

ISAPS® NEWS

OFFICIAL NEWS OF THE INTERNATIONAL
SOCIETY OF AESTHETIC PLASTIC SURGERY

2

Volume 16 | Number 2



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Brow Lift:
How I Do It

**ISAPS World
Congress 2022: Message
from the President**

**Culture: Flamenco: Between
the Earth and Heaven**

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MESSAGE FROM

the Editor-in-Chief



ARTURO RAMÍREZ-MONTAÑANA, MD - MEXICO
Editor-in-Chief, *ISAPS News*

ACADEMIC EVENTS, FINALLY IN PERSON

As part of the current edition of *ISAPS News*, the scientific topic is Brow Lift: How I Do It, and we invited some of the best surgeons from different parts of the world to write an article regarding this challenging topic. I want to thank all of them for accepting the invitation: Drs. Patricio Centurion, Gerald O'Daniel, Mario Pelle Ceravolo, Renato Saltz, Ira Savetsky & Alan Matarasso, Ozan Sozer, and Fausto Viterbo. Thanks to them, we now have a spectacular collection of articles showing different approaches on how to solve eyebrow ptosis in one single magazine.

For the next *ISAPS News* issue, the scientific topic is **The Navel: How I Do It**, and we invite everyone to participate by sending your articles on this topic. If you are interested in sharing an article, please send your submission to isapsnews@isaps.org by July 15.

It seems that we are returning more and more to normal life every day, where the in-person meetings are increasingly frequent and busy, and in some countries a COVID test, or even face masks, are no longer required to allow us to attend these gatherings (please see the local requirements in every county before attending your meetings).

A few months ago in April, the Annual Congress of the American Society for Aesthetic Plastic Surgery (ASAPS) was held in San Diego, CA, United States, where many ISAPS members participated as faculties and moderators thanks to the extraordinary relationship and mutual academic collaboration between our associations, ISAPS/ASAPS. We want to congratulate Dr. William P. Adams for his extraordinary

management as the head of ASAPS during his administration (2021-2022), and we also congratulate and welcome Dr. Jennifer L. Walden as the first woman to become president of such an important association (2022-2023); the ISAPS family wishes them every success.

Then on May 19-21, the German/Brazilian Aesthetic Meeting (GBAM) was held in Berlin, Germany, where German and Brazilian surgeon communities organized an extraordinary, and very crowded, academic and social events meeting.

The French community celebrated in Toulouse the 34th edition of their French Society of Plastic Aesthetic Surgeons (SOFCEP) on June 2-4, 2022. As part of the scientific program, presented by SOFCEP President Aurélie Fabie-Boulard, they offered mixed lectures including surgical topics as well as aesthetic medicine which is a very important part of our daily practice.

A few days ago, we also had a Contour Surgery Academic event organized by Dr. Alfredo Hoyos in the city of Cartagena, Colombia from June 9-11, and later in June, our dear friend Dr. Gustavo Abrile, from Argentina, South America, invites us to visit the Iguazu Falls, one of the most beautiful places in the world, where the IV Aesthetic Meeting will take place from June 23-25.

I want to remind all of you that we are only three months away from our next **ISAPS Biennial Congress** in Istanbul, Turkey. This great event will be held this September 20-24 and will offer a fantastic scientific program being prepared

by our Education Council Chair, Dr. Ozan Sozer, and his Vice Chair, Dr. Francisco Bravo. With more than 450 faculties, this amazing program will feature sessions on surgical/non-surgical procedures, new technologies being applied in our specialty, and business courses. Besides that, several extraordinary social events are being planned for all of us. See you all there!

Lastly, with deep pain in my heart, I must mention that the war conflicts between Ukraine and Russia continue. Our ISAPS organization, through its Humanitarian Programs Committee, will take action to help those in need, hoping

that this situation will end as soon as possible for the sake of everyone. Regardless of what the causes of this terrible catastrophe are, let us raise our prayers, beyond any religion that any of us practice, so that it may happen.

Sincerely,



Arturo Ramírez-Montañana, MD
Editor-in-Chief, *ISAPS News*

FAITH OF ERRATA:

During the previous edition of our newsletter, published last March, I wrote as part of my editorial, some of the history of several procedures we still currently perform, including nasal reconstruction. In that editorial, I incorrectly mentioned that Sushruta from India was doing nasal reconstruction using cow leather, pork leather, and even leaves from trees, however, those materials were used only as molds for the design of the forehead flap that he described and performed with great success. He was the first one who used this technique that we continue performing today. I apologize for the mistake I made. Thanks to Dr. Devesh Mehta for alerting me so that I had the opportunity to correct myself.



MESSAGE FROM

the ISAPS News Co-Chair



FABIAN CORTIÑAS, MD - ARGENTINA
Co-Chair, ISAPS News



LEADERS LEAD

Dear Colleagues and Friends,

Does anyone know why he or she is holding a specific position? I mean, are we fully aware of which paths have led us to the place where we are now? In our family, our job, our business, ties with a scientific society, in a group of friends, etc.?

There are many different reasons that can explain each particular case, however, they all have one common component: desire.

Desire is one of the most powerful psychological drives and the triggering force or engine of many other drives. For example, the desire of being a doctor or, more specifically, a plastic surgeon, the desire of having a family, or of living alone. The desires of our childhood are an important component of the multiple reasons why we are where we are today.

Societies are created by and made up of individuals who have decided that an association is much stronger than each isolated individual. Societies also have desires, the ones which come from their components, or members.

The desire of ISAPS, at least this last and present one, has been expressed in our slogan: **Global Leaders in Aesthetics.**

This ambitious desire leaves us in the position of leading aesthetics in a complex world: the world of developed countries and the world of developing countries too, the world of prosperity and the world of crisis, a world that includes a war, and war always divide people, but in this current case it divides brothers. A painful situation that impacts and influences all members of our community that has openly, clearly, and undoubtedly called for peace.

Therefore, our leadership position requires the action of leading all over the world, including different scenarios, playing our role with creativity, knowledge, and determination.

Each ISAPS member, as an essential component of the organization, has this specific task in their geographical area and within the Society's structure. Each one of us has the opportunity to embrace our slogan and make it their own. However, the process of leading aesthetics requires deep aesthetic knowledge, unbiased and free from the powerful influence of the industry and the media.

True leaders will work for the benefit of patients using their vision and wisdom to enlighten the best solution for each and everyone. We, as leaders, need to find the paths to travel in search of a better future and share this knowledge.

Let's meet in Istanbul this September to improve what we have learned throughout the years, and bring the best of us to our patients, and keep contributing to the aim of leading aesthetics worldwide.

See you in Istanbul.

Best regards,

Fabian Cortiñas, MD
Co-Chair, ISAPS News



MESSAGE FROM

the ISAPS President

Dear Friends and Colleagues,

I have been working diligently alongside our Executive and Marketing Teams and the Education Council to organize an unforgettable **ISAPS World Congress** this September in my beautiful hometown of Istanbul, and you will see my passion for my city and all it has to offer in culture and cuisine reflected in the pages of this issue of our *ISAPS News*!

The Education Council (EC) has prepared an outstanding scientific program that is now available to explore on our website. In particular I hope you won't miss the chance to register for our pre-Congress live surgeries day on September 20, which features our most ambitious live surgeries program yet: 12 surgeries in 6 parallel operating theatres to ensure there is truly something for everyone. The main Congress will include our first non-surgical symposium, as well as a vast array of in-depth panel discussions, keynotes, workshops, and master classes put on by some of the world's most renowned surgeons and experts of course. If you have not yet taken advantage of our early-bird fees, which are available until **August 20**, remember that **ISAPS members pay much less to attend**, so I urge you to **apply for or renew your membership today** if you have not done so already and get a significantly lower registration rate. I was delighted to see that so many of you took advantage of our special spring fees to attend. We have 750 registered so far and ISAPS Istanbul World Congress promises to be one of the most-attended meetings in aesthetic plastic surgery.

In the last three months, I have been very busy with extensive travel and many meetings. I attended the meetings in Panama, Thailand, Italy, Mexico, US, Guatemala, Serbia, and France which were all great opportunities to represent ISAPS and to get together with colleagues from around the world. I am happy to report that there has been a great amount of interest in the **ISAPS Fellowship Program**, with a record number of applications for the upcoming year.

We are also excited to announce two new locations for next year, Marbella, Spain, and Sydney, Australia! The program is a terrific opportunity for last year's residents and young plastic surgeons to learn from ISAPS masters. Thank you to all of you who are participating and sharing your experiences.

To complement the ISAPS Fellowship Program, we have launched a monthly **ISAPS Aesthetic Plastic Surgery Journal Club**, which is a great opportunity, particularly for young members and residents to come together with leading experts to discuss current papers and related issues. I thank the APS Journal Editor-in-Chief, Bahman Guyuron, EC Chair, Ozan Sozer, Resident Committee Chair, Maria Wiedner, and all other team members who worked on this project.

The Board of Directors Election for 2020-2024 will take place soon using our new electronic voting system. Your participation as a member of ISAPS is essential for the future of our beloved Society, and we thank you in advance for your input. Most importantly this month I urge you please to support and participate in our **Annual Global Survey**. Your input is invaluable, as the more surgeons we have from different countries, the more complete the survey will be in raising awareness and improving understanding of aesthetic plastic surgery worldwide.

I hope that the articles that follow in these pages will offer useful guidance for you during your stay in Turkey for ISAPS World Congress. See you soon in Istanbul!

Sincerely,

A handwritten signature in blue ink that reads "Nazim Cerkes".

Nazim Cerkes, MD, PhD
ISAPS President, 2020-2022

MESSAGE FROM the Education Council Chair



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

Dear ISAPS Members and Colleagues,

In March, we completed a very successful live meeting in Phuket, Thailand. This was our first live event in Asia since the start of the pandemic (**Figures 1-3**). Drs. Francisco Bravo, Tim Papadopoulos, and Sanguan Kunaporn put a very exciting program together, which included a live surgery broadcast in real-time during the conference.



Figure 1. Presentation at ISAPS Thailand 2022.

The content of this meeting is available to our members On Demand on the [ISAPS website](#).

April was a busy month for ISAPS. We contributed virtually to the Annual Meeting of Korean and Taiwanese Aesthetic Societies, and at the end of the month,

ISAPS organized a mini-symposium during the Annual Meeting of the Aesthetic Society in San Diego, CA, United States. This was a live event that was well attended.

Our faculty included Drs. Alfredo Hoyos, Stefan Danilla, Ricardo Herrera Ventura, and for HD body contouring we had Drs. Andre Auersvald, Gerald O'Daniel and myself. The sessions were successfully moderated by Drs. Arturo Ramirez-Montañana and Renato Saltz.



Figure 2. Faculty of ISAPS Thailand 2022.

Now all our attention is geared toward the ISAPS Biennial **World Congress in Istanbul, Turkey**. This year the World Congress will feature two separate components: surgical and non-surgical, for which both [programs](#)



Figure 3. Presentation at ISAPS Thailand 2022.

[are completed](#). Of course, we make daily changes to the schedule as we receive feedback from our faculty. Currently, we have over 450 confirmed faculty and over 250 learning hours planned. We are also looking forward to offering a live surgery event on September 20, the day before the main meeting.

The registration for the meeting is open and the next [Early-bird deadline is August 20](#), so be sure to sign up before then to save. In addition to the world-class educational opportunities, we are preparing exciting social activities to make sure your experience in Istanbul will be complete and unforgettable.

Looking forward to seeing you in Istanbul this September!

Sincerely,



Ozan Sozer, MD



ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

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

COMMITTEE REPORT

ISAPS Governance Committee



IVAR VAN HEIJNINGEN, MD - BELGIUM
Chair, ISAPS Governance Committee

GOVERNANCE: WE NEED RULES TO RULE!

GOVERNANCE: HOW DO WE DO THE JOB?

Governance is the way rules, policies, and actions are structured, sustained, and regulated to reach the goal of an organization, and how board members and the management team are held accountable for their actions. It describes how everyBODY in an organization does the right thing to make it thrive. This newsletter article explains the rules, the policies, the terms of reference (TOR), and other documents that help us do the job in the best possible way.

GOOD INTENTIONS

When a position on a committee or on the board of an organization is accepted, most individuals have the best intentions to perform their job in the best possible way. However, medical associations do not have a traditional introduction for these individuals for their job, and what is expected of them. If you are lucky, an alinea in the bylaws describes your tasks, but more often than not you must start your job without a task description. So, you ask your predecessor how they did the job and/or you make up what you feel is needed. According to good governance, everyBODY is entitled to better guidance. That is what policies and TORs are for, and they need to be introduced by induction.

BOARD AND COMMITTEE INDUCTION

For an organization or society to function at its best, it is important that new board and committee members know what is expected of them. It is a sign of good governance

when there is a process in place that introduces them to all aspects of governance and explains to them what is expected in their position. They need to know that bylaws and articles of incorporation describe the reason the society exists, the strategic document narrows down the goals for a given period, and the policies and TOR

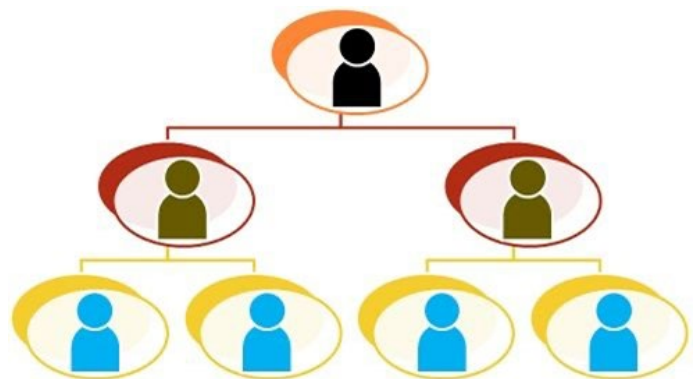


Figure 1. Authority Chart example. In order of hierarchy: board of directors, followed by the executive committee, executive directors, and all committee chairs, finishing with executive committee members, office staff, and committee members.

put the limits on what is allowed and what is not. The Authority Chart (**Figure 1**) clarifies who reports to whom and a function-specific task description explains what exactly is expected of a board or committee member. The governance manual describes governance in general and lists all the relevant documents, policies, and TORs. This helps board and committee members execute their tasks in a professional and ethical way.

AUTHORITY CHART

It must be clear in every organization who has the power to decide. In a non-profit medical society such as ISAPS, that is the elected Board of Directors (BOD). Of course, it is not practical to consult with all members on every decision, so these are often delegated to appropriate individuals. The Executive Committee (EXCO) takes care of the day-to-day running of the Society and prepares decisions to be taken to the BOD. The Executive Director leads the office and decides on tasks that are delegated to him/her. Committees do the same, they prepare new decisions to be taken by the BOD, or they execute tasks delegated to them. A clear example is the planning of ISAPS courses and webinars: the content is prepared by the Education Council (EC), the practical organization by the office and a local organizer, and the results are presented to the BOD by the EC Chair.

Time-consuming tasks such as membership management, website maintenance, marketing, and the practical organization of events, are delegated to the Executive Office, or in some cases outsourced. To keep track of who decides what, an authority chart is prepared so that it is clear who is responsible for what, and how they report to the BOD.

This is most important when it comes to spending money on behalf of the Society and the use of office support. When significant sums must be spent, or a lot is asked from the office staff, a prior decision of the entire BOD is mandatory.

POLICIES AND TERMS OF REFERENCE

When you want to do what is expected of you, you need some description that you can use as a reference. All committees will have terms of reference (TOR). It describes:

1. the purpose of the committee;
2. the composition: the chair, how many members, their term, quorum of meetings, and staff involvement/support;
3. the mandate of the committee;
4. the responsibilities of the committee (members): what is expected of them, which documents they must maintain, the policies that are applicable to them, and an introduction to their job.

5. Modus Operandi describes how the committee goes about reaching their goals, how the meetings are organized, and how they report to the BOD.
6. The references list all relevant documents that the committee uses to do its job.

Policies describe processes that the board agreed on so that certain procedures can be processed in a consistent and transparent way. The Nomination and Election policy of board members is an example of such a process.

CONCLUSION

A medical organization must be effective. For most board and committee members their function is a voluntary job they do in addition to their main medical function. It must be clear for everyBODY in the organization to understand what is expected of them, and how they agree to do things. That is where policies and TORs describe in more detail how everyone agrees to do their job. A proper induction, when people start in a function, helps them serve the organization to the best of their abilities.

Sincerely,



Ivar van Heijningen, MD



GLOBAL SURVEY

CONTRIBUTE TO THE VISIBILITY OF YOUR SPECIALTY AND COUNTRY!

The ISAPS Global Survey is the only international scientific study on aesthetic surgical and non-surgical procedures performed by plastic surgeons.

ISAPS will be able to raise **more awareness** and **improve the understanding of aesthetic plastic surgery worldwide** with your participation!

Only countries with enough data provided will be published, so make sure to represent your country today!

Include your email address when completing the Global Survey and be entered into a prize draw each month for the chance to receive one of our exciting prizes including free attendance at one of our ISAPS Educational events, or a free MedOne subscription. If you're not an ISAPS member and you complete the survey, you will pay no application fee when you **join ISAPS** (up to \$100 discount).

[CLICK HERE TO PARTICIPATE IN THE GLOBAL SURVEY!](#)

4TH NORWEGIAN-AMERICAN AESTHETIC HYBRID MEETING AND ISAPS SYMPOSIUM - OSLO, NORWAY & VIRTUAL



AMIN KALAAJI, MD, PHD - NORWAY
ISAPS National Secretary



Dear friends and colleagues,

The 4th Norwegian-American Aesthetic Meeting and ISAPS Symposium (NAAM4) was held on October 29, 2021. It was phenomenally successful, with more than 170 participants from 25 countries and five continents! Happily, this turnout was more than expected during those complicated times.

After the success of the 1st, 2nd, and 3rd Norwegian-American Aesthetic Surgery Meetings in Oslo, Norway in 2015, 2017, and 2019 respectively, the Norwegian Society for Aesthetic Plastic Surgery (NSAPS) and the American Society for Aesthetic Plastic Surgery (ASAPS) were pleased to invite you to the 4th Norwegian American Aesthetic Surgery Meeting this past October. This time, NAAM4 was combined with the first Norway ISAPS Symposium. Because of the COVID-19 pandemic, this joint meeting was held in a hybrid format.

We were so overwhelmed that we could adapt, and succeed, in the 'new normal' times by making a hybrid meeting with worldwide participation. We should never give up on education and should adapt to the new reality, and to the needs and comfort of our colleagues when traveling is hindered for any reason. One thing is for sure, we should consider this hybrid form as a new standard in our meetings as much as possible.

As something new, we were able to share a link highlighting the exhibitors' activity for all participants in a separate correspondence after the meeting, since some of the exhibitors were participating only virtually.

