They deal not only with the single action and but also with the use of all the muscles which move shoulder, arm, forearm, hand, fingers, thumb, thighs, leg, foot and toes.” Part three examines the movements related to breathing and to the vertebro-cranial column. For Duchenne, the study of the muscular action of the motion should finish here. But, at the request of the editor, he added part four, which included experimental research on the physiology of the facial muscles. Duchenne considered an interesting message for the reader “to add an analysis of his research useful for the aesthetic, which shows new anatomical aspects applicable for the diagnosis and for the rational treatment of paralysis and partial contractures of the facial muscles.”

In *Physiologie des Mouvements*, he tried to explain the action of the muscles alone and in groups, produced by selective electric stimulations in normal and in pathologic individuals with different types of isolated or combined forms of paralysis. He demonstrated that isolated

contraction of a muscle is impossible, but it should be accompanied by the simultaneous contraction of the antagonist. The idea of multiple participation of muscles (direct and antagonists) is probably Duchenne’s greatest contribution to the physiology of muscular action.

CONCLUSIONS

Duchenne was a maverick and an individualist at the same time. He worked alone in various Parisian hospitals. He spent his life triggering muscular actions with electrical probes, using a device invented by him, in normal and pathologic individuals, describing for the first time numerous neuromuscular disorders which eponymically bear his name. He wanted to establish how the muscles in the human face are responsible for different facial expressions, which, according to him, are directly related to the soul of the human being. He understood the importance of recording the results of his studies and the often-grotesque expressions of terror, fear, pain, joy and surprise not by drawing or painting, as it was currently done, but with something more scientific and comparable. For this, he referred to the recently invented camera. He should be acknowledged as a pioneer in medical photography. The album *Mécanisme de la Physionomie Humaine*, issued in 1862, was the first publication on the expression of human emotions using photography. Regrettably, the value of Duchenne’s work was not fully recognized by his contemporaries.

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IN MEMORIAM



CARL HARTRAMPF
1933 - 2019

A true southern gentleman, a fine surgeon, an innovator and an educator, Carl Hartrampf was also a mentor to two generations of Emory University plastic surgery residents. I was fortunate enough to be one of them.

A native Atlantan, Carl passed away at home with his family by his side on June 20, 2019. He was 86 years old. A 1956 graduate of the Medical College of Georgia, he completed general surgery training at the University of North Carolina Chapel Hill and a plastic surgery residency at Barnes Hospital at Washington University in St. Louis. As one of the first half dozen or so plastic surgeons in Atlanta, he established Atlanta Plastic Surgery.

He is best known and will always be remembered for the description and development of the TRAM flap, advocating breast reconstruction with autologous tissue or as he liked to say “living tissue.” With visitors from all over the world flocking to Atlanta to observe him operate, he established a small meeting to teach his Tram Flap procedure. Over the years, with the involvement of the Southeastern Society of Plastic Surgeons, his little meeting has evolved into the world-renowned Atlanta Breast Symposium held annually each January. That the symposium will celebrate 36 years next January is a tribute to Carl, his vision, innovation and ongoing interest in breast surgery.

Carl’s expertise and passion extended well beyond the TRAM flap. He was an accomplished hand, cleft and reconstructive surgeon. He was an effective teacher befriending the Emory residents and his breast surgery fellows. Beyond educating us, he was a friend, interested in our families and our aspirations, and followed our careers with keen interest.

In addition to caring for his patients and his love and passion for plastic surgery, Carl had many other interests. He and his wife Pat were avid collectors of antique maps and books, furniture and primitive tools which adorned their homes in Atlanta and Sea Island Georgia. They graciously and generously donated their collections to the Atlanta History Museum with books going to libraries at the University of Georgia in Athens.

To honor Carl, and to mark his accomplishments, the Breast Symposium established the Hartrampf Lecture as part of this annual event. I was honored as the Hartrampf Lecturer in 2013 and delighted that Carl himself had chosen to introduce me. Many years ago, as a resident, I had given Carl a small gift depicting his interest and expertise in hand surgery. He had kept the gift all those years and showed it to the audience. I was touched by it, but that was Carl - the essence of the man, always caring, always thoughtful, always generous and gracious.

Our specialty has lost an innovator, a leader and a thinker. I have lost a mentor and a dear friend whom I will never forget.

