The PIP Problem

What happened?

In 1991, Jean-Claude Mas, founded a company called PIP (Poly Implants Prothèses) headquartered in France. He stated that he had developed firm silicone and promoted lifelong durability of his product. In 1997, Monsieur Mas managed to obtain the CE certificate and was regularly inspected by TÜV Rheinland. The approval of implants filled with saline had been refused in the US by the Food and Drug Administration (FDA) in the year 2000 due to considerable quality failure.

See pages 14-17 for information about the ISAPS Congress in Geneva, Switzerland September 4-8, 2012
MESSAGE FROM THE EDITOR

J. Peter Rubin, MD – United States
ISAPS News Editor

What does it mean to be a member of ISAPS? It means that you are a steward of our profession and that you uphold and promote the very highest standards of patient safety, excellent practice, and ongoing education in aesthetic plastic surgery. This issue of ISAPS News highlights the global crisis concerning PIP implants. Dr. Dirk Richter writes a comprehensive piece covering the history of these implants and the current situation. He implores of us, as surgeons and ambassadors of our specialty, to take the most responsible approach going forward.

A trust has been violated. Even though this was not a transgression by the international plastic surgery community, we are unwilling participants. We are responsible for the health and welfare of our patients and I applaud Dr. Richter’s sage advice. This is a critical time for all plastic surgeons to step up, show our true level of professionalism and compassion, and help our patients through this difficult period. We are responsible for the outcome, even though we did not create the problem.

Also in this issue, we see your society at work producing valuable data to support our specialties practices. ISAPS statistics on aesthetic procedures appear summarized in this issue, and I thank our Communications Committee headed by Dr. Joca Sampiao Goes, our survey analyst Scott Hackworth, and our member surgeons for providing data for this project. I hope that the summary of figures and trends will be informative and useful to you in your practice.

Dr. Mark Jewell presents a very interesting global perspective on lipoplasty that will help frame our current techniques. Dr. Ricardo Mazzola, our resident expert on medical history, tells us the story of fat grafting throughout medical practice. This is a wonderful article, not to be missed.

You will also find information about our 2012 Congress in Geneva as we prepare for that biennial event. I look forward to seeing you in Geneva in September and I hope you enjoy this issue of ISAPS News.

In 2009, the French authorities were informed about the increasing frequency of early rupturing and unusually high leakage of the PIP prostheses. In addition, indications of criminal activity led to prosecutors’ investigations. Bills were found in the PIP files for unusually high amounts of industrial-grade silicone which had been purchased from a company in Germany since 2001. In contrast to any medical-grade silicone, the substandard silicone had not undergone a cleaning process. A higher amount of low molecular weight species that can be left over as part of the manufacturing process remained and showed high biological activity. This silicone can thus much more easily pass through the shell by inducing instability thereby causing irritation and inflammatory processes in the surrounding tissues.

By omitting the cleaning process, the company saved about €1 million per year. A higher amount of low molecular weight species that can be left over as part of the manufacturing process remained and showed high biological activity. This silicone can thus much more easily pass through the shell by inducing instability thereby causing irritation and inflammatory processes in the surrounding tissues.

By omitting the cleaning process, the company saved about €1 million per year. The implants also contained the lubricant Baysilone, a petroleum product, and the substances Silopren and Rhodoril which are used in the rubber industry. In April 2010, the implants were withdrawn from the market along with the implants of the company Roalf Medical in the Netherlands, which were manufactured under a PIP license and were “identical.”

The prosecutors’ investigations revealed that a high degree of heterogeneity existed in the nature of the gel: a layer silicone shell had been replaced by a single-layer shell to reduce production costs.

The French health products safety agency, AFSSAPS, was able to demonstrate through its own investigations an increased inflammatory reaction by the silicone used. The results of the intra-dermal irritation tests it performed showed an irritant potential of the PIP silicone gel that was not found with the silicone gels from other prostheses, nor with the gel declared in the manufacturer’s dossier.

Experiments on mice showed no genetic changes nor were there indications of toxicity or increased carcinogenicity. According to many reports from colleagues, the PIP implants are associated with increased leaking and a higher rate of rupture. This was confirmed by the investigations of the French authorities. However, the controversial methodology and the statistical results are not fully reliable.

