

ISAPS NEWS

Official Newsletter of the International Society of Aesthetic Plastic Surgery



**INTERNATIONAL SOCIETY OF
AESTHETIC PLASTIC SURGERY**

22nd CONGRESS

**September 19-22, 2014
Rio de Janeiro, Brazil**

www.isapscongress.org

Join us in Rio de Janeiro for the 22nd Congress of ISAPS in a very exciting location. We will have by far the largest faculty in our 44-year history. Registration is exceeding previous congresses at this point in the process, with plastic surgeons coming to Rio from 70 countries. Our hosts in Brazil have planned wonderful social events with a Brazilian flavor, as you would expect. Rio is a truly fabulous destination worthy of hosting the World Cup—and ISAPS!

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MESSAGE FROM THE EDITOR



Welcome to this issue of *ISAPS News* which is such a wonderful representation of the activities of our society. As we prepare for the world Congress in Rio de Janeiro, we celebrate the accomplishments and leadership of our members in the areas of patient safety, advocacy, education, and scholarly contribution. This is a wonderful prelude to gathering in Brazil with our president, Carlos Uebel, and our other ISAPS leaders who have assembled a truly outstanding program.

In this issue, we feature a Global Perspectives series on the topic of post massive weight loss plastic surgery. This is a special interest for me, and we are fortunate to have contributions on this topic from experts across the globe. Notably,

this patient population has many struggles with body image as they go through the process of weight loss and the evolution of problems with hanging skin. We are fortunate to have a piece on the psychosocial considerations of body contouring after massive weight loss by notable professor of psychology, Dr. David Sarwar from the University of Pennsylvania.

Patient safety is highlighted in this issue with an important article from Dr. Ronald Iverson on international surgical facilities accreditation and breaking news from Dr. Ivar van Heijningen on the adoption of a new European Standard for aesthetic surgery services. This is a landmark action for responsible surgical practice and patient safety.

You'll find our usual reports of ISAPS activities in all parts of the world, too many to mention by name in this brief introduction. I hope you enjoy the news of our wonderful international society, and I look forward to seeing all of you in Rio de Janeiro!

I hope you enjoy this latest issue of *ISAPS News*.

Warmest regards,


J. Peter Rubin, MD, FACS
ISAPS News Editor



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PRESIDENTIAL EDITORIAL

Dear Colleagues,

Our Society is quickly growing. We have almost 3,000 members, and what is most important, colleagues filled with an extraordinary energy to bring our specialty to the highest standard in the world.

In my presidential term, I have visited more than 22 countries and have seen the tremendous enthusiasm of colleagues working for our Society, organizing courses, symposia and fellowship programs in their national societies and universities. Wherever I have visited, I have seen our flag fluttering with friendship and education and this is certainly our goal in ISAPS—to maintain our roots established 44 years ago by our founders and to construct new bridges for our new members, especially the young people who are joining us now and represent our future.

Our Society is responsible for bringing new tools and developing new strategies for aesthetic education to the world. To accomplish this, we have sent Visiting Professor Programs organized by Renato Saltz to Brazil, Romania, India, Dubai and Russia already, with another three scheduled by the end of this year in the US, Hong Kong and Argentina. In total, eleven professors have donated their time to this important program. This program sends dedicated faculty to institutions who request them to demonstrate their techniques especially to young surgeons who cannot easily travel to courses outside their country. We have endorsed many other educational programs and fellowships provided by our colleagues.

In addition to our wonderful journal, *Aesthetic Plastic Surgery*, and our great newsletter, we have a new website where you can discover many new features and your patients can read important information in ten languages. We now have **ajax**, our newly developed journal app that allows you to read our journal on your iPad—soon this service will be available on Androids and your desktop computer, too. Our unique insurance program has many subscribers and several claims have now been paid—a positive development. The ISAPS Public Relations office in New York, with our dedicated staff of Leigh Hope Fountain and Gloria Gasaatura, have done an excellent job of promoting ISAPS in the media and expanding the ISAPS brand in new ways. Of course our important survey of worldwide aesthetic surgery procedures is now in analysis and the results will be published later in July. The response rate was far above any previous survey, but not all countries participated. It is a difficult task to collect this information on such a global scale.



Our most important activity has been our education program executed by Nazim Cerkes. Twenty-eight official courses and symposia were produced (or are scheduled) in 2013 and 2014—an amazing program with incredible acceptance by our membership in countries from Uruguay, South Africa, Poland, and Japan, to Azerbaijan—to mention only a few countries on four continents that welcomed ISAPS education programs and our dedicated faculty.

And finally our largest summit event—the RIO WORLD CONGRESS 2014 in Rio de Janeiro from 19th to 22nd September this year. An enormous scientific program has been executed by Jorge Herrera and the Scientific Committee. You can see the program and faculty on our Congress website www.isapscongress.org. The program will include 260 invited faculty, 240 free paper presenters, and many more moderators and chairs. This will be one of the largest meetings in ISAPS's history. The social activities were planned by our dearest colleague, Ruy Vieira, who passed away recently, and certainly you will have the opportunity to enjoy Rio and to create new friendships. In September, the spring season starts in Brazil and it is a wonderful time to extend your visit to other regions of South America.

As this is my last editorial as President in *ISAPS News*, I would like to thank our Executive Committee, Board of Directors, Committee Chairs, National Secretaries, and our Executive Director, Catherine Foss, and her incredible team for the many hours, talent, and hard work they have contributed to the functioning of this organization. In September, our new President, Susumu Takayanagi from Japan, will take over the top leadership position in ISAPS and I wish him great success over the next two years.

Kind regards and welcome to Brazil,



Carlos Oscar Uebel
ISAPS President

PATIENT SAFETY IS SERVED WITH THE ADOPTION OF THE NEW EUROPEAN STANDARD FOR AESTHETIC SURGERY SERVICES

Ivar van Heijningen, MD – Belgium

Chair, ISAPS Membership Committee and National Secretary for Belgium



It was a close call and a little bit unexpected, but the weighted vote found 78.1% of the necessary 71% in favor of the European Standard. It has been a hard-fought victory where everything was tried to bring this effort down. Lawyers were hired to send threatening letters. Colleague specialists were misled into believing that this was just an effort by plastic surgeons to protect their turf. Medical organizations did everything in their power to stop this for political reasons. Patient protection organizations, however, were very happy with this initiative and many others valued it for the reason it was started: to create a level playing field for all involved in aesthetic surgical services to protect the patients from mishaps.



EUROPEAN COMMITTEE FOR STANDARDISATION
COMITÉ EUROPÉEN DE NORMALISATION
EUROPÄISCHES KOMITEE FÜR NORMUNG

What It Is

This European Standard is the result of the collaboration of 21 of the 33 CEN members. These countries contributed actively and discussed the draft of the Standard within so-called mirror committees in their respective countries wherein all interested in this topic had the opportunity to be represented including: other specialists, non-core aesthetic doctors, nurses, consumer organizations, clinic owners, government officials, insurance representatives, and product manufacturers. All these countries had the opportunity to send a representative to the seven meetings we had where the draft was discussed and consensus was reached line by line.

This European Standard provides a set of requirements which are deemed to be essential for the provision of aesthetic surgery services. Recommendations for other aspects of good practice are provided. However, attention is drawn to the fact that in certain countries specific national regulations apply and take precedence over this European Standard.

Emphasis is placed on defining requirements for the quality of the aesthetic surgery services offered in order to ensure patient safety. Other factors which influence the overall quality of service include: qualifications and professional competencies, staff behavior, facility design and choice of products and suppliers.

This European Standard is designed to bring the following advantages to those who adopt it:

- improvement in aesthetic surgery services that can enhance patient safety and reduce the risk of complications;
- to promote consistently high standards for aesthetic surgery service providers across Europe;
- enhanced patient satisfaction.

This European Standard will be implemented in all 33 CEN member states and will replace any other standards if they exist on this topic. This creates a level playing field for all European countries with respect to aesthetic surgery services.

What It Is Not

This standard is *not a law*. It is voluntary. It is the consensus of a group of experts who tried to describe what best practice is, realizing that there are huge differences from one country to the next. Any country's laws always take precedence over standards.

This standard is *not a European Council regulation*. Healthcare regulations and laws are the responsibility of the individual member states of the European community. However, countries are free to base future regulation on this standard.

This standard is *not an effort to exclude certain professionals from doing their job*; neither is it an attempt to reserve this field exclusively for plastic surgeons. It does raise the bar for those who want to engage in this field and requires proper training, safe facilities and ethical behavior.

This standard is *not an effort to restrict aesthetic surgery procedures to certain specialists*. It only states that it is logical that doctors do procedures that they are trained for and that are allowed to them in their country.

Content of the standard

It is impossible to discuss the entire content of the Standard in a single article so I will describe some of the most important aspects.

In the chapter on **Competencies**, aesthetic surgery is restricted to surgeons. A lot of debate focused on whether non-specialist doctors were allowed to do aesthetic procedures or not. Since nobody should be excluded, it was allowed under strict conditions.

The competent, qualified, experienced medical doctor shall have had appropriate basic surgical training of two years followed by at least four years training in aesthetic surgery supervised by a national authorized trainer in aesthetic surgery.

Although they agreed in the meeting where this point was decided, now many aesthetic doctors challenge these conditions. Besides training, emphasis is placed on continuing medical education.

The chapter on **Management and communication with patients** mainly deals with the organizational aspect of aesthetic surgery services, which should be done in an ethical way. Discussion points included a cooling off period, whether or not to treat minors (not), publicity and advertising (should be avoided), traveling

long distance (is rarely in the patient's best interest) and multiple aesthetic surgical procedures. Another important point was advice on registration as already implemented under Danish law:

All practitioners and clinics shall be registered and/or authorized with the appropriate regulatory bodies in the country of practice, and these details shall be available to the public.

The chapter on **Facilities** follows the recommendations of AAAASFI which were modified to reach consensus. A lot of discussion went into the requirements for minor aesthetic procedures which were perceived as severe for some specialties. In the best interest of the patients, we managed to keep them at a sufficiently high level.

The last chapter on **Procedures** was one of the most difficult. Everyone agreed that the outcome of an aesthetic surgical procedure is influenced by the following factors: the practitioner (surgeon), the facility, level of anesthesia, patient physical status and age, risk level of the procedure, and the duration of the procedure.

Making links among these factors and procedures led to endless discussions. It only became possible after excluding the practitioner as a factor in a table provided in the Standard, although everyone agreed that the practitioner is the most important identifying factor.

Conclusion

When we started this initiative four years ago, we didn't know what we were getting ourselves into, but we were all convinced that patients were not protected as well for aesthetic surgical procedures as in regular surgical procedures. Most delegates worked diligently to create a document that would protect patients. Although some tried to sabotage this for personal reasons, the European Standard for Aesthetic Surgical Services is now a fact! Let's follow these standards and protect our patients.

The European Standard for Aesthetic Surgery Services can be downloaded from the ISAPS website in the NEWS section. 

Cover story, continued from page 1

Our President's theme for the last two years has been *Aesthetic Education Worldwide*. The Congress Program Committee has worked hard to create a dynamic and inclusive educational event as befits this biennial super event and this motto.

The Congress will again feature sixteen early morning Master Classes, dual sessions in all aspects of aesthetic surgery featuring video presentations, panels, and free papers, lunch-time seminars sponsored by our corporate colleagues, and a few special features.

The Welcome Reception will take over the conference center making it convenient for everyone. Our traditional Presidential Dinner will take you to the Lajedo Forest and Gardens and our official housing bureau can arrange special tours of any length to help you explore this vast and interesting country.

We thank all our exhibiting companies without whom these world events could not offer the educational opportunities they do, which is, after all, our main focus. Our exhibit staff makes a special effort to both display their products and services and to educate our audience about the latest trends and advances in the industry that supports your efforts as surgeons. Please visit with them and appreciate that their contribution supports both ISAPS and you.

Of course every meeting needs a sizeable group of dedicated individuals to make sure that every detail is managed. From the extensive educational program and social event planning to the development and maintenance of the special congress website; from the collection, review and assignment of over 400 submitted abstracts to the printing of promotional materials and programs; from the extensive work to provide a comfortable shop away from home for our exhibitors to the food selection and production of name badges and congress bags; from the coordination of more than 500 faculty and presenters to the hotel accommodations—nothing has been left to chance. It is impossible to include the list of all the details involved, or the names of all the staff and committee members who work for years to make all this happen.

Your attendance at this year's Congress will make all our hard work worthwhile—and you will not be disappointed. Meet old friends and make some new ones. If you have visited Rio in the past, you know what a beautiful place it is. If you have not, you will certainly not regret your visit.

We look forward to welcoming you to Rio de Janeiro in September! 

SPOTLIGHT ON PATIENT SAFETY: INTERNATIONAL SURGICAL FACILITIES ACCREDITATION

Ronald E. Iverson, MD – United States

President AAAASFI



This is an important year for the advancement of patient safety and international accreditation. AAAASFI continues to develop its relationships and profile in the international community. With the ISAPS Congress in Rio fast approaching, AAAASFI is excited about making patient safety a major point of emphasis among attendees.

AAAASFI held its 3rd International Breakfast at the American Society for Aesthetic Plastic Surgery (ASAPS) meeting in San Francisco in April. The breakfast provides a venue for invitees and the leadership of ISAPS to discuss patient safety and accreditation challenges with AAAASFI representatives. Catherine Foss, Executive Director of ISAPS, and several ISAPS National Secretaries contributed to an informative discussion that has inspired several new initiatives at AAAASFI. Look for additional details in upcoming issues of ISAPS News.

The Colombian and Peruvian Aesthetic Societies have requested additional information about accreditation as a result of the ASAPS event. AAAASFI is planning engagement events with the leadership of both societies in the coming months. Their interest is a positive step for global patient safety initiatives and fuels the momentum created by the Swiss Society's Accreditation Mandate in 2013.

In May, AAAASFI's Director of Accreditation, Tom Terranova, presented at the Medical Travel International Business Summit on the critical role of physicians to ensure patient safety and quality of care in medical travel. The event is hosted by

The Council for the International Promotion of Costa Rica Medicine (ProMed) and brings together stakeholders in medical travel from all over Latin America. It is a unique opportunity to address safety across many specialties. Over the past 4 years, this meeting has created a dialogue in which facilities are no longer contemplating the idea of accreditation but rather which accreditation organization they will chose, signifying the crystallization of patient safety as a necessary component of care in Costa Rica.

In anticipation of the ISAPS Congress in September, AAAASFI is preparing for another exciting chance to engage ISAPS

members through a surveyor training and accreditation workshop. The 2012 International Surveyor Training in Geneva was extremely successful. The event was a valuable opportunity to communicate patient safety concepts to a geographically diverse audience and reconnect with surveyors, many of whom now represent AAAASFI on surveys throughout Europe. With a large number of ISAPS members in the region and a growing population of accredited facilities nearby, Brazil offers an excellent opportunity to prioritize patient safety in South America.

AAAASFI demonstrates its own quality for the benefit of the international

Is your clinic ready for international accreditation?