We were proud to announce that we had gathered 13 distinguished colleagues for the faculty:



William Adams
US



Kjersti Ausen
NORWAY



Francisco Bravo
SPAIN



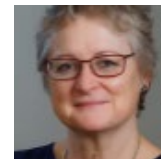
Nazim Cerkes
TURKEY



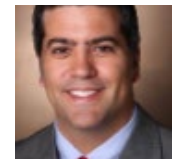
Ruth Graf
BRAZIL



Gudjon Gunnarsson
NORWAY



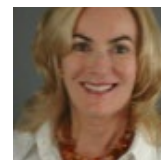
Elizabeth Hall-Findlay
CANADA



Kent Higdon
US



Mark Jewell
US



Mary Jewell
US



Amin Kalaaji
NORWAY



Timothy Marten
US



Bjørn Tvedt
NORWAY

As tradition obliges, the program was divided into seven sessions:

- Rhinoplasty
- Breast 1, including the latest on breast implant illness
- Patient Safety and Practice Management
- Breast 2, including the latest on ALCL and updates on recent innovations
- Regenerative Surgery and Fat Grafting in Body Contouring, including BBL
- Face: Facelift, Neck Lift, Fat Grafting, and Ancillary Procedures
- Intimate Surgery

Rather than simply presenting a limited number of topics, we covered as many aspects of aesthetic surgery as possible within these seven sessions. This last time we had many topics, and from some faculty members numerous lectures, on their related topics in a compact continuous format. We believe, as does our faculty, that this did enhance critical

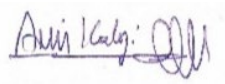
thought and stimulate discussion, allowing our colleagues to reflect on the discussions and come up with new ways of thinking.

While the meeting was held in a hybrid format, there were some attendees who preferred to travel to Oslo, the beautiful capital of Norway, with its fjords and natural surroundings; the weather was partially sunny and chilly in late October, about 16°C (60°F).

I thank all of you – faculty, moderators, exhibitors, and delegates – for your support and participation.

Don't forget to pencil in the date for the 5th Norwegian-American Aesthetic and ISAPS Meeting (NAAM5), October 27, 2023. Follow the updates at www.naam.no.

Sincerely,



Amin Kalaaji, MD, PhD
The Meeting Chair

ISAPS JOURNAL

MESSAGE FROM THE EDITOR-IN-CHIEF



BAHMAN GUYURON, MD, FACS - UNITED STATES
 Editor-in-Chief, *Aesthetic Plastic Surgery*

Dear ISAPS Members,

Our collective efforts in improving every aspect of the Journal continues. Soon you will be seeing a category called “My Way.” These are articles that are submitted by invitation and offer details of a procedure that an author is recognized for. The article will include a video detailing the precise way in which the author conducts the surgery and achieves results that are successful and safe. The means by which the safety of the operation can be augmented will be described.

Additionally, the appearance of the Journal is under assessment and refinement, and we hope you will enjoy the improved façade and content of the Journal.

In May, we had our first **Aesthetic Plastic Surgery Journal Club** which is primarily designed for the residents, but the way these are planned could be sufficiently informative for any level of practice. For each meeting, we select four of the most recent highly educational articles. The Journal Club is moderated by one or two experts in the field, and each article is reviewed and discussed by the moderators in the presence of the lead author.

We could use the services of additional reviewers in the areas of blepharoplasty and genital and gender surgery. If you are interested in reviewing articles in these fields, please send me your name, email address, and CV, if possible.

I hope you are planning to attend the ISAPS Biennial Congress in Turkey this September. The Scientific Committee has put



together an incredible program and the experience of visiting Turkey in September is unmatched.

It is also important to note that the final manuscript of the abstracts submitted to the ISAPS Biennial Congress is submitted to the *Aesthetic Plastic Surgery* Journal for review and potential publication. Considering the relationship between the organization holding the Congress and the Journal, this is a natural requirement. However, notwithstanding the relationship between ISAPS and the Journal, the mere fact that the *Aesthetic Plastic Surgery* Journal has the largest distribution amongst the aesthetic journals, reaching over 10,000 sites and read by over 4,500 plastic surgeons

who are interested in aesthetic surgery internationally, makes submission of articles presented during the ISAPS Congress to our Journal a logical and prudent choice.

We could use the services of additional reviewers in the areas of blepharoplasty and genital and gender surgery. If you are interested in reviewing articles in these fields, **please send** me your name, email address, and CV, if possible.

Sincerely,

Bahman Guyuron, MD, FACS

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RICCARDO MAZZOLA, MD - ITALY

ALBRECHT DÜRER (1471-1528): AUTHOR OF THE FIRST MATHEMATICAL CALCULATIONS OF THE PROPORTIONS OF THE HUMAN BODY

LIFE

Painter, engraver, and mathematician, Albrecht Dürer (1471-1528), was born in Nuremberg, Germany¹. The son of a goldsmith, he studied painting in the workshop of Michael Wohlgemut, also in Nuremberg.

Considerably influenced by the Italian Renaissance and by the art of the Venetian painters, in 1495 Dürer moved to Venice, where he remained for one year. While in Venice he showed great interest in anatomy, performing cadaveric dissections to study the human body, and its proportions and symmetry.

Knowledge of anatomy was an essential requirement of the Italian theory of art. Painters and sculptors of the Italian Renaissance became interested in anatomy, for the sake of reproducing human forms and proportions accurately in their works of art. We have ample evidence that besides Leonardo da Vinci, Michelangelo Buonarroti (1475-1564), Albrecht Dürer (1471-1528), Raphael Sanzio (1483-1521), and other artists, used the scalpel to improve their illustrations of the human body and left drawings of their own dissections².

By performing cadaveric dissection, artists like Pollaiuolo, Leonardo, and Raphael achieved incredible perfection in representing the human body, skeleton, muscles, and proportions generally speaking. They studied muscles, their movement, and specific parts of the body such as the face, hands, extremities, breast, and abdomen. In Germany, strict regulations impaired the dissection of corpses.

In 1505, he made a second trip to Venice, where he remained for 18 months and met Leonardo da Vinci. Back in Germany, he continued his activity as a painter and engraver. In 1511, he became the protégé of Maximilian I, Holy Roman Emperor, who ordered several paintings.

In the last period of his life, he studied mathematics, perspective, and the proportions of the human body. He published two important works on these subjects, *Unterweisung der Messung* (Treatise on Mensuration) in Nuremberg in 1525, and *Von menschlicher Proportion* (Proportions of the Human Body), in four books, posthumously issued in 1528. He died on April 6, 1528, probably from malaria contracted during his trip to the Netherlands. For the versatility of his mind, as well as for

his interest in paintings, science, and anatomy, Dürer has often been associated with Leonardo da Vinci.

WORKS AND LEGACY

Unterweisung der Messung (Treatise on Mensuration) and *Von menschlicher Proportion* (Proportions of the Human Body) are linked by a series of common points of view, with a third of the work published by Dürer during his lifetime, *The Instruction on the Fortification of Cities, Castles, and Towns* (1527). In the first two works, Dürer studied the ideal men, whereas in the last one he planned the ideal town and fortification.

Soon after his first trip to Venice, Dürer began formulating mathematical rules of the proportions of the human form. He extrapolated them from the works of antiquity, mainly Euclides (4th–3rd centuries BC), Vitruvius (70–23 BC), from the mathematical and architectural studies of Leonardo da Vinci (1452–1519), Piero della Francesca (1415–1492), and Luca Pacioli (1446–1517).

However, Dürer's goal was to establish a scientific basis for aesthetics, and to provide practical guidelines for draftsmanship, so as to achieve anatomical perfection. He even designed specially dedicated mechanical instruments to evaluate the details of the human form, and dissected cadavers to better understand the human body. He used the height of the human body as the basic unit of reference: he analyzed and defined the distances between like points in relation to the height of these bodies in order to obtain precise values. Dürer began his own series of studies in anatomical proportion, obtaining measurements of the bodies of a large sample set of men, women, and children.

Fascinated by the theories on proportions of the Venetian painter and engraver, Jacopo de' Barbari's (1460–1516), and by his representation of the nude using detailed measurements and numbers, Dürer referred to a geometric-mathematical concept, crucial in determining the key points of the proportions and symmetry of the human figure. Mathematical and geometrical rules, highlighted in his work on geometry *Unterweisung der Messung*, were applied in *Von menschlicher Proportion* for the first time, so as to evaluate the canon of proportions and the principles of aesthetics. The aim of his system of anthropometry was to provide the artist with precise instruments to assess the human figure, mathematically calculated.

Dürer published the results of his own studies in his four-volume work *Von menschlicher Proportion* and was probably only able to correct the proofs. The text was translated into Latin in 1532 by the humanist, Joachim Camerarius (1500–1574), with the following title *De Symmetria Partium in Rectis Formis Humanorum Corporum* (On the Symmetry of the Human Body Incorrect Forms), and personally supervised by Agnes Frey, Dürer's widow³. The original books of the first German edition were used. The translation popularized Dürer's fame throughout Europe. Without this translation, his writings would not have achieved exceptional dissemination and Michelangelo would never have appreciated Dürer's theory of proportion.

Books one and two deal with the proportions and symmetry of the whole human body: in fat, medium build, and thin adult figures, as well as those of infants, including calculations of the total or partial measurements of the upper and lower limbs, hand, foot, and face, using a precise mathematical scale. For him, the essence of true form was primarily a mathematic figure (e.g., straight line, curve, or circle), constructed arithmetically or geometrically, to which the canon of proportion should be applied. Particular care was given to the analysis of the face, hand, and foot.

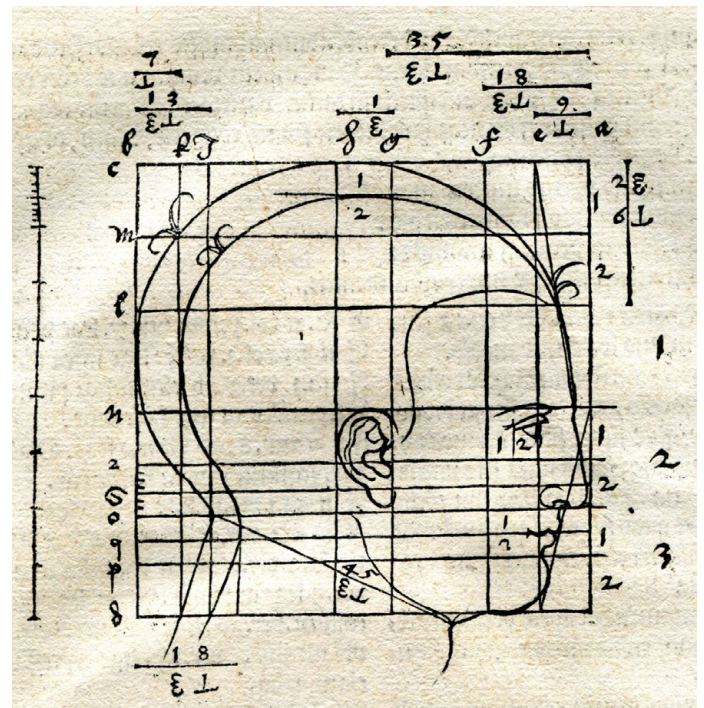


Figure 1. Facial analysis with the measurements of different parts of the face, "Dürer A. De Symmetria Partium". Nuremberg, 1532.

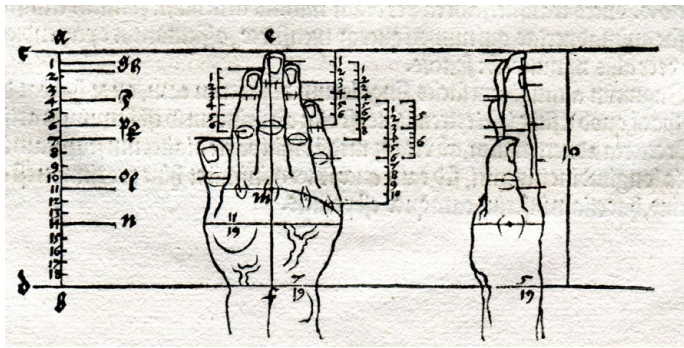


Figure 2. Mathematical calculations of the proportions of the hand, according to Dürer.

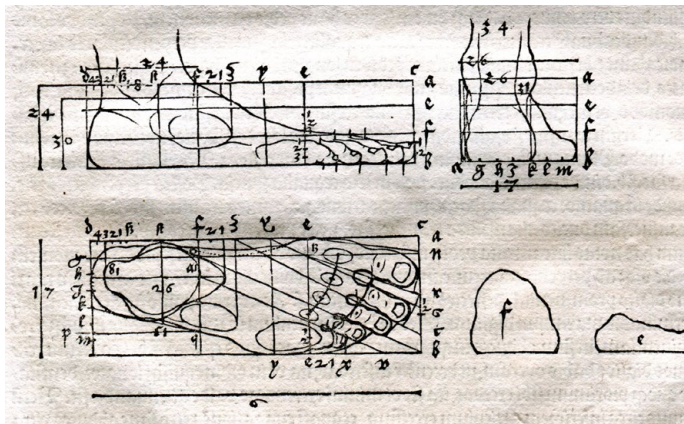


Figure 3. Mathematical calculations of the proportions of the foot, according to Dürer.

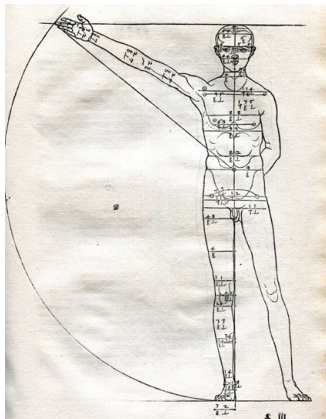


Figure 4. Mathematical calculations of the proportions of the human body.



Figure 5. Dürer's signature: a great capital "A" surmounting a smaller capital "D". It is regarded as the first example of a logo.

In performing facial analysis, Leonardo da Vinci and Luca Pacioli divided the face horizontally into thirds. Dürer applied the same basic principles to the division of the face in thirds but, unlike Leonardo, he used more detailed parameters. To understand this concept, one must examine the illustration of the profile of the face. The ideal length of the nose should be comprised of a line drawn in the supratarsal fold, with the eye in a forward gaze and a line, parallel to the previous one, drawn on the underside of the nostril. This represents one-third of the face; the other two-thirds being represented by the forehead, and the chin/mouth (Figure 1). The same meticulous and rigid mathematical calculations were used for the hand, first examined in its entirety and then divided along its joints (Figure 2), for the foot (Figure 3), and for the entire human body (Figure 4). These measurements constitute the quintessence of Dürer's theory of proportion and one of the leitmotifs of the Renaissance canon of beauty.

Interestingly, Dürer's signature was represented by a great capital "A" surmounting a smaller capital "D". It is regarded as the first example of a logo (Figure 5).

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3. Dürer A. De Symmetria Partium in Rectis Formis Humanorum Corporum (On the Symmetry of the Human Body). Nuremberg, in the house of Dürer's widow, 1532

A woman with long brown hair, wearing a vibrant red, sheer, multi-layered dress, is captured in a joyful dance. She is smiling broadly, with her arms outstretched and one leg lifted. The scene is set in a bright room with large windows in the background, through which sunlight filters, creating a warm and airy atmosphere. To the right, a portion of a black grand piano is visible. The overall mood is one of elegance and happiness.

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**BROW
LIFT:**
HOW I DO IT



FAUSTO VITERBO, MD, PHD - BRAZIL

GLIDING BROW LIFTING

Undoubtedly, the aging process causes the drooping of the eyebrows. It is almost a consensus that facial rejuvenation should approach this region with a brow lift.

To date, there are many options for this procedure, with skin resections in the frontal, intra- or pre-capillary region, or even in the middle of the forehead, associated or not with skin or subperiosteal detachments, subperiosteal endoscopic lifting, or traction threads.

Aspects such as recurrence, scarring, and remodeling capacity are considered and define the method of choice.

After going through all these options, we have found the gliding brow lift to be the simplest and most effective way in terms of remodeling, in addition to the lowest

recurrence rate.

A three-millimeter intracapillary incision in the scalp on each side allows for detachment of the skin from the lateral frontal, temporal, and paraorbital region. If



Figure 1. Patient one: before gliding brow lift.

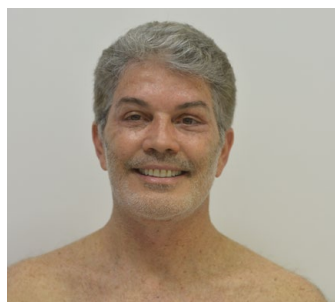


Figure 2. Patient one: after gliding brow lift.



Figure 3. Patient two: before gliding brow lift.



Figure 4. Patient two: after gliding brow lift.

manipulation of the medial region of the brow is indicated, a third midline incision, also on the scalp, can be added.

The skin is then lifted in the lower part, allowing the elevation and alteration of the shape of the eyebrow, according to the patient's wishes. The skin excess in the upper part will be shrunken with stitches in the middle and repeated until all the skin is accommodated.



Figure 5. Patient three: before gliding brow lift.



Figure 6. Patient three: after gliding brow lift.

Separate or continuous external stitches, described as hemostatic net, compromising skin and subcutaneous tissue, will allow fixation and hemostasis and will be removed after 48–72 hours. Two stitches are placed on the eyebrows and left for six days, as they will not leave marks, giving greater security against recurrence.

The wide release of the skin allows you to raise or lower the eyebrows widely, which is an advantage but also increases the risk of asymmetries, which requires greater care.

When associated with a facelift, periorbital detachment allows the elevation of the skin in this region without the need to place a temporal pre- or intrapilous skin incision. The stitch marks disappear in two to three weeks.

Three-millimeter incisions make skin detachment impossible with usual instruments. For this, we have developed special dissectors produced by **FAGA Medical** and we receive royalties for this.

We started this new technique in 2014 and published it in 2019¹, together with Drs. Auersvald and O'Daniel.

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PERSONAL APPROACH TO GLIDING PERIORBITAL SHAPING



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

INTRODUCTION

Brow lift has been a popular procedure for many decades. There are many ways of lifting the brow such as direct excision, endoscopic, or temporal approach. They all produce good results if they are performed well on the right patient. I think the key to choosing the optimal procedure is identifying what the patient needs, combined with the patient's desires. When I watch presentations in meetings or review the literature, including articles I published myself, I see wrong operations performed over and over again. The brow may be too elevated, the wrong portion of the brow was elevated, or the patient did not need a brow lift but needed some part of the brow lowered.

I believe we must steer away from the concept of brow lifting and start thinking of periorbital shaping. The importance of the periorbital area in determining beauty and attractiveness has been clearly demonstrated by anthropologists and psychologists^{1,2}.