On the 23rd of December 2011, the French authorities recommended that women with PIP implants discuss their removal with their surgeon. The German authorities initially advised to check the implants, but changed the recommendation on the 6th of January 2012 as a result of their own findings. They advised patients to remove the implants, even if symptoms and signs of rupture were lacking. In the European Union, the Netherlands and the Czech Republic followed the German recommendations. Other countries such as Britain, where about 50,000 patients are estimated to have received the PIP implants, plus Spain and Italy advised twice yearly clinical examinations and imaging, such as ultrasound and MRI.

What is the right decision?

How reliable is the data? What should we recommend to our patients and our members? All of these issues arose at the turn of the year 2011/2012 and concerned the Board of ISAPS. Remarkably, we received numerous opinions and estimations from our army of National Secretaries which were very valuable to
Based on our mission of patient safety, we have only one option: to advocate the removal of the implants.

But how do we trace our patients? How do our patients find out what type of implants they have once the implant ID card is lost, and the former surgeon cannot be found, or the obligation to store the patient file has expired? These commonly raised questions once again demand a centralized implant registry like those already existing in some countries. A registry can trace each implant from the manufacturer to the patient, comparable to a recall in the automotive industry. Now our own initiative on a national and international level is needed. And we should make use of our influence on legislative authorities.

What else did we learn from this?

We learned that even highly recognized regulatory institutions like the German TÜV Rheinland cannot completely protect both surgeons and patients from criminal activity. We can only hope that the resulting loss of trust in us as physicians will not be too great as the media naturally suggest that the surgeons used cheap implants intentionally and for their own profit. Yet these implants were not at all cheap, but were sold in the middle price range of comparable products. What we need to postulate at this stage is that an amendment to the act of medical products must be filed. Especially with regard to unannounced inspections which are now possible at the very first suspicion. We, the physicians, have to be ready for a sudden and unexpected inspection by the local health authority and unexpected inspection by the local health authority every day. Why should there be unequal principles for the industry? The American FDA has proved to be more effective in its controlling function even though it failed by poor communication to its peers worldwide regarding the faulty quality at PIP. Did you ever wonder why big companies conduct trials in Europe in order to obtain the desired CE certificate? The past has proven this way to be the quickest to an accreditation for a big market whereas an American accreditation is very bureaucratic and tedious, thus cost intensive. Time is money.

One is tempted to believe that Europeans are being used like guinea pigs for the Americans.

What about our own reputation?

The past has shown that crises like the Dow Corning scandal in the early nineties, problems concerning saline or hydrogel implants, and the unprecedented recall of soy oil implants, never last long. A woman’s wish for an upsise, or the desire for a breast reconstruction, often exceeds her worries about risks.

This phenomenon is being experienced again by concerned PIP patients today who, almost without exception, all ask for a replacement. Almost none decline new implants as it means a clearly better quality of life. And this is something we should feel proud of as plastic surgeons! Scientifically we are on the right track: studies of the highest evidence level have proven a significantly improved quality of life for women with implants, both for augmentations as well as reconstructions following breast cancer. Even the ten-year survival rate exceeds the one of the matching comparison group. It should be pointed out that the patients with implants have a smaller risk of cancer through better monitoring and a smaller target organ. Additionally, medical silicone is the most researched material for the human body. Medical silicone, that is!

We cannot provide better proof that we are still doing the right thing after all. And if only to protect our own reputation, we should inform the public that the scandal was about cheap silicone as opposed to cheap products for doctors. The only one who gained, if at all, was Monsieur Max, who is now being held to account. Surprisingly, the guy himself does not feel remorse at all and cannot understand the scaremongering. To him, our acts are politically motivated and in no way rational. Poor old man!

However, we have to accept some mild reproach from the authorities for apparently not sufficiently attending to our duty to report faulty implants. We obviously know too little about the structured processes and hence it is necessary to clarify the fact that each failure connected to a medical product is subject to report in most countries. This is usually not a big deal and is a necessary requirement for the controlling institution to take note of faulty products that we are already discussing at conventions or private gatherings. Please check if there are similar requirements in your country.

We should not be surprised or even raise our voice about the fact that now, with some delay, actions are taken in a bold yet considerate manner.

Are we sufficiently attending to our duty to follow up and secure safety information? Or should we rather be awakened by the current events? If patients, worried by daily headlines, cautiously enquire whether implanted prostheses of 1975 have to be checked by now, there must be something wrong. How do we ensure that each patient returns for an annual routine checkup, really? The annual renewal of a vehicle inspection sticker is compulsory. Why not medical products? And can we sustain lifetime warranties for implants, or are the rupture rates of 10 to 15% after 8 to 10 years for the big manufacturers like Mentor and Allergan hitting at a different conclusion?