- Narcotics stored in locked container and logged
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- Staff attends regular training programs
- Surgeons have admitting privileges and can transfer patients in jeopardy to a hospital
- Backup power can support the operative room in a disaster
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- There is a fully stocked and up to date emergency cart

If you checked at least 7 of these boxes, international accreditation is closer than you think. You already comply with many of the most critical areas of accreditation. Contact us for an application to complete the process and be recognized for your commitment to patient safety.
www.aaaasfi.org – TEL: 001.847.775.1970

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Book a tour to fantastic Iguazu Falls

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Flavia Cosmelli - flavia.cosmelli@havasbrazil.com.br

The name of the falls originates from the Tupi or Guarani language, and means “big water.” While the ancient Brazilian tribes knew of its thunderous beauty, it was only officially ‘discovered’ in 1541, when the European explorer, the Spanish Conquistador Álvar Núñez Cabeza de Vaca, came across its awe-inspiring beauty. Today, the Iguazu Falls are owned by the two UNESCO World Heritage Sites: the Iguazu National Park in Argentina and the Iguazu National Park in Brazil.



ISAPS COURSE & VISITING PROFESSOR PROGRAM – MOSCOW

Renato Saltz – United States

ISAPS First Vice President
Chair, Visiting Professor Program



The 5th International Symposium on Plastic Surgery: New Perspectives in Aesthetic Medicine was held in Moscow on May 16-18, 2014. The three-day forum was attended by 900 participants from Russia, Asia, the Middle East and many European countries. It included practical and theoretical education on all aspects of Aesthetic Surgery including 25 experts from all over the world.

Dr. Natalia Manturova, head of the faculty of Plastic and Reconstructive Surgery, Cosmetology, and Cell Technologies of the Research Medical University in Moscow was the local organizer and did a phenomenal job putting this scientific meeting together. Drs. Nazim Cerkes (Turkey) and Fabio Nahas (Brazil) were the course directors.

Preceding the ISAPS course in Russia, our fifth Visiting Professor Program (VPP) at Moscow University had the enthusiastic attention more than of 200 Russian colleagues.

VPP faculty included Drs. Bryan Mendelson (Australia) and Nazim Cerkes (Turkey) who performed four live surgery demonstrations over the two days. Dr. Cerkes demonstrated one open rhinoplasty and one calf augmentation the first day, and Dr. Mendelson showed the audience face lift and upper and lower blepharoplasty operations on the second day.

After each of the live surgery demonstrations, technical details of the surgeries were discussed with the participants in the meeting hall. The Visiting Professors gave talks about the techniques



ISAPS Course Faculty at the Bolshoi Ballet: Selahattin Ozmen, Renato Saltz, Nazim Cerkes, Bryan Mendelson, Woffles Wu, Anna Pimenova, Foad Nahai and Sanguan Kunaporn.

they used and answered the questions from the audience. As we have seen with each for the Visiting Professor Programs, there is enormous interest in this more intimate form of teaching.

The program continues through the end of this year with additional visits already scheduled and under discussion.

Peter Rubin	Brazil – September 2013
Olivier Gerbault	Romania – October 2013
Nuri Çelik & Renato Saltz	India – January 2014
Vakis Kontoes & Nazim Cerkes	Dubai – April 2014
Bryan Mendelson & Nazim Cerkes	Moscow – May 2014
Raul Gonzalez	US – August 2014
Foad Nahai	Hong Kong – November 2014
Mustapha Hamdi	Argentina – November 2014

In its revised and well organized new format, the Visiting Professor Program is proving the importance and acceptance of our global aesthetic surgery education program. Guidelines and a list of all participating Professors is on our website under Medical Professionals >>> Visiting Professor Program. National secretaries should contact Renato Saltz to request a VPP for their clinic, hospital or academic institution. We are developing the 2015 schedule now.

Congratulations to the meeting organizers and course directors for another great scientific program and outstanding social events.



Faculty at the Press Conference facing more than 100 reporters.

ISAPS COURSE & VISITING PROFESSOR PROGRAM – UNITED ARAB EMIRATES

Prof. Vakis Kontoes from Greece and Prof. Nazim Cerkes from Turkey presented another very successful ISAPS Visiting Professor Program (VPP) in the United Arab Emirates (UAE) on April 11-13, 2014.

The program was approved and organized in cooperation with the Emirates Plastic Surgery Society, the Emirates Medical Association, the University of Sharjah, and the Sharjah Surgical Institute. The hosts included Dr. Marwan Al Zarouni, ISAPS National Secretary for the UAE and President of the Emirates Plastic Surgery Society, Associate Prof. Nabil Sulaiman, Director of Sharjah University Clinical and Surgical Training Center, and Prof. Hossam Hamdy, Vice Chancellor of Medical and Health Science Colleges of the University of Sharjah.

The local arrangements were organized by Mr. Fadi Dannoura, Director of Med Org PCO.

Laser equipment was sponsored and offered by the University for Sharjah Laser Training and Research Center (SULTARC) and its director, Dr. Taher Khalil.

The program was held in the Clinical and Surgical Training Center at the University of Sharjah, a wonderful location with outstanding audiovisual and cadaver dissection facilities. The class consisted of twelve UAE plastic surgeons.

The three-day program started on Friday morning with lectures by Prof. Kontoes on periorbital anatomy, techniques in blepharoplasty and periorbital rejuvenation, and laser applications. A very interactive discussion with the participants during the morning session resulted in an interesting scientific outcome. The class had the opportunity to clarify techniques step by step while watching videos of all the described procedures,



Prof. Cerkes in the cadaver lab.

interacting with the speaker, and keeping notes in order to apply the procedures in the cadaver dissection session that followed.

After a lunch break, the afternoon session consisted of fresh cadaver dissection as Prof. Kontoes demonstrated blepharoplasty techniques, including the Single Traction Suture Technique for periorbital rejuvenation, laser techniques, and detailed anatomy of the region. After this demonstration, the participants performed these techniques on the cadavers under the supervision of Prof. Kontoes. Photography was allowed during dissection and it was impressive that all the participants made their own photo albums during the surgical demonstration.

On Saturday, Prof. Cerkes started the day with his very prominent lectures and videos on rhinoplasty anatomy and techniques for the correction of the deviated nose, classic open rhinoplasty, use of perichondral, periosteal and spreader grafts, and refinement of tip and nasal dorsum. Students were again excited by the very detailed and practical tips and tricks for nasal surgery, interacting with the speaker during the whole morning session. After lunch, Prof. Cerkes demonstrated many different techniques on fresh cadavers and the participants had a chance for hands-on surgery using the cadavers under his supervision.

Sunday was dedicated to facial structures anatomy, face lift techniques, and ancillary laser techniques for facial rejuvenation. Prof. Kontoes lectured and showed videos on how to avoid complications, how to elevate and rearrange the SMAS, and how to apply laser on the facial skin in face lift surgery. One more



The VPP Class at the Clinical and Surgical Training Center, University of Sharjah, UAE

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ISAPS COURSE CAPE TOWN

Peter Scott, MD – South Africa

National Secretary for South Africa

A three-day ISAPS Course was run in the beautiful city of Cape Town, South Africa at the five-star Cape Sun. Education Council chair, Nazim Cerkes, assembled a superb faculty from all over the world with 11 international and three local speakers who presented top-quality and up-to-date lectures in their fields of expertise.

Cape Town has been ranked as the top holiday destination for 2014 by the British newspaper, *The Guardian* and *The New York Times* and has chosen it as the World Design Capital for 2014.

The faculty included: from Turkey, Drs. Nazim Cerkes, Nuri Celek, Fethi Orak, and Akin Yücel; from Italy, Drs. Giovanni Botti and Mario Pelle Ceravolo; from Germany, Drs. Wolfgang Gubisch, Dirk Richter and Joachim Graf von Finckenstein; from Canada, Dr. Frank Lista; and from Brazil Dr. Osvaldo Saldanha. Local speakers included Drs. Fernandes, Ewa Siolo and Peet van Deventer. The course was attended by approximately 160 plastic surgeons of which 130 were from South Africa and accounted for most of the active plastic surgeons who work here.

Nazim put together a very balanced program that covered facial rejuvenation, periorbital rejuvenation, rhinoplasty, breast augmentation and reduction mastopexy, and body contouring. In addition, selected lectures were also presented by our expert panel on topics such as buttock augmentation and labiaplasty at the request of our local members.

Joining me on the organizing committee were Ewa Siola and Russell Walton, the past national secretary for South Africa and an ISAPS professor.

The trade pulled out all the stops to sponsor the course and to present their

latest products. The meeting started with a sponsored sushi evening in the course venue. The faculty dinner was at Riempiers Restaurant with a tasting menu by the executive chef Alfred Henry and wine pairing by the sommelier Georgio Meletiou. The entertainment was spontaneous



Cape Town faculty on Safari

and local and presented in two sessions by the high-energy song and dance troupe Amazink Live. Audience participation was the name of the game and it was wonderful to see the international faculty dancing with the performers to the Shakira song “Waka Waka” from the Soccer World Cup which was hosted in South Africa so successfully in 2010.

The Ladies Program was organized by my wife, Sue Scott, and Hendrika van der Merwe, our wonderful course organizer. The ladies group visited the Cape Nature Reserve and Cape Point on the first day and the Stellenbosch wine land area on the second day.

Most of the faculty were then hosted by ISAPS member Dr. Andre Meyer on

a true African safari. They travelled to the Simbavati River Lodge in the Timbavati Game Reserve which is part of the greater Kruger National Park, home of the legendary Big 5. Wolfgang Gubisch mentioned that they had seen a young leopard up close and at night hippos very near their

terrace. All together it was an unforgettable experience to round off a hugely successful ISAPS Course.

For me, as the local organizer, it was a pleasure to work with Nazim Cerkes and to have an international faculty who were prepared to travel all this way at their own cost to give of their expertise to the South African plastic surgery community. South Africa has a fairly poor exchange rate, making international travel expensive, and our South African surgeons were treated to the whole spectrum of aesthetic surgery on their doorstep. I have had nothing but compliments from the local community and many requests to join ISAPS.



4TH MEETING ON SECONDARY OPTIMIZING SURGERY (SOS), STUTTGART 2014

Dirk Richter, MD – Germany

ISAPS Treasurer



With the leading headline: “Meet the best—see them live” the ISAPS endorsed symposium for Secondary Optimizing Surgery (SOS), launched by Wolfgang Gubisch, Axel-Maria Feller and me took place for the fourth time from February 28th to the 1st of March 2014. More than 200 participants from 32 different countries met at the Movenpick Hotel Stuttgart Airport, to which live operations from the Marienhospital were broadcast. Secondary procedures after complicated rhinoplasty, face lifts, lid-surgery, abdominoplasty, thigh lifts, as well as breast surgery were performed parallel in three operating theaters by world-renowned surgeons and ISAPS members including Giovanni Botti (Italy), Rick Davis (USA), Mustapha Hamdi (Belgium), Timothy J. Marten (USA), the current ISAPS-President Carlos Uebel (Brasil), Wolfgang Gubisch (Germany) and me. Moderated by Bahman Guyuron (USA), those in the auditorium were given the opportunity to communicate with the surgeons during the procedures so that all of the participants had the chance to get personal experts’ advice.

On the second day, speakers presented typical complications after aesthetic surgery and gave advice for corrections—and even more important, how to avoid them. The opportunity to present extraordinarily complex cases was given and to discuss solution possibilities. Furthermore, the first long-term outcomes of the previous SOS symposium—cases from 2011 to 2013 were presented. The Guest of Honor, Neven Olivari (Germany), with his



Pictured from left to right: Helmut Fischer, Wolfgang Gubisch, Carlos Uebel, Axel-Mario Feller, Neven Olivari, Dirk Richter, Nina Schwaiger

probably longest experience in aesthetic surgery, participated and commented on the sophisticated techniques of the present time. Exciting discussions kept most of the participants engaged until the end of the congress.

This new format of live surgery on complication cases was inaugurated at the first ISAPS-SOS-Course in Stuttgart in 2011 and was a huge success.

At the end of the meeting, Chairman Axel-Maria Feller passed the baton for the next SOS-Symposium in Munich to Christoph Heitmann who will be organizing the fifth Symposium in collaboration with Wolfgang Gubisch and me on the November 20-21, 2015. Save the date!



Patient Safety, *continued from page 6*

community. AAAASF’s parent organization, AAAASF, is a deeming authority in the United States. The designation means that the Federal Government has determined that AAAASF’s programs to be of such rigor and quality to satisfy government requirements. AAAASF is

seeking a similar designation of quality by a third party. The International Society for Quality in Health Care Ltd (ISQua) publishes principles to assess accreditors and AAAASF expects to complete the ISQua accreditation process in the next year.

AAAASF looks forward to assisting

ISAPS and its members to promote quality and safety in outpatient clinics. Please contact the AAAASF with any questions or if you would like to get involved in any of our upcoming events. Direct any inquiries to katie@aaaasf.org



ISAPS COURSE PHILIPPINES

Carlos Lasa Jr., MD – Philippines

Chair, ISAPS Course Organizing Committee



The first ISAPS Instructional Course in the Philippines was held at the EDSA Shangri-la Hotel in Mandaluyong City, Metro Manila, on March 3 - 4, 2014. The course was hosted by the Philippine Association of Plastic Reconstructive and Aesthetic Surgeons, Inc. (PAPRAS), the Philippines' specialty organization of board-certified plastic surgeons, which aims to bring to global standards the level of knowledge, skills and practice of Filipino plastic surgeons.

The theme of the course was "Asian Techniques in Aesthetic Surgery." The roster of Asian speakers was headed by Course Director and ISAPS President-Elect, Susumu Takayanagi. Faculty members included Charan Mahatumarat (Thailand), Kotaro Yoshimura (Japan), Hiroko Yanaga (Japan), Kazuyoshi Yajima (Japan), Man-Koon Suh (South Korea), David DaeHwan Park (South Korea), Jie Luan (China), Martin Huang (Singapore), Marco Faria-Correa (Singapore), Theodorus Prasetyono (Indonesia) and Gonzalo Bosch (Uruguay). Speakers from the Philippines included Carlos Lasa Jr. (PAPRAS president), Florencio Lucero (Philippine National Secretary for ISAPS), Jesusito Zubiri and Rene Valerio. Topics in the course focused on ethnocentric cosmetic concerns of the Asian patient.

The Philippine Organizing Committee was led by Carlos Lasa, Jr. (PAPRAS president), with the following members: Jose Joven Cruz, Catherine Asedillo and Jay Estoya (scientific program); Gerald Sy (ways and means); Briccio Alcantara and Angelito Alava (physical arrangement and reception); Arnold Angeles (documenta-



SPEAKER'S NIGHT FELLOWSHIP

Seated (left to right): Susumu Takayanagi (Japan), Charan Mahatumarat (Thailand), Carlos Lasa Jr. (Philippines) Standing (left to right): Alexander de Leon (Philippines), Gonzalo Bosch (Uruguay), Dr. & Mrs. Kazuyoshi Yajima (Japan), Misako Takayanagi (Japan), Dr. & Mrs. Marco Correa (Singapore), Dr. & Mrs. Florencio Lucero (Philippines)

tation, website and souvenir program); Christopher Aro (socials and publicity); Benjamin Herbosa and Gene Tiongco (accommodation, transportation and tours); Alexander de Leon (adviser); and Florencio Lucero (Philippine National Secretary for ISAPS). The ISAPS Course was preceded by the First National Meeting of the PAPRAS, which featured a full day of lectures by local plastic surgeons.

