

ISAPS NEWS

Official Newsletter of the International Society of Aesthetic Plastic Surgery

From the Office of the President:

ISAPS's Survey and Results – Towards a New Future

The ISAPS board has always discussed what is beneficial to ISAPS members and what ISAPS should do for the safety of our members' patients and uses these discussions to review its policies for the future.

During the board meeting held in Rome last November, the following points were raised: as our daily clinical statistics have made clear, and as any member from around the world would admit, the number of non-surgical treatments is increasing. At the same time, the number of participants in ISAPS courses and symposia has been declining.

Based on the aforementioned circumstances, it is our opinion that we can learn techniques and increase our knowledge about other clinical fields important to our practice and patients by inviting core specialists to present at our meetings. We also discussed whether we should admit leaders in the fields of aesthetic surgery and non-surgical aesthetic procedures as members in order for ISAPS to become a leader in both fields. Furthermore, we discussed how we can expect discussion and interactions at meetings at a higher level than before by allowing board-certified dermatologists, board-certified oculoplastic surgeons, and board-certified facial plastic surgeons to enter into the academic meeting sites. As a result of discussions and voting at the board meeting, as you know, proposals were made to ISAPS members.

ISAPS board members then received many opinions from ISAPS members throughout the world, including opinions that agreed with our proposals. However, many doctors, in particular, those in South America, told us that they have always been in conflict with doctors in other fields and that it is a serious issue for them if these doctors enter into the field of plastic surgery in their countries.

In particular, we received many opinions that were seriously against the affiliate members we proposed.

The ISAPS board recognized that there are conflicts in some countries and we therefore decided to ask the opinion of ISAPS members around the world directly. This resulted in the recently implemented ISAPS survey which proved that the issues with other core specialists are more serious than we imagined.

It is our mission to serve all ISAPS members. Our members are like a family and it is important that we listen to their opinions carefully. The survey results, although small in number, are clear, with more than half of the respondents from around the world being against establishing a new affiliate membership category and to allow other core specialists to attend our meetings. However, the majority agree that core specialists should be invited as faculty to teach at our meetings.

This ISAPS survey was very valuable. We learned that there is a variety of issues in each country and that the magnitude of the issues varies. Consequently, we announce the following:

1. ISAPS will not establish an affiliate member category.
2. ISAPS will not allow other core specialists to attend our meetings except by special invitation of the President.
3. ISAPS will invite excellent core specialists from other fields to teach at our courses, symposia, and congresses. ISAPS will evaluate them and will not invite them back if they have a bad evaluation—the same process we use for the plastic surgery faculty.

As President of ISAPS, I deeply appreciate your comments and valuable opinions.

Susumu Takayanagi, MD
ISAPS President 2014-2016



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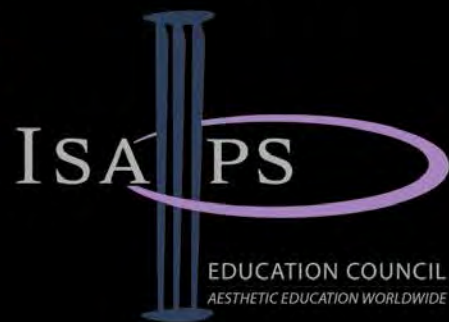
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MESSAGE FROM THE EDITOR



It is my pleasure to welcome you to this issue of *ISAPS News*. In this edition, you will learn about our society's efforts to survey and listen to our members regarding proposed changes as described by Dr. Takayanagi in his message to the membership.

Consistent with our mission of patient safety and excellent standards of care, Ivar van Heijningen reports on the new European Standard in relation to Aesthetic Surgery services (EN

16372) that encompasses all aspects of practice. Dr. Lina Triana, Chair of the Education Council, gives a wonderful update on all of the exciting educational plans for ISAPS. We also present a report from our journal editor, Dr. Henry Spinelli, highlighting the successful growth of our journal, *Aesthetic Plastic Surgery*.

Our Global Perspectives Series in this issue focuses on trends in non-invasive treatments. This is a great opportunity to read about practice patterns in different regions of the globe as presented by our members. This global perspectives topic is complemented by an informative article on the psychosocial aspects of minimally invasive procedures by Dr. David Sarwer. Our regular history section this time focuses on the fascinating story of Jaques Riverdin, a pioneer in skin grafting, presented by Dr. Denys Montandon.

I hope you enjoy this issue of *ISAPS News* where you can read about these topics, as well as several humanitarian efforts, past and upcoming educational programs, and much, much more. Warmest regards,

J. Peter Rubin, MD, FACS

ISAPS News Editor



photo Bruce D. Jones, 1957

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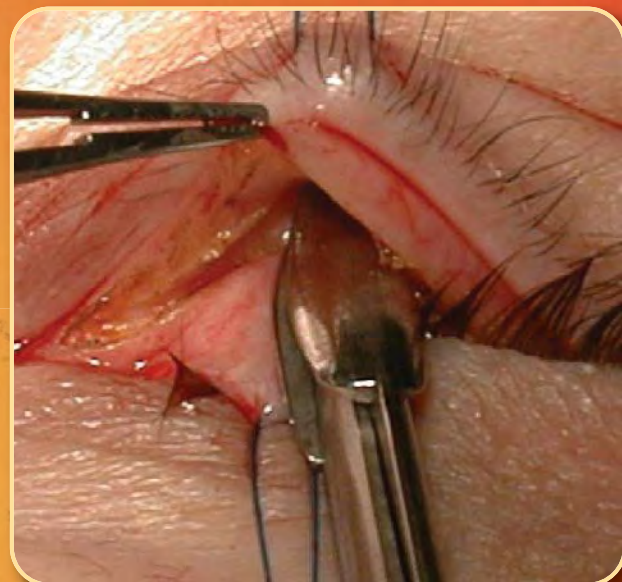
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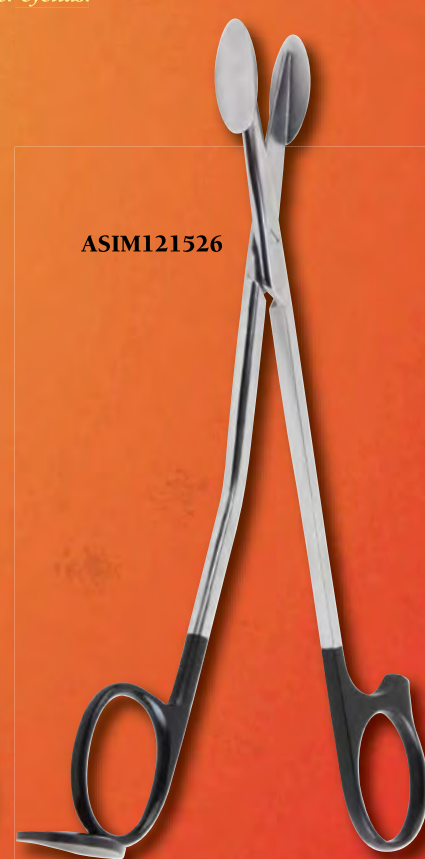
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ISAPS EDUCATION EXPANSION PLANS

Lina Triana, MD – Colombia

Chair, Education Council



We are living today in a globalized world where strategic alliances are very important to stay on board in any business. We see this in different industries and now it is time for us as plastic surgeons to catch up with this flow.

ISAPS members have read in my past articles in this newsletter and in a recent letter sent by our president, Dr. Takayanagi, how ISAPS is expanding its mission in education.

Now I want to once more bring to you our updated ISAPS goals. We are expanding from our initial mission of surgical education only to even more comprehensive aesthetic procedure education worldwide.

To pursue and achieve these goals, we must extend our strategic alliances to include core specialties that perform both aesthetic surgical and non-surgical procedures. By doing so, we will become a more inclusive society sharing and enriching each other in our areas of expertise. We must always keep in mind that this can only be done with those who have true, formal education in aesthetic procedures. This includes only those specialists who have completed their residency and advanced training and who have experience in the specific surgical or non-surgical aesthetic procedure they claim to do. These are the core specialists with whom we truly share competencies in aesthetic procedures.

We must never forget why we are here: for our patients. If we want to offer them the best in aesthetic procedures, we must become an inclusive society where we ALL work together and learn from each other. The times when isolation was best have changed. ISAPS is stepping in with these alliances to expand our plastic sur-


gery universe. Today we have the responsibility to lead in this globalized world of aesthetic procedures.

Following this new ISAPS trend that has been mandated by our Board of Directors led by our president, Dr. Takayanagi, the EC team has a big responsibility and will play an active role in these changes. We are now open to learn from those in the core specialties by including them as faculty in our scientific programs.

The EC team and our ISAPS National Secretaries are still working according to the high standards established by Dr. Nazim Cerkes for our ISAPS courses, symposia and meeting endorsements throughout the world. Recent courses in Pattaya, Thailand and Liege, Belgium have been very successful and I invite you to maintain this good energy so that we can continue with what past ISAPS EC Chairs had achieved — providing education in plastic surgery worldwide, but now expanded to all aesthetic procedures.

Finally, since we are all connected, the ISAPS EC team would like to encourage those who present at our meetings to further share their knowledge by submitting papers to our ISAPS journal, *Aesthetic Plastic Surgery*. We invite you to become ISAPS ambassadors not only during ISAPS scientific meetings, but at any meeting you attend. Be open to recruiting interesting new information and concepts to be submitted to our journal.

The ISAPS leadership is demonstrating a straightforward message and offering an open invitation for us as members to take an active role in plastic surgery expansion to include all aesthetic procedures worldwide that will ultimately enhance our practices and allow us all to grow.

I want to thank my EC Team and our National Secretaries, and especially to our Board of Directors for their efforts to help ISAPS grow and maintain our excellence in education into the future. 

Show your patients that you are an ISAPS member.



Our distinguished member plaques have silver or gold metal on highly-polished piano finish wood and are 8 by 10 inches (20 by 25 cm) or 12 by 15 inches (30.5 by 38 cm). The order form can be downloaded from the Member Area of our website. Each plaque costs \$300 for 8 by 10 and \$500 for 12 by 15 including the cost of shipping.

CEN UPDATE

Ivar van Heijningen, MD – Belgium

ISAPS National Secretary for Belgium and Membership Committee Chair



It is with great joy that I welcome the CEN press release on the European Standard for Aesthetic Surgery Services. My membership in ISAPS helped me a lot with this standard. The ISAPS safety diamond was taken as the basis and the AAAASF-I accreditation manual was also used as a base for discussion. In this sense ISAPS contributed a lot to this standard which finally took form thanks to the input of numerous people in the standard institutes of most European countries whom I thank for this. —Ivan van Heijningen

CEN publishes standard on Aesthetic Surgery services Brussels, 20 January 2015 — CEN is pleased to announce the publication of a new European Standard in relation to Aesthetic Surgery services (EN 16372). It is expected that this standard will help to improve the quality of these services, enhance the safety and satisfaction of patients, and reduce the risk of complications.

The market for aesthetic surgery interventions has grown over the last few years. The increased availability of affordable travel and the internet mean that medical tourism in relation to aesthetic surgery has become a reality. There is a rising need to ensure that patients are fully informed and able to rely on safe aesthetic surgery interventions, whether at home or abroad.

The new European Standard (EN 16372) addresses requirements for surgical services provided to patients who wish to change their physical appearance. This new voluntary Standard provides requirements and recommendations in relation to services provided by aesthetic surgery practitioners. These recommendations concern various aspects such as: ethics and marketing, information provided to patients, competencies of the surgeons, the consultation procedure, requirements for clinical facilities and post-operative follow-up.

The new European Standard (EN 16372) was developed by CEN's Project Committee on "Aesthetic Surgery and Aesthetic Non-surgical Medical services" (CEN/TC 403), which was set up in 2010. This Committee includes practitioners nominated by CEN Members as well as other stakeholders including ANEC, which represents consumer interests in standardization.

The new European Standard (EN 16372) was formally approved by CEN in October 2014 and the final version of the standard was made available to all CEN Members (National Standardization Bodies) on 17 December. Before the end of June 2015 (at the lat-

est), this standard will be published at national level by CEN Members in 33 European countries.

The Project Committee CEN/TC 403 is chaired by Dr Johann Umschaden from Vienna (Austria), who is a Specialist in Plastic, Aesthetic and Reconstructive Surgery. Dr Umschaden states: "The new European Standard defines a high level of quality for aesthetic surgery services and provides the basis for optimal patient safety".

The Belgian Plastic Surgeon Ivar van Heijningen was one of those who initiated the project to develop a European Standard for Aesthetic Surgery services, alongside Dr Umschaden. According to Dr van Heijningen: "This European Standard is a landmark for health care services, especially considering the cross-border mobility of patients in Europe."

"Whether they are being treated in their own country or abroad, patients expect to be treated by competent practitioners in a safe environment and to be informed about relevant issues related to their treatment, including risks. These expectations are addressed by the new European Standard for aesthetic surgery services," continues Dr van Heijningen.

"Some EU member states have specific regulations on aesthetic surgery, but most countries don't have. This gap can now be closed by the voluntary European Standard for the mutual benefit of practitioners and patients," adds Dr van Heijningen, who is the National Secretary of ISAPS (International Society of Aesthetic Plastic Surgery) in Belgium.

According to the chair of CEN/TC 403, Dr Johann Umschaden: "Even if there are specific regulations in some EU Member States on aesthetic surgery, some of them are lacking in terms of hygienic, technical issues, or they don't include a risk analysis. Recent reports on incidents in the context of Aesthetic Surgery emphasize

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14TH OSAPS MEETS IN THAILAND COMBINED WITH ISAPS SYMPOSIUM

Kamol Wattanakrai, MD – Thailand **Sanguan Kunaporn, MD – Thailand**
National Secretary for Thailand *Past National Secretary for Thailand*

On October 27-29, 2014, the 14th International Congress of the Oriental Society of Aesthetic Plastic Surgery (OSAPS) met in Pattaya, Thailand with 262 local delegates and 194 international participants. In all, 24 countries were represented. Scientific sessions covered 10 topic areas with Live Surgery demonstrations on Mammoplasty and Rhinoplasty. The opening address was the Seichi Ohmori Memorial lecture given by US Prof. Gordon H. Sasaki from USA.

An ISAPS Symposium was included and the opening remarks were given by Dr. Susumu Takayanagi, president of ISAPS. The faculty included Dr. Selahattin Ozmen, Dr. Mehmet Bayramicli



and Dr. Sacit Karademir from Turkey, Dr. Kotaro Yoshimura and Dr. Kunihiko Nohira from Japan. The topics covered were breast surgery, hair restoration, rhinoplasty and facial transplantation.

Free papers were presented in the areas of mammoplasty, rhinoplasty, breast, facial, eyelid, and cosmetic surgery with 25 oral presentations and eight posters. There were 27 faculty members from nine countries.

Social events included a welcome reception at the beautiful infinity-edge swimming pool of The Royal Cliff Beach Resort Hotel, a presidential dinner for faculty and speakers, a banquet for all delegates, and private tours to Nongnuj botanical garden for ISAPS speakers.



THE FOURTH CONGRESS OF THE WORLD ASSOCIATION FOR PLASTIC SURGEONS OF CHINESE DESCENT

**David S.Y. Wong, MBBS, FRCS, LLB – Hong Kong and
Lee L.Q. Pu, MD, PhD, FACS – United States**



The Fourth Congress of the World Association for Plastic Surgeons of Chinese Descent (WAPSCD) took place at the Hong Kong Academy of Medicine with its ISAPS-Endorsed scientific program from November 6th to 8th. This was preceded by four workshops on aspects of aesthetic surgery.

The opening ceremony adopted the favorite Chinese customary eye-dotting and lion dance. It is a traditional belief that the awakened lion scares away bad elements to ensure good luck (Figure 1).



Fig. 1 Lion Dance and eye-dotting at the opening ceremony

Some 300 delegates came from Mainland China, Taiwan, USA, Singapore, UK, Canada, Ireland, Korea, Australia, France, India, Israel, Macau, Malaysia, New Zealand in addition to Hong Kong (Figure 2).

The scientific program included comprehensive coverage of all current and important aspects of plastic surgery. Concurrent reconstructive and aesthetic ses-



Fig. 2 Group photo 4th Congress WAPSCD

sions took place in two adjoining theatres. Twenty panel sessions were interspersed with nine plenary sessions with speakers of extraordinary caliber. There were 82 invited speakers, 86 oral paper abstracts and 22 posters, and 27 sponsor booths. Each mid-day there was a sponsored lunch symposium.