Do we have to actively approach our patients and hand out appointment reminder cards like most dentists do already? We should try to see things positively! As specialists in Plastic Surgery, we bought a regular priced medical product in good faith – a product that was accredited by the German TÜV. And we did the best job possible. We cannot be blamed for criminal activities, the profiteering of unscrupulous manufacturers, or the purchase of cheap products. We can learn a lot from this episode – once again – and should improve on the deficiencies mentioned above: Implant registry + attending to our duty to report + duty to follow up = “customer care”! We should make use of this opportunity! Hopefully there will not be another chance that soon.
ISAPS INTERNATIONAL SURVEY ON AESTHETIC/COSMETIC PROCEDURES PERFORMED IN 2010
Scott Hackworth, CPA – United States
Senior Vice President, Industry Insights, Inc.

ISAPS global surveys are the work of the Communications Committee under the direction of Dr. Joao C. Sampaio Goes, MD, Brazil.

Methodology:

Survey participants completed a two-page, English-based questionnaire that focused on the number of surgical and non-surgical procedures they performed in 2010.

The International Society of Aesthetic Plastic Surgeons (ISAPS) issued an invitation to participate in the study to approximately 20,000 plastic surgeons whose contact information is housed in their proprietary database. In addition, a request was made that all National Societies encourage their members/constituents to take part in the survey. Three reminder requests were distributed in order to maximize the response.

A total of 698 completed responses were received in time for tabulation.

Final figures have been projected to reflect international statistics and are exclusively based on the estimated number of plastic surgeons in each country and the responding sample. Whereas the U.S.-based study funded by the American Society of Aesthetic Plastic Surgery includes board-certified plastic surgeons, dermatologists, and otolaryngologists, this international survey is focused entirely on board-certified (or national equivalent) plastic surgeons.

To aid in tallying the worldwide number of plastic surgeons, representatives from National Societies provided the counts for over 90% of the 33,000 total estimated plastic surgeons. In cases where a country received an insufficient survey response, the projection base included respondents from the country’s continent. A weighting system was employed to emphasize responses from the particular country.

Caution is urged when comparing against prior years, because studies such as this can experience substantial variances within specific procedures. In addition, the overall methodology was slightly modified and National Societies from several countries materially restated their estimated number of plastic surgeons for 2010. Figures for 2009 were not recomputed.

Though the confidence intervals change by procedure and by country – depending on the sample size and response variance of each – the overall survey portion of this research holds a standard error of +/- 3.67% at a 95% level of confidence.

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PERSPECTIVES ON LIPOPLASTY
Mark Jewell, MD – United States

Lipoplasty remains the “gold standard” for contouring surgery. Its evolution over the last 27 years in America has produced remarkable advances in clinical outcomes that make surgical lipoplasty the most common form of aesthetic surgery in the United States. Having been around from the start of lipoplasty to where we are in 2012, it is interesting for me to look back and review progress in this procedure. There have been all sorts of techniques and technologies applied, yet few have consistently produced safer and better outcomes than simple measures of epiinephrine-containing wetting solutions and limiting lidocaine to <35mg/kg body weight. Ultrasonic solid probe lipoplasty appears to have overcome technologic shortcomings of earlier devices and causes less blood loss than conventional lipoplasty.

What is remarkable about this procedure is both its safety and the predictability of its outcomes when performed by a well-trained practitioner. Former problem areas of lidocaine toxicity, blood loss, and poor aesthetic outcome now appear less frequently due to the educational efforts of plastic surgery societies. Americans have learned from their Brazilian colleagues that lipoplasty can be safely performed at the time of excisional body contouring in order to improve contouring in all aesthetic units. The lipoadminoplasy procedure appears to have outcome benefits including reduced seroma incidence and less reliance on quilting sutures to abolish dead space.

Laser-assisted lipoplasty, while marketed by manufacturers as a “fat melting” technology, appears not to be capable of delivering improved outcomes over existing lipoplasty technology. The same can be said for radiofrequency (RF)-assisted lipoplasty. Tissue thermodynamics become problematic beyond 45°C for damage, yet do not reach the 55-60°C required to tighten collagen. Tissue just does not like being heated to near-lethal temperatures with RF or laser under the guise of “tissue tightening.” The use of liposapire for autologous fat grafting (AFT) has become a popular technique in the United States. While this may be an unintended consequence, what was discarded is now being reclaimed (reinjected). Cutaneous reshaping is largely dominated by AFT and implants are a rarity. AFT within the face, performed at the time of facial rejuvenation procedures, is well accepted by surgeons to address atrithrotrophic aging. Even lipoplasty outcomes had been shown to be improved with the reinjection of limited amounts of liposapire.