One hundred twenty delegates attended the course, coming mainly from the Philippines, Indonesia, Japan, Malaysia, Singapore, South Korea, Chinese Taipei, China and Thailand. A few delegates came from Australia, Brazil, India, Saudi Arabia, United Arab Emirates and

Uruguay. Scientific sessions were very well-attended and participation in the different social events was enthusiastic. The delegates were entertained during the fellowship night by the world-renowned Bayanihan Philippine National Folk Dance Company. The dance group takes its name from the Filipino word "bayanihan," which means working together for a common good. This "bayanihan" spirit could also very well describe the atmosphere of intellectual exchanges and social interactions among the delegates during the two-day conference.



ISAPS SYMPOSIUM TOURS

Michel Rouif, MD – France

President, SOFCEP



A one-day ISAPS Symposium was held on May 22nd before the XXVIIIth Annual Meeting of the French Society of Aesthetic Plastic Surgeons (SOFCEP) in Tours, Loire Valley, France.

The venue was the Centre de Congrès International Vinci, in the center of Tours. The scientific program of the Symposium, opened by President Carlos Uebel, featured interactive video sessions in the morning on Neck Rejuvenation and Rhinoplasty, with Breast Augmentation Revision and Surgical Body Contouring in the afternoon.

All the presentations during the Symposium were in English and, for the first time during an annual SOFCEP meeting and now required for the future, all the slides were in English for the French Annual Meeting with simultaneous translation. The guest faculty included Brannon Claytor (USA), Gal Moreira Dini (Brazil), Julius Few (USA), Jack Fisher (USA), James Grotting (USA), Joachim von Finckenstein (Germany), Nimrod Friedman (Israel), Raul Gonzalez (Brazil), Sebastian Haack (Germany), Milos Kovacevic (Germany), Alfredo Hoyos (Colombia), Foad Nahai (USA), Cemal Senyuva (Turkey), Susumu Takayanagi (Japan), Patrick Tonnard (Belgium), Lina Triana (Colombia); and from France, Richard Abs, Jacques Bardot, Alain Bonnefon, Jean-Claude Dardour, Emmanuel Delay, Denis Delonca, Jean-Brice Durond,

Alain Fogli, Yves Jallut, Jean-Luc Jauffret, Daniel Labbé, and Jean-François Pascal.

We would like to thank the more than 300 attendees who were present early in the morning, and the numerous companies (more than 30) that supported the three-day meeting.

An excellent, gastronomic French dinner welcomed our international guests the evening before the Symposium. A private visit to the Chateau d'Amboise, including the chapel where Leonardo da Vinci is resting for eternity, was organized just before an amazing and memorable Faculty Dinner for our guests – including a visit by ghosts of the King's court, dressed in Renaissance fashion who were happy to pose for photographs.

After the SOFCEP Annual meeting, a balloon flight over the castles and the Loire Valley - wake up at 5am! - was scheduled followed by conferences (dissections of Leonardo, Bionics) and a private visit of Leonardo da Vinci's last house in Amboise, marvelously presented by the owner of the castle, Mr. Gonzague Saint Bris, a famous French historian and writer.

Thank you to everyone who made this Symposium so successful, especially Eric Auclair; Alain Fogli; Olivier Gerbault; Bernard Mole, ISAPS National Secretary for France; Nazim Cerkes, Chair of the ISAPS Education Council; and Carlos Uebel, president of ISAPS.



Faculty at the Chateau d'Amboise, before the Chapel where Leonardo da Vinci is buried.

ISAPS COURSE AZERBAIJAN

Nazim Cerkes, MD – Turkey
Chair, ISAPS Education Council

On May 31 and June 1, 2014 an ISAPS Course was held in Baku, Azerbaijan. The conference was declared open by the Rector of Azerbaijan Medical University Ahliman Amiraslanov with sixty plastic surgeons attending from Azerbaijan, Turkey, France, Russia, Australia and Iran. The international faculty included from France, Eric Auclair; from Iran, Kamran Asadi; and from Turkey, Nazim Cerkes, Cemal Senyuva, Tunc Tiryaki, Leyla Arvas, Fuat Yuksel, Erhan Eryilmaz, Cemal Aygit, Erdem Guven, Aylin Bilgin, Derya Özçelik, and Aylin Kurt. From our host country, the following surgeons also participated as faculty: Vagif Galandarov, Abbas Ahmedli, Teymur Babayev, Mircafar Seyidov, Rauf Karimov, Samira Huseynova, Ilyas Axundzade,

Araz Salmanov, Nigar Sultanova, Sevinc Tabrizli, Elchin Mammadov, Elman Aliyev, Mahir Aliyev, Chingiz Rahimov, Hasan Asadov, Reza Fathi, Mahammad Davudov, Dilgam Maharramov, Parviz Abbasov, Ismayil Farzaliyev, Ruslan Maharramov. There was lively interest in the scientific sessions and the Local Organizing Chair, our ISAPS National Secretary for Azerbaijan, Vaqif Galandarov, did an outstanding job organizing the course and the very nice social program. It is the mission of ISAPS to bring our education program to countries whose surgeons are less likely to be able to travel to larger meetings. The success of this course in Azerbaijan is therefore rewarding not only to our local colleagues, but also to the ISAPS Education Council.



Local course organizer Vaqif Galandarov addresses the group.



The enthusiastic audience in Baku, Azerbaijan.

MEMBERSHIP IMPROVEMENTS OVER THE LAST TWO YEARS

Ivar van Heijningen, MD– Belgium

Chair, ISAPS Membership Committee and National Secretary for Belgium



In the last two years, the membership committee has been working hard to improve a number of issues. ISAPS needs a membership base sufficient to sustain the quality of the education we offer, to support all our member benefits, and to make this organization work. Our president, Carlos Uebel, made us focus on attaining 3,000 members by the time of the 2014 congress while retaining the quality of the membership. This goal is within reach. How did we do this?

Statistical analysis

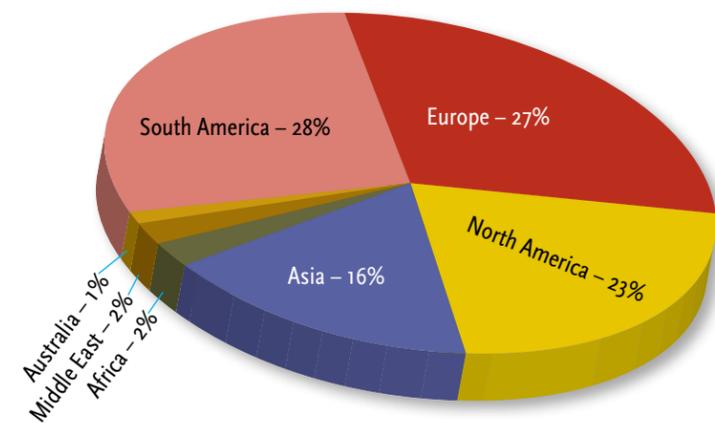
We looked at the current membership and realized that with an estimated 32,500 plastic surgeons in the world, we would need an average of 9% to reach 3,000 members in ISAPS. If we ana-

lyse our membership, we see that it is pretty evenly distributed around the globe. Europe is a little better represented in ISAPS than North and South America.

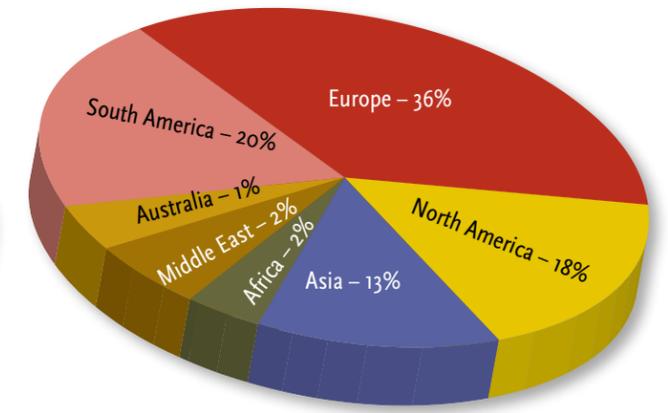
Some countries have many more members while others have fewer than the expected 9%, but if we look at the countries who are significantly under-represented in ISAPS, and thus have the biggest growth potential, then this gives us the following top five:

1. United States
2. Brazil
3. China
4. South Korea
5. Japan

PERCENT OF PLASTIC SURGEONS WORLDWIDE



PERCENT OF TOTAL ISAPS MEMBERSHIP



Identification of Problems and Solutions

We contacted all the ISAPS National Secretaries and asked them what they saw as the primary obstacles in the application process as well as reasons why plastic surgeons do not join ISAPS. Their response made clear that our members value QUALITY more importantly than QUANTITY, but having said that, a number of suggestions came up with respect to our membership. With this information we identified four potential new member groups:

Group 1. Know ISAPS and want to become a member

This group wants to join, but have not yet for a number of reasons:

1. Do not understand the application procedure
2. Find the application procedure difficult

3. Have difficulty finding sponsors
4. Cannot fulfill requirements (e.g., active membership in local national society)

We improved the application process making it easier and more accessible on the website; we adjusted the requirements for sponsorship and national society membership (including a proposed By-Laws change); and we changed admission from three times a year to monthly. We also created a Fast Track procedure for groups of members of an aesthetic plastic surgery society who have already been screened by that society to be admitted en masse. We signed a Memorandum of Understanding with China to make it easier for Chinese plastic surgeons to join us.

continued on page 19

MESSAGE TO THE NATIONAL SECRETARIES

Gianluca Campiglio, MD – Italy

Chair, National Secretaries



This is my last message as Chair of the ISAPS National Secretaries as my two-year term will end in September and, as already communicated at the last National Secretaries Meeting in San Francisco, I will not be a candidate for a second term.

These last two years have been a wonderful, but also very demanding experience. I travelled a lot, participating in more than 20 scientific meetings, thus having the opportunity to know many of you better. I have always been welcomed with open arms and in most cases a sincere friendship was also established.

I collaborated shoulder to shoulder with Catherine and her indefatigable staff trying to solve various problems, sometimes small, sometimes great, with which you promptly helped us. We worked to standardize the election process for National Secretary and Assistant National Secretary as it was so different from country to country. Now it is a very transparent, democratic and effective process which has already been successfully experienced quite recently in Italy, Colombia, France, Greece, and Ukraine. We have also reviewed our By-Laws in order to redefine the role and election procedure of the National Secretary in our society.

Together with the Membership Committee, we simplified the membership application process by eliminating or reducing some requirements and speeding up the procedure.

We also promoted our education program by obtaining credit that is usable in the US and Europe. The Cannes ISAPS Course was the first meeting with formal CME accreditation and others will come in the future.

I tried to be, and honestly I think I have been, a reliable connection between the “family” of our 72 National Secretaries and the Board. Every problem or complaint you reported to me was passed on to the Board where it was debated and analyzed in order to find a solution. At the same time, the strategic decisions of the Board were shared with you and problems were addressed democratically.

I would like to thank my Assistant Chair, Sami Saad of Lebanon, with whom I always collaborated when we needed to make important decisions.

Two years is the right term for so demanding a task and now it is time that the members, through their National Secretaries, and the National Secretaries themselves choose their new Chair. I assure you that there are outstanding candidates among our “family.”

New National Secretaries

We welcome newly elected National Secretaries:

- Chinese Taipei Chien-Tzung CHEN, MD
- Colombia Maria Isabel CADENA RIOS, MD, PhD
- France Bernard Mole, MD – *Re-elected*
- France Michel Rouif, MD – *Assistant National Secretary*
- Germany Dennis O. von HEIMBURG, MD, PhD – *Re-elected*
- Germany Joachim Graf von FINCKENSTEIN, MD – *Assistant National Secretary*
- Greece Panagiotis N. MANTALOS, MD, PhD
- Italy Giovanni BOTTI, MD
- Japan Hiroyuki OHJIMI, MD, PhD
- Slovenia Tomaz JANEZIC, MD
- Ukraine Pavlo DENYSHCHUK, MD
- Uruguay Oscar JACOBO, MD
- USA Mark Jewell, MD – *Re-elected*
- USA W. Grant Stevens, MD – *Assistant National Secretary*
- Venezuela Gabriel OBAYI TAHAN, MD

MESSAGE FROM THE COMMUNICATIONS COMMITTEE

Sami Saad, MD – Lebanon

Chair, Communications Committee and Assistant Chair of National Secretaries



Social media, including Facebook, Twitter, LinkedIn, Google+, and many others, as well as newspapers, magazines, and TV shows, have all come to play a major role in the widespread knowledge and distribution of information throughout the world. Plastic surgeons worldwide have realized the importance of media to promote exposure to their clientele, and a great majority of them are quite active in this field. Some even have specialized staff or firms handling their social media accounts.

ISAPS realized the necessity of such exposure several years ago, and is getting more and more involved in social media. One of the key points and influencing factors in such exposure is the statistics that we publish on a yearly basis, which are being quoted repeatedly by media through-



out the world. These numbers are eagerly awaited. The participation of plastic surgeons in the collection of these numbers by responding to the ISAPS survey, and the analysis of these numbers by specialized people to produce reasonable and meaningful statistics to give to the world, all play a major role in the final outcome.

These numbers are now almost ready and will be release to the media soon, as well as on the totally revamped ISAPS website, before the Biennial Congress that will take place in September in Rio de Janeiro. We hope that these statistics will reflect the true situations in all countries, and that they will be an additional push towards establishing ISAPS as THE source of information on aesthetic plastic surgery worldwide.

VPP, continued from page 9

very interactive session took place that afternoon when the techniques presented were demonstrated on fresh cadavers. The students again had the opportunity to apply these techniques individually on the cadavers.

During the evenings, everyone enjoyed the wonderful social events which were outstandingly organized by MedOrg and the very hospitable Fadi Dannoura who did his best to make everyone enjoy these events after the long, but edifying, days of teaching.

The impressive premises of the Sharjah University and the ceaseless efforts of the local staff to offer everything that would make this course successful were appreciated by both the students and the professors.

At the end of the program, the students were asking when the next one will take place in the UAE with different topics, and expressed their enthusiasm for this wonderful ISAPS initiative to spread education worldwide through the Visiting Professor Program.

Survey Winning Numbers

Our 2014 Global Survey of Aesthetic Procedures offered 20 certificates valued at \$200 toward any official ISAPS Course or this year’s Congress. If you submitted responses to the survey, you were sent a confirmation email with a code number. The winning code numbers are listed below. These were randomly selected by our survey analysts. To claim your \$200 certificate, simply forward your confirmation email with the code number to the ISAPS Executive Office at either isaps@conmx.net or fax it to 1-603-643-1444.