One could easily feel excited being a part of this meeting because we saw legendary authorities everywhere, speaking, passing by, talking to someone, having a cup of coffee or visiting the exhibition booths. Notable examples were Professors Fu-Chan Wei, Yu-Ray Chen, Yilin Cao, Lee L.Q. Pu, David T.W. Chiu, and Dae-Hwan Park, and too many others to mention.

Several specially invited speakers added extra highlights. Sir Gordon Wu, an entrepreneur, philanthropist, and successful engineer delivered a speech on China's role in the world. That stimulated a lot of views from the audience. Professor KM Chan, founding Secretary General (1994-2006) and president (2006-2009) of the Chinese Speaking Orthopedic Society, generously shared how our ortho-

pedic counterpart has joined the effort to develop their specialty to greater heights and to deliver better care for patients.

Professor Foad Nahai came as an ISAPS Visiting Professor. He arrived before the meeting to teach in the two university hospitals and then at the Hong Kong Society of Plastic, Reconstructive & Aesthetic Surgeons (HKSPRAS). At the Congress, he traced the origin and development of plastic surgery and illustrated the importance of innovation in its further evolution (Figure 3).



Fig. 3 ISAPS Visiting Professor Foad Nahai was giving his lecture during the congress

The Faculty and Congress Dinners took place off the coastline aboard the Lantau and the Jumbo. Both involved a boat cruise to allow participants to experience the autumn breeze. The former was a special restaurant next to the waters and the latter a floating marine vessel. Deliciously cooked fresh seafood and fine wine helped wash away the tension of the

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MESSAGE FROM THE CHAIR OF NATIONAL SECRETARIES

Peter Scott, MD – South Africa

Chair of National Secretaries

Greetings to all our National Secretaries from a very warm and sunny South Africa. ISAPS is entering into a very exciting phase under the leadership of Susumu Takayanagi. His message in this issue describes changes in future course content and faculty that will allow our society to grow from strength to strength and keep at the cutting edge of our speciality.

Over the Christmas period, the ISAPS office under the capable leadership of Catherine Foss, continued to work away quietly in the background with Jordan Carney keeping a very active role in sorting out membership applications.

As a member of the Membership Committee, I have noted that we have attracted new members who may well be the only ISAPS members in their country and we have encouraged them to get involved in regional meetings. In particular for instance, as the NS for South Africa, we have two active members in Mauritius who have fallen under the umbrella of ISAPS South Africa and have been invited to our local meetings. The membership numbers in Bolivia have grown to the stage where we now have recently appointed Maria Theresa Rojas as the first National Secretary for Bolivia. I would encourage NS who are neighbors of countries where there is no or poor representation to take them under your wing and to grow the foot print of ISAPS in their country.

As part of my role on the Education Council, I would like to compliment Lina Triana on stepping into the very big shoes of Nazim Cerkes and tirelessly working on faculty members for upcoming meetings. In the course of being involved as the ISAPS Course Director for the October Australian meeting, I have enjoyed the efficiency with which Lina has been able to put a group of expert lecturers on the “fat transfer” focus of this one-day symposium.



Several National Secretary elections will take place in 2015 as terms expire. Since my last message, we have had elections in Bahrain, Luxembourg, Bolivia, Brazil and Denmark.

One of the continual gripes of the chair of NS is the poor response to emails sent specifically to the NS by the ISAPS Board. I have found that the same NS always reply promptly and the same reply to a second email, but about 70% of our NS ignore emails. The ISAPS Board does realize that we are all running busy practices; however, you take on this four-year position representing your country to improve the standard of aesthetic surgery to ensure successful transfer of skills to the younger surgeons in training. We realise that circumstances change and that various NS may have personal health issues or become too busy or disinterested in the position. If this is the case, you are welcome to approach Catherine Foss or myself to organize an early election in your country.


For ISAPS to function effectively as a world leader we need your active involvement.

I wish you all a prosperous, successful and healthy 2015 and I look forward to meeting up with you at one of the upcoming meetings this year.

New National Secretaries

We welcome newly-elected National Secretaries:

Bahrain	Rajesh Gawai, MD
Brazil	Antonio Graziosi, MD
Bolivia	Maria Theresa Rojas, MD
Denmark	Andreas Printzlau, MD
Luxembourg	Serge Schmitz, MD

We thank the outgoing NSs for all their hard work over the last four years. 

Have you submitted your data yet?

Global statistics on the number of aesthetic procedures performed are difficult to determine — and requested all the time. ISAPS is the only organization in the world that undertakes an annual study of this information. Please send us your data and help us provide the most accurate information we can.

The link to the one-page survey is: www.iisecure.com/ISAPS/survey.asp



Global Survey

GLOBAL SURVEY REPORT

David Daehwan Park, MD – Korea

Chair, Ad Hoc Survey Committee, ISAPS Assistant Chair of National Secretaries



Collection of data for the ISAPS Global Statistics Study for procedures in 2014 began on January 8, 2015. We expect to have results ready by June. The information generated from these annual surveys is important to all plastic surgeons, the international press, industry and the public. The international media eagerly awaits our results.

Our committee is composed of eight members including me. They include: the chair of the Communications Committee, Arturo Ramirez-Montana (Mexico); ISAPS Board Member Sami Saad (Lebanon); two members of the Industry Relations Committee, Grant Stevens (USA) and Wayne Perron (Canada); and Asian members Yuzo Komuro (Japan), Sufan Wu (China), and Yong-ho Shin (Korea).

The company charged with collection and analysis of the data, Industry Insights, is the same. They have refined the survey questions based on what we learned last year. In head and neck cosmetic surgery, for example, fat grafting and facial bone contouring are important procedures;

however, these were omitted in previous surveys and have been added. Chin augmentation is also included under facial bone contouring procedures.


A very important issue is how to increase participation. Our survey analysts tell us that 30 responses per country is sufficient for the data to be statistically valid. In some countries, surgeons customarily under report their procedural information to their government which means that they simply ignore our survey. Group emails from ISAPS are systematically blocked by powerful spam filters in some countries.

Our committee encourages sending all plastic surgeons e-mails in their country to ISAPS where this is permitted. We also encourage national secretaries to send the survey again to ISAPS members in their countries from their own email address to avoid these distribution problems. Asking national societies to forward the survey to their members will also help us.

We will focus on East Asian countries this year as China, Japan and Korea are

very strong in cosmetic surgery with many patients and procedures. China, Japan and Korea could be in the top ten in the world in the number of cosmetic surgical procedures; however, China, Japan and Korea were excluded from last year's survey because their response rate was too low to provide valid statistics.

Survey Committee members will contact via telephone or e-mail our friends, colleagues, graduates, and fellows in Korea, Japan and China and in other Asian countries using our network to encourage participation. We urge all national secretaries and survey committee members to help us generate much higher response rates in their respective countries.

Finally, our committee wants all ISAPS members to use personal e-mail and telephone to encourage their friends, colleagues, graduates, fellows and all plastic surgeons in their country, including non-members, to respond to the ISAPS survey. The link to the one page survey is: www.iisecure.com/ISAPS/survey.asp Thank you very much. 

ISAPS PATIENT SAFETY SURVEY

Lokesh Kumar, MD – India

ISAPS Board Trustee, Acting Chair, ISAPS Patient Safety Committee



ISAPS recently circulated a survey to all National Secretaries asking their opinion about issues pertaining to patient safety in their country. Sixty-one (75%) National Secretaries responded. The results are included here.

- 54 report that plastic surgeons are required to be board certified in their countries. 7 said no.
- 43 said that re-certification is not required, 17 said that it is. Frequency of re-certification varied from 1-10 years, with the majority reporting that recertification is required every five years.

■ 26 responded that malpractice insurance is required as a condition of licensure, while 34 said it was not.

■ 48 said that hospital privileges are not required as a condition of practicing plastic surgery; 13 said that they are required.

■ The majority reported that surgeons practice in private surgical clinics, while half mentioned that surgeons in their country also practiced in third-party surgical clinics.

■ 35 reported that surgeons must operate in an accredited facility. 24 said that this is not required.

MEMBERSHIP COMMITTEE REPORT

Ivar van Heijningen, MD – Belgium

ISAPS National Secretary for Belgium and Membership Committee Chair



Since meeting during the Congress in Rio in September, we have created a Membership Committee Team to address all issues with respect to membership. We organized the team in such a way that each of us oversees a continent. James Grotting (US) was kind enough to oversee North America; Maria Isabel Cadena (Colombia), South America; Sufan Wu (China) addresses issues in Asia and Australia; and Bouraoui Kotti (Tunisia) covers Africa and the Middle East. As Chair, I will cover Europe. Ex officio members Catherine Foss, our Executive Director, and Peter Scott (South Africa), the Chair of National Secretaries, complete the team.

During the board meeting held in Rome in November, changes over the last year and current membership status were reported. Of 2,843 current members,

2,473 are *Active*, 178 are *Associate*, 186 are *Life* and 6 are *Honorary*. The growth was steady over the last months with an average of 35 new members per month. The procedure has been improved to admit applicants on a monthly basis and we now archive applications that have not been finished within a year. The fast track procedure allows countries to admit larger groups of pre-selected members of an Aesthetic Plastic Surgery Society saving the cost of the application fee. This has worked well.

After discussion in the board meeting, it was decided that membership in multiple countries is **not** allowed. Members are free to work in more than one country, but they must choose under which country they want to be listed and pay only one membership fee.

A survey on the issue of affiliate membership showed that members welcome presenters from other specialties, but prefer to reserve membership for plastic surgeons. Growth of our membership should come more from the younger generation, so promoting Associate Membership for those in training and just finished is a priority. Internet modules for e-learning (e.g., webinars, video streaming of courses) need to be developed and senior members are encouraged to be open to contacts from the younger generation.

CME accreditation of ISAPS courses and the ISAPS biennial congress is a goal for the future so we can offer these credit points to surgeons from countries that need them to maintain their registration.



Membership changes?

ISAPS has been a plastic surgeons' society from the beginning. But 44 years ago we were basically the only specialty doing procedures to enhance the aesthetics of the human body. We have devoted ourselves to training plastic surgeons to be the best aesthetic surgeons in the most ethical way possible with a focus on patient safety.

Things have changed, whether we like it or not. Other specialties have embraced aesthetic procedures and the majority of these procedures are no longer surgical. Besides, other specialties' non-core doctors are doing aesthetic procedures and even a lot of non-doctors, nurses being the best of these. We may not like it, but it is the reality.

Now, we can hang on to the fond memories of the good old times and hope that they return, or we can face reality and acknowledge that others are out there and embrace the best of them.

If we wish to continue to lead in the field of aesthetic procedures, then we must acknowledge that dermatologists in general do better Laser treatments than most of us, that many ENT

surgeons do good rhinoplasties, and that there are maxillofacial surgeons who achieve amazing aesthetic results with midface advancements.

Having said that, what are our options?

1. Remain a plastic surgeons only society, with teaching done by plastic surgeons only;
2. Remain a plastic surgeons society only, but allow some experts from other specialties to teach us;
3. Allow other specialties to become members of our society;
4. Allow everybody with an interest in aesthetic treatments to join our society.

Now option 4 is clearly unacceptable, with worldwide endangering of patient safety as the result of non-core doctors who do procedures without any training and we are clearly not going to teach them. But we do want to be the gold standard—a society that the best aesthetic surgeons aspire to join.

We have already let go of option 1 and said that we will allow other specialties to teach us. So will it just be that (option 2), or are we opening our doors wider?

Let us consider option 3 seriously for a moment.:

- ▶ We can attract the best from other specialties as faculty;
- ▶ We gain knowledge in areas that are less core plastic surgery: i.e., non-surgical medical treatments and teach that better;
- ▶ We will have more submissions for our journal, *Aesthetic Plastic Surgery*;
- ▶ We can continue to lead the way in aesthetic procedures;
- ▶ We can emphasize Patient Safety and Ethics across specialties;
- ▶ We will have more reach for our courses and congresses;
- ▶ We will stand stronger when creating Standards and negotiating with governments.

From my work on the European Standard for Aesthetic Surgery Services, I have learned that we are not the only ones doing good aesthetic procedures. I still think we are best placed, but our number is limited, especially where non-core doctors are concerned, so we might be better off to join forces with core-specialists who at least had well defined and proper training. We can form a front with them and still hold the key position if we start it.

In fact some of our members are non-plastic surgeons doing only aesthetic plastic surgery; some of them are double and triple-boarded; and some of them are faculty in our courses and very well respected.

Considering all these arguments, the board issued a survey to consult its members. The majority opted for option 2.



REPORT OF THE AD HOC COMMITTEE ON PUBLIC RELATIONS

Dirk Richter, MD, PhD – Germany

ISAPS 1st Vice President



The ad hoc public relations committee was inaugurated at the last meeting of the Board of Directors in Rome, December 2014.

The aim of this committee is to analyze the current situation of ISAPS in terms of public relations, marketing, branding and corporate identity to be sure that it meets the needs of our membership.

We already completed a detailed survey among the committee members asking about the past, present and the possible future situation.

As an international society, the requirements for public relations are challenging and need to be addressed. Social media has been identified as a promising tool especially to maintain contact with the younger generation of plastic surgeons and to inform patients about ISAPS activities and aesthetic surgery in general in order to increase the visibility of our society.

Currently, we are analyzing the experiences of our national societies and what has worked best for them. With these results we will implement potentially good ideas into new concepts of our marketing strategy.



WAPSCD, continued from page 9

day. Everyone was exhilarated and chatting joyfully and having fun going around shaking hands and proposing toasts (Figure 4).

New in the organization of this 4th Congress was that it was no longer hospital based. The then president of the society, Dr. David SY Wong, now Chief of Plastic Surgery at the Chinese University of Hong Kong, decided that the HKSPRAS would draw on more people with capabilities and foster a stronger sense of unity amongst local colleagues. The call was further extended to the Hong Kong Association of Cosmetic Surgery, the surgical departments of the two universities, and the College of Surgeons of Hong Kong as co-sponsors. That laid the foundation for the organization of an event truly on an international scale.

Coordination and liaison went to the



Fig. 4 Delegates celebrating at the Faculty Dinner

international advisory committee. This consisted of Professors Yilin Cao, David T.W. Chiu, Shuzhong Guo, Lee L.Q. Pu and Fu-Chan Wei. Professor Pu, from the University of California, Davis, in particular, deserves credit for being instrumental in helping with the contacts of many surgeons, arrangements with societies and publishers, and advising on marketing strategies.

The two-yearly Congresses of the WAPSCD have evolved into regular opportunities for re-union of brothers and sisters of Chinese descent and friends and colleagues of other races. The warm friendship and sincere atmosphere are aspects distinct to these meetings and have certainly given participants a sense of homecoming and reunion.

The next Congress will be held in Chengdu in conjunction with the annual meeting of the Chinese Society of Plastic Surgeons from October 13 to 16, 2016. We are planning to invite another ISAPS professor to our congress and welcome plastic surgeons of Chinese descent or all races from all over the world to attend another magnificent scientific forum of international plastic surgery. Please stay tuned for updates.



ISAPS INSURANCE CHANGES ARE COMING!

Jose Carlos Parreira, MD – Portugal

Chair, ISAPS Insurance Committee



Every year, the ISAPS Insurance scheme has seen positive changes and this year is no exception. The insurance is being split into two types of cover as shown below:

ISAPS Revision Cover

Revision cover is for any ISAPS member surgeon to use and no application is necessary. Each surgeon will be contacted to ask if they would like to use the scheme.

Following a surgical procedure, if the patient needs a revision procedure, this will be available at no extra cost to them. The patient and premium amount chosen must be declared for cover before any complications have been diagnosed. The ISAPS member surgeon will then be invoiced for the premiums. The cost of this cover may be passed on to the patient and a personalized guarantee is created for each ISAPS member surgeon. This guarantee is for the surgeon to present to the patient so that the patient knows they are covered for up to 24 months post surgery.

The insurance premium for this cover is being reduced as the claims on the current scheme have been below expected levels.

ISAPS Cross Border Revision Cover

Similar to the scheme outlined above, this version has the added benefit that the patient may be treated once back in their own country by another ISAPS surgeon if remedial treatment is necessary following a complication. The insurance premium for this cover will be higher than the basic revision cover due to the additional benefits being offered.