The other areas of interest in lipoplasty are the emergence of non-invasive lipoplasty devices, based on High-Intensity-Focused Ultrasound (HIFU) and cryolipolysis. Both approaches have been extensively studied and have a solid basic science mechanism of effect. While both of these technologies cannot inherently match the outcomes of surgical lipoplasty, neither has the downtime of a surgical procedure. Strategically, these devices have the potential to fill an unmet need of body contouring in men who are interested in losing waist circumference, but who cannot take time off from work to recover from surgical lipoplasty. Men seem inclined to want to invest about as much time as it takes for a teeth cleaning procedure in terms of using one of these non-invasive technologies to improve body contour.

Plastic surgeons are well-positioned to offer patients seeking body contouring the entire spectrum of options, from non-invasive, to minimally-invasive, to combination excision/lipoplasty procedures.
What started as a conversation on a boat on the Neva River in St. Petersburg, Russia last June has rapidly developed into a new ISAPS humanitarian program. The Boards of Directors of ISAPS and The LEAP Foundation (LEAP) have agreed to collaborate to create a new ISAPS-LEAP Strike Force. In global disasters such as the recent earthquakes in Haiti and Turkey, the tsunami in Japan, and extensive flooding in Thailand, attention to the victims by various aid organizations, the military and surgical teams within hours is vital. However, what happens in the following days is the focus of this new initiative.

While not generally addressed in most plastic surgery societies’ plans, recent natural disasters around the world suggest that it would be prudent for health professionals to improve their preparedness for a mass casualty incident. While acute search and rescue is usually carried out by governmental organizations, these efforts are limited to the first 72 hours after which the hope of rescue diminishes rapidly. Immediate triage and surgical intervention by emergency medical personnel during this period is critical; however, between the 3rd and 10th days, there is a major shortfall in both the triage activities and the first surgical interventions on the injured. These interventions are very often related to plastic surgery.

continued on page 26
In the beginning, surgeons enthusiastically favored the technique of fat grafting, alone or in combination with skin flaps, as it often represented a unique tool to easily solve major problems. But in the '50s, with growing experience, clinicians realized that the very encouraging early results worsened at long term due to unpredictable reabsorption rates and a tendency to form cysts and become fibrotic. This is the reason why use of fat transplantation was considered questionable.

In the '80s, Lyndon Peer (1898-1977) accurately investigated the fate of autogenous adipose tissue transfer at one year and demonstrated that about 50% of fat cells rupture and die after transplantation and the graft structure is replaced by fibrous tissue. Cells which do not rupture survive and these constitute the adipose tissue that remains.

The new blood circulation in free autogenous fat graft arises at about the fourth day through anastomosis between host and graft blood vessels. If this does not occur, early death of cells may develop with oil cyst formation in areas that have not been revascularized.

Due to these considerations, fat grafting to the face fell from favour, gradually becoming an almost obsolete procedure.

At the end of the nineteenth century, paraffin was popular among beauty doctors to correct depressions, re-establish contour and modify sunken noses. These unpleasant deformities – charlatans advertised – could be easily modified in beauty salons and drugstores by simple local injections, avoiding any surgical procedure. Disasters appeared soon. Paraffin migrated causing not only hard swellings, difficult to remove, the so-called paraffinomas, but also pulmonary embolism and infections. This recalls the recent story of liquid silicone injections, with the devastating side effects, the siliconomas, which affected the plastic surgery scenario from the '60s onwards.

In the first decade of the twentieth century, to contrast the paraffin complications, the German surgeon Eugene Holländer (1867-1932) proposed the injection of fat, a more natural filler. Adipose tissue, harvested from “healthy patients,” was mixed with a harder type of fat collected from rams to minimize reabsorption. The cocktail of human and ram adipose tissue was moderately heated until it became fluid and ready for introduction at blood temperature, so as to improve unaesthetic deformities like depressions, facial atrophy or post-mastectomy scars.

In 1926, across the ocean, the US cosmetic surgeon Charles C. Miller (1886-1950) from Chicago recommended a variety of fillers like gutta percha, ground rubber and fat to correct nasoalbaloid folds, crow’s feet and saddle nose. He harvested a piece of adipose tissue from the abdomen, inserted it into a screw piston syringe, and injected it subcutaneously to fill in depressions.