Thank you to the many individuals who submitted their procedural data to this year’s survey. The results are being analyzed and will be released later in July. Watch our website for the final report at <http://www.isaps.org/news/isaps-global-statistics>

Confirmation Code Number

- IG6RC6WG
- JND0DELW
- EQ5LTZE5
- UHEN49Go
- WF2LFPIU
- G5VGE07D
- 3NKTV934
- 5S24J26S
- F6TFWT27
- K9SKG35M
- KJR9STA
- X4UFCN6C
- UQ2UE0DE
- C88YWZ8
- MMR2ARFM
- UUVBUG
- 9XRHKRQX
- MBUM1466
- YTWY3W7F
- G5RXT985

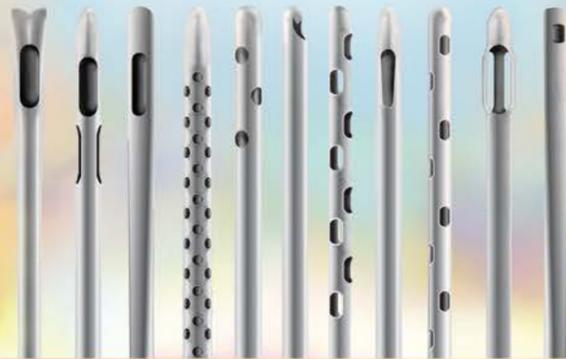


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Membership Committee Report, continued from page 15

Group 2. Former ISAPS members

This group includes previous members who did not renew because:

1. Stopped working (age related)
2. Found membership fee too expensive for what it offers them
3. Not enough courses near to them
4. National or local societies provide all they need

We organized a "lure back plan" in 2013 and offered a reduced fee to encourage them to rejoin us. We try to continually improve the membership benefits to make membership more attractive in order to retain our members.

Group 3. Know about ISAPS, but don't join

This group has heard of ISAPS, but has not considered membership yet or do not want to become a member because:

1. They do not see the benefits
2. They have no urge to belong ("anyone can join . . .")
3. Just another organization . . . ("I already belong to so many . . .")
4. Too expensive

We added the new **ajax** iPad App to enable easy access to our blue journal, *Aesthetic Plastic Surgery* anywhere you want; we now offer ISAPS plaques, lab coats and scrubs with the ISAPS logo; and we have dramatically improved our website to include patient content in ten languages.

Group 4. Don't know ISAPS

This group has never heard of us. We have improved the visibility of ISAPS enormously by working with a dedicated PR office that has created functional Facebook, LinkedIn and Twitter accounts for us. A new NEWS section of the website features current news items that usually quote ISAPS members. ISAPS statistics gathering brings us huge media attention. We are working on an Aesthetic Plastic Surgery Curriculum to define what we are about. The education effort has increased in a number of ways: the Visiting Professor Program; the enhanced number of courses and symposia; endorsed fellow-

ships; and we acquire credit points where possible. At most courses and symposia, we try to have a booth with dedicated staff with online access to process applications on-site where potential new members can also check a list of ISAPS member attendees and request their sponsorship while at the course.

The Future

We are all aging, fortunately with our line of work, but as an organization as well. This means we have people become life-members every year and we need young people to join us. The associate member group is growing, but not at a pace we would like. Especially given our core-business—"education"—we should do better. In the next two years, we will focus on our associate members more to make it more attractive for residents and young plastic surgeons to join us. We are working on a plan to do this, but always welcome member input.

Conclusion

A lot of work has been done in a collaborative effort by the membership committee, the board, other committees and of course the hard work of our staff in the Executive Office. It looks like we may reach 3,000 members by the time of the Rio congress, but we cannot rest, because the next goal is to retain all these members! The only way to do this is to focus on what we are as an organization and emphasize our strong points: Education (our courses and journal), Ethics, Patient Safety and the collegiality that comes from being a member of a unique, growing, and vibrant international organization of like-minded professionals.



Guess Who!



See page 49 for details.

LIFE IN THE FAST LANE

Tunc Tiryaki, MD – Turkey



“Hotel California” is the cult song with which the classic rock band, Eagles, has become famous all around the world. However, my favorite Eagles song is not this one. It is and has always been the song “Life in the Fast Lane.”

The cords, lyrics, similar songs and similar groups alongside 88 million similar results as well as the background of the title can all be found on the Internet. This single example of the amount of information we see or can access every day, and the speed with which it comes to us, indeed deserves to be called *life in the fast lane*.

We live fast. We see patients daily. We operate on some of them. At the same time, we send and answer emails, keep up with new developments in plastic surgery, discuss surgical obstacles with our colleagues—we learn, we follow and we share.

To make things easier, something like a professional Facebook was needed. It was missing, though desired, for a long time. But now we have it. It is called **ajax**.

The name AJAX comes from *Aesthetic Journal Access*. This recently released tool is the new education and collaboration platform—a long awaited ISAPS member benefit.

Simply put, it is our professional social network. It allows ISAPS members to create a private means to discuss ideas, innovations, and new technology with trusted member colleagues. Maybe more importantly, it is here for everyone—from seasoned veterans to younger physicians and residents-in-training. And yes, it is very user-friendly, like Facebook or Twitter.

Download it to your iPad from the App Store as “AnzuMedical.” Set up your account using your ISAPS Member ID for both

the Login and Password. Instructions are on the home page of the ISAPS website Member Area. An even more expanded version for iPhones, Androids and desktop computers is coming this summer.

As ISAPS members, we are all pre-registered and can access the ISAPS library automatically with the past 16 years of *Aesthetic Plastic Surgery* already delivered. If we are also members of ASAPS, we can access their journal issues by simply clicking on that society in the directory.

We can create our private worldwide contact list, search, reach and follow friends or world experts on any topic of interest. We can design our own library, annotate, organize, and share all content and multimedia attachments, and collaborate with each other in real time.

Notes and bookmarked videos can be saved in our personal electronic binders for instant access at any time. We can share our binders and annotated documents from our personal library with members of our private network.

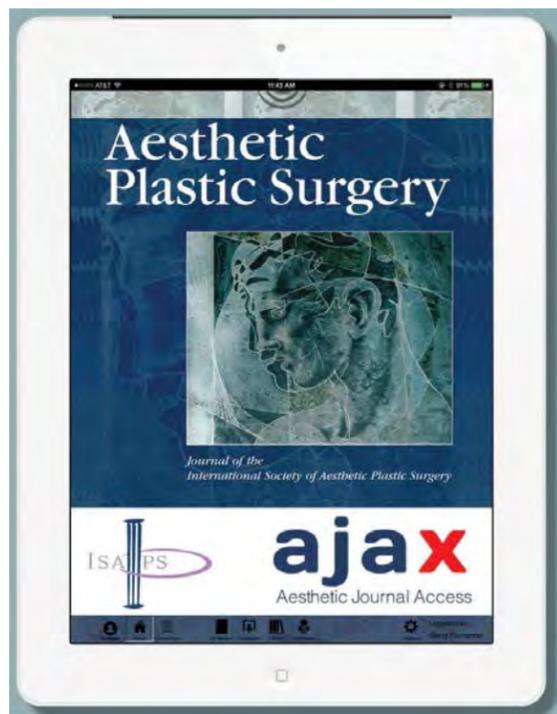
Even a global discussion that contains attachments (audio notes, photos, videos) can be initiated. A web link **ajax** Discussion Board allows the worldwide exchange of clinical ideas, information and techniques

among us ISAPS members.

In order to be “Livin’ on the Edge,” we need to stay connected, learn from each other, and teach each other.

ajax is our new way to live in the fast lane smartly. 

Editorial reprinted with permission of Springer and ISAPS; first published in APS, Volume 38, issue 2 (April) 2014



CORRECTION SURGERY – NO CHARGES TO THE PATIENT

Alison Thornberry – United Kingdom

Managing Director, Sure Insurance



No surgeon operates on a patient without explaining the possible complications that can occur following surgery. However, does the patient fully understand the difference between an immediate medical complication normally covered by the surgeon and/or the hospital’s aftercare policy, against longer term corrections that may be necessary?

For example, does the patient understand that should they suffer a capsular contracture or asymmetry, the additional cost for remedial treatment would not normally be covered under their original payment for the cosmetic surgery? It is quite normal for a patient to present themselves to their surgeon six to 18 months or even longer after the surgery to complain that they have issues and that these issues are causing them emotional worries.

Clearly, cosmetic surgery is not the answer to emotional stresses a patient may already be suffering, but no surgeon would want to add stress to a patient’s life because they have suffered a complication following their operation. Offering the patient a remedial procedure to correct the problem is, of course, the ethical thing to do. However, who pays for this? The hospital, surgeon and anesthetist will quite correctly feel the additional time, costs and medical supplies were not included in the original charges. Negotiations between these parties often take place for these additional charges or the surgeon may have to explain to the patient that they will be invoiced for the remedial treatment.

ISAPS Insurance was created to assist with the costs of remedial treatment. The question of who pays disappears!

How does it work?

There is no cost for an ISAPS member surgeon to register for this program. The member is then entitled to notify ISAPS Insurance administrators of any patients they wish to cover. Once registered, the surgeon simply sends a list of patients to be covered once a month (in the month following the patient’s operation) and the surgeon is sent an invoice for the premiums due. The member surgeon is entitled to charge their patient for their guarantee of remedial treatment.

Of course, it is very important that patients know if a member offers ISAPS Insurance. The member surgeon is easily identi-

fied by an ISAPS Insurance logo next to their name in the membership directory on the ISAPS website, www.isaps.org

There is also a directory of surgeons who have already registered for the ISAPS Insurance program with more detailed information at the dedicated website www.isapsinsurance.com

Many member surgeons ask: “How complicated is it to make a claim?” The answer is: very easy! It is a given that as an international society there may be language issues or different interpretations of diagnosed conditions and therefore a tick box claim form has been created for easy processing. The surgeon simply confirms that they originally covered the patient with ISAPS Insurance together with the type of procedure, date and place of surgery. Then they tick a box to confirm the procedure, diagnosed condition, and explain the remedial treatment they wish to perform. Once the patient has given their permission, this information, the patient notes, before and after photographs, and the estimated cost of the remedial treatment are submitted for processing. Claim payments made to date have been sent with seven to ten days of receipt of these documents.

Another question often asked is: “If the surgeon-patient relationship has broken down, as the original surgeon, can I appoint another surgeon to carry out the remedial treatment?” The answer is: “Yes, as long as the second surgeon appointed is also an ISAPS member.”

Good News!

ISAPS Insurance has now been extended so that a registered member may offer their patients remedial cover for two years following the date of the original procedure. The number of procedures covered by ISAPS Insurance has also been increased to over twenty.

ISAPS Members: To request a copy of our new Surgeon’s Guide, send an email to Stephanie@isapsinsurance.com You may also speak directly with a member of the team by calling: 0044 (0) 207 374 4022 in London.

You may also request contact details of an ISAPS member surgeon who is already using the ISAPS Insurance Program to ask their opinion of the cover and the service provided.

ISAPS Insurance is managed by our partners at Sure Insurance in London and is underwritten by certain underwriters at Lloyd’s.



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2nd Congress	Jerusalem, Israel Leo Bornstein, <i>Local Arrangements Chair</i> Paul Wilflingseder, <i>Scientific Program Chair</i>	June 1973	13th Congress	New York City, USA Blair O. Rogers, <i>Local Arrangements Chair</i> Peter B. Fodor, <i>Scientific Program Chair</i>	September 1995
3rd Congress	Paris, France Roger Mouly, <i>Local Arrangements Chair</i> Jacques Oulié, <i>Local Arrangements Co-Chair</i> Lester Cramer, <i>Scientific Program Chair</i>	August 1975	14th Congress	São Paulo, Brazil João Carlos Sampaio Góes, <i>Local Arrangements Chair</i> Rolf Gemperli, <i>Scientific Program Chair</i>	June 1997
4th Congress	Mexico City, Mexico Mario González-Ulloa, <i>Local Arrangements Chair</i> José Guerrerosantos, <i>Scientific Program Chair</i>	April 1977	15th Congress	Tokyo, Japan Nobuyuki Shioya, <i>Local Arrangements Chair</i> Kitaro Ohmori, <i>Scientific Program Chair</i>	April 2000
5th Congress	Rio de Janeiro, Brazil Ricardo Baroudi, <i>Local Arrangements Chair</i> Mario González-Ulloa, <i>Scientific Program Chair</i>	May 1979	16th Congress	Istanbul, Turkey K. Güler Gürsu, <i>Local Arrangements Chair</i> Sabri Acartürk, <i>Scientific Program Chair</i>	May 2002
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8th Congress	Madrid, Spain Benito Vilar-Sancho, <i>Local Arrangements Chair</i> Ulrich T. Hinderer, <i>Scientific Program Chair</i>	September 1985	19th Congress	Melbourne, Australia Peter Callan, <i>Local Arrangements Chair</i> Susumu Takayanagi, <i>Scientific Program Chair</i>	February 2008
9th Congress	New York City, USA James Smith, <i>Local Arrangements Chair</i> Sherrell Aston, <i>Scientific Program Chair</i>	October 1987	20th Congress	San Francisco, USA Bryant Toth and Bud Alpert, <i>Local Arrangements Chairs</i> Renato Saltz, <i>Scientific Program Chair</i>	August 2010
10th Congress	Zurich, Switzerland Trudy Vogt-Suter, <i>Local Arrangements Chair</i> Frederick Nicolle, <i>Scientific Program Chair</i>	September 1989	21st Congress	Geneva, Switzerland Kai-Uwe Schlaudraff, <i>Local Arrangements Chair</i> Alain Fogli, <i>Scientific Program Chair</i>	September 2012
11th Congress	Guadalajara, Mexico José Guerrerosantos, <i>Local Arrangements Chair</i> Thomas Biggs, <i>Scientific Program Chair</i>	February 1992	22nd Congress	Rio de Janeiro, Brazil The late Ruy Vieira and Eduardo Sucupira Pinto <i>Local Arrangements Chairs</i> Jorge Herrera, <i>Scientific Program Chair</i>	September 2014

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BODY CONTOURING AFTER MASSIVE WEIGHT LOSS: PSYCHOSOCIAL CONSIDERATIONS

David B. Sarwer, PhD – United States

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Obesity is accompanied by significant psychosocial distress for many individuals who suffer with the disease. The presence of excess body weight is associated with lower levels of quality of life and self-esteem as well as increased symptoms of depression and body image dissatisfaction. For most individuals, the degree of dissatisfaction is related to the amount of excess weight a person has, although persons do report dissatisfaction with their entire bodies or with specific features. Body image dissatisfaction is believed to be a central motivation for weight loss, even among those with significant weight-related health problems.