Foad Nahai

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MEETINGS CALENDAR

MELBOURNE ADVANCED FACIAL ANATOMY COURSE (MAFAC) 2019

DATES: 02 October – 03 October 2019

LOCATION: Brisbane, QLD, AUSTRALIA

VENUE: MERF, Queensland University of Technology

CONTACT: Jilda Cosentino

TEL: +61 3 98260977

EMAIL: info@mafac.com.au

WEBSITE: <http://www.mafac.com.au>



ISAPS SYMPOSIUM – AUSTRALIA

Immediately preceding the annual ASAPS meeting

DATE: 03 October 2019

LOCATION: Brisbane, QLD, AUSTRALIA

VENUE: Sofitel

Additional details pending



CSAPS/ISAPS SYMPOSIUM – CANADA

DATE: 03 October 2019

LOCATION: Vancouver, BC, CANADA

FOCUS: Body and Breast – Redefined

VENUE: Fairmont Hotel Vancouver

CONTACT: Tara Hewitt

TEL: (905) 655-9889

FAX: (905) 655-7319

EMAIL: csapsoffice@gmail.com

WEBSITE: www.csaps.ca



ISAPS SYMPOSIUM – POLAND

Immediately following the XVII Congress of Polish Society of Plastic, Reconstructive and Aesthetic Surgery, October 10-11

DATE: 12 October 2019

LOCATION: Poznan, POLAND

CONTACT: Dr. Maciej Kuczynski

EMAIL: kuczynski@ptchprie.pl

WEBSITE: <https://www.isaps.org/event/isaps-symposium-poland/>

REGISTRATION: <https://www.17zjazd.ptchprie.pl/lang-en/>



ISAPS SYMPOSIUM – UK – RHINOPLASTY

DATE: 12 October 2019

LOCATION: London, UK

VENUE: Wellcome Collection

CONTACT: Aleiya Lonsdale

TELEPHONE: +44 (0) 20 3196 4375

EMAIL: Aleiya.lonsdale@easyfairs.com/isaps-symposiumuk@easyfairs.com

WEBSITE: www.isaps-symposium.co.uk



EASAPS BIENNIAL MEETING ON FACIAL REJUVENATION

DATES: 17 October – 19 October 2019

LOCATION: Bruges, BELGIUM

VENUE: Oud St Jan Convention Center

CONTACT: MZ Congressi srl

TEL: +39 02 66802323

FAX: +39 02 6686699

EMAIL: congress@easaps.org

WEBSITE: http://www.easaps.org/?page_id=2238



ISAPS SYMPOSIUM FOR RESIDENTS AND FELLOWS

Immediately preceding the EASAPS Biennial Meeting on Facial Rejuvenation

DATE: 17 October 2019

LOCATION: Brugges, BELGIUM

VENUE: Oud St Jan Convention Center

EMAIL: easaps@mzcongressi.com

WEBSITE: <http://www.easaps.org>



ADVANCED AESTHETIC RHINOPLASTY AND FACE CONTOURING 2019

DATES: 24 October – 27 October 2019

LOCATION: St. Petersburg, RUSSIA

VENUE: Corinthia Hotel (Nevsky Palace)

CONTACT: Victoria Rudevich

TEL: +7 (903) 096-62-01

EMAIL: vr@aasurgery.ru

WEBSITE: <https://www.aasurgery.ru/>



3RD NORWEGIAN-AMERICAN AESTHETIC SURGERY MEETING (NAAM3)

DATES: 25 October – 26 October 2019

LOCATION: Oslo, NORWAY

VENUE: Oslo Military Society

CONTACT: Kaisa Filtvedt

EMAIL: oslomeeting@naam.no

WEBSITE: <https://www.naam.no>



ISAPS SYMPOSIUM – SPAIN

Immediately preceding the AECEP meeting

DATES: 06 November 2019

LOCATION: Madrid, SPAIN

TOPIC: Patient Safety and Prevention of Complications

CME: 6 hours approved by EACCME

CONTACT: BN&Co. Congress and Event Management

TEL: +34 91 571 93 90

EMAIL: info@bnyco.com



ISAPS COURSE – MONACO – LIVE PLASTIC SURGERY (FOCUS: FACE)

DATES: 07 November – 09 November 2019

LOCATION: MONACO

VENUE: Grimaldi Forum

CONTACT: Dr. Henry Delmar & Catherine Decuyper

EMAILS: henry@henry-delmar.com & catherine@euromedicom.com

WEBSITE: <https://www.euromedicom.com/lps/en/participants/about-isaps-course-monaco.html>