However, fat injection never became popular among the plastic surgical circles and was seldom employed until the advent of liposuction. On the contrary, for numerous years paraffin remained the filler of choice for nose and breast augmentation despite its dramatic consequences.

THE ADVENT OF LIPOSUCTION

In the 1980s, Pierre Fournier and Yves-Gerard Illouz, both from Paris, independently introduced a new procedure for removing fat from the abdomen and thighs of wealthy, overweight Parisian ladies. Liposuction was an incredible success which spread all over the world rapidly. On occasion, a too enthusiastic aspiration of fat resulted in disappointing contour irregularities with depressions and holes. Reintroduction of the lipospirore using a syringe was regarded as the solution of choice. But within a few weeks complete or almost complete reabsorption of the re-injected material was reported.

Fat injection

Despite this unpleasant drawback, the idea of filling contour depressions concurrent with liposuction using the same adipose tissue just harvested, awakened new interest in autologous fat re-injection.

At the end of the 1980s, the Argentinean plastic surgeon, Abel Chajchir, described favourable and long-lasting results using fat injection. He considered cautious manipulation of the adipocytes to reduce potential rupture of its fragile cell, rinsing the lipospirore in saline to eliminate dead cells and...
delirious, and finally grafting fat into close contact with well vascularized tissue – crucial steps to minimize failure.

In the 1990s, New York plastic surgeon Sydney Coleman systematized the procedure. His recommendations were: harvesting fat using a 3mm blunt cannula connected to a 10ml syringe at low negative pressure to reduce adipocyte trauma, purification by means of centrifugation for separating the oily, aqueous and adipose components, and finally, placement in multiple tunnels and in tight contact with well vascularized surrounding tissue, using a 18G cannula. He called this technique Liposstructure.

In 1998, the first course on autologous fat graft was organized in Marseille by Prof. Guy Magalon, having Syd- ney Coleman as guest speaker. This marked the diffusion of the technique in Europe easier. At that time, indications were mainly correction of contour deformities, post-burn scars, Romberg disease, hemifacial microsomia, and chronic sores of the leg. In 2005, Coleman published the first book on fat grafting, where the procedure is exposed in detail along with numerous clinical applications coming from his experience.5

THE ADIPOSE-DERIVED STEM CELLS: A crucial discovery

At the beginning of the new millennium, the University of Pittsburgh’s team of plastic surgeons and researchers co-ordinated by Bill Futrell, made a crucial discovery: that adipose tissue is the greatest source of adult mesenchymal stem cells, the so-called Adipose-Derived Stem Cells (ADSCs), capable of differentiating into other types of tissues.9,10 This accounts for the reparative properties of fat for replacing damaged or missing cells, once transferred into another part of the body. Gino Rigotti and co-workers11 applied the therapeu- tic effects of the ADSCs, for the first time in a human being. He successfully managed the radiation tissue damage with complete restitutio ad integrum of the treated tissues, through a process of replacement in a series of patients. This could be considered an example of Regenerative Medicine.

In May 2006, during the 17th Annual Meeting of the European Association of Plastic Surgeons (EUFAPS), Riccardo Mazzola, at that time president of the association, organized the first international panel: Fat injection, expand- ing opportunities. A wide variety of clinical applications of fat transfer in the field of Regenerative Medicine were pre- sented by the faculty.

The impact of the panel was significant. The procedure was regarded as one of great clinical value. From that panel evolved the first textbook on this topic, Fat Injection from Filling to Regeneration, which was published soon afterwards.12

CONCLUSIONS

Fat injection, empirically started 100 years ago to correct contour deformities by combining human and ram fat,5 nowadays ranks among the most popular procedures, for it provides the physician with an incredible range of aesthetic and reconstructive clinical applications with amazing regen- erative effects on the surrounding tissues.