The brow is just one of the structures of the periorbital area that constitutes such a very important part of the human face. To create a natural look with our brow surgery, we must address all the periorbital structures for a successful outcome.

In my personal practice, I used an endoscopic brow lift for many years before eliminating the endoscope and performing the same operation blindly, and the endotine was used to secure the elevation in both operations. Four years ago, Dr. Fausto Viterbo introduced me to his technique of the gliding brow lift (GBL)^{3,4}. In my hands, the technique has

evolved into a procedure of total periorbital shaping. In this article, I would like to share with you my personal approach to gliding periorbital shaping (GPS).

SURGICAL TECHNIQUE

In preparation for this operation, the whole periorbital area is evaluated as a unit and micro fat grafting (MFG) is used to restore the periorbital areas, as indicated in over 90% of the cases. As indicated, upper blepharoplasty and/or transconjunctival lower blepharoplasty are included in the procedure. The upper blepharoplasty skin excision should be only two or three millimeters and should not extend beyond the lateral canthus.

The procedure usually starts with MFG to allow precise placement of fat. The upper and lower blepharoplasties are then performed as indicated.

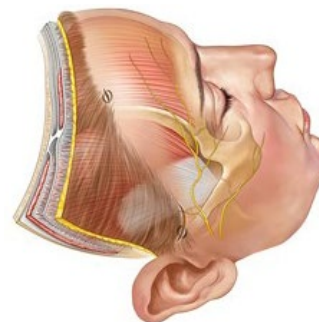


Figure 1. Location of the incisions.

The gliding periorbital procedure begins with two incisions that are placed for subcutaneous infiltration of the lateral forehead, periorbital area, and upper face (**Figure 1**).

The solution utilized consists of 1000cc NS, 50cc lidocaine 1%, 1ml epinephrine 1:1000, 1000mg/10ml tranexamic acid, 1ml (150 USP units/ml) hyaluronidase. Around 100cc is injected into each side subcutaneously. After the administration of the solution, a

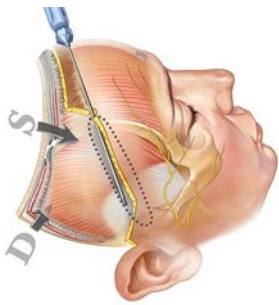


Figure 2. Blind subcutaneous tunneling with Viterbo Dissector. Frontal nerve travels medially.

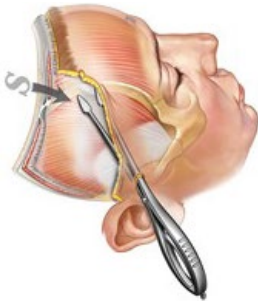


Figure 3. Completion of a tunnel of subcutaneous dissection right in front of the hairline.

The next step is creating a dissection plane over the deep temporal fascia. The fascia is visualized through the sideburn incision and bluntly elevated in the avascular plane between the galea and deep temporal fascia. This creates two separate planes of dissection: subcutaneous in front of the hairline and over the deep temporal fascia behind the hairline. These two planes do not communicate, they are separated by a mesentery of soft tissue. The two planes are joined together by using a two-millimeter liposuction cannula to pass a loop of 3-0 vicryl suture around the separating tissue and the suture is then used as a jigsaw to divide this tissue (Figure 4).

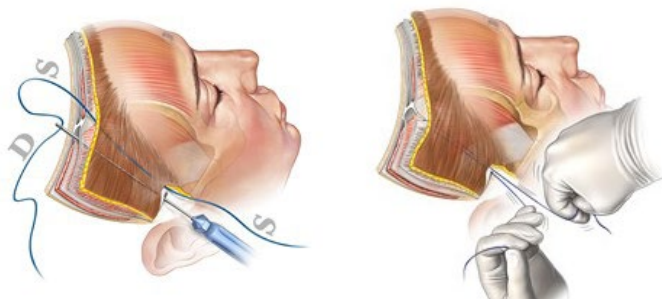


Figure 4. The two planes are joined together by using a two-millimeter liposuction cannula.

To access the rest of the periorbital area, the sideburn incision is enlarged superiorly to accommodate a lighted retractor and a better visual field. The rest of the procedure

is done under direct vision (Figure 5).

The whole subcutaneous dissection of the lateral forehead, lateral orbital area, and midface can be approached through this incision under direct vision allowing complete control of the plane of dissection. It is important to note that at the lateral orbital rim the skin gets very thin as the dissection approaches the corner of the eye. In this area, a triangle of orbicularis oculi muscle is included in the skin flap. This maneuver will allow better mobilization of the lateral orbital rim in plain sight right above

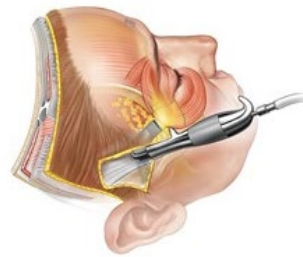


Figure 5. Incision is enlarged to accommodate a lighted retractor.

is done under direct vision (Figure 5).

The whole subcutaneous dissection of the lateral forehead, lateral orbital area, and midface can be approached through this incision under direct vision allowing complete control of the plane of dissection. It is

important to note that at the lateral orbital rim the skin gets very thin as the dissection approaches the corner of the eye. In this area, a triangle of orbicularis oculi muscle is included in the skin flap. This maneuver will allow better mobilization of the lateral orbital rim in plain sight right above

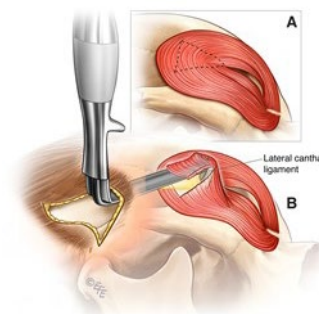


Figure 6. Triangle of orbicularis oculi muscle is included in the skin flap exposing the lateral canthal ligament.

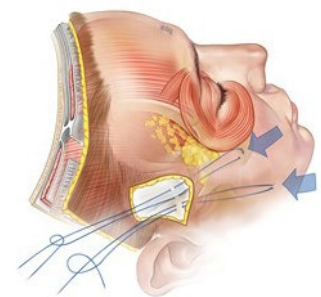


Figure 7. Suspension of the SMAS to the deep temporal fascia.

the periosteum. The exposure provided with this approach allows easy visualization of the cantal ligament that can be easily managed as indicated (Figure 6). The dissection is extended to the midface and SMAS is either plicated or suspended through the same incision (Figure 7).

The skin traction is applied vertically by hooks while a surgical net suture is placed. I usually use a 5-0 prolene suture with a 19mm PS2 needle (Figure 8). Surgical net sutures are removed in two or three days.

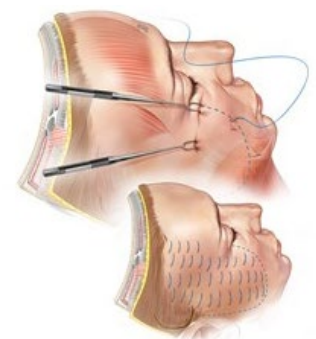


Figure 8. Vertical traction and placement of surgical net.

The space over the deep temporal fascia is obliterated with external 2-0 prolene sutures. These are removed in seven days. There are no surgical dressings, and patients can wash their hair and face the next day.

DISCUSSION

The introduction of Dr. Andre Auersvald’s surgical net has been a game-changer in aesthetic surgery. Although Dr. Auersvald used the technique for mostly hemostasis, it has several additional benefits. The two most significant additional benefits of the Auersvald net are the ability to precisely redrape the skin with strategic placement of the net, and the net creates multiple points of adherence to assure firm reattachment of the glided tissues in an optimal position. The skin draping ability allows the surgeon to perform procedures through small incisions without skin excision. The multiple points of adherence will contribute to the longevity of the result (Figures 9, 10).



Figure 9. Before and two days postoperative following GPS, MFG, TCLB, and short scar neck lift.



Figure 10. Three years postoperative.

The GBL, which was developed by Dr. Viterbo, is a blind procedure and I have used his technique successfully on many patients (Figure 11).

GBL is not only an effective way of brow lifting, but it has the power to shape the entire brow as indicated. Not every patient needs a brow lift; sometimes part of the brow may be too high and GBL can effectively lower the brow when needed (Figure 12).

The modifications I am suggesting in this article are geared to create a complete dissection of all the involved areas under direct vision and better mobilization. Complete periorbital dissection creates an effect-like canthopexy (Figure 13).



Figure 11. Before, one-and-a-half years after, and three-and-a-half years after a GBL done under local anesthesia.

Even in select cases, the canthal ligament can be divided and reoriented to change the axis of the eye.



Figure 12. Before and after brow shaping; left medial brow is lowered and right lateral brow is elevated.

CONCLUSION

GPS is a combination of procedures which rejuvenates and improves the periorbital area as a unit. I believe the gliding procedure can be applied to different parts of the face and will be a game-changer in facial plastic surgery (Figure 14).



Figure 13. Effect like canthopexy.



Figure 14. An actual canthoplasty was performed through the GPS incision and MFG.

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BROW LIFT: HOW I DO IT



PATRICIO CENTURION, MD - PERU

In search of alternatives for lateral brow lifts to offer a less traumatic procedure with lasting results, we developed a simple technique that involves suspending the lateral portion of the frontalis muscle. Replacing raising the temporal flap in a conventional facelift.

We present a technique that was published for the first time in 2010 (DOI:10.1007/s00266-010-9537-3) as lateral brow lift. Today this technique continues to be effective and less invasive, always associated with short scar facelifts. For the last eight years, it's also been associated with facial fat graft (DOI:10.1007/s00238-020-01643-x). The vertical vector permits a natural result.

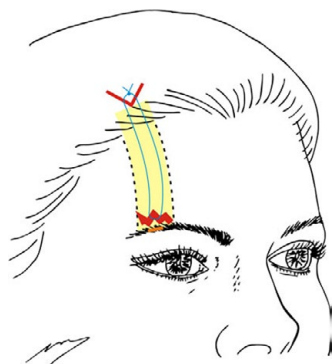


Figure 1. Schematic diagram of suspension suture.

The first sign of facial aging is laxity in the upper third of the face. The gravity, weakness in the adherence of the lateral third of the brow, and movement of the lateral portion of the orbicularis oculi

muscle, and the patient's intrinsic factors, are cause for eyebrow descent causing a sad and tired look generating a pseudo excess of skin in both lateral thirds of the upper eyelid.

The developed technique is simple to reproduce and provides lasting results. It involves suspending the lateral portion of the frontalis muscle. This procedure is easy to perform, reduces patient recovery time, and implies few complications.

First, the traction vector is determined while the patient is in a standing position, taking into consideration the distance

to be lifted in millimeters. In surgery, local anesthesia (0.35% lidocaine and 1/200,000 epinephrine solution) is applied to the eyebrow, scalp, and forehead.

A v-shaped incision is made behind the hairline, pointing towards the traction vector. Metzenbaum scissors are used to dissect the frontal flap at the subgaleal plane until the eyebrow is reached. The dissection is performed with the end of the scissors pointing down. The width of the dissected tunnel should correspond to the portion to be lifted and the temporal fusion line described by Knize will determine its lateral border (Figure 1).

The temporal ligamentous adhesion is freed at the supraorbital rim; we move back 1.5cm above the eyebrow and turn the scissor point upward to separate the interdigitations present at the upper border of the orbicularis oculi muscle (Figure 2).

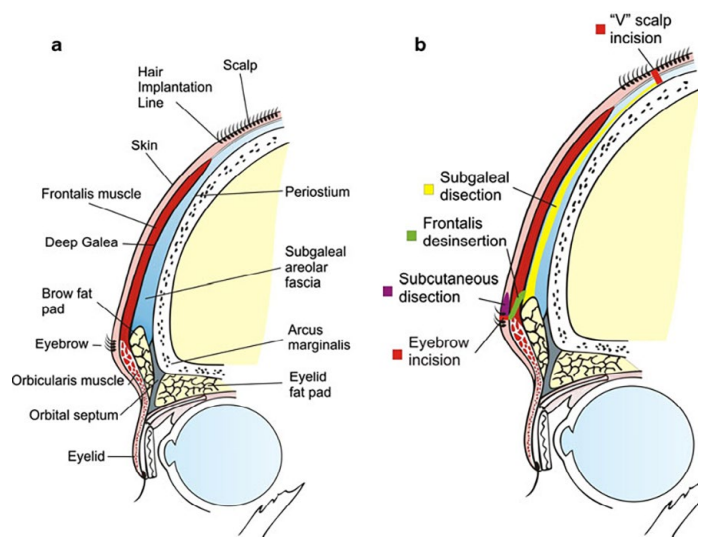
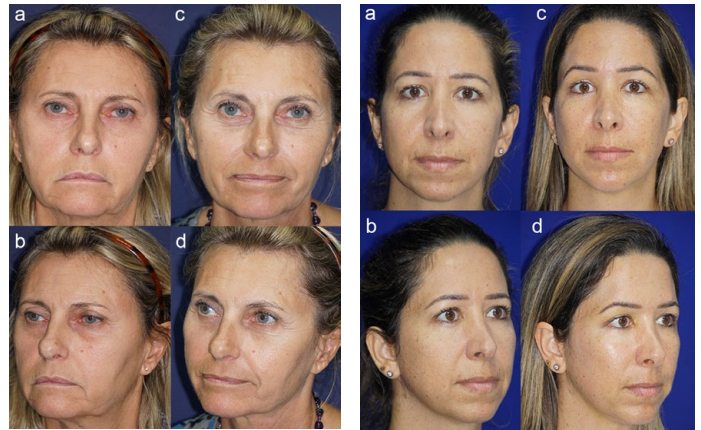


Figure 2. Sagittal view of the upper third of the face: a. Anatomic landmarks; b. Dissection planes.

A 1.0cm incision is made along the eyebrow line to ensure that no postoperative pinching of the skin occurs. On the “V” incision, a 3-0 nylon suture is placed on the galea, moving the needle from the subgaleal plane toward the eyebrow incision. The same suture is inserted in the freed edge of the frontalis muscle and is brought back from the brow incision to the scalp incision.

Both ends are pulled at the same time achieving the lateral brow lift sought (around 5mm) and two double knots are made. The scalp is closed with two surgical staples while the brow is closed with sutures of 5-0 nylon.

Results were considered optimum at one month in 98.6% of cases, whereas the rates at three and six months were 94.4 and 93.0%, respectively. Postoperative pain was mild in all cases and was controlled by the use of analgesics and cold compresses (**Figures 3, 4**).



Figures 3, 4. Case 1: Brow lift a, b preoperative views. c, d postoperative, views.



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ISAPS Education Council

MANAGING THE TEMPORAL SKIN AND BROW WITH LIMITED INCISION AND HEMOSTATIC NET IN FACE LIFTING WITHOUT BROW LIFT

With some of the world's best plastic surgeons describing in detail their approach to optimizing brow position and shape, I will take the opportunity to share a trick I have used on the temporal skin and brow management with minimal incision during routine facelift surgery that does not include a specific brow lift procedure.

In contemporary facelift surgery, the surgeon will generally use a two-vector approach to facial rejuvenation. Since the initial description of the superficial musculoaponeurotic system (SMAS), multiple techniques have been described to utilize the SMAS to elevate the mobile portion of the anterior SMAS to reshape the face. In addition, this SMAS flap will offload tension on the facelift skin flap to avoid

traction complications. The mobile SMAS is generally fixated in an oblique direction at least parallel to the zygomaticus major muscle, and in some instances a completely vertical vector as in the short scar SMASectomy and MACS lift. The SMAS elevation inevitably results in a "bunching" of the lateral orbital and temporal skin, requiring specific steps to allow accommodation of the recruited skin to avoid a dog ear type deformity. Redraping of the facelift skin flap after SMAS fixation will most often be in a different vector than the SMAS flap. Generous release of the tethered skin flap from the fixated SMAS flap will diminish the obvious skin excess in the lateral orbital and temporal area. However, it is common that specific steps must be performed to

address this redundant skin consequence of SMAS elevation. Numerous strategies have been advocated to manage the lateral orbital and temporal skin redundancy. Some authors advocate avoidance of medial fixation of the SMAS flap to reduce the potential of exceeding skin at the medial rotation point of the SMAS flap. Distant temporal scalp incisions have been advocated to redrape the skin, while others only offer combined brow lift in all facelifts to allow movement of the temporal skin into the lateral forehead. The most common remedy is an extension of the facelift incision that is placed anteriorly in the precapillary temporal hairline.



Figure 1. A well-healed scar that is still obvious and not concealed with makeup or hair.

While this extension allows the dog ear to be worked out, it comes with a cost. Design and closure of the precapillary incision for dog ear elimination takes extra time, and the scar - even when it heals without incident - can be obvious and difficult to conceal (Figure 1).

Since the initial description of the “hemostatic net” by Drs. Andre and Luiz Auersvald as a continuous running suture to create a net for hemostasis, numerous authors have explored

expanded uses and indications for the application of the hemostatic net (see accompanying articles by Dr. Viterbo and Dr. Sozer in this publication). The basic principle is suturing the skin to the underlying soft tissue to eliminate the potential space for the accumulation of blood and fluid to prevent hematomas and seromas. The suture is placed such, that there are numerous fixation points that secure the skin to the underlying tissues as quickly as 48-72 hours, at the time when the net is removed. With the wide usage of the net today by plastic surgeons all over the world, new applications are rapidly evolving. The ability to redistribute skin in the neck without excision of skin, proved the power of redraping excess skin with the net. Subsequently, Dr. Viterbo described the gliding brow lift (GBL), a closed brow lift procedure that uses the hemostatic net to fixate the brow with the net without skin excision, further proving the power of skin redistribution with temporary multiple point fixation.

Using these findings, I modified my incisions and have relied on the hemostatic net for temporal skin redistribution. The incision design for access to the temporal face is confined to a horizontal incision just beneath the sideburn. Tumescant

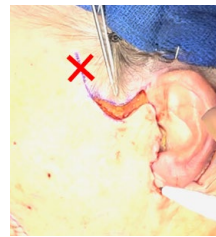


Figure 2a. The sideburn incision does not extend into the precapillary temporal hair.



Figure 2b. The skin is undermined in the subcutaneous plane.



Figure 2c. Redundant skin is apparent.



Figure 2d. The skin is redistributed with traction from a single hook (yellow arrow) and assistants' hands.



Figure 2e. The hemostatic net applied effectively redistributing redundant skin.