The launch of these new types of cover will be within the next few months and each member surgeon will be provided with all the necessary information.

In the meantime, should you have an enquiry or wish to cover a patient, please contact Stephanie@isapsinsurance.com or telephone 0044 207 374 4022 in our London office.



ISAPS Insurance Committee

Jose Carlos Parreira, Portugal – Chair
Gianluca Campiglio, Italy
Alison Thornberry, UK – Ex officio

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

Where in the World?



See page 51 for the answer.

MCH (AESTHETIC PLASTIC SURGERY PRACTICE)

Professor James D. Frame, FRCS, FRCS(Plast)

Consultant Plastic Surgeon, Anglia Ruskin University, Chelmsford, UK

Dr. Ruth Jackson

Pro Vice Chancellor and Dean of Faculty of Medical Science

Director of Postgraduate Medical Institute, Anglia Ruskin University, Chelmsford, UK



Fully-trained and accredited plastic surgeons are able to practice aesthetic surgery within the independent sector with medical indemnity insurance, but are increasingly aware in the early period of their consultancy of a need for supervised specialist training in aesthetic and cosmetic surgery.

The majority of aesthetic procedures performed in the UK now occur in the private sector. There is therefore an obvious deficiency in aesthetic surgery exposure during basic plastic surgery training within the National Health Service. This has also been recognized in the United States, but many other countries have had a similar experience. It is difficult for newly-qualified surgeons to fully understand the needs and demands of patient groups to which they have had limited exposure. Whilst many of the skills in their surgical training programs are transferable, there are distinct differences which must be acknowledged.

For example closing a DIEP flap donor is unlike closing a Brazilian abdominoplasty where the seroma complication rate should approximate zero percent, but sadly it is nearer 20%. Similarly, removing a basal cell carcinoma from a lower eyelid or nose and closing a related wound would not necessarily impart the full skill set required to understand a blepharoplasty or rhinoplasty.

Medical indemnity insurance companies have been very slow to demand evidence of training in cosmetic surgery and the resultant collective legal framework of risk assessment is important in their overall calculation of premiums for surgeons. Consequently plastic surgeons pay premiums calculated on a collective risk that includes non-plastic surgeons who may pay very low premiums because they don't necessarily declare their whole practice. The difficulty is that plastic surgeons can't prove that they are any more trained or get better outcomes with lower complications than other specialties or indeed non-medical people who have attended weekend workshops and gained certificates of competency in injectable fillers and botulinum toxin. This quite simply is because plastic surgeons rarely generate data on comparative outcomes nor routinely provide data on complications or outcomes to the public.

It is precisely for reasons of patient safety that UKAAPS, ISAPS and the Anglia Ruskin University have recognized the importance of tailoring a qualification in aesthetic surgery with a plastic surgeon's ambition to develop aesthetic surgery skills and marketable practice. A plastic surgeon declaring a qualification in a super-specialty interest gives the patient the opportunity to identify practitioners that demonstrate evidence of prolonged pro-active hands-on training specifically in cosmetic surgery and non-surgical procedures.

Whilst plastic surgeons can specialize in cleft, burn, hand, or oncological breast surgery to the exclusion of others, then it is interesting that the 'super-specialty' of aesthetic surgery is not similarly recognized and supported. This is an integral limb of the ISAPS Patient Safety Diamond that was so elegantly presented to the ISAPS membership by our esteemed Past President, Professor Foad Nahai. Certification with validated evidence of supervised practical hands-on training and oral examination in 14 aesthetic competencies is a module within the Masters in Aesthetic Surgery Training program (MCh) developed from the collaborative efforts of the UK Association of Aesthetic Plastic Surgeons (UKAAPS) and the Department of Allied Health and Medicine at the Anglia Ruskin University. The full MCh training program of 180 credits has Fellowship Program Endorsement by the Education Council of the International Society of Aesthetic Plastic Surgery (ISAPS).

The Fourteen Compulsory Aesthetic Procedures Are:

1. Breast Augmentation
2. Mastopexy
3. Mastopexy/Augmentation
4. Breast Reduction
5. Liposuction
6. Blepharoplasty
7. Facelift
8. Innovative Procedures – e.g. I-Guide Neck Suture Suspension, Suture Suspension, Browlift, Gynaecomastia, and Buttock Implants

9. Abdominoplasty
10. Thigh Lift
11. Inner Arm Reduction
12. Autologous Fat Transfer
13. Rhinoplasty
14. Non-Surgical Aesthetics – i.e., Botulinum Toxin, Fillers, Skin rejuvenation and injection liposculpture

This is a validated university course and candidates are assessed on their ability to analyze a patient's psychology and perceptions before deciding upon a course of action, then proceeding to supervised surgery, and finally reflecting on the outcome. This evidence is recorded in a standard form that is reviewed by a university appointed panel of expert academic plastic surgeons. The program is designed to demonstrate and train plastic surgeons to perform safe, low risk surgery, but great importance is placed on careful patient selection and being able to say no. The examiner's role is not just to assess their ability and understanding of the common aesthetic procedures, but to also look for evidence of:

1. The trainee's concept of informed consent for surgery;
2. Identifying the relevance of proper photographic consent;
3. Careful patient selection;
4. The ability to seek advice and support from colleagues.

A main attraction to the plastic surgeon participating in this course is the exposure to a complete range of aesthetic procedures with demonstrations, assisted and supervised independent surgery and critical review by appointed preceptors. Both the supervised surgeon and indirectly the training preceptor are ultimately examined at the oral Viva examination after sign off from the competencies. The oral Viva exam is split into two one-hour sessions describing cases representing each of the fourteen competencies. The first seven competencies being assessed are preselected by the examinee and the final seven competencies are assessed

either from the candidate's own remaining cases or cases introduced by the examiners. These could include the management of complications.

The 2014 Examinations

This year there have been two certification Viva examinations held at the Postgraduate Medical Institute, Anglia Ruskin University in Chelmsford.

The examiners on these occasions were Professor Neil McLean, Consultant Plastic Surgeon, Hexham, Newcastle; Mr. Niri Niranjani, Consultant Plastic Surgeon, Anglia Ruskin University; Professor David Smith, Chief of Surgery, Plastic Surgeon, Florida; and Professor James Frame, Plastic Surgeon, Anglia Ruskin University. The candidate's training instructor is permitted to observe the Viva examination, but is not permitted to ask questions. Mr. Paul Levick, Consultant Plastic Surgeon, Birmingham, attended the most recent Viva in this capacity. Both candidates succeeded in passing the examination.

The examination process has adapted to lessons learned from previous examinations. It is important to note that the final examiners have no responsibility as preceptors in the training or 'signing off' on the trainee's competency portfolios. The examiners were therefore also in a position to critically review the trainers "sign off" for the fourteen competencies.

The exam is two hours in total and with fourteen competencies, each subject is discussed in just under nine minutes. A pre-Viva discussion of over two hours between the examiners on the presentation of the candidate's workbook assists in the process by honing in on specifically related questions. The candidate's name has been omitted and the closed marking system per competency examined is: 50% is a pass, 51% is a good pass, 49% is a fail mark that can be neutralized by a good pass on another competency and 48% is a straight fail that cannot be compensated and a retake exam may be offered.

Provided that no 48% per competency scores are recorded, then an average of 50% for competency subjects must be achieved for a pass. A certificate is awarded to successful candidates. Further credits are required for the award of a diploma, but this can often be achieved from previous academic study. The MCh is awarded to candidates that submit an academic dissertation on a related aesthetic subject. Topics selected to date include aesthetic procedures to hands, capsular contracture and problems related to breast implants.

The Anglia Ruskin University is proud to have developed this program. It is reflective of good aesthetic working practice and by certification, allows patients the means to identify that a plastic surgeon has undergone additional voluntary training and passed a rigorous assessment in cosmetic surgery, putting themselves above others. This program is also already working in Dubai with UKAAPS and ISAPS member plastic surgeon Jaffer Khan as training instructor and it is likely to be offered in Mumbai in 2015 with UKAAPS/ISAPS member plastic surgeon Shailesh Vadodaria as training instructor. These surgeons are members of the faculty of the Anglia Ruskin University. The ambition is that this course be sufficiently internationally flexible to develop in any ISAPS member country in association with Anglia Ruskin University. Of course EU qualified plastic surgeons have a right to practice in the UK and thence join the UK training program, but for non-EU plastic surgeons and those from more remote countries, the course can be adapted to run from their home country. The facility, care pathways and trainer surgeons must be thoroughly assessed by prior visits from the university before granting training status. A British university degree still has value and respect.

Plastic Surgeons interested in participating in the scheme, either as trainees or as preceptors, may contact Mr. Roger Acres, Course Supervisor and Lead, Anglia Ruskin University, Roger.Acres@anglia.ac.uk

THE ROAD TO KYOTO: TWO FESTIVALS ON OCTOBER 22ND

Susumu Takayanagi, MD – Japan

ISAPS President



On October 22nd you will find Kyoto tremendously crowded having two well-known festivals on the same day: *Jidai Matsuri* during the day and *Kurama-no-Himatsuri* (Fire Festival) in the evening. The ISAPS Congress will begin immediately after these festivals. If you are interested in taking this opportunity to enjoy them, you are strongly advised to make your hotel reservations early. Our headquarters hotel will be the Westin Miyako Hotel.

Please note that both festivals will be held on the next day if it rains. For inquiries, contact the JTB Western Japan Corporation ISAPS 2016 desk at westec_op2@west.jtb.jp

Jidai Matsuri

This festival includes several related events of which the most famous is the costume parade. Approximately 2,000 people



in ancient Japanese costumes, beginning with the late 8th century and ending with the late 19th century, parade in the streets in Kyoto City. Paid seats for the audience are provided, but these are no more than plain fold-

ing chairs that allow people to secure a place to seat themselves among a huge crowd. The seats are supposed to be in *Kyoto Gyoen National Garden* (Kyoto Imperial Palace), *Oike Street* and *Heian Jingu-michi*, where the beginning of the costume parade is expected around 12:00, 13:00 and 14:20 respectively. The entire parade takes about two hours. The paid seats are all reserved with advance booking required. To make a reservation, contact <http://www.jtb.co.jp/shop/itdw/info/e/>

The parade consists of twenty groups representing different eras in the history of Japan. The group representing the latest era is in the lead, and the oldest era is at the end. The two most popular groups are the medieval ladies and the ladies of the Heian period in which a number of legend-



ary women are represented. Roles of renowned beauties such as *Yodo-gimi* and *Shizuka-gozen* are played mainly by apprentice geisha girls (*Maiko*) from the entertainment quarters of Kyoto. They fascinate the audience with their beauty in the proudest moment of their lives. www.heianjingu.or.jp/english/o3o1.html

Kurama Fire Festival

To attend the *Kurama Fire Festival*, you are advised to take a train of the Eizan Electric Railway ahead of time. Toward the end of *Jidai Matsuri*, there will be a growing crowd around several Eizan-train stations.



This is a solemn shrine ritual performed on a mountain that is about 50 minutes by train from the center of Kyoto City.

Despite the inconvenience and danger often found at this event, the Kurama Fire Festival attracts a lot of tourists every year, perhaps because of the mysterious wooden torches blazing up in the darkness.

There is a series of movies called *Kurama Tengu* including a film titled *Kurama-no-Himatsuri* in the last eight minutes of which the Kurama Fire Festival is featured. The film was produced over 60 years ago and *Kurama Tengu*, a masked swordsman, became a very popular hero. You can find a short video

extracted from the film on the internet, using search words: *Kurama Tengu* and *Himatsuri*.

At 18:00, a bonfire called *Eji* is built in front of each house in *Kurama*. About 21:00, people with wooden torches gather around the gate of *Yuki Shrine* leading to a ritual called *Shimenawa-kiri* (cutting of *Shimenawa*, a sacred straw rope). This is the highlight of the festival which tourists don't want to miss. After this, visitors get ready to go home. However, it is after the end of this part that two sacred palanquins (*Mikoshi*) show up to be carried around the festival area.

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INTERNATIONAL SOCIETY OF
AESTHETIC PLASTIC SURGERY

ISAPS 2016 Kyoto, JAPAN

23rd CONGRESS

in conjunction
with

The 39th Annual Meeting of Japan Society of
Aesthetic Plastic Surgery (JSAPS)

October 23-27, 2016

Venue: Miyakomesse, Kyoto, JAPAN

www.isapscongress.org

ISAPS VISITING PROFESSOR IN HONG KONG

Foad Nahai, MD, FACS – United States

ISAPS Past President



I was deeply honored and delighted to be invited to Hong Kong as a plenary lecturer for the 4th Congress of the World Association for Plastic Surgeons of Chinese Descent and as ISAPS Visiting Professor at both the University of Hong Kong and the Chinese University of Hong Kong.

After a very long, almost 24-hour, but pleasant journey from Atlanta I arrived in Hong Kong at 10 pm on a Monday night. Even at that time of night, during the ride to the hotel I was introduced to Hong Kong traffic. Wide awake and looking forward to my stay, I saw evidence of the amazing growth since my last visit several years ago. New construction of high rises, roads, and the new underground train system were all too evident. To my surprise, so were Christmas decorations in early November! The vitality and hustle and bustle of Hong Kong we all love was unchanged and all around.

After a comfortable first night, I woke up to the view of Hong Kong Island across Victoria Harbor from the hotel room — a magnificent view, which I could not enjoy for too long as I had to prepare for the busy day ahead. The morning to be spent with Dr. Joseph Hon Ping Chung, Dr. George Li, their trainees and staff at the University of Hong Kong St. Mary's hospital and the afternoon with Dr. David S.Y. Wong, his staff and trainees at the Chinese University of Hong Kong Prince of Wales Hospital across town.

At St. Mary's, perched high on the mountain side, I made rounds with the group who presented a number of challenging cases. I was not only impressed with the complexity of the cases and their treatment, but also

the magnificent view from the patients' rooms, with the green mountains on one side and the sea on the other. After the "ward rounds" I presented a formal lecture on "Contemporary Blepharoplasty." After the discussion that followed the lecture, the faculty and I left for lunch at the Hong Kong club hosted by Dr. Gordon Ma where we were joined by our ISAPS National Secretary Dr. Ming Shiaw Cheng. After lunch, Dr. Wong and I left for the Prince of Wales hospital across town, a long drive through Hong Kong's traffic which was heavier than expected due to the students' "occupy central" activities.



Staff at St. Mary's



Staff at Prince of Wales

Arriving later than planned at the Prince of Wales, we went straight into the conference room. The afternoon was spent on case presentations in aesthetic surgery. I was impressed and pleased to see the level of interest in the aesthetic cases that were presented.

That evening's lecture and dinner was held at the Hong Kong Golf Club, a beautiful facility with lush gardens. Members of the Hong Kong Society of Plastic Surgeons, staff and trainees from both hospitals were in attendance. I presented a lecture entitled "The Role of Evidence-Based Medicine in Aesthetic Surgery" followed by lively discussion and a multi-course dinner.

After a day of touring Hong Kong, arranged by my hosts with Dr. Josephine Mak as our guide, it was time for the 4th Congress of the World Association for Plastic Surgeons of Chinese Descent. I was again

humbled and honored to be asked to present a plenary lecture at this prestigious meeting.

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Congress, continued from page 18

Around 23:15, the sacred palanquins arrive at *Otabisho*, the destination of the *Mikoshi* procession. This arrival is called *Miya-iri* — *Mikoshi's* entrance into precincts of a shrine — and followed by a performance of *Kagura* (music and dance in dedication to Shinto Gods). At the Kurama station, after 22:30 you can get on a train without a long wait. The last train leaves from the station around 0:20.



Kurama is a very small town and its main road is quite narrow. On this road, people with more than 100 wooden torches go back and forth on the night of the festival, and over 10,000 tourists are expected to come to see them. As it is more than 5°C colder in Kurama than in Kyoto City, you should wear something warm, but

make sure to choose flameproof clothes. Also, be aware that your clothes may get soot-blackened during the festival. Another thing to note is that it is hard to find restroom facilities in the festival area.

Although there are both spas and Japanese inns in Kurama, it is difficult to make a room reservation during the period of Kurama Fire Festival because of the limited number of accommodations. It is recommended that you make a one-day trip to Kurama, to take a train or a taxi (advance reservation required) at the best possible time when the crowd is supposed to be smaller, and to walk in areas where taxis cannot enter. To be honest, I have never seen this fire festival because there are so many people and it is not easy to go and come back from Kurama — even though I was born and grew up in Kyoto.