REFERENCES


THE LATEST ISSUE OF THE ISAPS JOURNAL IS VASTLY UPDATED

The latest issue of the official ISAPS Journal, Aesthetic Plastic Surgery, has undergone a number of changes to improve its already stellar quality. Over the past several months, we have reformed the journal to be more reader-friendly by adding colored tabs at the top of each page designating six different topical sections: Aesthetic, Breast, General Reconstruction, Non-Surgical Aesthetic, Craniofacial/Maxillofacial, and Experimental/Special Subjects. In a newly negotiated contract with our publisher, the page count has been increased to accommodate submissions that are currently at an all-time high. Most importantly, we have replaced the previous Editorial Board with Section Editors who will help us streamline the review process to ensure that accurate decisions are made regarding publication of submitted manuscripts. Our esteemed group of 113 Section Editors, distributed over 29 areas of expertise, are individually assigned manuscripts to oversee through the review process. Furthermore, we have added a new Advisory Board to help philosophically guide the journal into the future. The masthead has been altered to reflect the addition of the new Section Editors and Advisory Board members and our newest affiliation with the Brazilian Society of Plastic Surgery. The first issue with these changes will be the March/April edition.

We anticipate that these changes will result in an even higher quality publication, and we are committed to continuously mak- ing improvements. As always, we welcome comments from our members regarding the direction of our journal.

THE JOURNAL

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Geneva is situated in the southwestern end of Lake Geneva, where the lake flows into the Rhône River. It is surrounded by two mountain chains, the Alps and the Jura, and is part of the Canton of Geneva.

- Second most populated city after Zurich
- Official language of Geneva – French
- Temperature in September – 10-20°C (50-70°F)
- Population – 192,000
- Elevation – 375 meters (1230 feet)

- The Geneva Conventions, comprised of four treaties and three additional protocols, establishing the standards of international law for the humanitarian treatment of victims of war were signed in Geneva in 1864, 1906, 1929 and 1949.

- The city has been referred to as the world’s most compact metropolis and the “Peace Capital.”

- Geneva first appears in history as a border town, fortified against the Celtic tribe Helvetii, which the Romans took in 121BC.

- The name, Geneva, is probably of Celtic origin with one theory proposing that Geneva is derived from Genévrier, the French word for juniper.

ISAAPS CONGRESS SOCIAL EVENTS PLANNED

Kai-Uwe Schlaudraff, MD – Switzerland

Local Arrangements Chair

A lain Fogli (France) and Nazim Cerkes (Turkey), the ISAPS Scientific Program Chairs, have gathered together a stellar faculty of more than 165 world renowned plastic surgeons for the 21st Biennial Congress of ISAPS in Geneva. The scientific program offers five days of intense training, round tables, hands-on courses and video presentations to keep you up to date with the latest surgical techniques plus advice from our Masters in Plastic Surgery during sixteen Master Classes. Jan Poëll and I are honored to welcome both ISAPS members and visitors from all over the world to Geneva in September.

Discover a vibrant city that combines Swiss traditions with the flair of a multitude of International Organizations headquartered in Geneva.

Enjoy authentic Swiss food, wine and traditional music at the Opening Ceremony and let yourself be carried away by the incredible Mime-Masque Theater, Mummenschanz.

Indulge in famous Swiss chocolate on one of our special tours, discover the world’s finest watches and jewelery on Rue du Rhône, and experience a truly incredible night at Circus Knie.

Learn about the stunning technology of the Large Hadron Collider (LHC) at the European Organization for Nuclear Research, the famous CERN, and hear our honored guest speaker tell us about the origin of our universe, or simply enjoy nature in the breathtaking mountain scenery of Verbier, Gstaad, Zermatt or Mont Blanc.

Join us in Geneva for an unforgettable experience. We are looking forward to having you here in September 2012!
WHEN EVERYONE WEARS THE T-SHIRT

Lina Triana, MD — Colombia
Chair of National Secretaries

Today I bring you an interesting perspective about two employees working in the same company. As you read these words, think about our organization, ISAPS.

John works hard and loves his job. Diana regularly sends her CV to other companies and obviously is not happy where she works. Interestingly, they work at the same company with identical salaries and the same boss. Why is John happy with his job and Diana is not?

The reason is pretty simple: they have different views about what their company sells. Diana thinks the company’s product is ordinary, with no real value. John knows his company is innovative in the field, continually making improvements that provide extra value for their customers. Diana believes that working in this company was not what she had dreamed of when she started her career and therefore has problems promoting the product to her customers. John knows he is successful because he works for a company that makes it possible for all of us all have a better life.

The difference is the symbolic value that each of them sees in their company. If we analyze their productivity, we discover that John sells more than Diana, his clients are more loyal, and in their company. If we analyze their productivity, we discover that provide extra value for their customers. Diana believes is innovative in the field, continually making improvements that are highlighted in bold. Recently elected National Secretaries are also highlighted in bold text.