ISAPS F.A.S.T. PROGRAM – MOSCOW

DATES: 15 November – 16 November 2019

LOCATION: Moscow, RUSSIAN FEDERATION

VENUE: Manturova Institute

TOPIC: Aesthetic Body Surgery – Part 3 of 3

CONTACT: Anna Pimenova

EMAIL: orgcom@isapsfast.ru

WEBSITE: www.isapsfast.ru



ENDOSCOPIC TRANSAXILLARY BREAST AUGMENTATION WORKSHOP

DATES: 29 November – 30 November 2019
LOCATION: Vienna, AUSTRIA
VENUE: Medical University of Vienna
CONTACT: Markus Klöppel
TEL: +49 89 790 70 780
EMAIL: training@drkloepfel.com
WEBSITE: <https://www.drkloepfel.com>



1ST ANNUAL SESPRS/ISAPS PERIORBITAL AND FACIAL SYMPOSIUM

DATE: 23 January 2020
LOCATION: Atlanta, Georgia, USA
VENUE: Intercontinental Hotel – Buckhead
CONTACT: Susan Russell
TEL: 1-435-901-2544
FAX: 1-435-497-2011
EMAIL: srussell@sesprs.org
WEBSITE: www.sesprs.org



AESTHETIC RECONSTRUCTION: PRINCIPLES AND EMERGING IDEAS

DATES: 29 November – 01 December 2019
LOCATION: City of Taguig, Manila, PHILIPPINES
VENUE: St. Luke's Medical Center
CONTACT: Laurence Loh, MD
TEL: 63-2-413-3375
EMAIL: papras09@yahoo.com
WEBSITE: <https://www.plasticsurgerymanila2019.com>



IMCAS LIVE AESTHETIC SURGERY COURSE

DATE: 31 January 2020
LOCATION: Paris, FRANCE
VENUE: Palais Des Congres
CONTACT: Olympe Barone
TEL: +33 1 40738282
EMAIL: contact@imcas.com
WEBSITE: <http://www.imcasurgery.com>



THE ASTON BAKER CUTTING EDGE AESTHETIC SURGERY SYMPOSIUM

DATES: 05 December – 07 December 2019
LOCATION: New York, NY, USA
VENUE: Marriot Marquis
CONTACT: Bernadette McGoldrick
TEL: 1-212-249-9028
EMAIL: bmg@astonbakersymposium.com
WEBSITE: <http://www.astonbakersymposium.com>



BAKER GORDON EDUCATIONAL SYMPOSIUM 2020

DATES: 06 February – 08 February 2020
LOCATION: Miami, Florida, USA
VENUE: Hyatt Regency Hotel
CONTACT: Mary Felpeto
TEL: 1-305-854-8828
EMAIL: maryfelpeto@bellsouth.net
WEBSITE: <http://www.bakergordonsymposium.com>



ISAPS COURSE – SAUDI ARABIA

Immediately following the Saudi Plastic Surgery Care Society (SPSCS) Meeting
DATES: 06 December – 09 December 2019
LOCATION: Riyadh, SAUDI ARABIA
VENUE: Crown Plaza Riyadh RDC Hotel & Convention Center
CONTACT: Anna Theresa P. Baltao, RM, BCHS
EMAIL: info@saudiplasticsurgery.org
WEBSITE: <http://www.saudiplasticsurgery.org/>



ISAPS SYMPOSIUM – INDIA

DATES: 15 February – 19 February 2020
LOCATION: Mumbai, INDIA
VENUE: Cruise Costa Victoria (Mumbai-Kochi route)
CONTACT: Mrs. Arohi Bhimajani
TEL: +91-99-6755-0000
EMAIL: AESURG2020@gmail.com
WEBSITE: www.aesurg2020.com



ISTANBUL LIVE SURGERY RHINOPLASTY COURSE

DATES: 13 December – 15 December 2019
LOCATION: Istanbul, TURKEY
VENUE: Florence Nightingale Hospital
CONTACT: Yagiz Tutuncuoglu
TEL: 90-533-7471423
EMAIL: yagiz@seveneventcompany.com
WEBSITE: <http://www.rhinoplastyistanbul.org/>