ISAPS ESTABLISHES GLOBAL ALLIANCE PARTNERSHIP

In an effort to unite all Aesthetic Plastic Surgery Societies into an international working group, ISAPS has begun the process of inviting our colleagues to work together on common issues.

Agreements have been signed by six societies already, while others are waiting for their boards to approve. Benefits to our Alliance Partners include public relations collaboration, mutually planned and implemented educational programs, affiliation with *Aesthetic Plastic Surgery*, visibility in *ISAPS News*, fast track group admission of new members, and a forum of alliance partners at each biennial ISAPS Congress. Additional benefits and strategies to benefit all members of the group will emerge over time.

Alliance member logos will appear on the ISAPS website soon.



ISAPS Global Alliance Participating Societies

- Associazione Italiana di Chirurgia Plastica Estetica (AICPE)
- Australasian Society of Aesthetic Plastic Surgery (ASAPS)
- European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
- Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
- Svensk Förening för Estetisk Plastikkirurgi (SFEP)
- United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)



ISAPS Board of Directors Meeting – November, 2014 – Rome, Italy
Board members and Committee Chairs
Front row: Gianluca Campiglio, Tom Davis, Nazim Cerkes, Susumu Takayanagi, Renato Salts, Carlos Uebel.
Back row: Peter Scott, Ivar van Heijningen, Lokesh Kumar, Tunc Tiryaki, Lina Triana, Kai Schlaudraff, Catherine Foss.

PSYCHOSOCIAL ASPECTS OF MINIMALLY-INVASIVE PROCEDURES

David B. Sarwer, PhD – United States

Professor of Psychology, Departments of Psychiatry and Surgery
Consultant, The Edwin and Fannie Gray Hall Center for Human Appearance
Perelman School of Medicine, University of Pennsylvania



Over the last several decades, a now relatively large body of research has investigated the psychosocial characteristics of individuals who present for aesthetic surgery. Many of these studies have been undertaken with the larger goal of identifying patients who may be experiencing psychological symptoms or conditions that would contraindicate surgery. While some degree of psychological distress likely motivates the pursuit of an aesthetic surgical procedure, excessive distress or profound psychopathology might contraindicate a procedure at a given point in time. Other studies have focused on the psychosocial changes that occur following aesthetic surgery. Many of these studies have documented improvements in body image and self-esteem in individuals who have undergone the most common surgical procedures, such as cosmetic breast augmentation.

In contrast, surprisingly little is known about the psychosocial characteristics of the millions of individuals who present for minimally-invasive aesthetic treatments. Concerns with changes in facial appearance associated with aging likely motivate the pursuit of minimally-invasive treatments. At the same time, excessive concern and body image dissatisfaction may suggest the presence of body dysmorphic disorder (BDD), generally defined as a preoccupation with a slight or imagined defect in appearance and that is associated with marked distress or impairment in social, occupational, or other areas of functioning.¹ While BDD is believed to occur in 1-2% of the general population, the rate among aesthetic surgery patients has been found to range from 7-21%.² A recent study of dermatological surgeons found that 94% were aware of BDD in their patients and 62% indicated that they refused to treat a patient believed to have the disorder.³

Is there a compelling reason not to treat patients with BDD? More than 90% of individuals with BDD who report undergoing appearance-enhancing medical treatments experience no improvements in their BDD symptoms.⁴ These patients also may be the ones most likely to threaten or actually



enact legal action or violent behavior directed toward their treating physician. In a 2002 survey, almost one-third of aesthetic surgeons reported that they were threatened legally by a patient with BDD; 17% reported that they had been threatened physically.⁵ Almost two-thirds of dermatological surgeons considered BDD to be a contraindication to a facial aesthetic procedure.³

Putting the issue of BDD aside, is there evidence to suggest that patients experience psychosocial benefit from aesthetic procedures of the face? While some procedures, such as rhinoplasty, can profoundly impact facial aesthetics, minimally-invasive procedures often produce subtle and temporary changes to discrete aspects of the face and which may not be readily observable to others. Along with colleagues in the Department of Dermatology, Division of Plastic Surgery and Center for Human Appearance at the Perelman School of Medicine at the University of Pennsylvania, we recently reviewed this literature in an article published in *JAMA Dermatology*.⁶ We found a number of studies have documented improvements in psychosocial functioning following facial aesthetic procedures in general, but we also found a lack of evidence for these changes after specific procedures. The most common procedures — including botulinum toxin and soft tissue augmentation — have the least data suggesting changes in psychosocial functioning.

An unanswered question at this point is how do minimally-invasive procedures impact psychosocial well being. One potential explanation is that patients who undergo these procedures experience improvements in their physical appearance that subsequently enhance their mood, self-esteem, and body image. The improvements in appearance, no matter how subtle, may allow the patient to feel more comfortable and less self-conscious in social interactions, thereby enhancing mood and body image. Another potential explanation comes from the facial feedback hypothesis. The hypothesis, which has a long history in the area of the psychology of emotions, suggests that muscular manipulations that result in more positive facial expressions may lead to more positive emotional states. For exam-

ple, an individual who forces herself to smile in response to visual stimuli will rate the stimuli more favorably. Other research has suggested that restricting the movement of facial muscles associated with the expression of negative emotions, such as anger or sadness, also can have a positive impact on mood.

This is particularly the case for neuromodulators such as botulinum toxins. Botulinum toxin injections can reduce negative facial expressions and may have a secondary effect of reducing the internal experience of negative emotions. At the same time, some preliminary evidence suggests that botulinum toxin injections may improve depressive symptoms in those with a history of depression.⁷ This is a particularly intriguing finding. Clearly, additional research of this issue, as well as research on other minimally invasive facial procedures, is needed to help us understand the psychosocial benefits that accompany them.

The author has no financial relationship with the manufacturer of any product mentioned in this article.



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CEN, continued from page 6

the importance of this comprehensive European Standard, which was developed through an open, inclusive, multi-disciplinary and evidence-based process."

Speaking on behalf of ANEC, Stephen Russell, ANEC Secretary-General, says: "ANEC welcomes the publication of EN 16372. ANEC sought the inclusion of consumer relevant requirements in the standard during its development and we consider the standard satisfactory from the consumer perspective. Promoting consistently high standards for aesthetic surgery service providers across Europe is increasingly important, as more and more consumers travel abroad for aesthetic treatment."

According to Mr Russell, the new European Standard (EN

16372) could help offer assurances to consumers in countries where there are no legal requirements in this area.

The CEN Project Committee on 'Aesthetic surgery and aesthetic non-surgical medical services' (CEN/TC 403) is currently developing a separate European Standard in relation to non-surgical medical procedures (prEN 16844). CEN Members will open public enquiries in order to invite comments on this draft standard (these enquiries are due to be launched at the end of February 2015).

For more information on European standardization in relation to services, please see the CEN website:

<http://www.cen.eu/work/areas/services/Pages/default.aspx>



REPORT FROM THE JOURNAL EDITOR

Henry M. Spinelli, MD – United States

Editor-in-Chief, *Aesthetic Plastic Surgery*



On behalf of the staff at *Aesthetic Plastic Surgery* (the blue journal) I would like to thank its readers, authors and reviewers for their continued support. We are very excited about the current state of the journal, which has grown significantly over the past five years under my leadership as Editor-in-Chief thanks to the efforts of many people. In partnership with our publisher, Springer, we have greatly altered the journal since my taking over the helm.

Recently, we had an important meeting in New York City attended by the chairman of the Journal Operations Committee, Renato Saltz, and our President, Susumu Takayanagi. Key representatives of Springer explained the intricacies and complexities of operating and publishing an international journal and an interactive, fruitful discussion was engaged in by all of us.

I would like to underscore changes in our journal which have occurred and what we are planning in the future. Many, if not most, of the changes we have undertaken seem to have been unnoticed or, as Springer executives pointed out, have occurred behind the scenes. In that respect, the meeting in New York City was very valuable. Furthermore, it gave both Springer and me an appreciation of the direction of our society. This will enable us to measure if the journal is improving accordingly, within the context of quality peer review and integrity of the content.

Aesthetic Plastic Surgery (APS) is larger and more diverse than ever. One only has to peruse old issues to notice the profound changes.

We have introduced independent double-blinded peer review for the first time. Evidence-based medicine (EBM) has been fully integrated into our journal. In fact, ours is only one of five journals in the Springer family of over 700 journals that utilizes this metric. Our proprietary watch glass icon and numeric scale allows the reader to immediately see the level of cogency of an article. The description of levels of evidence (I-V) has been provided to authors, reviewers and readers.

The EBM levels were incorporated into the submission process and countless hours of altering and instituting many other changes to the online submission process instituted during my tenure, in concert with the Springer group to ensure a fair, objective and timely review process.

We completely changed our editors to represent most specialties including dermatology, ophthalmology, urology, gynecology, statistics, law, ethics and basic science, to name a few. In fact, APS was significantly ahead of the ISAPS initiative to introduce other specialists beyond our core plastic surgeons into our society's family.

The page count of each issue was increased by 40%. In keeping with our modern times, APS is fully accessible digitally using the ajax app instituted over the last year. Likewise, all issues are accessible to members in the Member Area of our website.

What are the results of just a few of these changes?

- The number of submissions has doubled and yet the turnaround time is at a record low. Selectivity has profoundly increased with fully 75-80% submitted papers rejected.
- The number of active recognized reviewers who have definitive expertise and interest has easily tripled. These dedicated men and women are from all corners of the world.
- Submission downloads of our published articles is fully international and in geographically in keeping with our society's membership.
- Manuscripts are routinely downloaded equally in North and South America, Europe and Asia. We are seeing more African continent participation as well.
- APS has generated record revenues for this publication to ISAPS and Springer.

These and many other changes have been laboriously instituted resulting in a quality publication and the results delineated above. In the future, Springer will be providing us with data concerning articles which were highly cited and/or downloaded in the recent past that we will share with you. Upcoming articles that are of special interest to us in the editorial office will also be highlighted for the readership.

We at the editorial office are never satisfied with the status quo and we are actively listening to our readership and membership for suggestions. Members have already been sent a reader survey to determine their opinions of the journal to help us make any needed adjustments. Authors will also be polled in due course.

At the New York meeting, we noticed that the Aims and Scope of the journal are out of date and will be updated reflecting the goals and aspirations of the society, but in keeping with the purpose of a peer-reviewed journal.

Finally the success of APS can only be assured by the active participation of the ISAPS board and the membership. Certainly challenges will arise, given the dual allegiances and obligations of many of our board and society members.

Our society and the journal have enormous strength and we can capitalize on these together. I look forward to working with the Journal Operations Committee and our esteemed president.



REPORT OF THE 2015 JOURNAL RETREAT

Renato Saltz, MD – United States

President-Elect and Chair, Journal Operations Committee



Our journal has a powerful and dedicated team working behind the scenes to produce our six annual issues. It is the responsibility of the Journal Operations Committee (JOC) to work as liaison among the publisher, the editor and the board. Once a year, a meeting is arranged by the publisher to review strategy and to inform the JOC about progress and to plan for the future. This year, the Journal Retreat was held in the New York offices of the publisher on January 30 and attended by Editor-in-Chief, Hank Spinelli; President, Susumu Takayanagi; Springer Vice President, Bill Curtis; Springer Publishing Editor, Victoria Ferrara; Springer Executive Editor, Antoinette Cimino; Executive Director, Catherine Foss, and me.

The day-long meeting provided many insights regarding operations governing our journal and also showed in several ways the strength of our major publication and primary member benefit. We came away with a new understanding of the complexities of producing the journal and developed strategies to take it to the next level. What follows is an outline of the discussion and resulting action items.

Main Retreat Objectives:

- Define the role of APS in relation to ISAPS' overall strategic plan (multi-specialty meetings and membership)
- Define the role of APS as a benefit of ISAPS membership
- Define the role of APS in the aesthetic plastic surgery community at large
- Synchronize with above APS Aims & Scope, Editorial Board composition

Action Items developed:

- Distribute a Membership Survey (what do our members think about the journal)
- Author Survey (identify why they submitted to APS and their interest in digital format)
- Author recruitment letter (invite renowned authors to publish in APS)
- Demographics (there is interesting the diversity of authorship and readership of our Journal — create strategy to engage more authors based on that diversity)
- Use the newsletter to “market” APS. (Hank will have a regular column in the newsletter to promote the journal where he will announce top articles coming up in future issues and discuss

top articles of previous issues. It will be his “connection” with the membership through our newsletter.)

- Rewrite the Aim & Scope of the Journal (we currently have a very antiquated statement that does not really represent what the journal does today)
- Editorial Board revamp (recruit new names to help “market the Journal.” Also include multi-specialty names since they will now be speaking at our meetings and soon will become affiliate members.)
- Involve ISAPS Course Directors as “Journal ambassadors” (recruit authors to publish in APS. Hank will work with Lina regarding future courses and approach course directors to help with the Journal. Since they are organizing the meeting, they know of any new technology/techniques being presented and will approach the authors in a much more directed way. Therefore, we don't need to have the editor-in-chief traveling to every single course but will have someone representing him there.)
- Course Directors to collect presentation summaries (bullets of course presentations) and submit to the editor for possible expansion in an article, editorial or topic supplements.

The editor-in-chief was very open to the recommendations made by all participants and appeared to be enthusiastic about the direction we are taking. He was reminded by President Takayanagi that the Board expects to see changes taking place within six months of the meeting in Rome. I believe this Journal Retreat was critical and very instrumental in setting the right path for the Journal, the publisher, and Dr. Spinelli as editor-in-chief. I am hopeful many of these changes will be already in place by the next Board Meeting in Montreal in May.

As the Chair of the Journal Operations Committee, it is my responsibility to insure that our journal is the best it can be and, along with my committee members, to work to continually review and recommend changes that will improve this publication. I call on all members to help us grow and develop this important asset. Our education programs serve to advance our skills. Our journal serves to represent ISAPS as the leading international aesthetic plastic surgery society in the world. Let us ALL contribute to make *Aesthetic Plastic Surgery* the highest ranking publication in our field.



NORTH AMERICA: UNITED STATES

Nina Naidu, MD


ISAPS Assistant National Secretary for the US



The demand for non-invasive cosmetic procedures continues to increase in the United States. According to the American Society of Aesthetic Plastic Surgeons (ASAPS), there was a 13% increase in non-surgical procedures from 2012 to 2013. The appeal is obvious: no incisions, no scars, minimal down-time (if any), and decreased cost. In my own practice, I have gradually shifted away from facelifts and towards minimally invasive and non-invasive procedures of the face and neck. This decision was influenced by two factors: 1) the growing number of patients who request facial rejuvenation without the use of surgery, and 2) the addition of an experienced and aggressive aesthetician to my practice. Unless a patient has significant skin laxity or platysmal banding, I advise them that a number of non-surgical regimens are available. I advise patients that while these treatments can never replace surgery, they are a good starting point, and do not preclude me from performing surgery in the future if the patient wishes to move forward.

In my practice, I currently offer professional facials, chemical peels, microdermabrasion, dermabrasion, microcurrent, Pellevé®, and Ultherapy®. Facials, chemical peels, and microdermabrasion have the benefit of gently introducing patients to what can be achieved non-invasively. In addition, they allow the patient to begin a maintenance regimen for healthy skin which will enhance any surgical outcome. Dermabrasion is a tool which is under-utilized by plastic surgeons in the United States, although it is widely used by dermatologists. This is my procedure of choice for addressing the fine wrinkles above the lip which plague many women over the age of 50. Microcurrent was introduced to me by my aesthetician. Electrodes are placed on the surface of the skin, and low electrical impulses are delivered which supposedly tone muscle and provide a temporary “micro-lift” of the face. While there is good data that demonstrates the utility of microcurrent in inducing wound healing, its use for cosmetic applications at this time remains anecdotal. Nonetheless, patients are pleased with the immediate results, and the machine costs less than \$1,000 USD.