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Sometimes we think innovation comes from the outside, when in fact there is great opportunity to impact directly on service to our clients, customers, members, from the inside. We need to develop the value of our brand. Once customers (or members) connect emotionally with the organization, they will “wear the company T-shirt” and begin to increase their productivity and results and make a difference with their customers.

We need to make what our company does more visible to everyone. How is our product used so customers can benefit from it without forgetting what make us different from others and why our innovations make it possible for others to have a better life. The difference between John’s vision and Diana’s is understanding that innovations expand the company’s vision. How can we transform the symbolic value of our product to values that our clients and collaborators will understand and appreciate is the challenge.

The difference between a proud and happy employee and one that is not lies in the symbolic value of the brand. What is the symbolic value of the ISAPS’s brand?
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Designed by:
Dr. Gonzalez, Associate Professor of Plastic Surgery,
University of Ribeirao Preto (UNAERP) Medical School, Brazil

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ABAM MEETING IN FLORIANOPOLIS, BRAZIL

Renato Saltz, MD – United States
ISAPS 2nd Vice President

The Fourth American-Brazilian Aesthetic Meeting took place in the beautiful island of Florianopolis, Brazil on February 1-5, 2012. Colleagues from 15 countries attended this year’s meeting endorsed by ISAPS, ASAPS and SBCP (The Brazilian Society of Plastic Surgery).

New features at this year’s meeting were simultaneous translation during all sessions, an extra day of Instructional Courses, a Resident Review Course, and a 2 hour Live Injection Evening Session. All these educational activities took place before the meeting even started on Thursday morning.

The attendance was over 300 plastic surgeons who enjoyed the beautiful beach resort of Jurere International with their families. The social events held every night were fully attended and many people enjoyed the Brazilian hospitality until the early hours of the morning.

For the first time since its inception in 2009, the American-Brazilian Aesthetic Meeting was sold out two months in advance. Attendees and industry representatives had a great time and are already planning to return for the next one when ABAM moves back to the United States for the weekend of February 14-18, 2013. We have reserved the Park City Marriott during President’s Weekend (US) and Carnaval Holidays (Brazil). Visit our website and reserve your place for next year’s meeting, www.americanbrazilianaestheticmeeting.com
June 2012

DATE: 01 JUNE 2012 - 03 JUNE 2012
Meeting: ISAPS Course - Como
Location: Como, Italy
Contact: Karen Rogerson
Email: isapscomo@cq-travel.com
Tel: +39 02 49542901
Fax: +39 02 43911650
Website: http://www.isapscomo2012.com

DATE: 06 JUNE 2012 - 08 JUNE 2012
Meeting: I-2012 European Breast Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 51 20
Fax: +49 214 235 20 80
Website: http://www.epsrc.eu

DATE: 09 JUNE 2012 - 11 JUNE 2012
Meeting: personalized Plastic Surgery Course
Location: Clinical Planas, Athens, Greece
Venue: University of Athens
Contact: D. P. Logothetis
Email: dpl@med.uoa.gr
Tel: +30-210-6998731
Fax: +30-210-6105320
Website: http://www.congressmed.gr

July 2012

DATE: 14 JUNE 2012 - 16 JUNE 2012
Meeting: 51st Plastic Surgery Research Council
Location: Ann Arbor, MI
Venue: University of Michigan
Contact: Catherine Foss
Email: crsc@connx.net
Tel: 734-936-1444
Fax: 734-936-1444
Website: http://www.ps.org

DATE: 21 JUNE 2012
Meeting: 4th European Plastic Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 51 20
Fax: +49 214 235 20 80
Website: http://www.epsrc.eu

DATE: 23 AUGUST 2012 - 26 AUGUST 2012
Meeting: 4th European Plastic Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 51 20
Fax: +49 214 235 20 80
Website: http://www.epsrc.eu

August 2012

DATE: 09 JUNE 2012 - 11 JUNE 2012
Meeting: IV-2012 European Breast Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 51 20
Fax: +49 214 235 20 80
Website: http://www.epsrc.eu

DATE: 23 AUGUST 2012 - 26 AUGUST 2012
Meeting: 4th European Plastic Surgery Research Council
Location: Hamburg Harbor, Germany
Venue: Freighter MS Cap San Diego
Contact: Kelli Gatewood
Email: info@epsrc.eu
Tel: +49 3641 311 51 20
Fax: +49 214 235 20 80
Website: http://www.epsrc.eu