Bariatric surgery is the most powerful tool currently available to treat obesity. It produces the largest and most durable weight losses that often lead to substantial improvements in morbidity and mortality. These weight losses also are associated with significant improvements in psychosocial status. Most psychosocial characteristics — including symptoms of depression and anxiety, health-related quality of life, and self-esteem — improve dramatically in the first year after surgery. Many of these benefits appear to endure throughout the first postoperative decade.

The massive weight loss typically seen with bariatric surgery is also associated with significant improvements in body image. Unfortunately, some patients who lose large amounts of weight report residual body image dissatisfaction related to the presence of loose, sagging skin of the abdomen, breasts, thighs and arms. Most post-bariatric surgery patients consider the development of excess skin to be a negative consequence of surgery. This dissatisfaction likely leads some individuals to seek plastic surgery to address these concerns.

According to the American Society of Plastic Surgeons, in 2013 approximately 42,000 patients underwent body contouring procedures after weight loss. The most common of these were abdominoplasties which were performed on over 16,000 women. Mastopexies are also common and were performed on almost 11,000 women. There is a growing body of knowledge related to the surgical aspects of these procedures. Far less is

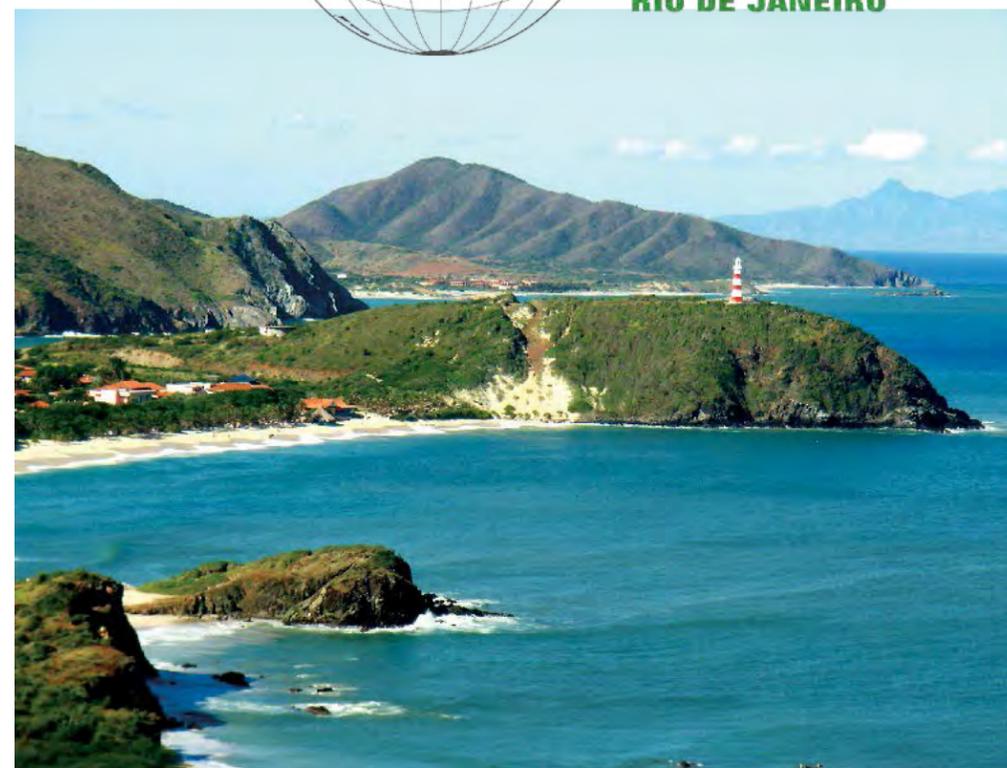
known about the psychological characteristics of these patients and the psychosocial changes they experience following body contouring.

As in other forms of plastic surgery, understanding the psychosocial characteristics of candidates for body contouring surgery patients plays an important role in their preoperative assessment and postoperative management. The preoperative psychological assessment of the patient who has lost a massive amount of weight should be a central part of the initial consultation with the plastic surgeon. The assessment should focus on several areas: motivations and expectations, appearance and body image concerns, and psychiatric status and history. In addition, the plastic surgeon should determine that patients are weight stable at the time of body contouring.

Many patients who have lost a massive amount of weight may hold unrealistic expectations about the anticipated results of body contouring. Some may incorrectly anticipate that body contouring surgery will result in a total body transformation that makes their bodies comparable to persons who never suffered with extreme obesity. Others may not fully understand that body contouring surgery often produces large and visible scars, skin irregularities, and residual deformities in body shape. Patients should be reminded that although surgery may improve body contour, it will not result in a “perfect” body shape.

The plastic surgeon should inquire about the patient’s expectations of the impact that body contouring surgery will have on romantic and sexual relationships. At least one study has found a higher than anticipated divorce rate following bariatric surgery. It is possible that body contouring surgery may be associated with similar changes in the dynamics of social and romantic relationships. Patients who express unrealistic expectations (e.g., that the change in appearance will save a troubled marriage) may be more likely to express disappointment and dissatisfaction with their postoperative result, even if the surgeon believes that the result is acceptable.

Patients’ subjective perception of the postoperative result is at the heart of the body image concerns of these, and all,



plastic surgery procedures. Thus, the assessment of patients’ body image is a critical part of the initial consultation. It is useful to have patients describe, in their own words, what they dislike about their appearance. In addition, the degree of dissatisfaction should be assessed. Some body image dissatisfaction is typical among patients who undergo plastic surgery and bariatric surgery. Those who report that they think about their appearance for more than one hour each day or those who report that their concerns lead to significant emotional upset or disruption in daily functioning may be experiencing extreme body image dissatisfaction. These patients likely should undergo a mental health evaluation before body-contouring surgery.

Individuals who undergo bariatric surgery have higher rates of psychopathology — mood and anxiety disorders, substance abuse, for example — than the general population. While the symptoms of these disorders improve for some individuals after surgery, others continue to struggle with these issues throughout their lives. The treating plastic surgeon should be aware of these issues, assess for the presence of these symptoms during the initial consultation, and refer the patient to a mental health professional for a preoperative consultation if significant psychopathology is suspected.

David B. Sarwer, PhD is a recognized authority on the psychological aspects of physical appearance and their relationship

to both cosmetic and reconstructive treatments. His work in this area over the past two decades has been published in peer reviewed journals covering plastic surgery, dermatology and psychology. He has co-edited two books in this area: Psychological Aspects of Reconstructive and Cosmetic Plastic Surgery (Lippincott, Williams & Wilkins, 2006) and Presurgical Psychological Screening (American Psychological Association, 2013). He also serves as an Associate Editor for Body Image and Health Psychology and serves on the Editorial Board for Aesthetic Surgery Journal and Plastic and Reconstructive Surgery. In a series of articles in the next few issues of ISAPS News, he will provide more in-depth information on the psychological aspects of aesthetic surgery.



NORTH AMERICA: UNITED STATES

J. Peter Rubin, MD, FACS



In the United States, body contouring after massive weight loss (MWL) has become recognized as a distinct sub-specialty in plastic and reconstructive surgery. The incredible growth of bariatric surgery, starting in the late 1990s, has fueled a whole new discipline as we have learned to understand the complex medical management and technical challenges inherent to the MWL patient. Currently, over 150,000 bariatric surgery procedures are performed in the U.S. every year. The range of procedures offered to these patients encompasses abdominal contouring, lower body lifts, brachioplasty, thigh lifting, facial rejuvenation, and a number of other unique procedures that have been developed for the MWL patient.

In order to address the technical challenges, several unique developments have evolved. For example, our center has pioneered techniques for breast reshaping after MWL that utilize principles of dermal suspension and parenchymal shaping. These powerful techniques allow the breast tissue to be suspended against the chest wall, directly to rib periosteum, and precisely shaped for long-lasting aesthetic outcomes. Additionally, this procedure has the ability to augment the breast volume with tissue from the lateral chest wall, transposed as a fasciocutaneous flap. This procedure has been widely published and presented.

Another area of innovation has been in the contouring of the upper trunk. These “upper body lift” operations often involve transverse resections of tissue along the posterior trunk set in

the bra line. Other variance includes lateral chest excisions that are performed bilaterally. Many times, incisions will be merged between brachioplasty and breast reshaping procedures.

Insurance coverage in the U.S. has been primarily focused on resolving symptoms of intertrigo on the lower abdomen due to an overhanging pannus. Patients must document medical treatment with topical therapy and persistence of rashes. Other procedures are not covered by insurance and are considered fee for service cosmetic operations.

Another evolution in the care of the post-bariatric patient has been the practice of safely combining multiple procedures. This is often done by experienced teams in a hospital setting. This allows major reshaping strategies to be commenced across anatomic regions in fewer stages. Staging is a very important concept for the care of the MWL patient, as it enables safe operative plans.

Body contouring after MWL is an incredibly rewarding area of practice that has high impact on patient quality of life. Body contouring truly completes the weight loss journey for our patients who have changed their lives through significant weight loss.

As the editor of *ISAPS News*, I am pleased to present to our members this Global Perspectives topic. I know that you will enjoy reading about the many challenges of this area of practice, and the creative solutions that our colleagues around the globe have developed. 

Global Perspectives – Future Themes

September – December

Rhinoplasty

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If you would like to contribute an article of 500-750 words, please forward to isaps@conmx.net. This is 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 region?

NORTH AMERICA: UNITED STATES

Sadri Ozan Sozer, MD



According to the latest statistics, there are 671 million obese people in the world. The United States is ranked number one among the most obese countries. As a result, the number of bariatric surgeries being performed is increasing dramatically. Body contouring after massive weight loss is becoming one of the main topics in plastic surgery. Fifteen years ago these types of surgeries were being performed in very few centers and nowadays they are common procedures in many offices.

While participating in several ASAPS and ISAPS courses in the last couple of years, I have met some of the leaders of body contouring after massive weight loss and had the opportunity to discuss several issues with them face to face. Although the procedures are common, there are still unanswered questions and different approaches. I believe the main issue in body contouring after massive weight loss in the USA is patient safety.

- Is it safe to perform combination procedures in one session?
- Is it safe to combine liposuction with other surgical procedures?
- When should we use DVT prophylaxis?

Surgeons who promote large combination procedures usually do not support including liposuction. Having a team of plastic surgeons with expertise is a must for these procedures. For that reason, these large combinations are usually performed in academic settings where these teams are readily available. On the other hand, advocates of combining liposuction with other procedures claim that results are better when liposuction is done at the same time, but do not recommend performing combinations of several procedures. Also, there is the question whether

these surgeries should be done in an outpatient or inpatient setting. Unless it is a large combination procedure, the trend in the United States is more towards an outpatient setting.

Depending on the risk factors, such as age, BMI, hours in the operating room, and combination procedures, DVT prophylaxis is recommended by the majority of surgeons. Certainly, there is an increased risk of hematoma and higher incidence of transfusions with DVT prophylaxis. Some surgeons are against DVT prophylaxis as long as they have a team to complete the procedures in less than four hours. Some surgeons support decreasing the risk factors before surgery so they do not need to use prophylaxis.

In addition to the issues of safety, there are different techniques for each operation. By now, we have all learned that there is more than one way of achieving a good result. It is the same way in the United States. There are different ways of doing abdominoplasties, buttock contouring, short scar, and long scar brachioplasties. Fat injection is becoming more popular, especially for buttock, hips and breast contouring. There is increasing use of barbed sutures. I believe scar quality is improving with the use of new sutures and adhesive tapes applied on top of the incisions.

Overall, in the United States, the experience in body contouring in massive weight loss is increasing due to the high demand. More surgeons are getting involved and there are now one-year fellowships with focused training.

I am looking forward to the ISAPS Congress in Rio where ideas on this topic from multiple nations will be discussed. That is what differentiates medicine from other professions. We do not patent our ideas. We share them.

Statistics Source: www.Nordbariatric.com



EUROPE: UNITED KINGDOM

James D. Frame, MD



There are few fortunate people who can maintain a low body mass index (BMI) and live a sedentary lifestyle. The scourge of the Western lifestyle is often associated with overweight men, women and children with varying degrees of obesity based upon BMI classification. Obesity is now endemic and often associated with low feelings of body image, addiction to food, low physical activity and little regular exercise. It can however be associated with injury or disability. For example, it is now well known in the Burn Management world that forcing an extra high-calorie intake, as advised in the 1980s, was wrong and often resulted in obese children, despite family genetics indicating the opposite should have happened. Recently, the national newspapers published an article referring to UK women having the highest incidence of obesity in Europe! There is clearly an individual's responsibility, but often there are significant underlying causes that need to be addressed. These factors will definitely impact on the response to any future plastic surgery and psychological assessment is vital.

For patients keen to improve their health and life expectancy, there are myriad diets, exercise and weight loss programs, including the last resort—which is surgery. Some patients jump in early and plastic surgeons may also be premature in trying to use liposuction, breast reduction, or abdominoplasty to improve body image where there may be more appropriate first-line general surgical methods that are of more value. Not all patients with weight loss require the services of a plastic surgeon; in fact, if the weight loss is maintained at about one pound a week, it is very possible that skin redundancy may not be an issue.

According to the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS), all Specialist Plastic Surgery Centres, within the UK's National Health Service (NHS), have the facility to operate on post-massive weight loss patients. Specialist beds and equipment are needed, but the surgery is considered standard. A multi-team approach, as is available within the NHS, is essential and it is vitally important to have multiple surgeons operating synchronously to reduce time under anaesthesia and prevent surgical morbidity or even mortality. This is semi-elective surgery with high risk and patients will require high dependency and often a time in an intensive care unit. This

is not therefore surgery to be carried out within a private hospital setting. The NHS, until very recently, was geared to concentrate expertise in Specialist Centres and in many respects this is sound logic, but if the family is out of reach then social and domestic issues arise. Clearly there is a sound argument for dangerously obese patients to receive this level of management. This may alter if health risks from morbid obesity are reduced, as weight is lost and maintained, and normal physiology returns. Some of the best plastic surgeons may not be included within an obesity management team at one centre, but low-risk patients may be managed nearer their homes for any plastic surgery. This may fit in with new NHS directives encouraging appropriate care nearer to the patient's home.

Unfortunately, there are many instances where massive weight loss (MWL) patients have succeeded in maintaining a low BMI, but still have significant morbidity from sub-laxing and hanging skin. Unless these patients are offered tidy-up procedures, they risk relapse and a return to health risk. Most reasonable people would consider this surgery as money well spent and that the NHS should fund the plastic surgery. This is often not available without difficult and protracted argument and even then may be refused. Sadly, the NHS does not even allow shared cost with the patient. Patients are either NHS or Private. For safety reasons, the "at-risk" should have "cosmetic" tidy-up within the NHS anyway and not in the private sector. A proportion of "lower risk" patients may, however, be forced to have surgery in the private sector because they don't fit the NHS criteria for inclusion.

The collective estimated costs for multiple procedures would often be in excess of £100,000. Maybe this cost could be met by a few, but not the majority that must remain in limbo. Obesity is a disease whether it is classified as psychological, hormonal or enforced and of course prevention is the cure, but cultural lifestyles have permanently changed and this needs debate. The warning is out for those nations not yet embroiled in this epidemic.