ISAPS F.A.S.T. ADVANCED 2020 – COMPLICATIONS AND DIFFICULT CASE MANAGEMENT

DATES: 13 March – 15 March 2020
TOPIC: Face and Rhino Advanced
LOCATION: Moscow, RUSSIA
VENUE: Golden Ring Hotel, Smolenskaya str., 5
CONTACT: Anna Pimenova
TEL: +7 (495) 287-46-45
FAX: +7 (495) 287-46-45
EMAIL: orgcom@isapsfast.ru
WEBSITE: www.isapsfast.ru



ISAPS COURSE – BELGIUM: INTERNATIONAL FRESH CADAVER AESTHETIC DISSECTION COURSE ON RHINOPLASTY AND FACIAL ANATOMY

DATES: 16 January – 18 January 2020
LOCATION: Liege, BELGIUM
NOTE: Limited to 32 participants
CONTACT: Mrs. Anne-Marie Gillain
TEL: 32 (0)4 242-5261
FAX: 32 (0)4 366-7061
EMAIL: amgillain@chu.ulg.ac.be
WEBSITE: www.isapscourse.be



ISAPS COURSE – SOUTH AFRICA

DATES: 20 March – 22 March 2020
LOCATION: Cape Town, SOUTH AFRICA
VENUE: Lord Charles Hotel, Somerset West
CONTACT: Hendrika van der Merwe
TEL: +27-21-981-3081
EMAIL: congress.isaps@eliteconfer.co.za
WEBSITE: <http://www.isapscourse.co.za>
NOTE: Optional post-course safari to Thornybush Game Lodge, March 23-25. See website for additional information and cost.



ISAPS COURSE – GREECE

DATES: 09 April – 11 April 2020
VENUE: War Museum www.warmuseum.gr
LOCATION: Athens, GREECE
CONTACT PERSON: Vicky Delidimitriou, vdelidimitriou@noufio.gr
TEL: +30 210-2775219
FAX: +30 210-2714437
WEBSITE: www.isapscourseathens2019.gr
ORGANIZING SECRETARIAT: NOUFIO www.noufio.gr



ISAPS SYMPOSIUM – SERBIA

DATE: 07 May 2020
LOCATION: Belgrade, SERBIA
VENUE: Hilton Hotel
CONTACT: Dr. Violeta Scorobac
TEL: +381-11-244-3152
EMAIL: dr.violeta@dionahospital.com
WEBSITE: *pending*



ISAPS F.A.S.T. ADVANCED 2020 – COMPLICATIONS AND DIFFICULT CASE MANAGEMENT

DATES: 22 May – 24 May 2020
TOPIC: Breast Advanced
LOCATION: Moscow, RUSSIA
VENUE: Golden Ring Hotel, Smolenskaya str., 5
CONTACT: Anna Pimenova
TEL: +7 (495) 287-46-45
FAX: +7 (495) 287-46-45
EMAIL: orgcom@isapsfast.ru
WEBSITE: www.isapsfast.ru



SECONDARY OPTIMIZING AESTHETIC SURGERY SYMPOSIUM (SOS) 2020

DATES: 31 August – 01 September 2020
LOCATION: Vienna, AUSTRIA
VENUE: Andaz Belvedere Vienna Hotel
CONTACT: Barbara Boeld
TEL: +49-89-18-90460
EMAIL: congress@bb-mc.com
WEBSITE: <http://www.sos2020.eu>



25TH WORLD CONGRESS

25th Congress of ISAPS – 50th Anniversary Celebration
DATES: 02 September – 05 September 2020
LOCATION: Vienna, AUSTRIA
VENUE: Austria Center Vienna
CONTACT: Barbara Boeld
TEL: +49-89-18-90460
EMAIL: congress@bb-mc.com
WEBSITE: www.isapsvienna2020.com



ISAPS F.A.S.T. ADVANCED 2020 – COMPLICATIONS AND DIFFICULT CASE MANAGEMENT

DATES: 20 November – 22 November 2020
TOPIC: Body Advanced
LOCATION: Moscow, RUSSIA
VENUE: Golden Ring Hotel, Smolenskaya str., 5
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SEPTEMBER 2 - 5, 2020
VIENNA, AUSTRIA

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HOT TOPICS

- Live Surgery on Complication Cases (SOS)
- Cadaver courses
- Marking courses
- Best & worst case session
- Problems and solutions panels
- Migraine surgery labs
- Best of the World competition
- Reboot your practice
- Innovations in industry
- Social media training

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