September 2012

DATE: 04 SEPTEMBER 2012 - 08 SEPTEMBER 2012
Meeting: 21st Congress of ISAPS
Location: Geneva, Switzerland
Venue: Centre International de Conferences Geneve
Contact: Catherine Foss
Email: isaps@connx.net
Tel: +1-603-643-2135
Fax: +1-603-643-1444
Website: http://www.isapscongress2012.org

DATE: 12 SEPTEMBER 2012 - 15 SEPTEMBER 2012
Meeting: Laser Insbruck 2012: Advances and Controversies in Laser and Aesthetic Surgery
Location: Innsbruck, Austria
Venue: Faculty of Catholic Theology of the University of Innsbruck
Contact: Katharina Russe-Willingseder, MD
Email: office@laserinsbruck.com
Tel: 43 512-25-2012
Fax: 43 512-25-2757
Website: http://www.laserinsbruck.com

DATE: 26 SEPTEMBER 2012 - 28 SEPTEMBER 2012
Meeting: XVIII International Course on Plastic & Aesthetic Surgery
Location: Barcelona, Spain
Venue: Clinical Planas
Contact: Course Secretariat
Email: cursos@clina-clinica-planas.com
Tel: 34-93-225-2812
Fax: 34-93-206-6989
Website: http://www.eurasian2012.org

October 2012

DATE: 04 OCTOBER 2012 - 07 OCTOBER 2012
Meeting: IFATS 10th Annual Meeting
Location: Quebec, Canada
Contact: Jordan Carney
Email: ifats@connx.net
Tel: +1-603-643-2135
Fax: +1-603-643-1444
Website: http://www.ifats.org

DATE: 10 OCTOBER 2012 - 13 OCTOBER 2012
Meeting: 2nd World Congress of Plastic Surgeons of Lebanese Descent
Location: Cancun, Mexico
Contact: Jose Luis Haddad Tame
Email: hatame55@gmail.com
Tel: 52-55-5615-3191
Fax: 52-55-5615-3391
Website: http://www.congressmexico.com/lepras2012

DATE: 12 OCTOBER 2012 - 14 OCTOBER 2012
Meeting: Third World Congress for Plastic Surgeons of Chinese Descent
Location: Xian, China
Contact: Dr. Wei Xia
Email: drxiawei@gmail.com
Tel: 86-29-84771312
Fax: 86-29-84775301
Website: http://www.2012wapscd.org

DATE: 26 OCTOBER 2012 - 30 OCTOBER 2012
Meeting: Plastic Surgery 2012
Location: New Orleans, LA, USA
Venue: New Orleans Convention Center
Contact: American Society of Plastic Surgeons
Email: registration@plasticsurgery.org
Tel: 1-847-228-9000
Fax: 1-847-228-9131
Website: http://www.plasticsurgery.org/

November 2012

DATE: 01 NOVEMBER 2012 - 03 NOVEMBER 2012
Meeting: ISAPS Course - Athens
Location: Athens, Greece
Contact: Vaikis Kontoes
Email: vaikis@hotmail.com
Tel: +30-210-6935666
Fax: +30-210-6938731
Website: http://www.isaps2012athens.com

In Memoriam

JANOS ZOLTAN, MD
Hungary

ELEAZAR FIGALLO, MD
Venezuela

IN MEMORIAM
This new ISAPS-LEAP collaboration results from the informal working relationship that developed following the 2010 earthquake in Haiti. LEAP, headed by CEO plastic surgeon and ISAPS member, Dr. Craig Hobar, was already on the scene with an established clinic in neighboring Dominican Republic, and ISAPS channeled both members’ financial donations and surgical skills through LEAP’s organizational infrastructure. While ISAPS members have the skills and the willingness to help, the society cannot manage global mobilization in times of urgent need.

After 21 years, LEAP is still a relatively small but active global volunteer organization working in 18 countries to provide surgical care where none is available on a non-emergency basis. In joining forces, ISAPS will encourage and enlist its member surgeons who are skilled in reconstructive plastic surgery to volunteer for short-term interventions in disaster zones, while LEAP will coordinate the mobilization they already provide through their established infrastructure. Together, they will register, help prepare and credential ISAPS volunteer surgeons to be ready when they are needed.

LEAP has already developed an informal, early interest, sign-up form on their website at www.leap-foundation.org/about/disaster-relief/ ISAPS is planning an informational lunch-time session during the Congress in November. The session will be sent to ISAPS members. We are very encouraged and enlist its member surgeons where possible to attend.

Thus the ISAPS-LEAP Strike Force will look at the disaster situations and will be glad to help when the need arises.