For further reading, the BAPRAS Commissioning guide: *Massive Weight Loss Body Contouring* is provided at this link: <http://www.bapras.org.uk/downloaddoc.asp?id=1120>



EUROPE: GERMANY

Dirk Richter, MD

ISAPS Treasurer



Comparing the European countries and the US, the biggest number of bariatric surgeries performed was recorded in the United States (250,000 surgeries). This distribution is easily explained by the population size of the US as well as the highest percentage of obese residents (35.7% of adults in the US are obese).

The second biggest number of weight loss surgeries performed was recorded in France (30,450 surgeries). However, the number of surgeries does not correlate with obesity rates, in this case. The obesity prevalence in France is one of the lowest in Europe (11%).

To calculate popularity of weight loss surgeries in particular countries, we used ratios of bariatric surgeries done per 10,000 residents and per 1,000 obese adults. According to the statistics, Sweden is the leader in obesity surgery with nine surgeries performed on 10,000 residents and nine surgeries performed on 1,000 obese adults. The US is close with eight surgeries performed on 10,000 residents, whereas France is following with five. What is interesting is that the other three big Western European countries such as the UK, Germany and Spain are well behind these trends each having ratio of only one – meaning that the popularity of bariatric surgeries in these countries is nine times lower than in Sweden.

The interest in bariatric surgery is growing for several reasons. Firstly, surgeries result in significant weight loss in a short period of time and improvement of various obesity-related comorbidities. It also enhances the quality of life and general wellbeing. Unfortunately, it might bring body changes that are not attractive including sagging skin, extensive skin folds or wrinkling. Due to laxity, the skin might become inflamed and moist which may become a health problem.

The severity of sagging skin depends on the weight before the procedure and how and when it was reduced. In addition,

individual features might also have an impact such as older age, malnutrition after bariatric surgery, and factors interfering with skin elasticity. In Germany we calculate that about 30-35% of the post-bariatric patients will require reconstructive plastic surgery not only for cosmetic, but also for medical reasons.

It is important to wait until weight loss is stable. Body contouring procedures are advised after 18 months following bariatric surgery.

In Germany, the gold standard for post-bariatric patients has become the lower body lift procedure as it takes care of the vertical and horizontal circumferential skin excess due to the weight loss.

In many cases, general insurance reimburses these procedures if there are hygienic and mechanical problems caused by the skin excess. Not only circumferential procedures are covered, but also arm lifts, breast lifts and thigh lifts if the patients can prove that intertriginous eczema has been treated unsuccessfully by a dermatologist for a duration of minimum six months. Most of those surgeries are performed in general hospitals.

The plastic surgeon has become an important role in the bariatric team as he is able to motivate the patients during the process of weight loss. He should accompany the patient and control the development of skin folds and weight loss. In Germany, we do not recommend post-bariatric reconstructive surgery above a BMI of 32 because of a high complication rate. If the BMI drop is not as high as expected, the patient should be referred back to the bariatric surgeon in order to consider other options for example to convert a sleeve gastrectomy into a bypass procedure.

The bariatric surgeon makes the patient healthy; the plastic surgeon makes the patient happy!

Statistics Source: www.Nordbariatric.com



SOUTH AMERICA: BRAZIL

Carlos Del Pino Roxo, MD

Chief of Plastic and Reconstructive Service, Andaraí Federal Hospital, Rio de Janeiro



In the last fifteen years, we were surprised by a new type of patient in our offices: a patient who, through surgical or clinical methods, has lost a great amount of weight causing deformities throughout the body requiring a true body remodeling.

I usually say that bariatric surgery restores health, but plastic surgery restores dignity, making the patient able to be noticed by their qualities, not by their defects.

We are dealing with a patient who has several degrees of sagging, going from moderate to extreme, with poor-quality skin and laxity of muscle and aponeurosis, usually combined with dermatological lesions in skin folds. This patient has low expectations and through reconstructive plastic surgery can achieve excellent aesthetic results.

The most wanted plastic surgeries for these patients are:

1. **Abdomen:** we rather make circumferential abdominoplasty, leaving a scar on anchor (Fleur de Lis) only for cases with median abdominal incisions prior, fact that is more unusual.
2. **Breast:** we prefer mammoplasty and mastopexy with silicone implants (sub-glandular or sub-facial, because of the great loss of mammary tissue) always using moderate size because of the poor quality of the skin that usually makes a short-term result, and avoiding the sub-muscular approach that gives a dissociation between the implant (sub-muscular) and the parenchyma, making an image of a double bubble.
3. **Pubis:** This is a region which constrains many patients, especially women, making difficult the hygiene and changing genital anatomy. The surgery provides a lot of satisfaction to patients, by repositioning the genitals and giving a cosmetic improvement.
4. **Arms:** A brachioplasty surgery is very much requested by female patients because the redundant tissue hinders both sports and clothing. The surgical outcome results in a large hidden scar, but with rewarding aesthetic results.
5. **Thighs:** This is perhaps the area of greatest complication rate and still presents very poor results compared with other areas of the body, but depending on the degree of deformity, body relief combined with hygiene and the possibility of using more youthful clothes makes rewards outweigh the risks.

Surgical Association

This is a very controversial point. In my opinion, they are safe since the surgical team is adequate and trained, marking the incisions on the day before, thereby facilitating approach of two or three areas of the body in only one surgical procedure and using the lowest possible detachment.

In our surgical practice, we adopted the approach without detachment or minimal detachment. In the case of body lift, it makes it much easier because we can draw the patient in the day before surgery and save a lot of time by relying on a trained staff and an appropriate number of assistants.

Normally, the most frequent surgical associations are body lifting with brachioplasty and body lifting with thighs lifting. In selected cases, we can perform three associations without increasing a lot the surgical time.

We always start body lifting surgeries by the dorsal region where we dissect without detachment above the fascia. We do not infiltrate any kind of solution. Hemostasis of the dissected tissue is made under direct vision. We always put a drain (blake type) that will emerge by the pubis—dorsal drain always on the left. Suture of the flap is made in four layers.

1. Deep: mononylon 3/0
2. Intermediate: mononylon 3/0
3. Subdermal: monocrill 3/0 - 4/0
4. Intradermal: monocrill 3/0 - 4/0

We use the glue Octil cyanoacrylate to protect the wound, which is taken from the third week.

With the back finished, the patient is rotated to the supine position and markings are tattooed as well as points of reference for the sutures.

The dissection is performed latero-medially, always in the plan above aponeurotic. After the flap is resected, we dissect a tunnel (Saldanha) that goes to the xiphoid appendix. After this dissection we draw the plicatura and determine the point where it will be fixed the umbilicus (plication is made with vicryll 0.0 in X).

At this point, we can decide whether or not to initiate the associated surgery. The patient should already have all the drawings which will make a total difference regarding the surgical procedure and the postoperative result. The closure is made in four layers and the drain from the abdomen (blake) comes out in the

pubic area (right side). (See fig 1 and 2: Patient before, marked and Post op, front and back view)

Conclusion

Plastic Surgery after major weight loss has evolved from difficult to simple, slow to quick, dangerous to safe, unsatisfactory to excellent results.

Finally, I believe that we plastic surgeons have a major challenge ahead: that is to write a number of pages that are still blank for plastic surgery after massive weight loss.



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Figure 1



Figure 2

SOUTH AMERICA: BRAZIL

Flávio Mendes, MD and Fausto Viterbo, MD



Massive weight loss patients have recently become a new and fast-growing field of plastic surgery, with emerging important modifications and refinements in order to handle the dramatic body contour deformities, especially to the worldwide increasing post-bariatric population. These patients encompass a diverse and generalized pattern of body morphologic changes, by the pathological behavior of the Skin/Superficial Fascial System (SFS) complex, due to severe obesity followed by the massive weight loss process. Orthostatic pictures of those patients may give us a pretty good idea of how the pathologic tissues behave after gravitational effects over the zones of adherence. Nevertheless, the mobility of the Skin/SFS complex around the body, which was described by Aly as the “translation of pull,” also figures as an important morphologic component related to the same pathophysiology.

Classification systems are important tools for body contouring surgery as they should allow a brief and most accurate description of patient conditions, so that all the involved medical team will share a better and unified comprehension of the installed deformities, in order to correlate those data to a feasible treatment plan. In 2005, Song, et al published the *Pittsburgh Rating Scale*, which happened to be the first system totally designed and scientifically validated for body contour classification of the massive weight loss patients. This initiative overcame several drawbacks of the previous existing classifications as it completely addresses the full range of post weight loss deformities found in this unique population, with an inclusive and illustrative classification system that also

allows to correlate a list of appropriate surgical interventions for the different levels of deformities.

We have been using the *Pittsburgh Rating Scale* ever since its publication, incorporating that system into our practice. However, after several years applying it to our post-bariatric patients, we found some drawbacks in our clinical use. Although it is an effective, comprehensive classification system that consistently allows us to assign a clear graduation of body contour deformities, the simple orthostatic visual observation may not offer the best possible and most accurate description about the laxity and mobility

of the covering tissue around the body, ultimately Skin and SFS. A fundamental purpose of any classification system is to provide the observer with some supportive data that will point out the effective treatment to be indicated according to the different levels of deformity. We learned that in many cases of post bariatric patients, the full body photograph analysis lead to a comprehension status that was not quite consistent when the patient was dynamically examined. That is especially true for those observers who are not closely familiar with the severe tissue changes after massive weight loss, and to some extent, still keep tied under the paradigm



Abdomen 1



Abdomen 2



Dorsal 1



Dorsal 2

MIDDLE EAST: DUBAI

Luiz S. Toledo, MD



The United Arab Emirates ranks as the fifth fattest nation in the world, according to a recent study published by a BMC Public Health journal. More than 66% of men and 60% of women in the UAE are overweight or obese, prompting researchers to issue a call for action for the region.

Although the index is high, the UAE ranks behind the US, Kuwait and Qatar. An average adult in the UAE and Qatar consumes over 3,000 calories per day, almost 20% above the average. The country ranked higher than the regional averages for rates in males younger than 20, men aged 20 or older, and girls and women younger than 20. Children are less physically active today which will make a large section of the population obese by the year 2016. The US accounts for almost one-third of the world's weight due to obesity. Asia in contrast has 61% of the world's population, but only 13% of the world's weight.

Bariatric surgery, one of the last resorts for weight loss, has become very popular in the UAE. Balloon, gastric banding and gastric sleeve procedures are performed routinely in Dubai's high tech hospitals. As plastic surgeons, we see every day patients who

have lost 70-80 pounds in one year and now come to us to solve their aesthetic problems. To add to the obesity, there is the fact that women here marry young and by the time they are 25 years old they already have five or six children (abdominal diastasis).

Post-bariatric surgery is a new specialty in the Gulf region, and we deal with the patients who have lost a lot of weight, have a lot of excess skin, and are probably malnourished, which increases the risk of complications and post-operative problems in the healing of the very long scars they need to eliminate the excess skin. We now have new techniques to treat these problems. First, we have to prepare them so they are fit for surgery, sometimes in two or three stages, in three-month intervals. We now perform surgeries to combine in one incision an arm lift, a reverse abdominoplasty and a breast lift. It is not rare to have a combination of circumferential body lift, abdominoplasty, with buttock and thigh lift. All these procedures can use liposuction or liposculpture, which can increase the risk of seromas and skin necrosis. We are also creating hospital services combining different specialties to treat these patients in a holistic manner, ensuring a good recuperation and a healthy diet in the future.



and concepts of conventional body contour deformities.

As no other classification system proposes any further quantitative assessment for Skin/SFS laxity, we addressed this deficiency by establishing a new and simple dynamic measuring protocol that should objectively estimate, describe and rate tissue excess for different body regions. *The Cutaneous Translation Index (CTI)* was designed to be applied along with the *Pittsburg Rating Scale*, and represents an extra dynamic assessment tool in order to enhance tissue comprehension for best classifying the full range of body contour deformities in massive weight loss patients. Data collection follows a simple protocol for ten different body regions, just as suggested in the *Pittsburgh Rating Scale*, measuring the skin movement range after sliding excessive tissue over itself through an anchor line towards a desired correction vector. Two

examiners are necessary in order to allow one of them to move the skin while the other one makes the ink markings and the measurements with a centimeter ruler.

A full description of the measuring protocol is on its way to scientific publication. We understand that standardized CTI measuring provides extra and important dynamic information about the laxity status of different body regions and so far enhances the observer's comprehension of contour deformities for the massive weight loss patients, as well as the treatment basis they might need. Incorporating CTI data to the regular patient examination file may also help to achieve higher levels of scientific evidence in future clinical trials as it should provide objective evaluation of treatment outcomes in a wider sense than just observing orthostatic images.



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

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ISAPS MEMBERSHIP PLAQUES, LAB COATS AND SCRUBS

Susumu Takayanagi, MD – Japan

ISAPS President-Elect



I am pleased to announce the release of plaques, lab coats and scrubs bearing the ISAPS logo for the purpose of raising funds for various activities of ISAPS.

All Active Members receive a membership certificate. However, pursuant to a significant number of requests from our members for something more impressive to display in their clinics, we have decided to produce a plaque. Two prototypes, gold and silver, were presented to the board. As the vote was even, both of them were approved. Accordingly you have a choice of gold or silver.

Lab coats and scrubs are plastic surgeons' must-have items. For several years, we had an American manufacturer sell their products to our members with a discount, but I didn't find the quality satisfactory. At the end of December 2013, we nominated a Japanese company to produce and distribute lab coats and scrubs bearing the ISAPS logo. There are three models now. For details, please visit the ISAPS website Members Area. You can see and purchase the ISAPS membership products on the following page of ISAPS website: <http://members.isaps.org/members-area-home.html>



ISAPS-LEAP SURGICAL RELIEF TEAMS QUIETLY CONTINUE TO HELP SYRIAN REFUGEES IN JORDAN

Ryan Snyder Thompson – United States

Director of International Disaster Relief, LEAP Foundation



As a result of the Syrian conflict, more than 9 million civilians have become displaced from their homes by the violence—some more than once after having relocated to other presumably safer areas of the country. Six-and-a-half million Syrians are considered to be internally displaced. According to the UN High Commission on Refugees (UNHCR), <http://data.unhcr.org/syrianrefugees/regional.php>, there are now nearly 2.8 million registered Syrian refugees with another 71,000 awaiting registration. More than 1.4 million are children and these are just the official tallies.

We have heard that the real number of persons externally displaced by the war were at least double what was being published in official accounts due to the large number of Syrian residents who have crossed international borders clandestinely. Though widely publicized, the Zaatari Camp in northern Jordan and its estimated 91,100 residents represents little more than 15 percent of the total number of persons of concern for UNHCR in Jordan. In fact, three out of every four Syrian refugees in Jordan actually live outside of formal camp settings in urban, host communities.