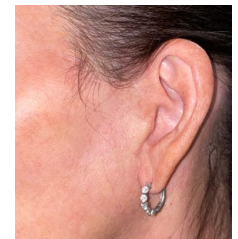


Figure 2f. One-year postoperative without temporal hairline incision.

solution is infiltrated into the subcutaneous plane to facilitate the dissection. The skin is elevated in the subcutaneous plane above the temporoparietal fascia, lateral orbicularis muscle, and temporal hairline. The dissection can be done under direct vision with a lighted retractor. The extent of dissection determined by the amount of redundant skin that must be accommodated (Figures 2a-f). The skin is redistributed with traction and secured with the hemostatic net utilizing a 5-0 nylon. The temporal hairline position is maintained and the horizontal scar is inconspicuous.

I have utilized the hemostatic net to manage the temporal skin redundancy in over 250 cases without the precapillary temporal incision. To date, I have not experienced any redundancy of skin, or obviously shifted sideburns (Figure 3).

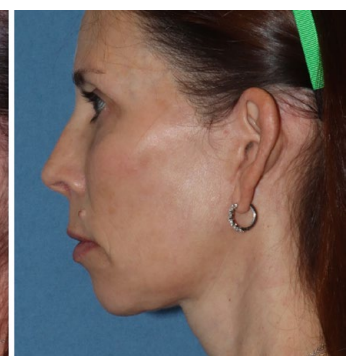
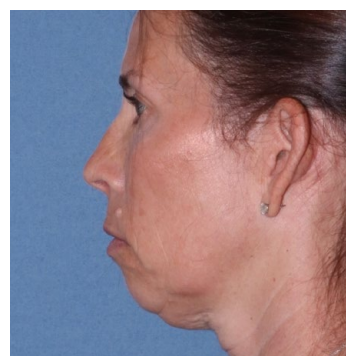


Figure 3. One year after face and deep cervicoplasty.

SUBCUTANEOUS LATERAL TEMPORAL LIFT



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PREOPERATIVE MARKINGS

Appropriate preoperative markings guide the surgeon in providing a symmetrical brow lift and appropriate forehead height. All markings are performed with the patient seated upright. The patient is first asked to relax their forehead and then the midline of the forehead (widow's peak in select patients) is marked. The ellipse begins approximately 3.5cm lateral from midline, which corresponds to about the midpupillary line. The ellipse is marked to be 4-5cm in length and 2-2.5cm in width depending on the amount of brow lift needed. The width is narrower in patients with a less ptotic brow and narrower forehead. The axis of the ellipse typically runs parallel to the brow.



Figure 1. A typical incision at the level of the hairline which begins at the midpupillary line and extends 5cm in length (printed with permission and copyrights retained by Alan Matarasso, MD, FACS).

if the incision is carefully made in the orientation of hair follicle growth, the incision can be well concealed.

The incision can be placed on either the hair-bearing scalp or at the hairline (Figure 1). A hairline incision would allow for the height of the forehead to be reduced. Additional thought must be taken for patients who have thin hair density and are less likely to hide a hair-bearing scalp incision. However,

SURGICAL TECHNIQUE

The patient's hair is combed back and wrapped in a blue towel. The operative field is prepped and the marked incisions are infiltrated with approximately 20mL of 0.5% lidocaine, with epinephrine at 1:200,000. Once adequate anesthesia has been achieved, the ellipse of skin is excised down to the subcutaneous tissue. The inferior dissection begins sharply with a #10 blade just above the frontalis muscle. Once the appropriate plane has been developed, blunt finger dissection ensues inferiorly, medially, and laterally. Any residual points of adhesion are taken down with facelift scissors until the upper edge of the eyebrow is reached. The dissection is slightly wider than the width of the initial ellipse to allow for appropriate elevation of the eyebrow and effective redraping of the forehead skin (Figure 2). Hemostasis is achieved on the first side and a sponge with 0.5% lidocaine, with epinephrine at 1:200,000, is packed into the wound. This is repeated on the contralateral side.

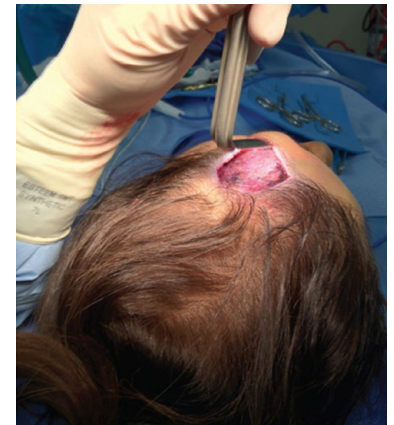


Figure 2. The dissection is extended to the upper edge of the eyebrow and is wider than the length of the incision (printed with permission and copyrights retained by Alan Matarasso, MD, FACS).

Attention is then turned back to the first side to achieve a final round of hemostasis.



Figure 3. The wound is closed with a 3-0 Monoderm Bidirectional Quill suture (Surgical Specialties Corporation, Tijuana, Mexico (printed with permission and copyrights retained by Alan Matarasso, MD, FACS).



Figure 4. Appearance of the on-table result after closure of the incision (printed with permission and copyrights retained by Alan Matarasso, MD, FACS).

Fibrin sealant is used in the wound and three minutes of pressure is applied on the forehead skin to allow for hemostatic curing of the sealant. The wound is closed with a 3-0 Monoderm Bidirectional Quill suture (Surgical Specialties Corporation, Tijuana, Mexico) with a diamond point needle (Figure 3).

Interrupted 5-0 Prolene sutures (Ethicon, New Brunswick, NJ, United States) are used to decrease any tension on the incision (Figure 4).

The incisions are not dressed and prolene sutures can be removed in three to five days. Patients were uniformly pleased with their postoperative results (Figure 5).



Figure 5. Two patients who underwent the senior authors subcutaneous lateral temporal lift with pre- and postoperative images (printed with permission and copyrights retained by Alan Matarasso, MD, FACS).

TRANSCUTANEOUS BROW SHAPING: MY PREFERRED APPROACH TO BROW PTOSIS



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INTRODUCTION

The eyebrow represents the upper frame of the eye, and its shape and position convey youthfulness and attractiveness^{1,7}. For women, most authors agree that the brow should arch above the supraorbital rim; for men, the brow should arch along the rim. In addition, the relationship between the medial third and the middle third of the brow is vital to brow aesthetics.

The medial brow should start approximately above the medial canthus, ascend laterally towards the supraorbital notch, and continue upward above the arch to peak, somewhere between the lateral limbus and a point just beyond the lateral canthus. The curvature of the arch varies considerably. In every case, the medial brow should be lower than the lateral peak².

The shape of the eyebrow is, then, far more aesthetically important than its height. For most patients, facial aesthetics are not compromised when the brow is slightly lower (e.g., by 2-3mm) than its optimal distance from the orbital ridge, as long as the brow has a pleasant shape. However, if the middle third of the brow is at the same level or lower than the medial third, or if the lateral third of the brow is at the same level or lower than the middle third, the result can be unattractive, with the patient appearing tired, aging, or sad. Conventional and endoscopic techniques for brow lift that involve distant incision (e.g., at the fronto-temporal hair-

bearing area, or in the anterior hairline) may be effective in raising the brow, but do not allow for precise shaping of the brow.

We have performed numerous brow lift techniques during the past 30 years. Although we have obtained satisfactory results with many patients, we have encountered challenges with brow shaping. Since 2002, we have employed a transcutaneous approach that was described by Castañares³ and subsequently by Vinas⁴. With some modifications, this technique has become our primary choice of treatment for brow lift. Herein, we described the technical details of transcutaneous brow shaping (TBS), our modified technique that combines brow lift with precise brow sculpting to create an ideal brow shape for each patient.

PREOPERATIVE ASSESSMENT

An assessment of the anatomy and function of the upper and lower eyelids is performed with meticulous attention paid to the presence of ptosis, the amount of skin in the upper lid, and the prominence of the eyeball. Photographs are taken with the patient's eyes opened and closed to evaluate static and dynamic brow malposition. The brows are pulled and repositioned manually to provide the patient with an approximation of the postoperative result. In addition, patients are shown images of various brow shapes, and expected results are discussed.

Markings for TBS are made with the patient standing. The planned brow is indicated by lifting the brow manually to the desired position, holding a pen at this level, letting the brow drop back into its original position, and marking the planned brow position on the skin. This maneuver is repeated along the upper brow contour to create a series of points that are connected to indicate the incision lines^{5,6}. The lower incision closely follows the hairline and occasionally is placed 1mm within the hairline, removing some stray hair follicles above the body of the brow;



Figure 1. Preoperative marking. The lower incision closely follows the hairline.

the body of the brow; this step is carried out frequently to make sure that the final scar stayed exactly at the brow's upper border. To create the desired shape of the postoperative brow, the markings are amended as needed

(e.g., the caudal concavity is accentuated, or the highest point of the curve is moved in a slightly lateral direction). The most medial portion of the brow is rarely marked because it is unusual for this region to require elevation (Figure 1).

Moreover, a scar in this area is likely to be highly noticeable, because the medial brow skin is thicker than the lateral skin^{7,8}. Asymmetric markings are made as needed to correct natural asymmetries of the brow.

For patients who concomitantly undergo upper blepharoplasty, preoperative markings of excess skin are adjusted based on our experience that excision of 2mm of forehead skin lifts the upper eyelid by 1mm. To determine the precise amount of excess skin of the upper lid, the eyebrow is held in its planned position with the surgeon's non-dominant hand while markings on the eyelid are made. This adjustment is vital to avoiding hypercorrection and lagophthalmos.

Two or three days before surgery, 5 U of botulinum toxin type A (Vistabex, Allergan, Irvine, CA) are injected into the frontalis muscle above the lateral two-thirds of each brow for two reasons: (1) to decrease the activity of the frontalis muscle, in turn reducing the tension on the wound postoperatively; (2) to allow for a slight lowering of the eyebrows, due to the muscle paralysis, in the early

postoperative period. Lowering the eyebrows helps patients adjust to the significant change in their facial aesthetics by allowing the brows to rise more progressively over time.

SURGICAL TECHNIQUE

Both local and general anesthesia are used depending mainly on the patient's request. The subcutaneous space and dermis are infiltrated with mepivacaine (2%) and epinephrine (1:100,000). Typically, the incision is begun 0.5-1cm lateral from the medial end. The incision rarely extends the length of the eyebrow and/or beyond the lateral end of the brow because it is rarely needed.



Figure 2. Upper and lower incisions are made with a no.11 scalpel blade beveled at 30°.

The incision, however, can be extended over the temporal area when it is indicated, since scars are hardly visible in these regions, especially in older patients.

Upper and lower incisions are made with a no.11 scalpel blade beveled at 30° (Figure 2). To compensate for some dropping of the brow postoperatively, the upper incision usually is overcorrected 1-1.5mm higher than the markings. Only the skin and the superficial part of the dermis are excised; the deep dermis and subcutaneous fat are retained to preserve volume and avoid a contour depression at the scar (Figure 3).

Limited undermining (i.e., 7-10mm) is performed below the eyebrow on the surface of the orbicularis oculi to



Figure 3. Deep dermis and subcutaneous fat are retained.



Figure 4. Undermining is avoided in the medial part of the brow.

increase brow mobility and avoid tension on the suture line. Meticulous care is taken to preserve the hair bulbs. Undermining is avoided in the medial part of the brow to prevent injury to the blood vessels and nerves in this area (**Figure 4**).

The upper flap is undermined for 2–3 mm to optimize eversion of the skin borders. Hemostasis is achieved with fine-tip cautery, with the instrument set to low voltage to avoid damaging the hair bulbs. Only very small vessels are encountered in this superficial plane.

In patients with a limited surplus skin of the upper eyelids, it is possible to avoid an upper blepharoplasty through the removal of the suprabrow skin. When an excess of orbicularis oculi is present in the upper eyelid, and an upper blepharoplasty is not being performed, the orbicularis oculi is suspended to the frontalis with two or three absorbable sutures to decrease the volume of the upper eyelid.

The deep dermal layer is approximated with 5-0 polyglycolic acid sutures (poliglecaprone 25 Ethicon) taking care in everting the cutaneous border, and 6/0 nylon (horizontal mattress interrupted or continuous) sutures are placed.

For patients who undergo TBS and upper blepharoplasty, TBS is performed first to obtain a precise brow position, and upper blepharoplasty follows with adjustments as needed.

COMPLICATIONS AND CONSIDERATIONS

For nearly 100 years, surgical techniques have been performed to elevate the brow and reduce the transverse and glabellar lines^{9–34}. In the majority of studies, authors perform so-called ‘distant-approach techniques’ (e.g., forehead lift), with or without endoscopic assistance, and describe the incision patterns, the treatment of the underlying structures, the methods of fixation, and so on. In an exhaustive report of the history of brow lift, Dr. Paul³⁵ described these procedures, which include direct brow lift, mid-forehead lift, open coronal lift, and endoscopic brow lift. Open techniques for brow lift involve skin excision and soft-tissue pexy, whereas endoscopic techniques comprise soft-tissue repositioning, or occasionally soft-tissue weakening, by means of myotomy or myectomy of the depressor muscles. Although effective in correcting brow ptosis, most of these procedures are associated with limitations and complications.

Graham *et al.*³⁴ reviewed studies of patients who underwent endoscopic and open approaches from 1992 to 2010 and noted that dysesthesia occurred in 0% to 57% of patients, alopecia developed in 0% to 19% of patients, and recurrent asymmetry occurred in 0% to 9% of patients. In a recent review, Byun *et al.*³⁶ evaluated 82 studies in which patients underwent endoscopic or open approach and found that a variety of complications were associated with these procedures. When brow lift was performed with excision in the subcutaneous plane of the anterior hairline, alopecia occurred in 8.5% of patients, paresthesia occurred in 5.4%, unacceptable scarring developed in 2.1%, skin necrosis occurred in 1.8%, hematoma developed in 0.5%, and infection occurred in 0.3%. Brow lift by means of coronal incisions in the subperiosteal plane was associated with the highest incidence of injury to the frontalis branch of the facial nerve³⁶ (6.4% of patients). Endoscopic brow lift with subperiosteal dissection was associated with the highest rates of complications: paresthesia occurred in 6.2% of patients, asymmetry developed in 3.6%, alopecia occurred in 3.0%, and lagophthalmos developed in 2.7%. Graham *et al.*³⁴ found that direct transcutaneous brow lift was performed in only five of 87 studies. We have received numerous personal communications confirming that surgeons are reticent to perform brow lifts with a transcutaneous approach, because of concerns that the technique will yield unsightly scars. However, in contrast to this opinion, Byun³⁶ found that unacceptable scars were present in only 1.4% of patients who underwent a direct transcutaneous approach. This represents the best results if compared with 2.1% of patients who underwent brow lift with an anterior hairline incision with subcutaneous dissection, 3.6% of patients who underwent coronal incision with subgaleal dissection, 2.5% of patients who underwent coronal incision with subperiosteal dissection, and 1.5% of patients who underwent endoscopic techniques.

In a paper published in 2017³⁷, we reported the results of a study carried out on 212 patients submitted by the same surgeon (M.P.C.) to TBS alone, or in association with upper blepharoplasties and/or other surgeries. No patient experienced infection, hematoma, or seroma. There were no hypertrophic scars or keloids. Mild paresthesia occurred in eight patients (3.8%), which resolved spontaneously in less than six months for seven of these patients, and one patient did not return for follow-up. Three patients (1.4%)

experienced mild transient alopecia of the brows. These patients were among the first to undergo treatment in this study. After observing these cases of alopecia, we began advising patients to apply local vasodilators pre- and postoperatively. Unilateral epidermal cysts developed in three patients. In two patients, these cysts resolved spontaneously and, in the one patient, the cyst was surgically removed six months postoperatively. Partial, unilateral dehiscence of the sutures occurred in one patient who was a heavy smoker. This patient underwent revisional surgery two months postoperatively to improve the appearance of the scar.



Figure 5a, b. Treatment of brow ptosis through TBS.



Figure 6a, b. Treatment of brow ptosis and absence of the arch through TBS.

209 (98.6%) of the 212 patients involved in our study³⁷ indicated that they were satisfied with the results of TBS (Figures 5 a-b, 6a-b).

During follow-up, we found that perceptions of the healing process varied enormously among patients. As expected, scars were virtually invisible in some patients after a few months, whereas the healing process was more protracted for other patients. However, scars that were noticeable to us at clinical evaluation several weeks postoperatively were often perceived by the patient as nearly invisible (154 of 212 patients, 72.6%), or as invisible (52 patients, 24.5%). Minor lowering of the brows occurs two to four months postoperatively for most patients who undergo TBS; hence, the skin marking is carried out accounting for a 10% to 15% hypercorrection. For several patients, comparable photographs were taken preoperatively, six

months postoperatively, and several years postoperatively. We determined from these photographs that the results of TBS remained stable over time. 97.5% of our patients were satisfied with scar appearance. Our results are consistent with those of other authors^{4,5,38} in suggesting that the direct approach is associated with minimal scar visibility. With regards to surgeons who find anecdotally that this approach yields unsightly scars, we maintain that an incorrect surgical technique is responsible for unfavorable results.

The three most common mistakes associated with TBS are incorrect placement of incisions, removal of volume from the eyebrow, and inappropriate suturing techniques. An incision that is placed 1–2mm from the hairline to preserve the integrity of the cranial hair will produce a visible scar. The most common feature of an unsightly scar is a localized suprabrow depression, which results from overzealous resection of underlying tissue. For TBS, we recommend removal of the epidermis and the superficial layer of the dermis. By preserving the deep layer of the dermis and subcutaneous fat, a contour depression at the scar can be avoided. The results of these precautions are not noticeable during surgery but become obvious after several weeks when edema has subsided. Similarly, Feinendegen³⁸ has advocated an incision on a 20° bevel to preserve the dermis and improve scar quality. Surgical procedures of the forehead and orbital area must accommodate the opposite tensions of the frontalis and the orbicularis oculi, which can cause introflexion of the skin borders. The preoperative use of botulinum toxin, besides avoiding dramatic postoperative changes in the immediate postop, creates a frontalis muscles paresis that decreases the tension on the incision during wound healing, improving so the quality of the scar. The incision for TBS is almost linear and seemingly easy to close, but the importance of appropriate suturing should not be underestimated. A fast, over-and-over, continuous suture can produce introflexion of the cutaneous borders and yield a depressed, visible scar. During suturing, the surgeon should be careful to maintain eversion of the cutaneous borders. Visible scars are more likely to develop in patients with weak hair bulbs, which may be damaged during undermining, cautery, and suturing. If hairs along the upper brow contour are lost, a noticeable scar will result 2–3mm from the eyebrow. We recommend pre- and postoperative application of a lotion formulated with minoxidil (e.g., Rogaine or Theroxidil) to reinforce the hair bulbs with

vasodilation. To minimize ecchymosis and swelling, and to facilitate recovery, we suggest only limited undermining be performed. Extensive dissection is associated with a higher rate of sensory disturbances resulting from damage to the delicate nerves in this region⁵. Most brow lift procedures are associated with patient satisfaction rates that exceed 95%^{4,5,24,38}. However, this high level of satisfaction may be based more on the decreased visibility of forehead and temporal wrinkles than on the new position and shape of the eyebrows. We maintain that it is virtually impossible to precisely shape the eyebrow and correct brow asymmetry with distant approaches. We suggest that subtle variations in the sharpness of the arch, or in the height of each portion of the brow, can be achieved only with TBS.