The two more “aggressive” (and expensive) technologies which I offer include Pellevé® and Ultherapy®. Pellevé® is a radio-frequency-based treatment that delivers energy to the dermal tissue. The heat emitted induces collagen denaturation and subsequent contraction, which creates skin tightening. There is a reasonable amount of literature supporting its safety and effectiveness for the treatment of fine wrinkles. Patients do see an immediate result, which is typically sustained following three treatments spaced one month apart. It takes 30 minutes to perform, is painless, and can be done in conjunction with other non-invasive procedures. I have been generally pleased with the results of Pellevé® treatments, although both the machine and disposable supplies are expensive. Ultherapy® uses intense, focused ultrasound energy to create thermal injury zones deep to the epidermis for non-invasive lifting of the neck, brow, and submental regions. Unfortunately, I have been relatively unimpressed by Ultherapy®. The treatment is painful, and somewhat costly for the patient (\$2,000-3,500 USD). Although results are seen, they are not, in my opinion, dramatic enough to justify the very high cost of the machine and its disposables. I have avoided lasers and fat dissolution machines in my office, as they are both expensive and readily available in almost every spa in New York City. Having an experienced aesthetician in the office is very helpful in both promoting and performing these treatments. Although I perform dermabrasion myself, my aesthetician is trained in all of the other modalities. Without her, I frankly wouldn’t have the time or patience to perform these procedures.

Despite our desire as surgeons to be in the operating room delivering immediate, dramatic results, we need to acknowledge the growing demand for and role of non-invasive procedures. If we don’t add these techniques to our arsenal, we will quickly lose patients to our non-surgical colleagues and the growing number of medi-spas. 

The author has no financial relationship with the manufacturers of any products mentioned.

EUROPE: ITALY

Dentists and aesthetic procedures: toward a new regulation in Italy

Gianluca Campiglio, MD, PhD

ISAPS Secretary




In Italy, the recent recession greatly reduced the number of patients who regularly consult dentists and undergo oral treatments. In the meantime, many students continued to take up this career which once was very profitable. This has resulted in a marked decrease of the mean yearly income of such professionals so that many of them have decided to offer various aesthetic procedures that were traditionally included in the armamentarium of plastic surgeons.

Currently in Italy two different types of dentists can treat dental problems. The first and larger group includes odontologists who concluded their five-year degree at specific schools for dentists according to European law. The second group consists of physicians who have been admitted to medical universities (six-year degree courses) before the institution of these specific schools for odontologists in 1985. This limited group will gradually disappear in the next years as, since then, it is no longer allowed to graduate in medicine

and work as a dentist.

Dentists who graduated in medicine can also perform any other medical procedure, including aesthetic medicine. Because of the current laws, nothing can be contested if these professionals decide to inject botox or fillers or perform a laser resurfacing. Unfortunately, in the last years odontologists (who are not medical doctors) also started to offer aesthetic procedures in the oral region stating that this was permitted as they are performing them in the anatomical area of their competence. This conduct raised a legal issue between core specialists (plastic surgeons and dermatologists) and odontologists which has been recently cleared by official advice of the Italian Health Minister. According to this document, odontologists can offer aesthetic procedures ONLY as a completion of a program of oral care and not with a pure cosmetic purpose, ONLY if addressed to correct lip defects (cheek, nasolabial folds and labiomental folds

are therefore excluded), and ONLY using products in an on-label way (botox injections are excluded as they are currently considered off-label in the perioral area). The debate is still open as odontologists rejected this advice and their lawyers are considering an appeal against the Health Minister.

Apart from the legal points, the safety of the patients should be the touchstone of any final decision by the health authorities. Injection of fillers or botox requires proper training and in-depth clinical experience especially where it concerns the prevention and treatment of potential complications. Companies and private schools are currently offering odontologists short and intensive courses which cannot be considered appropriate for these purposes. Secondly, the present insurance for odontologists does not cover any “aesthetic” risk so the patients (as well as the professionals) would not be properly protected in case of litigation. 

Global Perspectives — Future Themes

July – **Optimizing Wound Healing and Scar Quality**

November – **Current trends in Liposuction and Lipoplasty**

If you would like to contribute an article of 500-750 words, please forward to isaps@isaps.org

This is a non-referenced opinion piece of several paragraphs giving your observations and perspectives on the topic.

What do you do in your practice?

What unique approaches do you use?

What do you see your colleagues doing in your region?

EUROPE: UNITED KINGDOM

Nigel Mercer, MD – United Kingdom

Past President, BAAPS and BAPRAS



At Bristol Plastic Surgery, our plastic surgeons work closely with two cosmetic doctors, Dr. Rita Rakus (aka The London Lip Queen), her young associate Dr. Sherina Balaratnam and a nurse injector in delivering state-of-the-art injectables and skin rejuvenation. Before any facial rejuvenation surgery, the patient will have an assessment of their individual needs to get their skin in as good condition as possible. This usually takes the part of Hydrafacial to start with for cleaning the skin and preparing it for topical skin products. Depending on the skin damage and laxity we may also recommend the use of RF (Thermage) and occasionally peels, which are usually TCA based. We found the side effects after phenol and croton oil were such that patients, whilst liking the effect on lines and skin tone, really did not like the need to stay away from the sun afterwards.

We use only FDA approved injectables for their safety profile and we believe in running a very safe practice. Any single

patient who has a bad experience will put five others off coming to you. As a result, the deeper fillers are done by our cosmetic medical colleagues and the surgeons do the surgery. Having the broad breadth of experts means that the patients can choose who looks after them in the knowledge that the treatment ('simple' BONTA and fillers) will be delivered in exactly the same way. We are not great fans of putting a lot of fat into faces. We always ask to see pictures of the patient in their 20s or 30s to allow us to assess what has happened to their facial volume. NONE of our patients want the risk of 'pillow face' or of fat from another anatomical site gaining weight as they age.

We believe strongly that it is always better to under treat a patient and top up if necessary.

The author has no financial relationship with the manufacturers of any products mentioned.

EUROPE: BELGIUM

Ivar van Heijningen, MD

ISAPS National Secretary for Belgium and Membership Committee Chair



Fortunately, in Belgium the majority of procedures are done by registered specialists mainly dermatologists and plastic surgeons. But the group of non-core doctors have worked hard to obtain a better position. This resulted in a law stating that "specialist in non-surgical aesthetic medicine" will be added to the list of specialties. However, where and how this specialty will be trained remains unclear.

The term "non-invasive medical treatments" is suggestive that these procedures are light, but a deep TCA peel or ablative laser treatment is more invasive to the patient than a simple upper blepharoplasty. The more important that proper training for these procedures is ensured, since they are definitely invasive.

Toxins, HA-fillers and laser procedures are the most frequently offered treatments in Belgium. Other devices such as RF treatments, LED and Coolsculpting® are scarce for sure in

the plastic surgery community, but there is an increased interest with the large number of patients electing non-surgical treatments.

It is of utmost importance that we as a specialty embrace non-surgical treatments which are an important part of aesthetic medical procedures. We need to offer these because we are better trained, know anatomy better, and thus get better results if we focus on this area. We also need to ensure that we are "in touch" with these patients when they decide on surgical options.

The author has no financial relationship with the manufacturer of any product or device mentioned in this article. He is on the faculty of the Allergan Medical Institute.

EUROPE: FINLAND

Timo Pakkanen, MD, PhD

ISAPS National Secretary



According to the ISAPS statistics, non-invasive therapies have been gaining popularity in recent years. The same trend applies in Finland. Considering the phenomenon known as 7-47 effect, we as plastic surgeons cannot afford to lose this rapidly growing market. In Hospital Siluetti, we are among the top three private clinics using lasers in Finland.

We have used CO2 laser for years for cutting purposes in the operating room. For peeling and resurfacing, we shifted from CO2 and Erbium to 2790-nm erbium:yttrium-scandium-gallium-garnet (Er:YSGG), but occasionally still also use CO2 laser. We use 1064-nm Nd:YAG (neodymium-doped yttrium aluminum garnet; Nd:Y3Al5O12) for vascular lesions, hair removal and to treat facial redness (Cutera Cool Glide, Lasergenesis).

We use RF with 810nm diode laser or RF with 915nm infrared therapy for hair removal and skin tightening (Syneron E-max DSL, -Matrix IR). Also 1100-1800nm infrared device (Cutera Titan) is used for skin tightening. IPL is used mainly for vascular or pigmented lesions (Cutera LimeLight 520-1100nm, Acutip 500-635nm) and hair removal (Cutera Prowave (770-1100nm)). The devices for hair removal are operated by our beauticians.

As an alternative for laser resurfacing, we also use chemical peels, such as TCA. These therapies usually consist of three to five consecutive treatments performed by our nurses.

Laser skin resurfacing — being performed in the operating theater — is often combined with face lifting procedures or fat grafting under general anesthesia. When performed as a solo procedure, local anesthetic and/or anesthetic cream can be used. The periodical skin tightening therapy and repetitive fat grafting sessions are also great options to be able to offer your patients to maintain the facelift result.

For fat dissolution we currently use Ultrashape 3, which is a combination of external mechanical suction, RF and ultrasound. This device is a perfect alternative for some patients, but most of all it also brings customers requiring liposuction to our clinic. Depending on the accumulating scientific data, we may consider a fat-freezing device in future.

We use IR (infrared), bi-polar RF (radiofrequency) and vacuum device (Vela Shape 3) for cellulite treatment and post liposuction therapy.

The most popular non-invasive therapies are injections (botulinum toxin and fillers) whose popularity has sky rocketed in the past ten years in Finland. The general trend also indicates these

therapies being gradually shifted away from plastic surgeons to non-core practitioners and non-physicians. The industry-driven marketing together with still lacking legislation is causing serious safety concerns all over Europe. The ultimate goal for the manufacturers for maximal distribution would undoubtedly be an "inject yourself" home kit.

From a physician's or clinic's point of view, these non-invasive procedures have become a valuable source of income as the devices can be operated (under a physician's supervision) by nurses and staff members, thus increasing their productivity while away from the operating theater. The remaining challenge is to find the right tools from the marketing jungle as only a few of the devices survive through serious peer-reviewed studies. A new device also needs to pay for itself before the competitors arrive with even newer models.

The author has no financial relationship with the manufacturer of any products mentioned in this article.

Guess who!



See page 51 for details.

ASIA: SOUTH KOREA

David Daehwan Park, MD

ISAPS Assistant Chair of National Secretaries



Even if lipoplasty remains the most performed procedure in western countries, periocular rejuvenation is the most common procedure in Asia and specifically in Korea. Asian periocular rejuvenation includes the use of all non-surgical and surgical technologies.

Non-invasive periocular rejuvenation is increasing rapidly in the Asian region. Botulinum Toxin Type A and fillers are most common non-surgical procedures for periocular rejuvenation. Korean doctors use three Korean-made Botulinum Toxin Type A: Botox, Neuronox and Nabota. Hyaluroidase is frequently used for filler dissolution.

Currently, I use two primary ways to resurface the skin of the periorbital area: fractionated carbon dioxide and IPL (Intensive Pulse Light). I don't use RF treatments or chemical peels.

A combination of invasive and non-invasive technologies is also increasing abruptly. Anatomical classification and staging is a powerful tool for the selection or combination of proper non-operative and operative procedures. Proper analysis and slow technique is needed in non-invasive procedures.

The author has no financial relationship with the manufacturers of any products mentioned.

MIDDLE EAST AND MEDITERRANEAN: DUBAI

Luiz S. Toledo, MD – United Arab Emirates

National Secretary for United Arab Emirates



For the last two years, I have been very happy with the Coolplas treatment in my office. It is an alternative to liposuction by fat freezing. The machine is based on the cryolipolysis technology. The cold energy under accurate control will be delivered to selected fatty areas via a non-invasive cold energy device. The fat treated by cold energy will consequently lead to apoptosis (a form of cell death necessary to make way for new cells,) and will be slowly removed from the body through normal metabolism, without any damage to other tissues.

The new machines with CE certification come with three different arms, with two different sized curved applicators for different areas, such as abdomen, flanks and back, and with one flat applicator which can be used for thighs and other areas. We can use two applicators simultaneously. I am now treating up to six areas per session.

The cryolipolysis machine is a skin cooling device, which mainly works for resolving the stubborn fat and reshaping upper arms, back, abdomen and flanks. According to the thickness of the fat, the system has three different size arms and five modes with five different temperatures and treatment times.

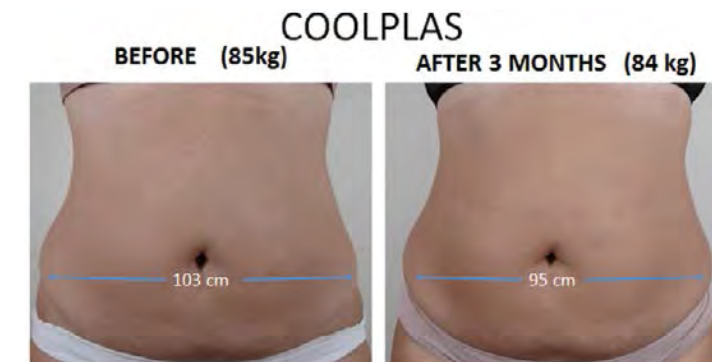
beginning one feels pressure and intense cold. It soon disappears - in a few minutes. Sessions last from forty-five minutes to one hour. Patients read, watch TV, play with their phones, or even take a nap during the treatment. They can return to normal activities right after the treatment, since it is non-surgical. Some patients experience redness, minor bruising, tingling, numbness or discomfort in the treated area, but this is temporary and will resolve completely.

The only disposable is the gel pad, which costs around four dollars each. I already bought my second machine. It keeps the office busy and patients who come for the procedure usually end up undergoing other aesthetic treatments while they are there, such as Botox and fillers. Some patients decide to have other surgical procedures. I photograph, measure and weigh patients during every visit to help document a noticeable reduction of fat in the treated area. After the initial treatment is complete, it is possible to have further reductions with additional treatments, resulting in even more fat loss, after one or two months. Some patients find that just one treatment fully addresses their goals. As long as the patient maintains a normal diet and exercise, the result should be permanent.

In the beginning, I was skeptical of the treatment, but seeing my results made me change my attitude. Patients start seeing results after one month, but final results are seen two months after the application. Patients are happy. They keep coming for more and referring friends.

Contraindications: Treatment with Coolplas is not indicated for patients who present any of the following conditions: hernia, abnormal bleeding time, during pregnancy or lactation period, Raynaud's disease, patients with pacemaker or who have recently undergone abdominal surgery. Other contraindications are the presence of infected wounds, eczema, dermatitis, or other skin problems.

The author has no financial relationship with Sincoheren, the manufacturer of the Coolplas system.



Liposuction procedures that use laser or ultrasound to remove fat require downtime for the body to heal. One of the advantages of Coolplas is that it targets fat cells alone, eliminating them in an easy, non-invasive manner that exercise and diet can't achieve as quickly or as effectively. The treatment is not painful. At the

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SOUTH AFRICA

My experience with minimally invasive and non-ablative surgical procedures: Thermage

Ewa A. Siolo, MD (Warsaw), MBChB (Natal), FCS Plast (SA)

ISAPS Assistant National Secretary



I use Thermage, a nonsurgical, non-ablative procedure for facial rejuvenation as an office procedure that can be done without anesthesia. Although oral analgesia can increase patient pain control and offers very mild sedation to decrease anxiety, I personally do not use sedation or local topical anaesthetic as patient comfort level is an indicator of the effectiveness of the procedure.

Adjusting the level of energy is crucial. It needs to be kept at the border of patient discomfort and pain threshold to assure a visible immediate result. Moisturizing the skin with special gel is very important as this assures a proper contact area of the tip to the skin conduction of radiofrequency waves. It is helpful to do one side of the treated area first and compare it with the untreated side so the patient gains confidence in the procedure.

It is very important to explain to the patient that the final result requires 4-6 months to properly show obtained rejuvenation. In my observations, the original, immediate result of smoothness of the skin may relapse 2-3 weeks after the procedure as initial swelling and inflammation settles. This is the time when patients can become disappointed because they don't see the expected result. The only way to deal with this is to reassure the patient and keep good standardized photographic examples.

This is not a surgical procedure where control of the final result is easily obtained during surgery and predictability of results is much higher. Different age groups, different genders and different types of skin give different results. For example, results

I am observing are on a younger group of patients (35-45) with thicker and less wrinkled skin. Males are also responding to treatment with better final results. This is due to thicker and better vascularized dermis in male patients.