While not all refugees require medical attention, many who can benefit from surgical intervention are being treated in one Amman area hospital by ISAPS-LEAP Surgical Relief Teams® (SRT). We have sent twelve surgical missions to Jordan since beginning the project in October 2013. Accordingly, we would like to thank the following volunteers representing not only plastic surgery, but also anesthesiology, orthopedics, neurosurgery, general medicine, and nursing who have taken time from their busy schedules to participate in a mission:



(L to R) ISAPS member Dr. Susan Lovelle-Allen (USA), third year resident Dr. Wissam, Syrian Program administrative assistant and Ms. Rachael Rayfield, PA (USA).

Czech Republic

Dr. Ondřej Měšťák, ISAPS member

France

Dr. Emad Ed Dannan, ISAPS member

India

Dr. Satish Arolkar

Dr. Chandni Hitkari

Dr. Rajesh Vasu

Ireland

Dr. Patricia Eadie, ISAPS member

Ms. Ciara O'Donohue, RN

Italy

Dr. Silvio Podda

Jordan

Dr. Firas Neshwati

Saudi Arabia

Dr. Ezdehar Fallatah

Dr. Jamal Omran al-Madani, ISAPS member

Slovak Republic

Dr. Martin Boháč, ISAPS member

Spain

Dr. Cristian Carrasco Lopez, ISAPS member

United Arab Emirates

Dr. Abeer Sawwaf, ISAPS member

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Dr. Diane Duncan, ISAPS member

Dr. Burt Faibisoff

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Dr. Gary Jacobs, ISAPS member

Ms. Rosemary Jacobs, CST

Dr. Drew Kreegel, ISAPS member

Dr. Susan Lovelle-Allen, ISAPS member

Ms. Anastasia Mitchell, PA

Ms. Rachael Rayfield, PA

Dr. Fares Samra

Dr. Aamir Siddiqui

Dr. Anthony Tran

Ms. Bonny Usery, RN

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ISAPS-LEAP MISSION IN JORDAN: A PERSONAL PERSPECTIVE

Ondřej Měšťák, MD – Czech Republic

ISAPS Associate Member



The civil war in Syria has lasted for more than three years and already claimed the lives of more than 300,000 people. Today, Syria is divided into areas controlled by the government and areas controlled by insurgents which are cut-off from the outside world. Apart from a lack of food, there is no medical care.

One-and-a-half years ago, a group of Syrian physicians created the *Treating the Wounded Syrian Program* to provide quality medical care to casualties of the Syrian conflict. It entails a sophisticated system in which patients are identified inside Syria, sorted on a border, minor injuries are treated by *Doctors Without Borders*, and severe injuries are sent to a hospital in Amman, Jordan.

One thousand patients have been treated since the beginning of the program, most of them affected with severe injuries, and 2,500 operations have been performed. The most common causes of injury are barrel bombs, bullets and burns. Most commonly solved diagnoses are injuries to extremities (comminuted open fractures, amputations), vascular injuries, abdominal injuries and craniotraumas. The list of the most common diagnoses implies needed specialists: orthopedics, vascular surgeons, neurosurgeons and plastic surgeons. Most of the patients need more than one operation.

The program team consists of Syrian doctors who are not allowed to legally practice medicine in Jor-

dan so they are covered by Jordanian doctors. In addition, there are some Jordanian doctors involved, including anesthesiologists and Jordanian nurses. Specialists such as plastic surgeons and orthopedic surgeons usually come from foreign countries. The ISAPS-LEAP organization supplies the program with plastic surgeons, predominantly members of ISAPS. Although their cooperation with the Syrian program only began several

months ago and participation is based on volunteering (surgeons cover all their own travel costs), the timetable of missions for upcoming weeks is remarkably filled. The support of Ryan Snyder Thompson, Director of International Disaster Relief at the LEAP Foundation, is fantastic. Preceding a mission, he organizes all communication between volunteering plastic surgeons and Syrian doctors. He also arranges work permits necessary for foreign physicians and advises about accommodations and transportation within Amman. Physicians from other specialties come on a different basis. During our stay, we met several visiting doctors from abroad. An orthopedist from Saudi Arabia with his own anesthesiologist (it is very beneficial to have one's own anesthesiologist, because then you become quite independent) and an infectious disease physician from London, UK.

The approach of the local medical staff was extremely nice. They were treating us with dignity and tried to help as much as possible. We were surprised by the quality of the equip-



Fig. 1. from left: Dr. Zaher, Dr. Měšťák, Dr. Boháč



Fig. 2. Wound dressing change (Dr. Měšťák)

continued on page 40

LEAP, Thompson *continued from page 38*



(L to R) Mr. Khaled, a Jordanian scrub tech, and Ms. Rachael Rayfield, PA (USA) prepare for surgery at al-Makassed Charity Hospital in Amman, Jordan.

In order to meet persistent patient needs for plastic and reconstructive procedures, SRT will continue organizing future surgical missions to Jordan. Currently, seven missions remain on the calendar for 2014 and we anticipate adding more. All individual surgeons and complete teams are welcome to begin the application process by filling out the Disaster Relief Medical Volunteer form on the LEAP Foundation website at www.leap-foundation.org/disaster-relief/. Once we receive your application, we will contact you to discuss available mission dates.

For those ISAPS members unable to serve on a mission to Jordan, we wish to extend the opportunity to sponsor patient surgeries by making a financial contribution (indicate Disaster Relief) on the LEAP Foundation website and/or donating essential surgical supplies including: surgical loupes (6.0x, 8.0x), plastic and microsurgery instrument sets, large and small bone drill/saw, upper and lower extremity fixation devices, electro-surgical instruments, vacuum-assisted wound therapy supplies, antiseptic wound dressings, dermatome blades, all varieties of sutures, disposable skin staplers, #10 and #15 scalpels, scissors, surgical drapes and disposable operating gowns, masks, caps and shoe covers.

Any questions regarding volunteer registration, mission scheduling, or donations of funds and/or materials may be directed to Ryan Snyder Thompson at ryansnyderthompson@leap-foundation.org



LEAP, Měšťák *continued from page 39*

ment in the hospital. They had everything we needed for most plastic surgery procedures. The only thing we were missing was a microscope. Several patients we evaluated were suitable for free flaps, especially those with wounds in the lower third of a calf. The LEAP organization is trying to get a microscope and suitable instruments to enable future missions to perform microsurgical procedures.

Our plastic surgery team, working under the combined ISAPS-LEAP Surgical Relief Teams and *Treating the Wounded Syrian Program* in the beginning of May 2014 consisted of Dr. Martin Boháč from Slovakia and me. We planned to stay one week. In the end, we stayed ten days to finish treating patients we had examined. During the mission, we examined about forty patients and performed approximately twenty operations. The most common procedures were wound debridement, skin grafts, flaps, tenolysis and tendon transfers. We also performed one reconstruction of a median nerve with a sural nerve graft. Some of the patients had undergone operations already by previous teams. We evaluated several patients with brachial plexus palsy. In future, it would be beneficial if plastic surgeons specialized in brachial plexus reconstruction were to take part in a mission.

I found that working in a team of two plastic surgeons was very beneficial. The cases we were dealing with, sometimes very complex, were much different from those we manage in our home countries. A second opinion was often very important to me.

We were ready to perform a large number of operations. However, the organization of work and delivery of patients is very complicated, so there is no possibility to do more than five procedures a day. Sometimes you have to wait for a procedure for several hours.

I felt this work was very rewarding. Since a lack of specialized physicians exists in the program, you could feel that your work makes a real difference.



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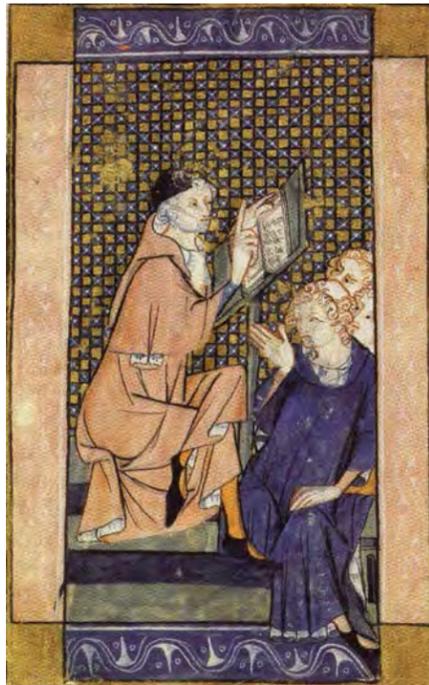
HENRI DE MONDEVILLE (1260-1320): A PRECURSOR IN AESTHETIC SURGERY

Denys Montandon, MD – Geneva, Switzerland

A native of Normandy, Henri de Mondeville was a well-read clerk who studied medicine in the city of Montpellier which had the first French university, created in 1220. Unlike the well known Renaissance surgeons like Ambroise Paré or Pierre Franco two and a half centuries later, Mondeville received the title of Doctor of Medicine which allowed him to be recognized as a true physician among his peers, as compared to the barbers or barber-surgeons who were considered as servants doing minor surgical procedures.

Mondeville completed his training in Paris under the direction of Lanfranco da Milano (1245-1345) who was the founder of the Parisian surgical school and had brought to France the knowledge acquired in the famous Italian universities of Salerno, Bologna and Padua. He also met another renowned surgeon, Jean Pitard (1228-1315) who was the surgeon of the king. With his support, Mondeville himself became one of the surgeons of King Philippe le Bel (1268-1314) and later of Louis le Hutin (1305-1316). Although he gained surgical experience on the battlefields, he lamented the ingratitude and perfidy of his regal patrons and did not hesitate to address his critics “to the shame of his Royal Majesty”:

On the order of our Lord the King, I have uselessly lost a great deal of time to my great despair in Arras, in England, in other parts of his realm, in several of his armies and at his Court, hoping that he would pay me what was due me, —after which, on further order of the King, renouncing all profit, I have returned to Paris and have lived there, at least for short intervals; I have wished again to take up little by little, the work which I have abandoned. Greatly occupied, however, in Paris: by virtue of the great reputation which I enjoy among the students, the citizens, the personages at Court and the stranger in passage, I am often hard put to write a line a day, without counting that I must go to the schools and run all day here and there to earn a living, until with the sole grace of God who



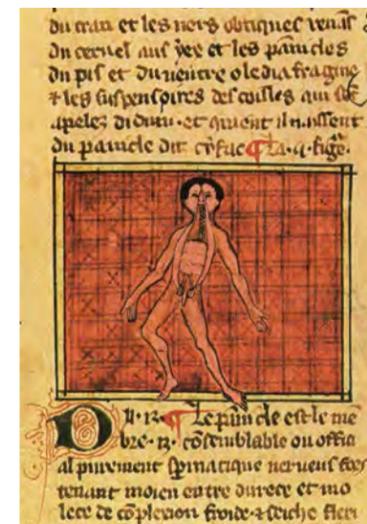
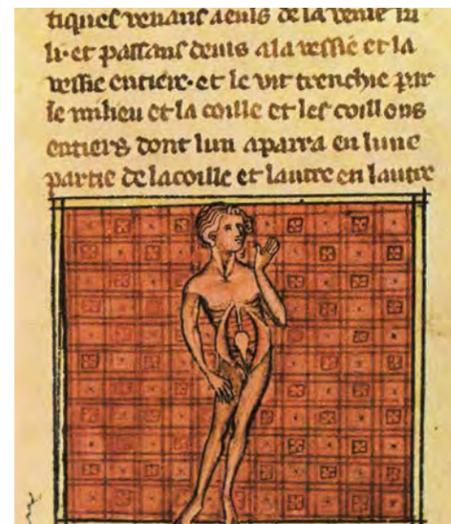
Henri de Mondeville, according to a miniature of French manuscript 2030 (Bibl. Nat. Paris), written in 1314.

during the life of Mondeville, but fell into oblivion for about 500 years. Although copied a few times during the Renaissance, one had to wait to the end of the nineteenth century to rediscover the original text of Mondeville, translated into modern French by Edouard Nicaise.

By disagreeing with his contemporaries and the mentalities of his time, he often appears as a transgressor. His innovative ideas were not recognized for their value. Claiming the autonomy of science in regard to theology, although he was initially a clerk, we can see through his writings the birth of a laic spirit in medicine, hostile to the medieval tradition of mystery. Defending the unity of medicine and surgery, Mondeville wanted to make of his art a specialty depending on a new medical science, based on anatomy. For the plastic surgeon, the writings of Mondeville are particularly interesting with regard to several aspects.

is not generous, I have provided by the work of my hands, all that is necessary for me and my household; not being either selfish, nor ambitious, nor avaricious, and not wishing avidly to embrace the whole world, but being content with that which is necessary for me to make a living; as I see our surgery, so indispensable to the human race, being insufficiently transmitted, and since I am able to arrange it a little better, not being obligated to any person as one will see later, not married out of fear that the perversity of a woman and the necessity of paying her expenses and furnishing her a home would divert my spirit from the composition of this book, and from the execution of other useful works of the same nature, and fearing for all these reasons the divine judgment and dreading to be held responsible for the ignorance of my colleagues, I have decided to resume the present work.

In fact, the so-called “present work” is a fourteen-year involvement on a medico-surgical treatise, which he was not able to finish before his death. *Cyurgia* has been translated from Latin to old French



Anatomical figures attributed to Mondeville

Treatment of wounds

According to the ancients, suppuration was useful, and if it was not produced of itself, it had to be provoked by the use of suppurative medicaments. These treatments often lead to inflammation and phlegmon. This was the method in vogue in Mondeville’s time to which he took violent objection. He insisted that suppuration was not only unnecessary to the healing of a wound, but was harmful and dangerous, that it increased suffering and disability, resulted in disfiguring scars, and led to complications and death. In its place he championed the method of Theodoric, claiming, “Every simple wound can be cured without the production of a notable quantity of pus, on condition that, without omitting any of the contingents, one treats them according to the teachings of Theodoric and ourselves.” This treatment entailed the immediate removal of foreign bodies, the prompt control of hemorrhage by whichever means was required, and the closure of the wound as quickly as possible, by bandaging alone if that sufficed, otherwise by suture. Dressings consisted of compresses wrung out in hot wine and held in place by adequate bandages. Sup-

portive treatment included rest, nourishing foods, and wine.

Mondeville graphically expressed the violence of the opposition to these innovations. He states,

It is rather dangerous for a surgeon to operate differently than is the custom of the other surgeons. We have experienced this in the treatment of wounds according to the method of Theodoric, Master Jean Pitard and myself who have first brought it to France, and have employed it in Paris and in several wars, against the wishes and opinions of all, in particular of the physicians. We have suffered the disdain and shameful words on the parts of laymen and of our colleagues, the surgeons; and even threats and dangers. From certain laymen and physicians, every day and at each change of dressing, we have endured disputes and words so violent that half-vanquished and fatigued with all the opposition, we would have been close to renouncing this treatment and abandoning it entirely, had it not been for the support of the most serene Count of Valois. But this Prince has come to our aid, as have several other personages who have seen wounds cared for in the camps by this method. We were further sustained by truth; but if we had not been firm in our faith, known to be close to the King, royal physicians and

somewhat lettered, it would have been necessary for us to abandon this treatment.