Many patients (140 of the 212 patients, 66.0%), in our study³⁷ presented brow asymmetry. In 82 patients (58.6%), the asymmetry was moderate, whereas it was obvious in 58 patients (41.4%). Thus, obtaining precise symmetry is an important issue in this operation. In this study, we did not evaluate results specifically related to the treatment of patients with brow asymmetries. However, we noted that brow symmetry was, in general, stably improved after TBS. Recently the gliding brow lift technique was published by Viterbo³⁹. This is an interesting technique that relies on extensive skin undermining and repositioning in conjunction with the Auerswald net⁴⁰. We limit its use to specific cases because it entails longer operating room time, a more complex postoperative course and, in our hands, it is less precise and predictable in achieving a precise brow shape.

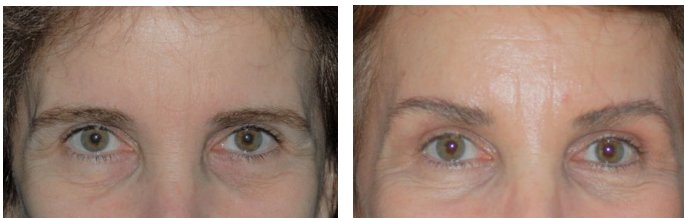


Figure 7a, b. TBS performed concurrently with upper blepharoplasty.

In our practice, we routinely perform TBS concurrently with upper blepharoplasty (**Figures 7 a, b**). This differs from other authors who perform upper blepharoplasty in a subsequent surgical session⁵. For patients with limited skin

and muscle excesses, TBS can also be useful to improve the upper eyelid, especially when suspension of the orbicularis oculi to the frontalis muscle is performed.

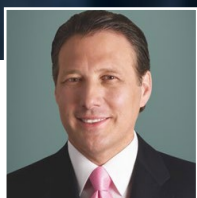
In contrast to many browlift procedures which concurrently improve wrinkles of the forehead, temporal region, and glabellar region, TBS cannot be performed to treat wrinkling in these areas unless the skin excision is much longer than usual. The ideal candidate for TBS is middle-aged with light, thin skin; brow hair that is thick and of high density; and a horizontally extended, poorly shaped brow contour. TBS would not be recommended for patients with vertically narrow brows; thin and sparse brow hair; or a short horizontal extension. In part, this is because we prefer to limit our incision to the length of the brow. For patients who are older, or have thin skin, we occasionally extend the incision more laterally, as suggested by Castañares³, to reduce the excess skin in the lateral eyelid and improve crow's feet while maintaining a low risk of visible scars.

CONCLUSIONS

Although concerns about scar visibility have discouraged many surgeons from performing transcutaneous brow lifts, the transcutaneous route is associated with the lowest incidence of lift techniques³⁶. We maintain that visible scarring with TBS is frequently a consequence of poor surgical technique. The most common errors with TBS include poor positioning of the incisions, overzealous tissue resection, and insufficient suturing. We have developed methods to avoid each of these errors, and we find that TBS is a straightforward procedure with short operating and recovery times, and a low risk of complications. TBS allows for dramatic and precise improvements to the brow. We regard TBS as our technique of choice to treat ptotic or asymmetric brows. In our practice, nowadays, distant brow lift procedures are performed only in patients for whom TBS is not indicated.

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RENATO SALTZ, MD, FACS - UNITED STATES
ISAPS Board of Directors, Trustee

BROW REJUVENATION

INDICATIONS

Brow aesthetics cannot be just arch shape and position of the brow. Although the brow should be evaluated based on gender, ethnicity, orbital shape, and overall facial aging and proportions, the main factor to consider is the ratio of the visible eyelid to the palpebral fold. The best candidates for forehead rejuvenation are patients with eyebrow ptosis, asymmetry, temporal hooding, and forehead wrinkles. Usually, they also have short, flat foreheads, and non-receding hairlines.

PREOPERATIVE PREPARATION

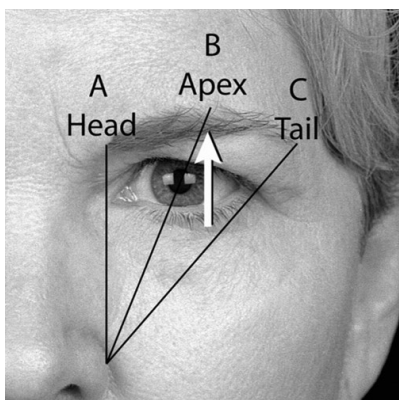


Figure 1. Brow aesthetics.

Assessment of the patient includes evaluation of both the medial and lateral brow position, the ratio from brow to upper eyelid, glabella and forehead lines, forehead shape and height, and the hairline. To assess the strength of the muscle action, movement, and

depth of soft tissue folds, the patient should be asked to frown as well as raise their eyebrows. The eyebrows should also be assessed for their thickness, shape, and position. During the preoperative consultation, the patient should be included and have a mirror to understand the desired position, number of incisions, and types of fixation for the desired new brow (*Figure 1*).

The endoscopic technique is based upon the use of modern technology, where the traditional eye-hand surgical coordination is done through a video-endoscopic system. Additional extensive training is necessary, not only for the surgeon but all medical and nursing personnel involved in the surgical case. The equipment is usually standard in centers where aesthetic surgeries are performed. The surgeon must have knowledge of the principles extending from training, mechanical equipment, and technical skills.

POSITION/MARKINGS

In preparation for the procedure, the patient is marked from a standing position to utilize the natural positioning of the brows. Markings should include the temporal ridge, sentinel veins, and the assumed position of supratrochlear and supraorbital nerve branches. If the sentinel vein cannot be found from an upright position, patients are asked to

lie flat. Patients are then asked to clench their teeth and, with palpation, the temporalis muscle and temporal crest

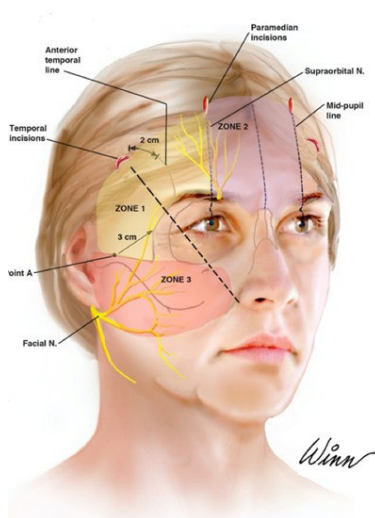


Figure 2. Anatomy and preoperative markings.

can be marked. Markings representing the incisions are made 1-2cm beyond the temporal hairline, checking that the incisions will be over the temporalis muscle. The lateral incision markings should be parallel to the brow, while the paramedian incision will be radial along the midline of the face, forehead, and skull (Figure 2).

ANESTHESIA

The two brow lift vectors are marked. They are determined by lifting the brow manually to the chosen aesthetic position. The lateral vector includes the tail of the brow, while the medial vector includes the arch of the brow; both use the lateral canthus and mouth, and also determine placement. Before infiltration, the hair is cleansed and braided to either side of the chosen incision sites, keeping the hair neatly away from the incision.

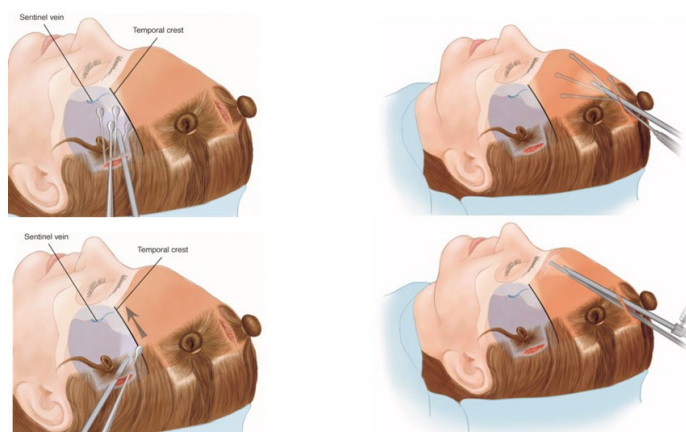


Figure 3. Sequence of temporal and subperiosteal dissection.

SURGICAL TECHNIQUE/DISSECTION

An incision is made from the scalp to the temporal fascia; this allows visualization and dissection to remain on top of the deep temporal fascia. Dissection is carried down to the fusion ligament (temporal ligament) by preserving the sentinel veins intact if possible. Dissection is then turned medially by dividing the temporal ligament and entering the subperiosteal plane. At this point, the dissection continues from the paramedian incisions communicating both pockets (deep temporal fascia with subperiosteal plane) (Figure 3). A 4mm 30° endoscope is once again calibrated with adequate focus, “white out”, irrigation system down, and inserted in the surgical field. The room lights are dimmed down to improve visualization on the screen.

With the endoscope at the temporal incision, the sentinel veins are found and preserved, when possible, while the surrounding adhesions are removed. Following the caudal aspect of the temporal crest, the “fusion ligament” (junction of deep temporal fascia and periosteum) is identified and divided with the endoscopic scissors. The supraorbital rim periosteum is divided from lateral to medial, identifying and preserving the supraorbital neurovascular bundle. The periosteum is then divided from each lateral orbital rim, which serves to allow more lateral brow elevation and provide access to the glabellar musculature. An island of periosteum is preserved at the midline to avoid elevation of the most medial brow.

The corrugator muscles are identified and excised/avulsed using endoscopic graspers. The assistant ‘pushes’ the external skin to help with the corrugators resection, and to allow the surgeon to visualize the dermis and avoid overresection causing an external depression (Figure 4). In case a depression is identified during the procedure, immediate fat grafting is recommended. The

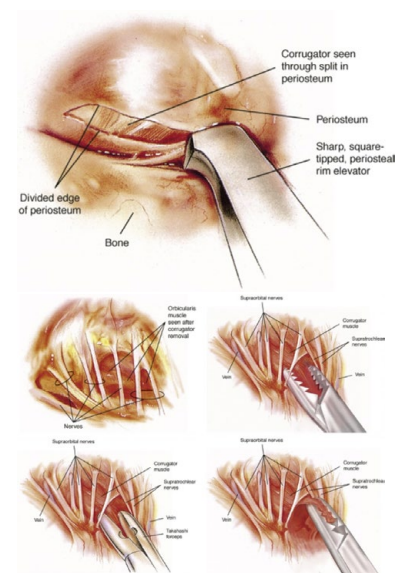


Figure 4. Division of supraorbital periosteum and corrugator resection.

completion of the procedure can be tested by moving the brow up and down, which should be mobile at this point. Dissection can continue in a subperiosteal plane along the lateral orbital rim and medial zygomatic arch for midface elevation in a very safe plane (Figure 5).

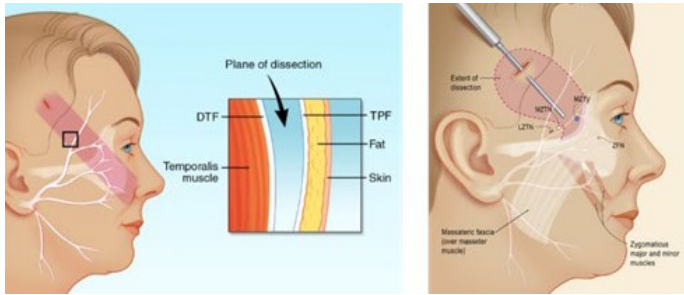


Figure 5. Temporal pocket dissected and brow fully released.

Also, the zygomatic ligament can be easily visualized and divided endoscopically releasing the SMAS in a safer, faster way than traditional SMAS techniques, if a facelift is combined with brow rejuvenation.

FIXATION

The temporal fixations are accomplished using interrupted sutures of 3-0 PDS connecting the superficial temporal fascia and the deep temporal fascia. The excess skin is removed, and the wound closed with 4-0 plain gut. The paramedian fixation is accomplished with the endotine/ ultratine devices. They are safely fixated to the outer

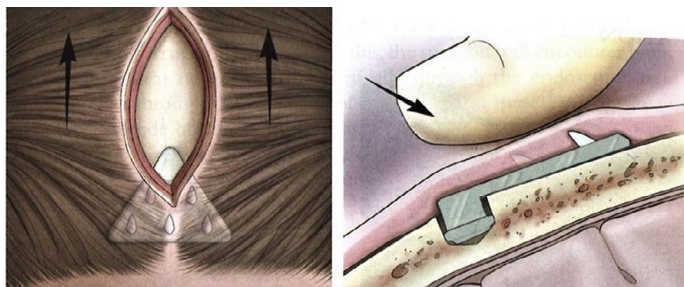


Figure 6. Brow fixation with endotine device.

table with a measured drill hole. The device is then securely inserted followed by digital pressure to hold the periosteum and galea in place (Figure 6). The patient is then assessed in a sitting position while still under general anesthesia. Measurements include pupil-top of the brow and lateral canthus-tail of the brow. The midface fixation is accomplished with endotine midface or ribbon

(Microaire). The hair is washed, and the patient is moved to the recovery room. No dressings are applied.

COMPLICATIONS

Temporary paresthesia and irregularities of the frontalis muscle can occur occasionally, but usually improve within three weeks. Cosmetic problems, such as uneven movement of the brows, surface deformities, and elevation of the arch of the brows can sometimes arise. The ‘surprised look’ can be avoided by keeping a bridge of periosteum at the midline and by avoiding over elevation of the middle third of the brow. Alopecia can be eliminated through the abandonment of percutaneous screw fixations. Early detection of postoperative brow asymmetry (24-48hrs) can be corrected by repositioning the paramedian fixation through re-elevation and posterior displacement of galea/skin from the endotine. Delayed temporary brow asymmetry can be improved with botox. If the brow asymmetry persists and there is obvious recurrence of brow ptosis, re-intervention is advised.

FINAL CONSIDERATIONS

The endoscopic brow lift results match those of similar ‘open’ procedures. They provide quicker recovery, fewer complications, and excellent long-term results. The better you can see, the more precise you can be. (Figures 7-9).

Recent introduction of non-endoscopic procedures for forehead rejuvenation, like the short scar temporal, the transblepharoplasty, and the anterior hairline approaches, are relatively ‘blind.’ They offer operative



Figure 7. Endoscopic brow lift combined to transconjunctival blepharoplasty. Ultratines used for paramedian fixation and 3-0 PDS for temporal fixation. Follow-up at one year.



Figure 8. Endoscopic brow lift combined with endoscopic midface lift using 2 temporal and 2 paramedian scalp 1cm incisions. Fixation of the brow with ultratines and fixation of the midface with the endotine midface device. Follow-up at three years.



Figure 9. Endoscopic brow lift combined to upper and lower blepharoplasty transconjunctival and neck liposuction. Endotines used for paramedian fixation and 3-0 PDS for temporal fixation. Follow-up at two years.



Figure 10. Endoscopic brow lift 2 temporal and 2 paramedian scalp 1cm incisions combined to facelift and neck lift. Endotines used for paramedian fixation and 3-0 PDS for temporal fixation. Follow-up at one year.

time no better than endoscopic surgery, blindly dissect around all potential anomalous variations of the supraorbital nerve, and require larger incisions with potential damage to the deep branch of the supraorbital nerve, resulting in sensory loss and visible scars. The non-endoscopic, temporal approach is applicable in selected patients where only lateral lift is needed, with no forehead wrinkles, and when no corrugator release is necessary.

The effectiveness and long-term results of the endoscopic brow lift have been well documented. The failure to release the temporal-orbital ligaments, inadequate division

of the supraorbital rim periosteum, and lack of proper fixation, have caused early relapse, lack of long-term results, and abandonment of the technique by poorly trained endoscopic surgeons. Also, anecdotal suggestions that endoscopic operative time is too long, that it creates over-lifting, alopecia, elevates the hairline, widens the interbrow region, and that the results do not last have never been proven right.

FOOTNOTES

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ISAPS CULTURE



VAKIS KONTOES, MD, PHD - GREECE
ISAPS Board of Directors, Membership Chair

PHILOSOPHICAL APPROACH OF IGNORANCE AND ITS IMPLEMENTATION IN AESTHETIC SURGERY

Socrates was a Greek philosopher and the main source of Western thought. Western philosophy encompasses the philosophical thought and work of the Western World (Figure 1). Historically, the term refers to the philosophical thinking of Western culture, beginning with the **ancient Greek philosophy** of the pre-Socratics. The word *philosophy* itself originated from the Ancient Greek *philosophía* (φιλοσοφία), literally, “the love of wisdom” (Ancient Greek: φιλεῖν *phileîn*, “to love”, and σοφία *sophia* “wisdom”).

Little is known of Socrates' life, except what was recorded by his students, especially Plato, the mentor of Aristotle

(Figures 2, 3), who in his turn was the teacher of Alexander the Great.

The classical period of ancient Greek philosophy centers on Socrates and the two generations of students following him.

Socrates experienced a life-changing event when his friend, Chaerephon, visited the Oracle of Delphi where the Pythia told him that no one in Athens

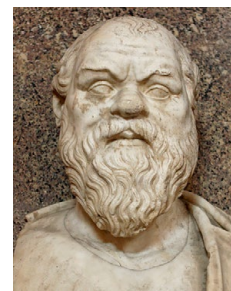


Figure 1. Bust of Socrates, Roman copy after a Greek original from the 4th century BCE.



Figure 2. "The School of Athens" fresco by Raphael, Italian Renaissance painter.

was wiser than Socrates. Learning of this, Socrates subsequently spent much of his life questioning anyone in Athens who would engage him, to investigate Pythia's claim. Socrates developed a critical approach, now called the **Socratic method**, to examine people's views. He focused on issues of human life: eudaimonia, justice, beauty, truth, and virtue. Although Socrates wrote nothing himself, two of his disciples, Plato and Xenophon, wrote about some of his conversations, although Plato also deployed Socrates as a fictional character in some of his dialogues. These Socratic Dialogues display the Socratic method being applied to examine philosophical problems.



Figure 3. Aristotle in "The School of Athens" by Raphael.

Socrates believed that philosophy should achieve practical results for the greater well-being of society. He attempted to establish an ethical system based on human reason, rather than theological doctrine. He pointed out that human choice was motivated by the desire for happiness. Ultimate wisdom comes from knowing oneself. The more a person knows, the greater his or her ability to reason and make choices that will bring true happiness through knowledge.