The level of discomfort that patients may experience during the treatment depends on the level of energy applied. In some areas, this may be more easily tolerated that in other areas such as bony prominences or nerve exits from the facial skeleton that may cause greater discomfort and pain. The physician doing the procedure should pay attention to the patient's reactions to maintain strict and proper application of the tip's surface area to the skin. Because there is a risk of causing superficial burns, I strongly recommend this procedure be done by the physician him or herself.

Although Thermage is a non-surgical and non-invasive procedure, complications can be expected. These include immediate superficial burns, prolonged erythema, or transient neuropraxia. Later, soft tissue depressions and nodules can appear, or there can be a lack of expected results.

Thermage as a non-surgical treatment for sagging skin and cellulite is a popular procedure in North America and Europe. It is a "lunch time" procedure providing the patient with improved skin elasticity with minimal downtime. Remodeling of collagen leads to clinically visible improvement in aging skin in its quality and elasticity. Remodeling of deep collagen in fibrous septae connecting dermis and fascia of the muscle allows improvement

in contour and cellulite appearance. The effects can vary from patient to patient and generally is assessed as 5-20% improvement in skin elasticity. Unfortunately that cannot be guaranteed so patient expectation must match the occasional unpredictability of the result.

The benefit of this procedure is that patients are usually complimented as less tired looking or questioned if they returned from holiday because results are obvious but subtle. That gives patients a lot of confidence as looking youthful without being accused of vanity or fighting the ageing process.

Thermage addresses only elasticity of the skin. Recent trends in facial rejuvenation emphasize replacement of volume which cannot be addressed with tightening sagging skin. So the next step in getting optimal results is a combination of volume replacement and skin tightening. Modes of treatment of volume depletion are fillers and autologous fat transfer. A few studies have already investigated tissue interactions of monopolar RF heating with commonly used fillers. It is apparent that there is no increased risk of local burns or observable effect on filler being persistent in the tissue. RF also does not cause any structural changes in fillers.

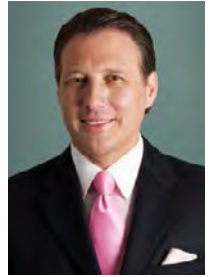
In my practice, I like a combination of Thermage and autologous fat transfers, usually about three weeks post-Thermage when any possible inflammatory reaction to Thermage wears off. Due to the contents of adipose derived stem cells, vascularity of soft tissue improves and the quality of skin improves dramatically due to formulation of new collagen.

continued on page 33

SKIN CARE SPECIALISTS: AN INTEGRAL PART OF YOUR PLASTIC SURGERY PRACTICE

Renato Saltz, MD – United States

ISAPS President-Elect



Twenty-two years ago, a group of aesthetic plastic surgeons recognized the need to provide an educational forum for the emerging specialty of plastic surgical skin care. It was their belief that a team approach can enhance and deliver better patient care, collaborating and forming a unified organization for the ancillary staff that supports the aesthetic surgeon's practice.

Today, the Society of Plastic Surgical Skin Care Specialists (SPSSCS) plays a seminal role in the education, training and service improvement of plastic surgery practices throughout the United States.



The skin care business within plastic surgery has become a necessary, revenue-generating adjunct to the aesthetic surgeons' patient portfolio, complementing and supporting their cosmetic surgical practices. Surgeons who have implemented these services know that many surgical and non-invasive procedures began in the aesthetician's suite.

The aesthetician's position on the practice team isn't limited to the introduction and uses of a skin care product. Today, skincare professionals integrate and coordinate the use of adjunct technologies such as lasers, permanent makeup, tattooing, injectables and peels to produce the best results for their clientele. Success in disseminating the technical knowledge and expertise, as well as the business savvy in packaging and marketing skin care services has led to recognition of their innovative thinking, and greater respect for their skills and expertise.

Today, The Society of Plastic Surgical Skin Care Specialists is an elite group, known internationally for its drive for knowledge, science and professionalism.

As the SPSSCS moves forward, the focus will remain on education and the advancement of the science and art of skin care and skin health. The members of the SPSSCS will continue to work alongside their surgeons to aid in safe and effective care for their patients. Just think - if every plastic surgeon were aware of the SPSSCS, and made a commitment to having their skin care specialists become a part of this elite organization — how successful the outcome would be.

My nurse and three master aestheticians have attended the Skin Care Society Annual Meetings. They benefit from it in so many ways, but especially they learn from doctors, nurses, and other aestheticians what works and what does not for skin care, treating pigmentation and other skin conditions. They enjoy the wide variety of panel speakers, the multidisciplinary approach to education and find the meetings very informative.

The SPSSCS 21st Annual Meeting is on May 12-15 in Montréal, Québec, Canada. For more information please visit <http://www.spsscs.org/microsites/meeting2015/index.php>



South Africa, continued from page 32

Thermage has proven to be useful for a specific group of patients who want subtle results with no downtime. I find it very satisfying in combination with minimally invasive surgical techniques which provide volume restoration like fat transfers.

Patient satisfaction with treatment is high as long as they are properly counseled about expected results. Thermage is a very good adjunct to cosmetic practice. I enjoy doing the procedure as I can see immediate response of treated areas and long term follow up will give me even more satisfaction.



The author has no financial relationship with the manufacturer of any product or device mentioned in this article.

ISAPS-LEAP SURGICAL RELIEF TEAMS® UPDATE

Ryan Snyder Thompson – United States

Director of International Disaster Relief, LEAP Foundation



As ISAPS-LEAP Surgical Relief Teams® continues to pursue and develop new mission opportunities for 2015 and beyond, we wish to highlight the achievements of 2014.

Participating in surgical missions to Jordan and Lebanon, an international collective of 27 plastic, reconstructive and aesthetic surgeons and six surgical assistants representing 14 countries evaluated more than 381 patients and treated 233 for all manner of war-related injuries, both acute and chronic.



Dr. Jamil Ahmad (ISAPS Canada) finalizing a donation of surgical supplies to the administrative staff of Treating the Wounded Syrian Program in Amman during Jordan Mission 16.

Invited as consultant surgeons to work alongside organizations including the Treating the Wounded Syrian Program, the Syrian Medical Relief Office, and the Syrian-American Medical Society, our volunteers have significantly increased the surgical capacity of these host programs. In the case of acute and traumatic wounds, ISAPS-LEAP surgeons provided expert level care alongside hosting general, orthopedic and burn surgeons. While the absence of key equipment and instrumentation have thus far prevented the use of free flaps, teams routinely performed a variety of local flaps, which incidentally provided unique educational opportunities for our hosts.

As for chronic injuries and wound management, ISAPS-LEAP surgeons focused primarily on returning as much mobility and functionality to the patient as possible. To keep expectations low, our teams sought to give their best working with patients who had often received less than adequate care for injuries sustained, in some cases more than two years prior. Particular attention was given to instruct and assist with proper wound debridement and dressing including, when available and appropriate, the proper use of negative pressure dressing therapies, and delayed primary or secondary closures.

While ISAPS-LEAP Surgical Relief Teams® was not initially established to provide surgical services in the midst of man-made civil conflicts, we felt that the need to assist a population of war-wounded persons represented a unique opportunity to offer disaster relief services particular to our international community of surgical specialists. In so doing, this innovation to the ISAPS-LEAP program has enabled us to help a population of people far more numerous than those our volunteers directly treated. We must also consider the lives of patients' family members who have likewise benefited from our charitable surgical services. As our teams have witnessed first-hand, the return of health, functionality and a semblance of the normalcy that was present prior to the Syrian war is a gift enjoyed by whole families.

This measure of success would not have been possible without the dedication and generosity shown by our volunteer surgeons and assisting medical professionals who graciously gave of their time and talents to participate in these surgical missions. Our success to date demonstrates the strength of this valuable partnership between the LEAP Foundation and ISAPS. We celebrate the international diversity of surgeons who have thus far brought tremendous skill and resources to the program. We also wish to thank again each of the aforementioned humanitarian partners and their hosting hospitals. To have worked with such profes-

sional and compassionate medical establishments has been an honor. We can only hope that each of these organizations have been blessed with an equally positive experience of our surgical team members.

As prospective avenues for future surgical missions develop, we anticipate expanding our work around the world where it is

needed most. At such time when opportunities arise, we eagerly await coordinating with new and returning volunteers. Should you have questions regarding the upcoming mission calendar and/or how you can support those ISAPS-LEAP Surgical Relief Teams®, we look forward to hearing from you. For information, contact me at: Ryansnyderthompson@leap-foundation.org



LEAP Foundation volunteer surgeon Dr. Burt Faibisoff (back left), LEAP Foundation Director of International Disaster Relief Ryan Snyder Thompson (back right), Rosemary Jacobs, CST (front left), ISAPS USA member surgeon Dr. Gary Jacobs (center) and Jordanian plastic surgeon Dr. Firas Neshwati at the conclusion of Jordan Mission 3.



ISAPS USA member surgeon Dr. Diane Duncan (center left) and ISAPS France member surgeon Dr. Emad Dannan (center right) with Jordanian OR personnel during Jordan Mission 5.

ISAPS-LEAP DONATIONS

We gratefully acknowledge the generous donation provided by Dr. Giovanni Botti (Italy) of \$40,000 in support of the ISAPS-LEAP Surgical Relief Teams® efforts that are highlighted in this issue of ISAPS News. The funds are held in an income generating account with our investment advisors at Morgan Stanley.

We have created a link on our website home page to make donations easily through ISAPS. Each donor will be sent a receipt for tax purposes. Donations are tax deductible, but we recommend that you check with your own financial advisor on this point.

Each donation is matched at twice its value by our partners at Marina Medical who provide surgical instruments to our mission teams. We appreciate your donation of money, time, supplies, and even frequent flyer miles to help our volunteers reach our mission destinations.

Donations can also be made through the LEAP Foundation.



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AICPEonlus RECOGNIZED BY THE PRESIDENT OF THE ITALIAN REPUBLIC

Claudio Bernardi, MD – Italy



President of AICPEonlus, ISAPS member

AICPEonlus, the non-profit association of the Italian Association of Aesthetic Plastic Surgery, received a donation from the president of the Italian Republic. Not only is this an effective economic aid, but also an important sign of recognition of our association and its aims. This is the purpose of the 3,000€ contribution that the non-profit association AICPEonlus, a branch of AICPE (the Italian Association of Aesthetic Plastic Surgery), dedicated to humanitarian activities in plastic surgery, has received by the Presidency of the Italian Republic.

Such contribution is also a major incentive for our association to continue to implement our projects. (*ISAPS News* Vol. 8, No. 1, p. 25 – www.isaps.org/Media/Default/newsletters/8_1_NL_int-1.pdf)

Following international alarm about the outbreak of the Ebola virus that has affected some countries in West Africa, AICPE-

onlus had to interrupt a few missions already planned in Togo, but created the new “Ebola Emergency Project,” which provides financial assistance to the hospital of Afagnan, Togo, to set up an insulation area, which is now lacking, in order to isolate possible early cases of infection.

Meanwhile, we have planned two humanitarian missions, one in Paraguay (Marco Stabile, treasurer of AICPEonlus and ISAPS member) and a second in Guatemala (Claudio Bernardi), pending continuation of those already started in Togo which will probably resume in May 2015.

Lastly, there has been a large number of patients from many Asian countries and western countries visiting Korea for rhinoplasty. Thus the Korean plastic surgery market has been focusing on medical tourism because the domestic situation has slowed down and become highly competitive!



In January 2010 the construction of a dispensary building in Aného, Togo begins.



April 2014: The Centre de Secours Medical *Fernando Giardinetti* is ready to start clinical activity.



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JAQUES REVERDIN, THE FIRST SKIN GRAFT? HISTORY OF A SURGICAL INNOVATION

Denys Montandon, MD – Geneva, Switzerland



Gentlemen! Anyone who has — at any time — studied the process of wound healing will always remain interested in this topic. Therefore, the beautiful invention of Reverdin's seemed to me an invitation to take up again my earlier researches in the healing process of wounds. —Carl Thiersch, 1874

This acknowledgment of Reverdin's invention was published five years after the first skin graft presentation by the Swiss surgeon, Jaques-Louis Reverdin, at the Imperial Surgical Society of Paris. During these five years, skin grafting had become a routine procedure all over Europe for treating and accelerating the healing process of granulating wounds.

Who was Jaques-Louis Reverdin?

Born in Geneva in 1842, Jaques Reverdin, like most of his French-Swiss colleagues, studied medicine in Paris because



Jaques Reverdin in 1870

there was no medical faculty in his city at that time. Already "Interne des Hôpitaux" in 1865, he was working at the Hôpital Necker in 1869, under the direction of Félix Guyon, a young chief-surgeon who became in 1876 the first professor of urology at the Faculty of Paris. During the Franco-Prussian war in 1870, Reverdin, although Swiss by nationality, collaborated with the French army, at the head of the

"Swiss Ambulance" in Paris, treating many wounded soldiers.

Back in Geneva two years later, he became chief-surgeon at the Hôpital Cantonal de Genève and the second professor of surgery in the newly created Faculty of Medicine at the University. He was the first Swiss surgeon to recognize the importance of Lister's antiseptic method and introduced it in the Geneva hospital. In 1884, he wrote a book on surgical antisepsis and asepsis and in 1910 a book on war surgery. During his 34 years of professorship, he published many papers, mainly on surgery of goiters, in which he had acquired a large experience. He is



Professor Gosselin and his interns at the Charité in 1870

credited to be the first to have noticed, before Theodor Kocher, another Swiss surgeon from Bern, the symptoms of hypothyroidism after extensive thyroidectomy and gave it the name of myxedema, suspecting an endocrine function of the gland. In 1908, he was invited to present his experience and observations on this subject in a major surgical meeting in Chicago. But in 1909, it was Kocher who received the Nobel price for his work on thyroid!

For cleft palate surgery, Reverdin created a needle for sutures which bears his name and is still commonly used in Europe. In 1881, with two other colleagues, he founded the *Revue Médicale de la Suisse Romande*,* which he then edited for 38 years. He retired from the University and the practice of surgery in 1910 and started a new career as a lepidopterologist (the study of butterflies), founding the Swiss Society of Lepidopterology and publishing 49 papers on this subject until his death in 1928.

* In 2014, the *Revue Médicale de la Suisse Romande* remains the most widely read journal by general practitioners in French-speaking Switzerland.



Reverdin showing his collection of butterflies to a colleague in 1920

it was never presented and published in a well-known medical academy. On another hand, the interesting experimental studies published by Giuseppe Baronio in 1804 and by Paul Bert in 1863 were performed only on animals. Johann Friedrich Dieffenbach had stimulated the latter to study skin grafting following a visit to Claude Bernard in Paris. The renowned Berlin surgeon had written his doctoral thesis on skin transplantation in 1822, but admitted that he failed to succeed in performing a free graft in humans. In 1869, the young Reverdin apparently had not read these publications. As he explained later on, the idea came to him from another German surgeon: "I had read in the surgical lessons of Billroth that sometimes islets of cicatrization can develop at a distance from the wound borders in burns or varicose ulcers. The apparition of these islets arose in spots where the deep dermis layers had been spared. The idea to imitate such a process surged in my mind briskly one night; I told myself: could we not, by placing small fragments of living epidermis on the surface of a granulating wound, stimulate the creation of islets of cicatrization? Would these small pieces of epidermis adhere? There was only one means to know; it was to attempt the experiment. I made this attempt the next

morning. I detached with a lancet on my own leg two to three fragments of skin as thin as possible and placed them on a granulating wound of one of my patients. I secured it with tape and a dressing and waited for the result with anxiety. After a few days, my previsions had been totally confirmed; not only the small pieces had taken and were solidly adherent, but around them new skin was forming, growing day after day at a distance from the borders of the wound."

This case report would have remained unnoticed if Félix Guyon, Reverdin's chief, had not decided that it should be reported as soon as possible to the Imperial Academy of Surgery in order to *prendre date* (a means of fixing a date). This was done the 8th of December 1869 and published three months later in the *Bulletin of the Society* with the commentaries of the eminent surgeons who had attended the presentation.

Grefte epidermique— expérience faite dans le service de M. le Docteur Guyon, à l'hôpital Necker.

Gentlemen: The communication, which I have the honor to make to the Society of Surgery, pertains to a very common question of pathology, apparently well understood, but which still presents some obscure and interesting points for elucidation. I refer to the cicatrization of wounds by second intention . . .