Concerning *facial wounds*, Mondeville made a special note on the treatment of nasal injury:

One has to notice that, mainly for the treatment of wounds of the nose, a completely separated or gangrenous piece will never reunite. Reason: because the vital spirit is instantaneously lost, and that it is as impossible to recover as for the soul. It is however possible to recover sensitivity when it has not been entirely separated. If it becomes adherent, it may be sufficient or insufficient. In the latter case, it is better to amputate and let the wound heal by itself. If it can be saved, one has to remove what has grown against nature, to freshen the tissues until they ooze blood for a better reincarnation and suture them with a triangular needle.”

The placement and the duration of the stitches have their importance:

The result can be modified by the suture, because if you are in a hurry to remove the stitches, the nose may not be incarnated or very little and with the movements of the nostrils, it will separate and that shall be worse than before. If you delay the removal, it will form a scar marked with a cross.

Mondeville takes this opportunity to make a few general thoughts:

Concerning nose cuts, one has to make the following general remark, that it is very difficult for a surgeon without celebrity, to dare employ a new way to operate while abandoning the one of the ancients, because, if the treatment is successful, people will say it would also have succeeded with the ancient method; if it goes wrong, it’s proof that the ancient method is better. A surgeon with great reputation does not have these difficulties.

Mondeville adds cynically:

If it is useful or necessary to make the

Mondeville, continued from page 43

trial of a new method, one has to do it before on the poor people; if it goes wrong, the surgeon can excuse himself more easily; if successful on several occasions, he might use it as an example for the rich.

Aesthetic medicine and surgery

The most original writings of Mondeville concern the embellishment of males and females by various methods such as dermabrasion and epilation. Of course, most of these methods had been described before, particularly in the 11th century's Trotula written by the women doctors of Salerno. However, Mondeville was the first to emphasize the reasons why qualified surgeons should include these treatments in their practice and justify the high fees of the surgeons compared to the physicians who do nothing with their hands! He is however somewhat ambiguous about this practice:

This embellishment is against God and Justice, and most often is not the treatment of a disease, but is made to falsify and fraud, besides that this subject does not please me. However, a surgeon who lives in provinces or cities where there would be many women of the court, and would be renown as a good operator in this art, could receive a considerable advantage and the favor of the ladies, which is not a small thing nowadays.

What are these cosmetic treatments for?

One must know that on men's face, especially on rich, noble and lascivious citizens, you may find ugliness curable and lucrative, which does not bother cultivators or peasants. The number of these uglinesses is 6: Excessive redness, superfluous whiteness, burns by the sun and the wind, dark and ugly colors, hair against nature, scarcity of the beard."

For women, Mondeville is more explicit. It concerns the care of the sexual regions, breasts, armpits, hair, face, neck, and hands. For a lasting epilation "we should pull out the hairs, and insert immediately in the holes of their roots hot needles. . . ." For big breasts, he advises tight bandaging. On the face in general, there are 17 conditions that should be considered for possible treatments, for the eyelids 25, for the nose 25 and around the mouth 57! The care of most of them requires sometimes an operating surgeon who wishes to help these women, mainly old women or courtesans who would like to feign youth.

A few women have the superficial layer of the skin removed with a fine razor, others apply a product made of cantaride and leaven which produces vesicles on the whole face; it forms thereafter a new skin. . . .

The sexual parts require double care, inside and outside.

Old courtesans require inside cares, mainly those who have an enlarged vulva, naturally or following repeated lubricous and easy coitus, in order to look younger or at least non-public.

At the end, Mondeville concludes that

. . . it is boring to relate and even more boring to operate; a whole day could not suffice to care for the whole body and each of its members. However, the careful artist, by praising the beauty and by praising his work, can take off a great profit, because the more a procedure is laborious in this kind of things, the more it is judged useful by the women.

The surgeons

Apart from these digressions on cosmetic medicine and surgery, Henri de Mondeville has written chapters on anatomy and is considered to be the first to have made dissections in France. He was also the first fully educated physician to defend the profession of surgeons:

There are more conditions to be fulfilled to make a surgeon than to make a physician. The perfect surgeon should know medicine and moreover learn the way to operate manually, things that requires a deep study pursued with concern and for a long time.

For this the surgeon should receive a decent salary:

What advantage does have a famous surgeon, renown and honest, if every day, from dawn to evening, without interruption, he runs from left to right, visiting his patients; if every night, reckoning in his mind what he has seen in each of his patients, he foresees and arranges what he should do the next day, if he spends all his forces for the others and if people says that he is doing great wonders, and then they don't give him a reputation and a retribution worth of his work.

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ISAPS PHOTO HISTORY PROJECT



Drs. Seiichi Ohmori and Ivo Pitanguy, 1950

We are planning a Photo Gallery during the Congress in Rio in September to honor ISAPS Founders and our history.

If you have photos to contribute from any ISAPS event, from any year, please send them to our Executive Office.

Include a caption to tell us who is in the photo and when and where it was taken if possible.



Drs. Blair Rogers, Tom Biggs, Bryan Mendelson, Foad Nahai and Alaa Gheita

Send photos by email to: Catherine Foss, Executive Director isaps@conmx.net

July 2014

DATE: JULY 18 – 19, 2014 ISAPS-OFFICIAL COURSE
Meeting: ISAPS Course – Mexico
Location: Los Cabos, MEXICO
Contact: Arturo Ramirez Montanana, MD
Email: docarturo@gmail.com
Website: http://www.isapsloscabos.com/

September 2014

DATE: SEPTEMBER 12 – 14, 2014 ISAPS-ENDORSED PROGRAM
Meeting: VIII International Plastic Surgery Course
Location: Ekaterinburg, RUSSIAN FEDERATION
Contact: Irina Vlokh
Email: irinav@plastic-surgery.ru
Tel: 7-343-3718802
Fax: 7-343-3718999
Website: http://www.b-med.ru

DATE: SEPTEMBER 19 – 22, 2014 ISAPS OFFICIAL CONGRESS
Meeting: 22nd Congress of ISAPS
Location: Rio de Janeiro, BRAZIL
Contact: Carolina Pepe
Email: mclp@relations.com.br
Tel: 55-11-5543-4142
Fax: 55-11-5092-5643

DATE: SEPTEMBER 25 – 26, 2014
Meeting: BAAPS Annual Scientific Meeting
Location: London, UNITED KINGDOM
Contact: Laura Manning, Administrator; Mr. Rajiv Grover, President
Email: secretariat@baaps.org.uk
Tel: 44 (0)7430 1840
Fax: 44 (0)7242 4922
Website: http://www.baaps.meeting.org.uk

October 2014

DATE: OCTOBER 17 – 18, 2014 ISAPS-ENDORSED PROGRAM
Meeting: São Paulo Breast Surgery Symposium
Location: São Paulo, BRAZIL
Contact: Joao Carlos Sampaio Goes, MD
Email: clinica@sampaio Goes.com
Tel: 55-11-3167-2200
Fax: 55-11-3167-5535
Website: http://www.saopaulobreastsymposium.com

DATE: OCTOBER 18 – 19, 2014 ISAPS-OFFICIAL COURSE
Meeting: ISAPS Course – Indonesia
 in conjunction with the 6th ASBPRS Meeting
Location: Bali, INDONESIA
Contact: Ms. Jessica
Email: isaps-asbprs2014@pharma-pro.com
Website: http://www.isapsasbprs2014.com/

DATE: OCTOBER 23 – 26, 2014
Meeting: 3rd World Congress of Plastic Surgeons of Lebanese Descent
Location: Beirut, LEBANON
Contact: Sami Saad, MD
Email: samsadmd@gmail.com
Tel: 961-01-754-734

DATE: OCTOBER 27, 2014 ISAPS SYMPOSIUM
Meeting: ISAPS Symposium - Thailand
Location: Pattaya, THAILAND
Contact: Sanguan Kunaporn, MD
Email: sanguank@me.com
Tel: 66-76-25-4764
Fax: 66-76-25-4765

November 2014

DATE: NOVEMBER 6- 8, 2014 ISAPS-ENDORSED PROGRAM
Meeting: 4th Congress of the World Association for Plastic Surgeons of Chinese Descent with ISAPS Visiting Professor Program
Location: Hong Kong, CHINA
Contact: Serence Tam
Email: serence.tam@mims.com
Tel: 852-2116-4348
Website: http://www.wapscd2014.org.hk

DATE: NOVEMBER 8 – 9, 2014 ISAPS-ENDORSED PROGRAM
Meeting: 1st International Video Symposium (IVS) in Plastic Surgery
Location: Hamburg, GERMANY
Contact: Stephanie Schubert
Email: stephanie.schubert@conventus.de
Website: http://www.vdtpc-symposium.de/

DATE: NOVEMBER 15 – 16, 2014 ISAPS-OFFICIAL COURSE
Meeting: ISAPS Course - Pakistan
Location: Lahor, PAKISTAN
Contact: Nazim Cerkes, MD, PhD
Email: ncerkes@hotmail.com

December 2014

DATE: DECEMBER 4 – 6, 2014 ISAPS-ENDORSED PROGRAM
Meeting: The Cutting Edge 2014 Aesthetic Surgery Symposium
Location: New York, New York, UNITED STATES
Contact: Bernadette McGoldrick
Email: registration@astonbakersymposium.com
Tel: 1-212-249-6000
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Website: http://www.astonbakersymposium.com

March 2015

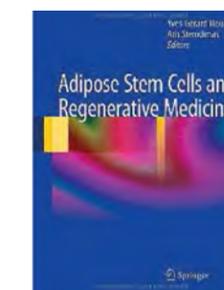
DATE: MARCH 11 – 14, 2015 ISAPS-OFFICIAL COURSE
Meeting: Plastic Surgery at the Red Sea
Location: Eilat, ISRAEL
Contact: Einat Bar-Ilan
Email: einat@duetevents.co.il
Tel: 972-54-4304045
Website: http://www.redseaplastics2015.com/

April 2016

DATE: APRIL 13, 2016 ISAPS SYMPOSIUM
Meeting: ISAPS Symposium - Argentina
Location: Location to be decided, ARGENTINA
Contact: Cristina Picon
Email: mariacristinapicon@hotmail.com.ar
Tel: 54-11-48032823
Fax: 54-11-48074883



Adipose Stem Cells & Regenerative Medicine



The therapeutic potential of the use of adipose stem cells in regenerative medicine has been increasingly recognized, and in recent years concrete clinical benefits have accrued as these cells have been explored for a variety of applications. The two editors of the book *Adipose Stem Cells*

and Regenerative Medicine, Dr. Yves Gerard Illouz and Dr. Aris Sterodimas, have vast experience in the field and have chosen leading experts from different countries to write on each topic. In his foreword about the book, Professor Ivo Pitanguy states: “It has been said that man is entering a new era of discoveries, the truly first revolution since the discovery and harnessing of fire. In a word: biotechnology. This vast and growing field of knowledge presents to us, on a daily basis, inventions that only a few years ago would have seemed to be taken out of a story by Jules Verne. The authors are to be congratulated for this pioneering publication.”

All aspects of the subject are considered, with particular attention to adipose cell biology, adipose tissue engineering strategies, and the diverse clinical applications of adipose stem cells. Kacey G. Marra and J. Peter Rubin stated in a recent review in *Aesthetic Surgery Journal* that “*Adipose Stem Cells and Regenerative Medicine* book is a compilation of writings on the latest advances in adipose stem cell research, consisting of 24 chapters by international experts in the field. The book contains many elegant and descriptive images and figures. This is an excellent reference book for clinicians and scientists with an interest in adipose stem cell research. It is mostly directed toward clinicians, namely plastic surgeons, but engineers and scientists will also find the clinical sections informative and beneficial.”



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Igor Niechajev, Sweden, competing in the Medical World Cup in Seefeld Austria.

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MICO (MITCHA) DJURICIC

Luiz S. Toledo – Dubai – UAE



I received a phone call in 1999, when I was still practicing in São Paulo, from a plastic surgeon from Serbia who was in town and wanted to visit my clinic to observe surgery. I arranged for him to come into surgery with me the next morning. As his English was not very good, and my Serbian was (and still is) non-existent, he brought along his

17-year-old daughter to provide English translation. This is how I met Mico Djuricic and his daughter Tijana. They were in São Paulo together with Mico's wife Koka for a week. They watched surgery and we went out for dinner and a friendship was forged that has lasted until today.

The following year, I was invited to lecture at an ISAPS course in Belgrade. It was my last year as ISAPS Course Director, after almost seven years on the job organizing many courses on all continents. Belgrade had just come out of the war and the city was still showing the scars of the "surgical bombing" it had suffered. The building with the communications antenna was just a skeleton (it would take years to be renovated) and a stroll through Knaz Milos Street, where Mico's Galathea clinic was located in an old building near the embassies, was like walking through a war zone. The bombed houses, still with furniture and carpets coming out of the blasted walls, were living proof of the suffering the people had gone through at the end of the old regime.

This ISAPS course, I believe, was a turning point for plastic surgery in Serbia and the Balkans. People became aware that something had to be done to improve the quality of medical care. Reconstructive surgery had been practiced there for many years and it was very good, but aesthetic and cosmetic procedures were something that few doctors (and patients) had access to until then. We appeared on several TV programs and gave interviews to newspapers and magazines reinforcing the fact that the country was going through a rebirth in all areas, from culture to science and medicine, and we felt a responsibility to do something to help.

Mico approached me and we came up with the idea to organize a series of small annual congresses, or workshops, based on the symposia I had organized in São Paulo in the late '80s and early '90s, which I called Recent Advances in Plastic Surgery—RAPS. And this is how it started.

I went back to Brazil and started planning the first Balkan RAPS Symposium. I called some friends who immediately accepted to go to Belgrade, not an easy task, with the fear of "conflict" zones, and Belgrade still healing from the Bosnian and Sarajevo problems. Tom Biggs and Bob Ersek from the US, and Ruy Vieira from Brazil came with me and we performed surgery at the old Galathea clinic with live transmission to the Hyatt hotel. The first symposium was a success and the partnership with Mico continued.

For the next ten years we organized annual meetings. Mico had invested a lot in creating in Belgrade a state-of-the-art facility, one which every foreign visitor was astonished to see, amazed by the fact that in a country coming out of the war they could build a clinic that was not only comparable to the best ones in the world, but better than most of them.

We had fun for a decade. Mico Djuricic fulfilled his dream and brought to Serbia, at his own expense, to share with his fellow Serbian surgeons the best that plastic surgery had to offer. All live surgeries and lectures were recorded and distributed to the audience. For this he had no support from the big medical companies and charged only a small fee from the attendees—ridiculously low compared to international prices for meetings of such caliber.

Recently, Mico had some health problems and we had to stop organizing our meetings. On April 14th he passed away in Belgrade. The Galathea clinic does not exist anymore, but its legacy still remains and no one will forget what we learned there.

Mico Djuricic was the pioneer of teaching aesthetic surgery in Serbia.



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1. As of January 2014 2. Data on file 3. Rabin Research

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