In Plato's writings, "I know that I know nothing" (Ancient Greek: ἐν οἶδα ὅτι οὐδὲν οἶδα, *hen oída hoti oudén oída*; Latin: *scio me nihil scire or scio me nescire*), is a well-known saying which is attributed to the Greek philosopher Socrates, who was Plato's teacher.

Socrates insisted on the wondrous way of the honest assumption of ignorance, which can turn into the beginning of true knowledge.

When an individual experiences this critical point without fear and without expectations, it seems that something very important is starting to happen in and around his or her life, gradually transforming into the microcosmic unit of existence and always seeking the timely Socratic teaching, founded in ancient Greece 2,500 years ago, from the great master of Greek and all humanity, philosopher Socrates.

According to this philosophy, the problem is the incumbent and established ignorance which, according to Plato (Figure 4), is represented by the following types: simple, dual, maximum, and sophistic.

Simple: ignorance is present when one ignores something, but at the same time has a notion that ignores it.

Dual: is the ignorance when one ignores something, and at the same time has no perception that ignores it.

Maximum: is that state of ignorance when someone ignores one thing, has felt the oblivious, but insists on views and opinions, without wanting to escape from his ignorance or abandon it.

Sophistic: is the ignorance when one ignores something but, with various speculations, unjustified opinions, and arbitrary conclusions, tries to cover and hide his ignorance.

This distinction corresponds to human types who develop by depending on traits within the society. The maximum and sophistic forms of ignorance, unfortunately, are the most widespread in our society today.

Moreover, another very important term, which can be advocated together with these two types of ignorance, is **sciolism**. The definition of the word is "the superficial show of knowledge and learning", in other words, the

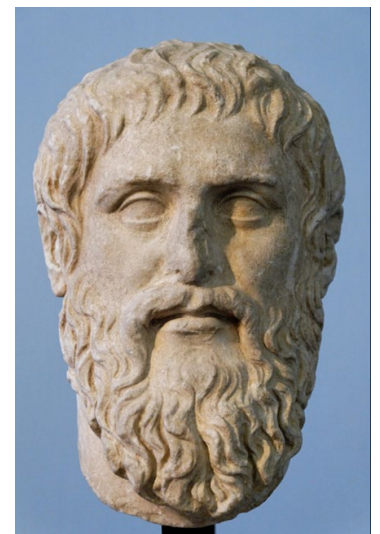


Figure 4. Plato, copy of the portrait made by Silanion 370 BC for the Academia in Athens.

partial or half knowledge, which undoubtedly is much worse than ignorance.

The second form of ignorance, the **dual one**, is mainly due to incorporated, negative conditions of existence of human societies. These individuals are usually well-intentioned; possibilities for knowledge and learning are there, but finally not exploited, despite the impression to the contrary. This potential for more knowledge is not exploited due to social or financial reasons, lack of opportunities for higher training, and occasionally self-reassurance.

The first form, the **simple**, is the “blessed” ignorance. It is the starting point of the Socratic philosophy and encouragement for enrollment into true knowledge. It is the moment where the individual understands its situation and exclaims, “What I know is that I know nothing.” These individuals are excellent candidates for unique opportunity of advanced knowledge and continuous education.

It is indeed very obvious how this philosophy, apart from our everyday life, should also be applied to our aesthetic surgery practice. Acquisition of knowledge and education is the golden standard, which will eradicate sciolism (partial knowledge) and minimize maximum and sophistic ignorance, which can lead to unsuccessful results to our patients.

And it was Socrates who first attempted to explore the definition of beauty, and he felt that aesthetics was a form of purity. His theory was, if you found pleasure in objects, they were to be found beautiful. This idea can

be considered a form of beauty but can be restricted. During Socrates’ lifetime, beauty could be easily measured by the standard of the gods, which was a stately and proportionate sculpture. “Good looks and proper bearing were important to a man’s political prospects”, according to Socrates. Beauty and god-like looks were linked into the popular imagination. Socrates himself was simplest, he found pleasure in the effortless geometric shapes, single colors, and musical notes.

But apart from the exact definition of beauty, the acceptance and understanding of simple and dual ignorance conditions in our life will encourage intensive and continuous training and education which will undoubtedly improve surgical skills, decision-making, and final outcomes in the everyday aesthetic surgery practice.

If we know what we know, and also know what we do not know, it is very likely that we seek and require more education or training. Further enrollment in acquisition of experience will minimize the complication rate in the everyday aesthetic surgery practice and create happy patients. Moreover, it will establish a higher standard of mutual trust between surgeons and patients, a very effective prerequisite for the long-term recognition and consistency of aesthetic surgery as a top specialty in the community.

FOOTNOTE

Part of the text from © Springer International Publishing AG 2017 *P. Kontoes, State of the Art in Blepharoplasty*, DOI 10.1007/978-3-319-52642-3_8

FLAMENCO: BETWEEN THE EARTH AND HEAVEN



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ISAPS National Secretary

Flamenco was inscribed as an Intangible Cultural Heritage of Humanity, by UNESCO in 2010¹. As defined on its website, "It is an artistic expression, fusing song (*cante*), dance (*baile*), and musicianship (*toque*)."

Cante is the vocal expression of flamenco, sung by men and women, preferably seated, with no backup singers. Flamenco *baile* is a dance of passion and courtship. *Toque*, or the art of guitar playing, has long surpassed its original role as accompaniment. Other instruments, including castanets, handclapping, and foot-stamping are also employed.



Figure 1. My teachers at Escuela Lucero Cardenas. From left to right: Lucero (Mexico), Derly (Venezuela), Ainhoa (Spain), Eri (Japan).

All of them may express different feelings, from sadness to joy. Flamenco is introspective and a fiesta at the same time.

Flamenco is known internationally, and there are no boundaries. In fact, some teachers at my school are Mexican, Venezuelan, and Japanese (Figure 1).

There are many different styles, or *palos*, within flamenco music, each with its own characteristic, *compás*. This is the rhythmic pattern that the dancer must follow while striking the ground. Understanding and following the *compás* is the first and most important thing to learn, and one of the first things that teachers show you. Dancing is percussive, and you can beat the floor, or *tablaó*,

with the *planta* (forefoot), the *golpe* (whole foot), or the *tacón* (heel). At the same time, you must be conscious of your posture, by stabilizing yourself with abdominal and hip muscles, and the movement of your arms.

I started to learn flamenco three years ago after a congress of the Spanish Society of Aesthetic Plastic Surgery (AECEP) in Madrid, Spain. One of the surgeons in that session was my friend

and Vice President of the AECEP, Dr. Gomez Bravo. We were lucky enough to be able to attend a spontaneous show by one of the best dancers in Spain, Antonio Canales. I said to myself, and to Dr. Gomez Bravo, "I have to do that."

Flamenco has allowed me to develop my artistic sense (Figure 2), and to 'reset' after my long journeys. It gives me the opportunity to train the muscles and joints of my body, something advisable for my age, and improve my posture, with my brain focused only on the *compás*. Operations and dancing are very similar: they need skills, planification, and include a learning curve, often with painful trial and error but, in the end, it's extremely gratifying.



Figure 2. Jesús Benito-Ruiz, MD, PhD, aka Dr. Flamenco.

REFERENCE

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ISAPS GOURMET



NAZIM CERKES, MD, PHD - TURKEY
ISAPS President

DELIGHTFUL TURKISH CUISINE

Turkey has diverse culinary options, which are sure to please the palate of everyone, ranging from vegetarians to carnivores. The dishes are full of an array of flavors and aromas, but you won't find anything terribly spicy.

Turkish cuisine is largely the heritage of **Ottoman cuisine**, which is the cuisine of **Ottoman Empire Palaces** and a **fusion of Mediterranean, Balkan, Middle Eastern, Central Asian, Eastern European, Armenian, and Georgian cuisines**.

In Ottoman Palaces, hundreds of cooks specializing in different dishes such as soup, rice, kebabs, vegetables, fish, bread, pastries, candy, helva, syrup, jams, and beverages, prepared food to feed thousands of people every day for several centuries.

Turkish cuisine varies across the country. The foods of western Turkey and the rest of Anatolia inherits many elements of **Ottoman court cuisine**, including moderate

use of spices, and wider availability of vegetable stews, **eggplant**, stuffed **dolmas**, and fish. The cuisine of the **Black Sea region** uses fish extensively, especially the **Black Sea anchovy**, and includes dishes prepared from corn. The cuisine of the southeast is famous for its variety of **kebabs, mezes**, and dough-based desserts such as **baklava, şöbiyet**, and **künefe**.

Olive oil is the major type of oil used for cooking, especially in the western parts of Turkey. The dishes of western Turkey and the **Mediterranean** regions are rich in vegetables, herbs, and fish. **Central Anatolia** has many famous specialties, including kashkek (a sort of ceremonial **meat, wheat or barley stew**), manti (mini ravioli), and **gözleme** (a savory **Turkish** stuffed **turnover**).

Turkish mezes (*Figure 1*) are a selection of small dishes served as appetizers and are often served as part of multi-course meals. Meze is generally accompanied by



Figure 1. Turkish meze.

raki which is a national alcoholic beverage. They may also be enjoyed with beer, wine, and other drinks.

Some of the common mezes are **acılı ezme** (hot pepper paste often with walnuts), **haydari** (thick strained yogurt with herbs), cold **eggplant** salad or puree, fried **calamari** or **squid**, stuffed or fried mussels, artichoke cooked with olive oil, **cacık** (yogurt with cucumber and garlic), **pilaki** (beans and other vegetables cooked in a special sauce), **dolma** or **sarma** (rice-stuffed vine leaves or other stuffed vegetables, such as **bell peppers**), **arnavut ciğeri** (a liver dish served cold), octopus salad, and lentil **kofte** (lentil meatballs with spices).

If you are a meat lover, you can taste your way through the 40 different varieties of kebabs. You can find **Turkish döner** kebabs on almost every street corner.

Adana kebab is a dish that consists of long, hand-minced meat **kebab** mounted on a wide iron skewer and grilled over **charcoal**. The dish is named after **Adana**, which is in southern Turkey, and one of the largest cities in the country.

Shish kebab is a kebab made by **skewering** and **grilling** cubes of **meat**. İskender kebab is another delicious dish you must taste, consisting of sliced **döner kebab**, topped with hot **tomato sauce** over pieces of **pita** bread and generously slathered with melted **butter** and Turkish **yogurt**.

Ottoman cuisine was rich in vegetable dishes, and today along with meat dishes, vegetable dishes are still a large part of Turkish cuisine. One of the most popular vegetable dishes is **karnıyarık** (“riven belly” in **Turkish**).

It consists of **eggplant** stuffed with a mix of sautéed chopped **onions**, **garlic**, black pepper, **tomatoes**, **green pepper**, and **ground meat**. İmam bayıldı (meaning “the imam fainted”) is a dish in **Ottoman cuisine**, which is a whole eggplant stuffed with **onion**, **garlic**, and **tomatoes**, and simmered in olive oil and usually served cold.

We also serve dolma, a general term used for stuffed vegetable dishes. There are two versions of dolma (**Figure 2**). One is ground meat and rice stuffed in vegetables and served hot as a main dish, often accompanied by Turkish yogurt. The other type of dolma is stuffed with only rice and various spices. It is cooked with olive oil and served cold as a meze. Any vegetable which can be filled with or wrapped around these types of mixes, can be used making dolma, including zucchini, eggplants, tomatoes, green pepper, cabbage, and grape leaves. One very famous type of dolma is called



Figure 2. Dolmas.

Sarma, which is stuffed grape leaves cooked with olive oil.

When you come to Turkey, you must also try the delicious seafood. Turkey is surrounded by seas that contain a large variety of fish from the Black and Mediterranean Seas. Fish are grilled, fried, or cooked slowly by steaming. In the Black Sea region, fish are usually fried with thick corn flour. There are many seafood restaurants along the coast of Istanbul that are famous for their seafood mezes prepared with different type of seafood. These include stuffed mussels, fried **mussels**, fried calamari (**squid**) with **tarator** sauce, marinated seabass, pickled (salted) bonito, fish balls, and grilled octopus. Perhaps one of the most delicious ways of eating fish is grilling it over charcoal, which allows the fish juices to hit the embers, encasing the fish with the smoke, bringing out the delicate flavors. The fish restaurants always have



Figure 3. Baklava.

an open-air section taking up space right by the sea.

When it comes to dessert choices, again there are many, but I would be remiss if I did not highlight **baklava (Figure 3)**! While the true origin of baklava remains elusive, the type of pastry as we know and love it today dates to Istanbul during the Ottoman rule. One cannot resist the flaky crust layered with chopped nuts, usually pistachios, almonds, or walnuts. This delightful pastry is then drizzled with

syrup or honey which adds just enough sweetness to make it an unforgettable gastronomic encounter. Another dessert drizzled with syrup is kunefe, a sweet cheese pastry. The dairy desserts include a variety of puddings, ranging from the very light and subtle pudding with rosewater, to milk pudding with strands of chicken breast.

To accompany your dessert, you should consider adding a wonderful cup of Turkish coffee. In Turkish tradition, coffee represents friendship and hospitality. In fact, it is not unusual to have coffee offered to you as you peruse the many shops in town.

I hope you enjoy the wide array of Turkish cuisine during your visit to Istanbul this September. I am sure there is something delicious for everyone, and that you will enjoy the many flavors Turkey has to offer.

FOOTNOTES

1. https://en.wikipedia.org/wiki/turkish_cuisine
2. Photos courtesy of Pixabay

ISAPS TRAVEL



AKIN YÜCEL, MD - TURKEY
ISAPS Patient Safety Committee

ISTANBUL: THE CITY IS CALLING YOU!

“Istanbul’s status as a world city is a gift of history. A Greek colonial city became the capital of three great empires, a phenomenon unique in history,” says Prof. Doğan Kuban, a prominent architect, and historian, in his book *Istanbul 1600 Yıllık Bir Müzedir* (Istanbul, a Museum of 1600 Years).

And this ancient city has been the favorite of Rome, Byzantium, and Ottomans throughout history. Despite it not being the capital of the Young Turkish Republic, it has been the financial and cultural capital and continues to be a center of attraction, as inherited from its history. Despite all the evolution, it has gone through, including huge exploitation and abuse of its natural and cultural assets, especially in modern times, and despite its increasing vertical profile rather than horizontal, it is still very beautiful after all.

This unique bridge connecting east and west is the meeting point of the old and the new, east and west, green and blue, magnificence and poverty, calmness and chaos. It is a small country with its own rules, living 24 hours a day, where the cuisine, music, and architecture of dozens of cultures merge.

Don’t be fooled by my word “small”; this city which we praise as being “paved with gold”, hosts a flood of around 20 million people.

What should a guest do in Istanbul for four to five days while visiting? It was very difficult to gather up a “must-see” collection for such a big city. I never considered the Anatolian side, that is, the other side of the city across the Bosphorus. I also unwittingly eliminated the neighborhoods that are far from the meeting center and where you might have difficulty finding transportation. Some of the mainstream suggestions in city guides are not listed in this article. Instead, I have selected the more unique districts and places that I think you may like, and that you can visit during the day. We have a saying: “There is no other Istanbul”, so, enjoy it!

SULTANAHMET AND SURROUNDINGS

If you have an opportunity to visit only one place in Istanbul, my number one recommendation is to visit the Sultanahmet. This neighborhood hosts wonderful buildings such as the Topkapı Palace, the Hagia Sophia Mosque, the Blue Mosque, the Grand

Bazaar (Figure 1), the Obelisk of Theodosius, the Serpent Column, the Turkish and Islamic Arts Museum, and the Hagia Irene Museum^{2,3}. It is a lively, very special place where you may follow the traces of the past and experience the “new” Turkey.

GRAND BAZAAR

Our list starts with this magical bazaar, which locals and tourists love very much. A poem was even written for this giant structure, which is a paradise of leather, jewelry, carpets, rugs, accessories, and souvenirs.



Figure 1. The famous Grand Bazaar.

Wikipedia says: “It is one of the largest and oldest covered markets in the world, with 61 covered streets and over 4,000 shops with 25,000 employees, on a total area of 30,700m², attracting about 500,000 visitors daily.



Figure 2. The famous Grand Bazaar.

Welcoming 91 million tourists a year, the bazaar is the most visited tourist attraction in the world”^{2, 4, 5}. *Skyfall*, a James Bond movie, much loved by viewers, was filmed in 2012 in the Grand Bazaar (Figure 2), and some exciting and unforgettable

chase scenes were shot on its roof. The Grand Bazaar and its surroundings are a place where you should spend at least half a day for sightseeing. Don’t leave without having a Turkish coffee at Fes Cafe in the bazaar.

This **Sultan Ahmet Mosque (Figure 3)**, which was built by the Ottoman Sultan Ahmed I and opened for service in 1617, was called the “Blue Mosque” by the Europeans because it was decorated with blue, green, and white İznik tiles^{2,6}. The inside of

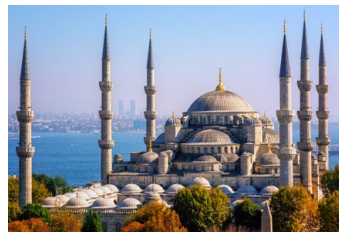


Figure 3. Sultan Ahmet Mosque.

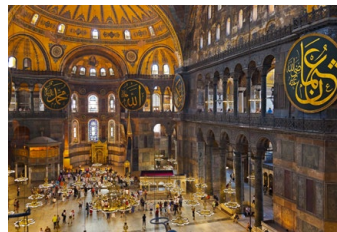


Figure 4. Hagia Sophia Mosque.

the dome was decorated with mostly blue hand-drawn works. The first six-minaret mosque of its period is worth seeing, alone for its decorations.

The **Hagia Sophia Mosque (Figure 4)**, which just recently opened for service, has been visited as a museum for many years. It is the largest church built by the Eastern Roman Empire in Istanbul and has been rebuilt three times in the same place. It was built by Byzantine Emperor Justinian and opened for worship in 537. It served as a cathedral as the largest church in the capital, where many monarchs were crowned throughout the history of the Eastern Roman Empire^{1,2,4,6}. The church, which survived from the 6th century, is considered the first structure built in a “Domed Basilica” style with its circular dome placed on a rectangular plan. The Hagia Sophia was listed on the UNESCO World Heritage list in 1985².

This large underground cistern is called the “Basilica Palace” (Figure 5), because of the marble columns that rise out of the water and appear to be countless. Covering a total area of 9,800m², the cistern is a giant structure with a water storage capacity of approximately 100,000 tons. There are 336 columns



Figure 5. Basilica Cistern (Palace).



Figure 6. Topkapı Palace.

in the cistern, each 9 meters tall, with two of them featuring upside-down Medusa Heads from the Roman period used as column pedestals^{2,4,7}.