A detailed description of the case report and the result obtained was then produced:

November 24, I tried the following experiment: I removed with the point of a lancet from the right arm of the patient three small slivers of epidermis. I placed my epidermic slivers in the middle of the wound, their deep surface in contact with the granulations and I supported them with some dichalon bandelettes.

December 1, the skin slivers have united and form a little pale white plaque; there has evidently grown a small epidermic zone around each of them. In the days

that followed, this pale border extended more and more to form a little pale and thin islet quite analogous to the epidermic border which has formed along the edges of the wound.

Today, December 8, it is observed, that the islet is notably enlarged and the wound practically healed.

The 28-year-old Reverdin then concludes:

Such are the facts that I have the honor to submit to the Society of Surgery. I report them now as a matter of record, but I pledge myself to pursue these researches. I will have to study as closely as possible the histological process: Is it a simple result of contact, of environment? Is there proliferation of the transplanted elements? Here are many questions, which deserve some researches that I intend to undertake.

No wonder, several questions and commentaries were very critical and would have discouraged many young surgeons from pursuing further research.

■ *M. Trélat*: M. Reverdin believes that epidermic proliferation must be attributed to the graft. In order for this experiment to have a real value, it would be necessary for it to be repeated a great many times, and that it nearly always succeeded. It is necessary, in fact, to exercise on this point a very great amount of reserve.

■ *M. Blot*: From the practical point of view the question of the epidermic graft, or that of the Malpighian or mucous layer, appears to me to be of no importance. To remove a piece of dermis from the arm or elsewhere to unite it to the surface of a suppurating wound which is slowly cicatrizing, just to save a little healing time, is to expose the patient, above all in our hospitals, to the danger of erysipelas.

■ *M. Léon le Fort*: I share completely the opinion of M. Blot. The recent wounds borne by the patient from which the epidermis had been taken were re-covered by a reddened crust showing that at least a bloody discharge had followed. Therefore, the epidermis alone had not been

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History, continued from page 39

removed; a fragment had been taken comprising capillaries and a door opened for erysipelas. As to the utility of the method, it is without importance, even granting that one can cast here and there a sort of seed, which by germination on the spot will result in cicatricial islets. This cicatrix will have, like all others, a tendency to contraction, and this autoplasty cannot replace that to which, for example, one has recourse to prevent the scar retraction of an eyelid which could result in ectropion, or one of the face causing a deformity.

The same Léon Lefort published two years later a case of eyelid ectropion's correction using a skin graft harvested from the arm!

As he promised, Reverdin undertook a series of researches performing more than fifty skin grafts in humans and studying experimental grafting in animals in the same laboratory as Paul Bert, the medical experimental lab of the *Collège de France*, directed by Claude Bernard, the founder of experimental and scientific medicine. For his memoir of 69 pages, published in the *Archives générales de Médecine*, Reverdin received the *Prix Amussat* of the Academy and, in November 1872, Claude Bernard himself presented Reverdin's memoir at the Academy of Science.

During the same two years, Reverdin, who was not yet thirty, started visiting other surgeons who had tried to perform skin grafts: Billroth in Vienna, Pacchiotti in Milano, and Pollock in London where even in a journal his visit had been announced: "to flatter my pride, they had imagined to announce in a medical journal the presence of my noble person in London. Noblesse oblige!"

What were the mistakes of Reverdin?

Considering nowadays the publications of Reverdin on skin grafting, one must conclude that he made two mistakes: 1) Even though he called it *epidermic graft*, he was transplanting pieces of epidermis with some dermis. 2) He pretended that he took skin from his own leg to cover the wound of his patient, and later on claimed successful grafts from Negroes to Whites, from rabbits to men, to cats, from man to sheep and to other species, while we know that these allografts could never have survived.

The first mistake is mainly a matter of language that the surgeons attending his first presentation had immediately noticed. He admitted that he could not harvest only epidermis, "it is almost impossible to do otherwise," but insisted on the importance of the epidermal cells for the healing of wounds. This wrong appellation gave the opportunity for others to claim new inventions or innovations (Pollock 1870, Lawson 1870, Ollier 1872, Lefort 1872, Thiersch 1874, Wolfe 1875, Krause 1893 and many others). Already in 1884, Emil Bock, an ophthalmologist, had collected more than 200 published articles describing var-

ious skin grafts.

The second mistake is more striking. How can we explain that he never realized that long-term all his allografts would fail? "I often took the skin fragments on myself, to graft them on patients who would refuse the operation, thinking that it was painful. In our first grafts, I had taken the tegument on the subject himself, but I became soon assured that the result was the same when transplanting grafts from one subject to another; this fact has been abundantly demonstrated . . ."

In fact, for decades, almost every surgeon believed that a skin transplant could be harvested on another person or even on animals. The use of cadavers or amputated limbs as donor sites was common and was almost never questioned until the nineteen twenties. Winston Churchill recorded a famous homograft in his memoirs. To replace a nurse who was fainting when asked to give a piece of her skin for a wounded officer during the battle of Omburmann in 1898, heroic Churchill offered himself: "The doctor then proceeded to cut a piece of skin and some flesh about the size of a shilling from the inside of my forearm. I managed to hold out until he had cut a beautiful piece of skin with a thin layer of flesh attached to it. This precious fragment was then grafted on to my friend's wound. It remains to this day and did him lasting good in many ways. I for my part keep the scar as a souvenir."

Even more surprising is the fact that many surgeons, particularly ophthalmologists, claimed to practice successful xenografts, using frog skin for eyelid repairs. Reverdin himself recorded the use of rabbit's periosteum in a case of partial nasal plasty. In the 16th century, Tagliacozzi was already doubtful in this matter: *An ex alieno corpore, an vero ex proprio tradux eligendus fix?**

Ollier, the father of bone and periosteal grafts, was in favor of allografts, but against the use of xenografts. One had to wait for Lexer's publication in 1914 to put serious doubts on the permanent viability of allografts or between different species. But even at that time, Alexis Carrel, Nobel Prize winner in 1912 for his research on organ transplantation, claimed that he had grafted successfully skin from a black dog to a white one!

Why has this so-called "invention" become a landmark in the practice of surgery?

The state of art of our profession is a compendium of surgical methods, which have been selected among thousands of innovations brought throughout the ages. According to Riskin

* Is it possible to take skin from another person, and if this is possible, will it be more successful and advantageous? No: the single character of each individual speaks against the harvesting on another one.

and Longaker, "innovation is a broad term defined as the act of introducing something new or the use of a new idea or method. In some instances, it is used synonymously with invention, although innovation is more precisely defined as something thought up or mentally fabricated. Importantly, no technology or its application is entirely new, as no inventor works within a vacuum. The discoverer has often proceeded by analogy." Reverdin followed the observations of Billroth on the healing of wounds of unequal depths, where islands of epidermis are growing from the remaining skin adnexae. He did not care about theory; he just wanted to improve the healing of his patient. Once it had been published, he realized that his idea could lead much further.

Surgical innovations may be *incremental*, meaning that it marginally improves upon currently available technology, or *enabling*, leading to further development of new procedures within a field. Reverdin's needle is an example of incremental innovation, whereas the idea of skin grafting wounds belongs definitely within the field of enabling innovations, opening not only on the field of the various methods of skin grafting, but also on other tissues and organ transplantations. During his experiments, Reverdin was also particularly concerned with the observations that the transplanted islets of skin were growing and the epidermal cells spreading to cover the wound: "The grafts, once adherent, the islands continue to grow, depending on the general state of the patient and the local status."

The concept of cell culture was born.

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I WANT TO BE THIS WAY: a new book dedicated to our patients

Gianluca Campiglio, MD, PhD

A plastic surgeon in Milan (Italy) and ISAPS Secretary, recently edited a book dedicated to aesthetic surgery patients. Written with an Italian journalist in a simple, clear, but at the same time very scientific way, it is 150 pages long and contains many pictures of clinical cases.



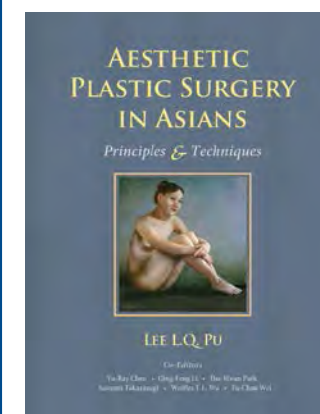
A preface by a professor of sociology describing the evolution of the concepts of beauty and attractiveness during the centuries enriches the book. The first part analyzes eight common myths about aesthetic surgery such as the risk of explosion of breast implants during flights or of poisoning after Botox injections. In each case, the origin and reasons why the information is incorrect is scientifically explained.

The second part refers to important practical suggestions on how to approach aesthetic surgery including the choice of a properly trained surgeon, limits of medical procedures, and typical categories of patients who consult a plastic surgeon's office. Another myth is that our patients are only actresses or aristocrats while most of them are normal, mentally healthy persons of every age and social background.

The third part lists the main surgical and non-surgical treatments currently available for aesthetic improvements of facial and corporal defects. The book concludes with data from several research studies about the positive effect of aesthetic surgery on the self-esteem and sexual life of patients and with a report of the personal experience of a psychologist who has also been a breast augmentation patient. The book is written in Italian and is currently available in libraries and on line. ISAPS

Aesthetic Plastic Surgery in Asians: Principles & Techniques

Lee L.Q. Pu



- Focuses on the differences in surgical techniques when treating Asian patients, as well as procedures specific to this group
- Contributors from Asian regions share their signature procedures
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Yves-Gerard Illouz, MD (1929-2015) – France

Contributed by
Dr. Jean-Claude Dardour
Translated from the French



Y-G Illouz was born in 1929 in Oran, Algeria into a modest family. At that time, Jews who had acquired French citizenship in 1870 by the Crémieux Decree wanted one thing: to integrate and become “true French.” For this, it was necessary to study and in this milieu that meant to become a doctor or lawyer. He told me that one of the major traumas of youth was the abolition of the Crémieux Decree from October 7, 1940 until 20 October 1943 by the Vichy Government. At the age of 11, for three years, he lost his French nationality of which he was always proud.

In 1945, he was sixteen years old when he decided to go to France to continue his studies, first in Montpellier, and then the following year in Paris. These years were not easy for him, with no money and without his family. He took courses in philosophy to achieve a diploma at the Sorbonne University — not surprising to those who knew his knowledge in this area.

When I met Y-G in 1980, some said then that he was not a surgeon and therefore his publications could not be trusted. It is true that the first photos, presenting the liposuction technique that he had developed, were not truly of a quality considered as “professional.”

On completing his thesis on acute breast cancers, he graduated and settled quickly into private practice, but, and this was one of his character traits, he was constantly looking for new things. In 1965, he realized his dream of creating his own clinic that he built in Montrouge, a suburb of Paris. He maintained this practice for only five years before he left to practice in Réunion. Fate led me to operate in this clinic at the beginning of my own practice in 1978. Little did I know that our paths would cross again two years later and that we would remain friends thereafter.

Y-G would stay less than two years in Réunion to operate, as one might imagine, in rudimentary conditions, but would undertake a variety of procedures combining general surgery, orthopedic surgery, reconstructive surgery, labio-nasal cleft surgery and surgery to treat after-effects of polio.

After the death of his father, he returned to settle in Paris again. It is there in 1971 that we can see his name appear among the founders of Doctors Without Borders alongside those of our colleagues Bernard Kouchner and Jacques Bérés. This would be the beginning of numerous trips around the world both private and professional.

Two character traits seem essential to understand Y-G Illouz:

instability with a huge need for recognition.

In his last book, *A la recherche d'Aphrodite*, Illouz cites this sentence of François Jacob, winner of the Nobel Prize in medicine: “Inspiration, the spirit of synthesis, patience but also ingenuity are components of scientific discovery. . . . Researchers are adventurers, science is bound to unusual minds, discovery remains the triumph of singularity, the achievement of an individual.” This sentence seems created to describe this man.

We know his career better after liposuction because this invention was a veritable Big Bang as much for us in the field of plastic surgery as for his personal and professional life.

Assuming that it was this tool that created the technique, and not the reverse, we can say that liposuction is not a technique but a tool which allowed fabulous progress not only in cosmetic surgery, but also in all areas of reconstructive surgery by a better understanding of the fatty tissue of the cutaneous vasculature and the consequences of subcutaneous dissection.

Y-G was recognized very late by his peers, as he had no time to be part of the Seraglio. Yet I was always amazed to see what patience, one can even say how selflessly, he agreed to receive the first colleagues who believed in him, and then secondarily those who had criticized him.

As always, the mysteries of life have shown the character that most know today. In the years 1977-78, an idea was in the air in surgery — to remove fat through a small hole, without making large scars: a challenge having seen at this time many more or less fanciful publications involving real disasters. This is where Y-G had the brilliant idea to develop this simple, effective technique, without risk, that the world knows today: emulsify fat by injecting hypotonic serum and aspirate via cannula by making tunnels and applying continuous suction. This idea occurred to him in order to meet the request of a pretty young woman who wanted to remove a large lipoma without scar.

The principle of the technique of liposuction is so basic that it could be developed and practiced simply using a cannula, a tube, and a vacuum machine. As for the postoperative period, complications are the exception, always related to the technician, never the technique. The technique is so simple that a number of general practitioners have unfortunately pierced the body which sometimes resulted in fatal complications. In France, it was necessary to legislate liposuction to prohibit practitioners who are not surgeons from practicing this procedure.

The first publication of Illouz’s technique of liposuction is dated 1979. The following one is from 1980 in the *Revue Française of Chirurgie Esthétique* and then in PRS in 1983. In 1988, we contributed to the drafting of several chapters of his book, *La sculpture chirurgicale par lipoplastie* (Churchill Livingstone), followed the same year by the English edition. In 1988, he published in *Aesthetic Plastic Surgery* the results of injections of fat in about 167 cases carried out from 1983 to 1987.

As early as 1986, liposuction was the second most common procedure performed in the US and by 1987 it would become the most practiced intervention by the combined specialties.

It is common to see some countries or some authors claim to be the first to describe certain techniques or certain diseases. This was never the case for liposuction.

Regarding the evolution of the technique itself, we can say that the only notable changes that have appeared since the original description have been the use of increasingly fine cannulas that allowed the exploration of virtually all parts of the body. So far, all processes invented to improve it did not really prove their superiority.


Since 1980, another adventure began creating his international celebrity, his travels around the world, and global recognition both by his peers and by the general public.

For Y-G, surgery was his life, his passion. Ceasing to operate was not for him synonymous with abandonment of the medical community. On the contrary, he began to publish and to teach

more than ever. We worked together in my office surgery from 1994 to 1999 and when he decided to stop we agreed to tell patients who telephoned that Dr. Illouz was not retired, but that he had simply decided to cease to operate for now and dedicate himself to research.

I thought it was a simple flirtation, but actually that was exactly what he did. There were more congresses, more conferences, and more books written since 1999.

But there was also the man: his qualities, intelligence, simplicity and even the flaws. Y-G was not a saint — far from it. He was a faithful friend who never failed — I never heard him speak ill of anyone — but he was also impulsive, versatile and especially impatient, the opposite of a contemplative. He always needed to go fast, he needed to move, he needed to change.

In conclusion, we wish to thank Y-G Illouz for the fundamental progress he brought to plastic surgery, but also for his contribution making France shine all over the world. 

Prof. Dr. med Johannes Franz Hönig (1956-2014) – Germany




Professor Dr. med Johannes Franz Hönig studied in Münster, Ulm, London, Paris, Brussels, Geneva, Würzburg and Göttingen and was professor at the Georg-August-University in Göttingen from 1996 until his death, where he instructed in the field of plastic and reconstructive surgery.

Professor Hönig was an internationally-renowned specialist in plastic surgery who developed and refined many new surgical techniques that are today part of accredited surgical methods, such as the endoscopic-video assisted facelift. He had countless patients and developed the “biological” fracture treatment through stabilizing the bone fracture fragments with punctiform osteosynthesis plates (Multi-Point-Contact-Plate), also establishing this in trauma surgery. Training in the USA led to specialist knowledge, including the use of diverse and customized operational methods. Prof. Hönig made a name for himself in treating facial deformities, lip and facial clefts, facial profile and nose correction through transposition osteotomies of the craniofacial bones, as well as in the field of reconstructive surgery after tumor diseases and trauma surgery.

Professor Hönig researched in the field of aesthetic and plastic surgery with a focus on the treatment of age-related changes. He was the author of over 200 scientific publications, released multiple instructional videos, gave more than 100 lectures at


national and international conferences and was a Visiting Professor in the USA and Japan. He possessed longstanding experience and qualifications and his work was honored by international organizations.