The construction of **Topkapı Palace (Figure 6)**, built on an area of 700,000 square meters on the East Roman acropolis in Sarayburnu, was started after the conquest of Istanbul by Sultan Mehmet II (Mehmed the Conqueror) and was expanded with additions^{1,2,4,8}. This iconic building was used as the administration, education, and art center of the empire for approximately 400 years until the 31st sovereign, Sultan Abdülmejid. It also served as the residence of the sultans and features one of the most beautiful views of the city. The Palace, which consists of several courtyards, gardens, and intertwined buildings, also attracts attention with its sections where imperial treasures, thrones, jewels, and clothes of sultans are exhibited. The History Museum in the Imperial Mint located next to the palace, and the Archaeological Museum, which contains a vast collection, are also worth seeing. If you complete your tour of the palace and head towards the Marmara Sea, you can opt for a nice

dinner at Balıkçı Sabahattin, one of the best fish restaurants in Istanbul, or at the Giritli Restaurant, which is famous for its Cretan appetizers.

The **Spice Bazaar (Figure 7)** (*Mısır Çarşısı*, meaning “Egyptian Bazaar”) is a covered market similar to the Grand Bazaar, but more specialized in food and beverages. It was built in 1664 to generate revenue for the New Mosque, which was under construction at the time. There are many traditional marketplaces that will blow your mind around this bazaar, where you can buy souvenirs, confectionery, porcelain, and leather products, to name a few^{1,2,4,9}. You may also wish to discover Tahtakale (Mercan Yokuşu), Eminönü Flower Market, and Coppersmiths’ Bazaar (Bakırcılar Çarşısı) which are also close by. You may want to arrange a vehicle for your visit around this bazaar, especially if you want to indulge yourself in shopping.

TAKSİM AND SURROUNDINGS



Figure 7. Spice Bazaar.



Figure 8. İstiklal Street.

Considered the most popular street in Turkey, **İstiklal Street (Figure 8)** is a 1.4km long street, and one of the most iconic places in Istanbul. It is located in the Taksim area, which is considered the heart of the city. With the Taksim Atatürk Monument and Atatürk Cultural Center at one end, and the world’s second-oldest subway at the other end, there are many historical places and tourist attractions. They include Hüseyin Ağa Mosque, St. Anthony of Padua Church, Madame Tussauds Wax Museum, Narmanlı Han, Atlas Pasajı, Historical Mısır Apartment, and Çiçek Pasajı along the street, as well as shops, restaurants, cafés, and bars. You can find restaurants representing the traditional Turkish cuisine, such as Hacı Abdullah Lokantası, Sahrap Pera, Lades, and Nevizade Street, where you will sit at a fasıl table, the indispensable entertainment of nightlife with arabesque musical performances, favorite places for kebab lovers (such as Zübeyir and Peymane) and taverns (meyhane) where our favorite appetizers are served (Refik, Asmalı Cavit, etc.). If you have not seen this street, you cannot say that you have visited Istanbul^{1,2,4}.

Located in the Taksim Square is Atatürk Cultural Center, a magnificent renovated modern building structure. It presents a splendid program of concerts and performances, so try to find one and watch it in the great hall.

The Orientalist Painting Collection, one of the richest collections in Turkey, is exhibited in the **Pera Museum (Figure 9)**. The works of European painters, especially those depicting the Ottoman Empire, the geography of Turkey from the 17th century to the early 20th century, as well as the works of Ottoman artists influenced by the movements of the period, are also included in the permanent exhibition of the museum¹⁰.



Figure 9. Pera Museum.

The works of Osman Hamdi Bey and his famous painting, “The Tortoise Trainer” are also exhibited as a part of this permanent collection¹⁰. Do not leave the museum without seeing the weight measuring tools and the other two permanent exhibitions of Kütahya tiles and ceramics. This museum is right in the heart of Beyoğlu, next to Pera Palace Hotel. [Click here for the current program](#). Located close by is the museum of Istanbul Modern Art, offering a rich modern art collection in its own building. [For more information, please visit the website.](#)

Galata is one of the oldest districts, a mosaic of cultures and languages, where minorities including Greek Orthodox, Armenian (Gregorian, Catholic, Protestant), Assyrian, Chaldean, Jewish (Romaniote, Karaite, Sephardic, Ashkenazi), Arabic, Gypsy, Albanian, French, and Levantine communities lived in the past along with Muslims. Galata, which has always been a lively trade and entertainment center, and a port area since ancient times, has numerous attractions with synagogues and Greek, Armenian, and Georgian churches such as St. Peter’s, 500 Year Foundation Turkish Jews Museum, Salt Galata Art Gallery, and Kamondo Stairs. The Arap Mosque, built in 717 and converted into a mosque in 1475, is the only gothic church that remained before the conquest of Istanbul, and bears the identity of the first mosque in Istanbul, is also in this area. Besides its historical nature, it is a colorful and pleasant neighborhood as the meeting point for fashioners, designers, and vintage shops. While here you should definitely go to the Neolokal restaurant, located in the Salt Galata Museum, for fine dining^{1,2,4}.

The district, named after the 147-year-old subway “Tünel” (Tunnel) (Figure 10), which connects Taksim to Karaköy and has been in service since 1871, is the “2nd oldest subway in the world”¹, and is another attractive destination. Also, the Galip Dede street, one of the most popular tourist streets in Istanbul, is worth a visit, featuring music shops, gift and designer shops, small boutiques, and cafés, as well as the Galata tower^{1,2,4,11}.

At the beginning of Galip Dede Street, on the left arm, the **Galata Mevlevi Lodge Museum (Figure 11)** awaits you. Here you can see the prayer rooms, holy relics of the followers



Figure 10. The district of the world’s 2nd oldest subway: Tünel.



Figure 11. Galata Mevlevi Lodge Museum, Sema Ceremony.

of Mevlana, the founder of Sufism, and examples of Islamic water marbling (*ebru*), and a calligraphy (*hat*) arts exhibited^{1,2,4}. If you want to witness a Sema, a whirling dervish ceremony, you can watch this very impressive religious rite in the hall of worship inside the museum, by purchasing a ticket online from www.biletinial.com (tickets are not available at the location). Sema Ceremonies are performed only on Wednesdays, at 7:30PM.

The **Galata Tower** is one of the symbols of Istanbul and the most shared place of the city on Instagram. Built by the Genoese in the 14th century, when Galata was a Genoese colony during the Byzantine Empire, the tower was first used as a dungeon, and then as a fire watchtower during the Ottoman period^{1,2,4}. There is also a museum in which works representing all periods of Istanbul are exhibited. You can enjoy one of the most beautiful panoramic views of Istanbul on the top floor of the tower. Galata Tower is listed on UNESCO Temporary Heritage list, together with the other Genoese Towers in the Mediterranean and Black Sea regions. Right at the foot of the Galata Tower is Nardis Jazz Club, the oldest jazz club in Istanbul, and is ideal for spending a pleasant night full of music with its historical and cozy atmosphere. Since the place is quite small, you should make a reservation.

KARAKÖY-ORTAKÖY FERRY ROUTE

This is the new pearl of Karaköy district and is a candidate to be one of the busiest ports of the future. **Galataport**



Figure 12. Galata Tower.

(Figure 13), which has a huge underground terminal of 29,000 square meters, has emerged with brand-new architecture transforming the historical city harbor into a world-class cruise liner port and tourist destination¹². This huge complex features dozens of shops, food, beverage, and entertainment venues, and will win your heart with its magnificent view. The port also includes the Tophane Clock Tower, which was built in 1848, has been restored and brought back to life with the project, and the Istanbul Painting and Sculpture Museum of Mimar Sinan University Fine Arts Faculty, which is one of the most important art venues of Istanbul.

The museum is Turkey’s first art museum in the western sense, with its collection extending from the late Ottoman period to the end of the 20th century. If you head towards Beşiktaş, the recently restored Naval Museum is also worth seeing.

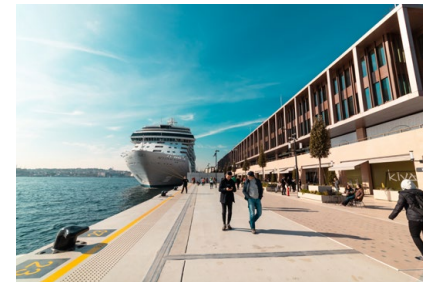


Figure 13. Galataport.

The **Dolmabahçe Palace (Figure 14)** was first built as a mansion during the reign of the Ottoman Sultan Yavuz Sultan Selim, then rebuilt in the same place by later sultans, eventually acquiring the current appearance. The Palace also hosted Mustafa



Figure 14. Dolmabahçe Palace.

Kemal Atatürk, the founder of the Turkish Republic, as the Presidential residence after the proclamation of the Republic. The four main parts of the palace are the Harem, the Mabeyn, the Clock Tower, and the Dolmabahçe Mosque.

The Palace is built on an area of 110,000 square meters including 285 rooms, 46 halls, and six baths. The clock tower located inside is considered one of the iconic historical monuments of Istanbul^{1,2,4}.

Perhaps the most beautiful place in the world is the **Bosphorus Strait (Figure 15)**. It runs through the city like a wide river and separates the continents of Asia and Europe. Small villages were scattered on the banks of each small stream along the Bosphorus. These small villages have been turned into districts of the city, lined up on both sides, each one famous for its special foods and flavors. It will undoubtedly be a unique experience to get on the Bosphorus ferry on a sunny and warm day, see the small piers



Figure 15. İstanbul Bosphorus.

and waterfront mansions along with the Bosphorus villages from the sea, and get off at a quay, eat something, and continue your visit. Istanbul's entertainment life is experienced along the Bosphorus. The most popular districts with nightclubs, fish restaurants, and bars are Kuruçeşme, Arnavutköy, and Bebek. A little further on is Emirgan, an amazing Ottoman village. Here, the Sabancı Museum has a very rich art collection. MSA Restaurant, located inside the museum, is one of the most beautiful fine dining venues in the city, with its exquisite view and warm ambiance.

WHERE & WHAT TO EAT?

Enjoy a magnificent Turkish cuisine experience in a 300-year-old Turkish bath at **Lokanta 1741**, the Cağaloğlu Hamamı (closed on Sunday).

Discover the Ottoman Palace Cuisine in an Ottoman Palace serving as a hotel in a historical venue (www.kempinski.com/tr/istanbul/ciragan-palace/dining/tugra/).

Located in Feriye Palace, offering one of the most beautiful views of Istanbul, this **seafront restaurant** features popular flavors of Turkish cuisine and selected dishes from around the world.

Featuring a magnificent view, dishes of contemporary Mediterranean cuisine are served here. There is also a DJ performance later in the night. Other eateries: Mikla (Pera), Neolokal (Galata), MSA Restaurant (Sabancı Museum, Emirgan), Mürver (Galata), Sunset (Ulus).

Traditional Turkish cuisine: **Hacı Abdullah Restaurant**, Antakya Mutfağı, Asitane, Sahrap Restaurant.

Grill and kebab restaurants: Hamdi, **Zübeyir**, Peymane, Ali Ocakbaşı.

Tavern (meyhane): Asmalı Cavit, Yakup, Leb-i Derya.

For a raki and fish table: Fisher Kahraman, Set Fish Restaurant, Fisher Sabahattin, Sahil Restaurant, Arnavutköy Fish Restaurant, Mavi **Balık** Seafood Restaurant, Karaköy Restaurant.

Inside the meeting venue: Gastronomy and entertainment complex: **Dekk and Borsa Restaurant**. Both are inside the Lütfi Kırdar Congress Center (ISAPS 2022 Congress venue).

NIGHT CLUB RECOMMENDATIONS

360 Istanbul, a panoramic view of Istanbul on the top floor of the historical Mısır Apartment on the İstiklal Street, with a wide range of drinks and various DJ shows.

Sortie, a favorite among tourists as well, is an entertainment complex with restaurants and bars, with one of the most beautiful views of the Bosphorus in Kuruçeşme.

One of the award-winning fine dining restaurants in the city and a frequent destination especially for sushi lovers, **Sunset**, is also popular for its bar, and popular views.

One of the most pleasant places, both for food and entertainment in Ortaköy with a restaurant and a two-story nightclub is **Ruby**. You can enjoy live music performances, as well as DJ shows.

Babylon, a gastronomy and entertainment complex within the Bomontiada, is one of the most popular concert venues in Istanbul. For the event calendar, please visit <https://babylon.com.tr/>.

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ADVENTURES IN TURKEY

We are excited to offer some exciting entertainment options for your pre- and post-Congress itinerary. There are some wonderful cultural places we plan to explore, and we hope you can join us!

PRE-CONGRESS TOUR 1: EPHESUS (3 DAYS) SEPTEMBER 17-19

Ephesus was an ancient port city whose well-preserved ruins are located in modern-day Turkey. The city was once considered the most important Greek city and the most important trading center in the Mediterranean region (*Figure 1*).



Figure 1. Ancient port city, Ephesus.

Day 1:

Early flight from Istanbul to Izmir, where you visit Ephesus to marvel at the extensive ruins including baths, gymnasium, theatres, and other monuments which line the marble streets. Also be sure to visit the reputed last home of the Virgin Mary, the Basilica of St. John, and the Seljuk Museum. Lunch will be provided in a local restaurant in Izmir, followed by dinner and accommodation at a local hotel.

Day 2:

Full-day tour to visit the Roman Agora, the Archaeological and Ethnographic Museum, and Kadifekale (Mt. Pagus). Lunch will be provided in a local restaurant in Izmir, followed by dinner and accommodation at a local hotel.

Day 3:

After breakfast, enjoy a visit to the historic Sirince Village (*Figure 2*), where you will have the chance to explore the small village which dates to the Hellenistic period. Lunch and departure flight from Izmir to Istanbul.



Figure 2. Statue in Sirince Village.

PRE-CONGRESS TOUR 2: CAPPADOCIA (3 DAYS) SEPTEMBER 17-19

Some three million years ago, violent volcanic eruptions covered the plateau in this area with tufa, a soft stone comprised of lava, ash, and mud. Subsequently, the wind and rain have eroded the brittle rock to form a spectacular surrealistic landscape of rock cones and capped pinnacles, called Fairy Chimneys (*Figure 3*) that are painted in colors ranging from warm reds and gold to cool greens and



Figure 3. Fairy Chimneys.

grays. During Byzantine times, Christian chapels and monasteries were hollowed out of the rock, and later these dwellings served as a refuge for Christians, persecuted by the Romans.

Day 1:

Early departure from Istanbul, flight to Kayseri-Nevşehir and continue to the Cappadocia region. Visit the underground, eleven-storied city of Kaymakli (**Figure 4**), and see the extraordinary rock formations at Uçhisar, and the charming



Figure 4. City of Uçhisar.

town of Ürgüp with its fairy chimneys. Lunch will be provided in the area, with dinner and accommodation at a local hotel.

Day 2:

Visit the rock dwellings, chapels, and monasteries of the Göreme Valley and Zelve Valley. You will also enjoy visiting the villages of Çavusin and Avcilar. Lunch will be provided in the area, with dinner and accommodation at a local hotel.

Day 3:

Early departure from the hotel to Kayseri-Nevşehir, with departure flight to Istanbul.

POST-CONGRESS TOUR 1: CAPPADOCIA (3 DAYS) SEPTEMBER 25-27

Itinerary is the same as the Pre-Congress Tour 2, Cappadocia; please reference for details.

POST-CONGRESS TOUR 2: GOCEK BAYS (4 DAYS) SEPTEMBER 25-28

Due to its well-protected geographical formations, the Gulf of Gocek is one of the most important spots for yacht tourism (**Figure 5**). A variety of islands and coves from large to small offer an abundance of options for boating with their low, high, deep, and shallow waters.

Day 1:

Welcoming and boarding starts at 4:00PM in Gocek Yacht

Marina. Visit Cleopatra Bay (Sunken Bath) where lunch will be served. Next, cruise to Aga Port for dinner and an overnight stay.

Day 2:

Visit Butterfly Valley located in the Oludeniz region. The reason it's called Butterfly Valley is that it's home to more than 80 butterfly species, including the Jersey Tiger. After a swim break, cruise to Oludeniz (Blue Lagoon). Dinner and overnight stay will be at Gemiler Island (Aya Nikolas Island).

Day 3:

After breakfast, cruise to Bedri Rahmi Bay (**Figure 6**) named by a famous Turkish painter, writer, and poet who came here in 1974. After lunch and another swim break,



Figure 5. Gulf of Gocek.



Figure 6. Bedri Rahmi Bay.

cruise to Tersane Island, the largest island of Gocek Bay. Dinner and overnight stay will be in the beautiful Yassica Islands region.

Day 4:

In the morning, cruise to Sarsala Bay for breakfast and swimming. Later, cruise to Incirlik Bay located on the southwestern side of Gocek Island for lunch and the last swim break on your Blue Cruise. After swimming, we will return to Gocek Harbor.

Pre- and post-Congress tours can be booked via the ISAPS World Congress website www.isapsistanbul2022.com.

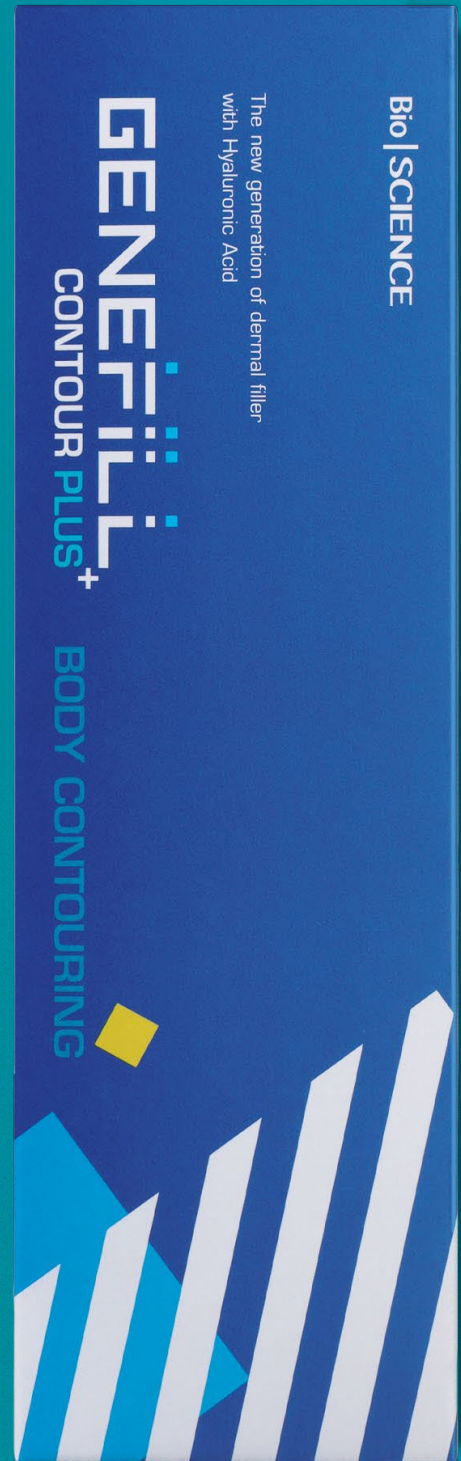
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ANEESH SURESH, MS - INDIA

LEARNING THROUGH THE LENS

From the historical daguerreotypes and talbotypes and an arduous journey through the American Civil War, photography got its essence in the 19th century. For the first time, a professional photographer named Percy Hennel worked alongside the stalwarts Sir Harold Gillies, Archibald McIndoe, and Ralph Millard, contributing more than 500 clinical photographs in the book *“The Principles and Art of Plastic Surgery.”* Gillies considered photography to be one of the most significant inventions of that time. The inspirations from these pensive minds laid the foundations for contemporary clinical photography.

Clinical photography within the confines of plastic surgery is an amalgamation of documentary, educational, and importantly, medicolegal significance. Plastic surgery residency is unlike any other, where photography becomes an integral part of our armamentarium. Only a handful of residents entering the training program are competent in photography, let alone clinical photography. The necessity for capturing multiple shots to get a good and representative image, lack of technical understanding, and changeovers between residents while taking photos, are a few of the unmistakable issues that need addressing. This breaks the rapport in the doctor-patient relationship and reduces their compliance, something I believe should be avoided.

As important as it is to master the art of plastic surgery, a resident should also be capable of handling a camera with finesse and achieve standardization and consistency in clinical photography. The camera is a viewfinder peeking into the surgeon’s mind and a reflection of what one perceives and understands.



Figure 1: A studio setup to ensure standardization and consistency in photography.



Figure 2: Few of the devices used in our department for photography and videography. A. DSLR, B. Mobile phone on an electronic gimbal, C. Go Pro, D. Mechanical gimbal.

Residency programs should include sessions on the basic concepts and principles of photography and videography, with considerations for patient positions, ambient conditions, and photo documentation (including consent) besides computerized photogrammetry (Figures 1, 2).

The guidance of our ‘gurus’ and colleagues, self-learning through trial and error, attending free online tutorials, and last but not

the least, joining the local photography tours on weekends (definitely a fun-filled way to bring one out of their monotonous residency period), would go a long way in setting the building blocks. Michelangelo rightly reflected, "If people knew how hard I worked to gain my mastery, it would not seem so wonderful at all." As daunting as it may seem to begin one's rendezvous with photography, it's the tiny steps along the learning curve that will bring efficiency and adeptness to our approach and execution.

Notwithstanding its obvious roles, clinical photography also reflects the patients' minds and plays a crucial role in shaping their body image. Plastic surgery has the power to bring a dramatic change to body image. The 'know-how' to conduct oneself around the patient, is the other

side of a coin that a resident needs to be well versed with. Making the patient comfortable, respecting their privacy, instructing them in a polite, yet confident manner, and diminishing their anxiety about the tribulations of the photoshoot, will help connect with them. This will improve compliance whilst ensuring the standards of clinical photography.

I would conclude by saying that every plastic surgery residency program should have periodic lectures and hands-on training sessions similar to the operative workshops to propagate the nuances of clinical photography, and stay up-to-date with the basic/advanced clinical imaging systems.

SIMPLIFIED LATERAL BROW LIFT FOR BEGINNERS



LUIS GERARDO SANDOVAL-ORTIZ, MD - PERU

The upper face, more than any other area, expresses aging in its earliest stages. Either by the appearance of wrinkles in the frontal area or by crow's feet at the periorbital level.

The gaze is what represents this upper third, an indistinguishable mark of aging, and is a vital part of interpersonal relationships, so treating this portion is a turning point in the manifestation of aging.

An easy procedure for rejuvenating the aged brow is the lateral brow lift. It is a combined approach with an upper blepharoplasty plus a brow lift, without endoscopy or extensive retraction, to correct lateral hooding.

This procedure can be applied in the office with minimal oral sedation, and local anesthesia as described by Drs. Thomas Mustoe *et al.* Please see my outline and draws with the key steps to understanding the procedure.

MARKINGS

Lateral temporal incision: 4-5cm parallel to the brow and 2-3cm posterior to the temporal hairline (crescent). (*Figure 1a*).

Blepharoplasty: as the degree of palpebral ptosis (*Figure 1b*).

The width of scalp excision - brow elevation in a 4:1 ratio (*Figure 1d*).

Local anesthetic with epinephrine infiltration. We must take care of the general path of the frontal branch of the facial nerve in the temporal region: the Pitanguy's line (*Figure 1c*).

UPPER BLEPHAROPLASTY INCISIONS

Medial portion: dissection superomedial, form a pocket to expose and divide the corrugator supercilii (*Figure 2. Yellow arrow*).

Lateral temporal incision (*Figure 2. Blue arrow*).

Skin removal: 1-1.5cm

Dissection to the temporalis fascia and above the deep temporal fascia.

Superior temporal septum dissection.

Subperiosteal plane (inferomedial).

Join the two dissection planes (fully release the superior temporal septum).

Deep temporal fascia: deep layer incised, superficial temporal fat pad is released (*Figure 3. Line of incision*).

Subperiosteal plane: hemi forehead undermined (one side).

Release periorbital adhesions.

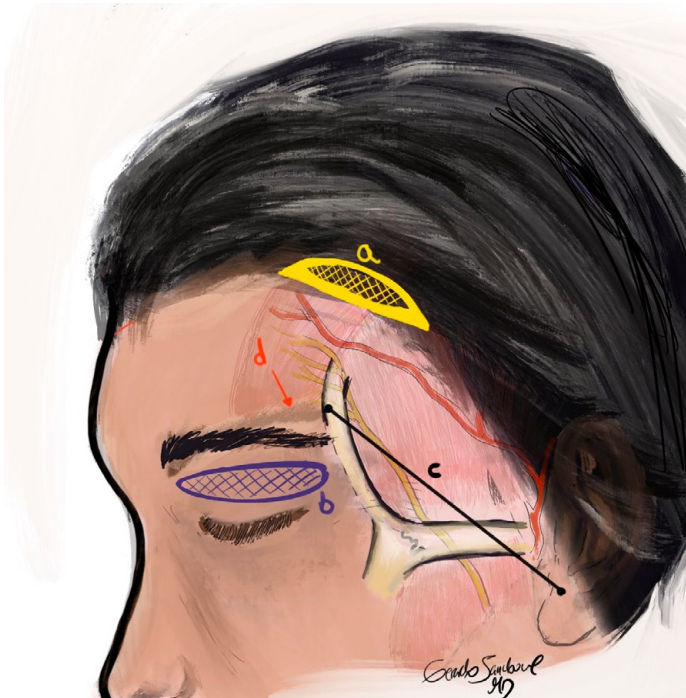


Figure 1. Markings and key points.

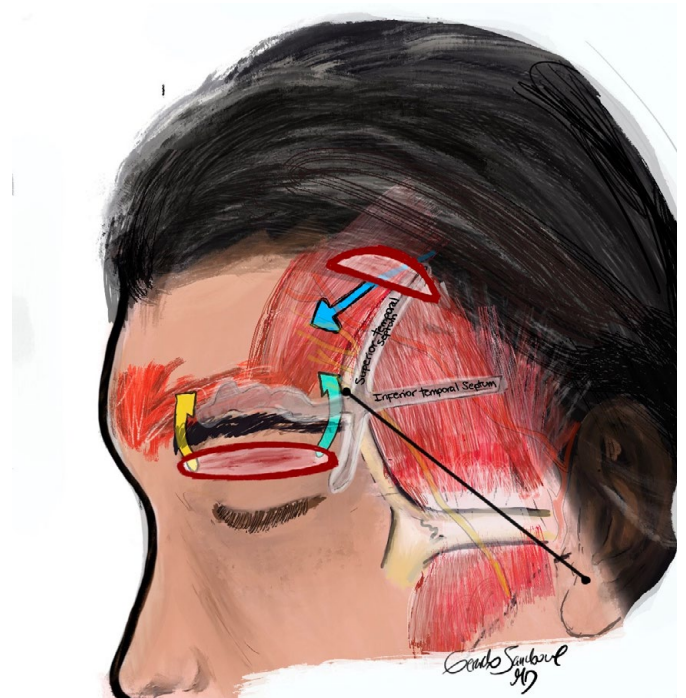


Figure 2. Zones of continuity of temporal incision and upper blepharoplasty.

Upper blepharoplasty incisions (Figure 2. Green arrow).

Lateral portion: orbital rim periosteum is incised - continue in the subperiosteal plane.

Orbital thickening released.

Super medial dissection.

Fixation: PDS Sutures 3-0: secure posterior superficial temporal fascia to anterior periosteal and superficial temporal fascia layer.

There is no need to use drains, and no compression wrap is needed. Ice can be applied to incisions for three to five days, and sutures can be removed in seven days.

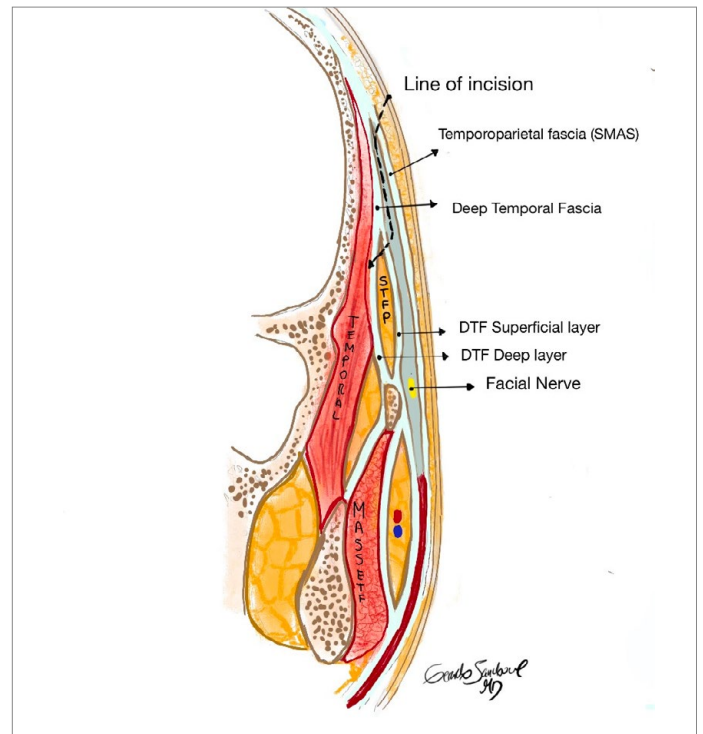


Figure 3. Transverse section at level of deep temporal fascia showing incision line for lateral brow lift.

FOOTNOTES

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Cross section of a MENTOR® MemoryGel Breast Implant
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* MemoryShape Post- Approval Cohort Study (formerly Contour Profile Gel Core Study) Final Clinical Study Report. Mentor Worldwide, LLC; 02 June 2015.
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† Based on patient survey at 10 years in the MENTOR® MemoryGel™ Breast Implant 10-Year Core Gel Clinical Study Final Report

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IN MEMORIAM

DR. SHEILA ROHATGI, MD (UNKNOWN-2022)



DR. SHEILA ROHATGI

written by Dr. Manoj Khanna, MD

Dr Sheila Rohatgi, or Sheila Di as we all called her, was a very well-known personality in the Indian plastic surgery world. She could be seen at conferences attending lectures and asking questions, and imbibing new ideas until her last day.

She was born at a time when women's education was not encouraged in India. She got married while she was in the final year of her MBBS, and it was her husband who, despite not being a doctor, helped her complete her studies. During those times, the females of the household had to be in 'purdah' and had to wear only saris. This habit of wearing a sari stayed with her until her last day. She looked graceful and immaculate in them.

After completing her MCh in Plastic Surgery, she went all around the world learning from masters of the craft like Prof. Skoog, Dr. Bruce Bailey, and Dr. Ohmori. In all her photographs, you can see her immaculately dressed in a sari. She came back to India and joined the West Bengal Health Service and was posted to Kalyani where the super-specialty department of plastic surgery had just been started. She was subsequently posted to Seth Sukhlal Karmani Memorial Hospital (SSKM) and then Medical College Kolkata.

At SSKM Hospital, she had kept her personal microscope in the Emergency Occupational Therapy Department, and used to attempt to re-implant at all times of the day and night. In Medical College Kolkata, she arranged many workshops including one on breast reconstruction.

As early as 1984, she performed the first liposuction in Kolkata. She had gone to attend the World Congress in Montreal and Ilouz's paper on liposuction enthralled her. Her husband, an

electrical engineer who was accompanying her, got intrigued by this new machine being used to suck out fat. He came back to Kolkata and designed his own liposuction machine, which Dr. Sheila Rohatgi used to perform her first liposuction. She did aesthetic surgery exclusively in her private practice and was among the first plastic surgeons to have her own website. She used social media extensively to advocate aesthetic surgery among the general population.

She was very brave and took her illness in stride. Those of you who attended APSICON at Bhubaneswar will remember her attending all seminars wearing dark glasses because of a huge black eye sustained after a fall en route to the conference.

Her enthusiasm was legendary and she made it a point to attend all conferences, taking notes, asking questions, and making points, even after her contemporaries stopped attending conferences. Her 'never say die' attitude is what she has passed on to the next generation. May her soul rest in eternal peace.

IN MEMORIAM

DR. JOHN TEBBETTS, MD (1946-2022)



DR. JOHN TEBBETTS

written by Dr. Steven Teitelbaum, MD

The specialty of plastic surgery has been graced with men and women of unusual brilliance and creativity. But even in that elite cadre John Tebbetts was a sui generis. He possessed unparalleled wisdom about surgery, his various hobbies, and the life advice he would readily offer to anyone who would listen. Quite simply he had the most fascinating mind of anyone I have ever known.

“Bubba” – his nom de guerre – approached surgery as he did each of his avocations, mastering every step of each endeavor to the highest level attainable, whether it was fly-fishing (he held records for bonefish and tarpon on fly), hang-gliding, rock-climbing, deep water scuba diving, racing motorcycles, or doing photography. His most recent passion was making customized drones entirely from scratch and our last conversation was about his learning to actually reprogram the embedded microchips, a daunting task even for a millennial techie. Before a trip to photograph the picturesque coast of southern Oregon, he studied countless photographs and blogs and put together a detailed shot schedule based upon whether he wanted to shoot a particular shore at high or low tide, at sunrise or at sunset. The first time he would shoot the coast he would do so armed with all the knowledge the experts had accumulated over the years.

It is that same precision, preparation, knowledge, and totality of control that he expected of himself in the operating room. Yes, in a typical morning he would do nine augmentations with an average operating time of 17.5 minutes (as witnessed by scores of surgeons he welcomed as visitors), with patients out to dinner that night and requiring no narcotics. But the

goal was not to be quick; it was to give patients a superior experience and long-term outcome. The speed was the result of optimizing every step from the patient’s initial contact with the practice through surgery and recovery.

The publication of which he was most proud presented a series of 50 consecutive augmentation patients with no reoperations at three years in a CRO-reviewed FDA PMA trial, because it objectively documented an unmatched track record that he thought would never be achieved by anyone again. That benchmark was based on techniques he described in a series of papers all published in 2001, which introduced us to the concept of the dual plane, rapid recovery, tissue-based implant sizing, and detailed descriptions of each step of surgery. It sounds cliché to say this, but even a single one of those papers would have made him a top contributor to the field of breast augmentation. If western philosophy is a footnote to Plato, then so too is all of breast augmentation knowledge a footnote to Tebbetts.

In addition to his textbook on breast surgery, his rhinoplasty textbook remains a classic and essential reading. He set the state-of-the-art in breast augmentation 20 years ago and it is anathema that none of us are meeting that level today. He freely admitted that his uncompromising and argumentative approach turned many off to his message. But he would angrily criticize “the brethren” (his choice term for his colleagues) for being too greedy and lazy to change what in their mind had been working for them, despite data showing there was something better for patients.

Young plastic surgeons cannot imagine the excitement of standing-room-only audiences crowding to hear his

presentations at the major meetings (he never gave the same talk twice and would only speak if he had something new to say.) He was quite a provocateur from the podium and “gutted” (his words) anyone courageous (or foolish) enough to challenge him. There were never holes in his logic; he anticipated every possible line of attack on his arguments and had prepared briefs to rebut those challenges.

By his own admission he was a redneck who had no patience for laziness or stupidity. He detested the way the brethren engaged in subjective rationalization of their preferred technique, which he called “surgeonspeak.” So too did he despise when other surgeons didn’t hold themselves accountable or were engaged in unctuous politicking at meetings simply to raise one’s standing in the societies – at the cost of challenging one another to do better.

He was the most focused and hardest working person I knew – but he was not a workaholic. He objected when people spoke of his extraordinary intelligence, instead attributing his accomplishments to his perseverance, focus, and hard work. He was fond of quizzing surgeons about exactly what it was that they thought they were selling to their patients. Most would answer that it was their skill, experience or knowledge, but he would remind them it was their “time” that they sold – that we all have whatever time we are given and that we cannot make time – and that you must manage it in the way that works for you. Though he published more and had a busier practice than just about anyone, he did so with such efficiency that he also had more time to pursue non-medical interests than just about anyone. He would always repeat that living a meaningful life was based on these seven words: “Life is about choices; I am responsible.”

Bubba worked hard and played hard, and always did it with a big heart, abundant humor, and country-boy wisdom. He always made life fun for himself and for those fortunate to be around him, though it was always a roller-coaster ride of humor and pugilism, with each encounter ultimately leaving you wiser and feeling more alive. He was a fantastic educator of surgeons and mentored many major contributors to plastic surgery. Any woman receiving a breast augmentation today enjoys a better outcome because of him. He was loyal to his friends, his patients, and to the concept of honesty.

He is survived by his long-term girlfriend Deborah Cody and his daughter Kas Tebbetts. He often said that he had no regrets. But I know he would have regretted dying just two months shy of Kas walking down the aisle as a graduate of Yale.

He held an indomitable spirit until his very last breath, which occurred suddenly while he was barbecuing a Texas-style steak luncheon for eight people. He once wrote in an email, “It occurred to me that a) I don’t give a f__ about what most folks have ever thought about me, and b) if you want to remember me, remember: I tried every day to see what is, focus on what lets me live, learn, and grow absent the noise of those and the world around me. Been there, done it, and I’m one happy mother__ because of it. Bubba.”



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Contact: Gustavo Abrile
Email: gustavoabrile@gmail.com
Tel: +54 3764 693461
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Venue: Le Plaza Hotel
Email: Moustapha.Hamdi@uzbrussel.be
Tel: +32 2 4799 172
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