He was admitted to, among others, the “Who’s Who in Medicine and Healthcare,” “Who’s Who in Science and Engineering” as well as “Wer ist Wer.” Moreover, he was an advising member of the European Academic Commission in Brussels and was added to the “Leaders of Plastic and Aesthetic Surgery” in 2004. He was a member of the German Society of Plastic, Reconstructive and Aesthetic Surgery, International Society of Aesthetic Plastic Surgery, American Society of Plastic Surgeons, American Society of Maxillofacial Surgeons, European Association for Cranio-Maxillo-Facial Surgery, Association of German Aesthetic Plastic Surgeons, and the German Society of Aesthetic Surgery.

Professor Jannes Franz Hönig died on December 24th, 2014. 

Mario Vahos, MD (1929-2014) – United States



Long-time ISAPS member, **Mario Vahos** passed away on December 28, 2014. He was a highly respected pioneering plastic surgeon at St. Agnes Hospital and other area hospitals in the Greater Baltimore area. He is survived by his children, Victoria and David and his wife, Alexa. 

Sergey Nudelman, MD (1956-2014) – Russian Federation

Former National Secretary for Russia



Dr. Sergey Nudelman passed away on December 7, 2014 in Ekaterinburg, Russia after a long fight with a chronic illness.

Dr. Nudelman founded the Cosmetology and Plastic Surgery Center which is now the largest clinic of aesthetic medicine in Russia. It was thanks to his pursuit of excellence that many Western surgical innovations and pioneering technologies, such as facial endoscopy, were first introduced in his clinic in Russia in the mid-1990s and early-2000s. In October 2014, the clinic celebrated its 25th anniversary.

Sergey Nudelman was the first Russian plastic surgeon who joined the International Society of Aesthetic Plastic Surgery in 2000. Serving as the ISAPS National Secretary (2000-2008), he opened the doors of this prestigious society for his Russian colleagues. Dr. Nudelman was also an international active member of ASAPS and a board member of the Russian SPRAS.

In 1996, Dr. Nudelman initiated an educational course in plastic surgery. The knowledge and experience of world-renowned plastic surgeons became available for Russian surgeons including those practicing in remote places in the country. Sergey Nudelman considered this course to be his mission and a matter of professional honor. Over time, this course has become a biannual international meeting and an integral part

of the major Beauty Medicine Forum. Dr. Nudelman earned great respect of his colleagues and trust of his patients for his professional honesty and decency. In July 2014 Sergey Nudelman was awarded the title of the Honored Doctor of the Russian Federation by a Presidential Decree. In November 2014 he received the “Golden Lancet” National Prize in aesthetic medicine for his contribution to the development of plastic surgery. Sergey Nudelman loved Ekaterinburg, which was the most beautiful and interesting town for him and he did everything for its prosperity. He participated in various social charity projects. He was known among artists and musicians as a connoisseur and patron of arts. He liked literature, music and fine arts of different genres and supported cultural institutions, artists and labor veterans. Many outstanding musicians, singers and poets, including Nikolay Petrov, Boris Berezovsky, Daniel Kramer, Andrey Voznesensky and Georgy Garanian gave friendly concerts in his clinic. He had a taste for authentic things and a brilliant sense of humor. However, his top priority was his family and children. His wife Irina was always by his side. His two daughters, Alexandra and Nataliya gave him adorable grandchildren. Sergey was a caring son, a loving husband and a wise father. This is a great loss for all his family, friends and colleagues. We will miss this extraordinary man, who changed the lives of so many of us for the better. ISAPS

Peter Randall, MD (1923-2014) – United States



Peter Randall, 91, was an innovator in the field of cleft palate surgery who brought his skills to patients in Philadelphia and abroad. He died on November 16 at his home in Pennsylvania.

Dr. Randall, a former chairman of the departments of plastic surgery at the Hospital of the University of Pennsylvania and Children’s Hospital of Philadelphia, focused his research on the repair and reconstruction of facial deformities, especially cleft lips and palates.

He helped to develop one of the most robust training programs for plastic surgeons in the United States and founded the Cleft Palate Clinic at Children’s Hospital. In the late 1980s, Dr. Randall battled the Federal Trade Commission against government criticism of board certification.

He was past president of the American Society of Plastic Surgeons, the American Cleft Palate Association and the Robert H. Ivy Society. He was a member of the International Society of Aesthetic Plastic Surgery, the American College of Surgeons and the unique Pithotomy Club. www.pithotomy.com. Dr. Randall traveled the world to train doctors and nurses to perform reconstructive surgery. In India, he operated on lepers to restore the use of their hands, and during the war in Vietnam he volunteered to teach local surgeons how to perform skin grafts on burn patients. Through several tours with Operation Smile, Peter, with his wife, Posey, and multidisciplinary medical teams, traveled to China, Israel, Vietnam and India to work with cleft lip and palate patients. His service and compassion changed the lives of thousands of patients. “Peter loved his work, and he loved to teach. He was driven by a deep faith and compassion to help his fellow man,” his family said in a tribute. Outside the operating room, Dr. Randall was cheerful and gentle. He was an enthusiastic singer, gardener, birder, and sailor. ISAPS

He was past president of the American Society of Plastic Sur-

Benito Vilar-Sancho Altet, MD (1924-2014) – Spain



Don Benito (as he liked to be called) was born in Valencia 90 years ago into a family with a long tradition of medical practice. His grandfather was a doctor, his father an ENT specialist and one of his uncles a dental surgeon. He graduated with distinction from the Valencia School of Medicine and then moved to Madrid to undertake doctoral studies. In 1950, he saw Sir Archibald McIndoe perform surgery in Madrid, which influenced him so much that he left his budding ear, nose & throat career to engage in plastic surgery at the Queen Victoria Hospital in England, alongside McIndoe and Mr. Percy Jayes. He returned to England on several occasions to further his studies, visiting Professor Kilner, Mr. Pet and Harold Gillies. From day one, he was fully dedicated to plastic surgery and his doctoral thesis “Surgical treatment of partial-thickness scalp defects” was perhaps one of the first in this speciality. After the creation of the National Institute of Medicine and Workplace Health and Safety in September 1952, he was appointed Head of Plastic Surgery. From then onwards, he paid particular interest to congenital facial malformations, publishing a classification of the cleft lip and palate and a procedure for unilateral cleft lip surgery. In 1956 he founded, along with Doctors Álvarez Lobel, José Sánchez Galindo and José Antonio Soraluece, the Spanish Society of Plastic Surgery (SECPRE). His knowledge of French, German, English and Italian enabled him to travel the world and rub shoulders with leading figures of the time. This also allowed him to organise and chair firstly the European Plastic Surgery Congress, then the World Aesthetic Surgery Congress and finally the World Plastic Surgery Congress, all of which were held in Madrid and thrust Spanish plastic surgery onto the international

stage. In 1983, the 7th ISAPS Congress was held in Montreal and he was elected as president of ISAPS, ultimately organising the 8th Congress of ISAPS in Madrid in 1985. He joined an array of plastic surgery associations, delivered speeches at congresses and symposia, and became chairman of the UEMS, where he approved the name change of our speciality to include the term AESTHETIC. In 1992, he chaired the IPRS World Congress, where he also successfully adopted the word aesthetic into the name of the International Confederation, it being renamed IPRAS. In 1960, the National Centre for Surgical Specialities was created and he won the official selection process to be named director. From then on, he worked at the former Pavilion Number 8 of the Madrid School of Medicine on all kinds of treatments: post-burn scars, congenital malformations, skin tumours and post-mastectomy reconstruction. He trained numerous resident doctors and worked with a team of highly-experienced plastic surgeons. It was commonplace for surgeons from both Spain and abroad to come and observe his work. Visits were constant both at Pavilion 8 and at his private consultations, especially to witness rhinoplasty surgery, a technique that he mastered and that his own father, Dr. Rafael Vilar-Sancho imported in 1922 from Germany, after seeing Dr. Joseph operate. He performed his last nose operation in 2007, the crowning point of forty years of practice. He retired to his beloved Ibiza, where he would sit in the spacious library of his house in San Antonio Bay, looking out to sea and recalling his other great passions: sailing, spearfishing and diving. He passed away on 21 December 2014 and was buried beside his mother, wife and two of his children. A man of immense culture, sharp intellect, extreme gentleness and subtle English humour, he has left a profound mark on Spanish medicine and plastic surgery in particular. ISAPS

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Lieutenant Colonel Awni Abu Lail (1970-2014) – Jordan

Contributed by Dr. Samer Haddad




On the 8th of December 2014, the Jordanian Royal Medical Services lost one of its finest plastic and reconstructive surgeons — **Lieutenant Colonel Awni Abu Lail**. Dr Awni died in the operating theater while preparing to operate on a patient. He was 43 years old.

Dr. Awni was born on the 15th of December 1970. He completed his secondary education in Zarqa, Jordan. He attended medical school at the university of science and technology in Irbid, Jordan. After graduating from medical school in 1994, he joined the Jordan Armed Forces Royal Medical Services where he did his residency in general surgery after which he sub-specialized in plastic and reconstructive surgery. During those 20 years he was often deployed as part of a Jordanian medical mission with the United Nations' peacekeeping force to many war-stricken countries such as Eritrea, Lebanon, Iraq and the Palestinian territories. He did so without ever complaining; on the contrary, wherever he went, he was always content, glad and proud to be of service to his country and humanity as a whole.

Dr. Awni was known for his happy demeanor, one could never be sad around him. He was always helpful in more ways than could be counted. He was considered a genius in computer technology and therefore took charge of organizing Royal Medical Services conferences whether national or international. He was approached by his friends and acquaintances and their families to help with computer issues and he would fix it for them no matter how difficult or time consuming it would turn out to be. He simply did not know how to say no to anyone.

Dr. Awni was a member of many distinguished societies including the International Society of Aesthetic and Plastic Surgery and the Jordanian Society of Plastic and Reconstructive Surgeons among many others. He was well acknowledged and appreciated by many members in those societies who knew him on a personal as well as professional level and who were very saddened by this great loss.

Dr. Awni did not believe in normal working hours. Whenever he was awake he was working. His loyalty to his job and friends sometimes came at the expense of his health and his family. He left behind a young wife and two lovely children. For anybody who had the pleasure of knowing him, although gone, he will never be forgotten. 




Visiting Professor Program, continued from page 20

The impressive opening ceremonies included a Dragon Dance and a warm welcome from Dr. Wing-man Ko, the secretary of food and health, Government of Hong Kong. This large gathering of plastic surgeons of Chinese descent from all over the globe included many of my world-renowned friends and colleagues such as Prof. Yi-Lin Cao, Fu-chan Wei, Yu-Ray Chen, Andy Lee, Lee Pu and David Chiu. I reflected on the significant contributions that these thought leaders and many more of the faculty in attendance have made to our specialty. It was a privilege for me to be amongst them, to listen to their talks, and to share ideas.

I was asked to present a talk on “The Future of Plastic Surgery” which is a challenging topic that I enjoyed preparing and presenting. Following two days of presentations in dual sessions, the meeting concluded with a Gala Dinner on the well known boat restaurant “Jumbo.”

My thanks go to friends and colleagues whom I have already mentioned and to Dr. Daniel Lee for their generous and warm hospitality. Whilst I will soon forget the heavy traffic and the mist that seemed to hang around during my visit, the friendship and kindness will remain with me 'til I next have the fortune of returning to Hong Kong.

Finally, I offer my gratitude to ISAPS for selecting me as a Visiting Professor. 



Fellowship opportunities


Anglia Ruskin University in the UK offers an MCh program in Aesthetic Surgery. Some members provide informal fellowships in their practices, clinics and academic settings. Our website lists programs offered by ISAPS members that accept plastic surgeons for short periods of training. Please contact the program directly for more information.

To see the current list or to add a fellowship that your facility offers, go to Medical Professionals at the top of our homepage www.isaps.org and click on Fellowship Programs.

Survey, continued from page 11

- **27** said their national society requires that their members practice in accredited facilities. **32** reported that this is not a requirement.
- **57 (98%)** supported the suggestion that ISAPS members should be required to operate in accredited facilities. **43 (86%)** thought that the members in their country would support an ISAPS membership requirement that they operate in accredited facilities.
- The majority reported that there is no patient safety committee in their country or society. However **42 (80%)** said that they use patient safety guidelines in their practice.
- **47 (82%)** answered yes when asked if we should have more content at ISAPS courses and congresses on the topic of patient safety.

- **24** felt that medical tourism is a positive factor in their country; **21** said it is a problem; **10** said they are indifferent, and **3** said this was not applicable for them.
- **39** reported seeing patients with complications from surgery performed in another country once or twice a year. **14** said they saw such patients once or twice a month. **2** reported seeing patients with problems once or twice a week.

ISAPS considers Patient Safety and Education the two primary purposes of our overall mission. Based on the responses to this survey, the Committee will to continue their work to advance patient safety among our members. 

May 2015

DATE: 14 MAY 2015 – 19 MAY 2015

Meeting: ASAPS/ASERF Annual Meeting & ISAPS Board
 Location: Montreal, QC, CANADA
 Contact: American Society for Aesthetic Plastic Surgery
 Email: asaps@surgery.org
 Tel: 1-800-364-2147
 Fax: 1-562-799-1098
 Website: <http://www.surgery.org/professionals>

June 2015

DATE: 04 JUNE 2015 – 06 JUNE 2015 ISAPS SYMPOSIUM

Meeting: ISAPS Symposium – Nice, France –
 Immediately preceding the 28th SOFCEP Congress
 Location: Nice, FRANCE
 Contact: SOFCEP
 Email: sofcep@vous-et-nous.com
 Tel: +33-05-3431-0134
 Website: <http://www.congres-sofcep.org/>

DATE: 10 JUNE 2015 – 14 JUNE 2015 ISAPS-ENDORSED PROGRAM

Meeting: Vegas Cosmetic Surgery and Aesthetic Dermatology
 Symposium & International Breast & Body Symposium
 Location: Las Vegas, Nevada, UNITED STATES
 Contact: Delphine Hepp
 Email: Delphine@multi-specialty.org
 Tel: 1-877-673-3273
 Fax: 1-859-422-5073
 Website: <http://www.vegascosmeticsurgery.com>

September 2015

DATE: 04 SEPTEMBER 2015 – 06 SEPTEMBER 2015

Meeting: CATFAS V ISAPS-ENDORSED PROGRAM
 Location: Ghent, BELGIUM
 Contact: Elie Van Loocke
 Email: elien@coupurecentrum.be
 Tel: 32-9-269-9494
 Fax: 32-9-269-9495
 Website: <http://www.coupureseminars.com/>

DATE: 05 SEPTEMBER 2015 - 06 SEPTEMBER 2015

Location: Taipei, CHINESE TAIPEI ISAPS-OFFICIAL COURSE
 Contact: Nancy Dsen
 Email: nd2430@cgmh.org.tw
 Tel: (886)-3-3273726
 Fax: (886)-3-3273369

DATE: 18 SEPTEMBER 2015 – 19 SEPTEMBER 2015

Meeting: 8th Mediterranean ISAPS-ENDORSED PROGRAM
 Congress of Aesthetic Surgery –
 Focus on the Face Lift and the Face Anti-Aging
 Location: Montpellier, FRANCE
 Email: jmed@atoutcom.com
 Tel: 33 4 42 54 42 60
 Website: <http://www.atoutcom.com>

DATE: 26 SEPTEMBER 2015 – 29 SEPTEMBER 2015

Meeting: ISAPS Course & Cadaver ISAPS-OFFICIAL COURSE
 Workshop – Czech Republic
 Location: Prague and Brno, CZECH REPUBLIC
 Contact: Gabriela Malá
 Email: contact@bos-congress.cz
 Tel: +420 725 809 870
 Website: <http://www.isapsprague.com>

October 2015

DATE: 08 OCTOBER 2015 – 10 OCTOBER 2015

Meeting: ISAPS Course – Serbia ISAPS-OFFICIAL COURSE
 Location: Belgrade, SERBIA
 Contact: Drs. Violeta Skorobac Asanin & Dana Jianu
 Email: dr.violeta@dionahospital.com
 Tel: 381-11-244-3152
 Fax: 381-11-244-3002
 Website: <http://www.belgradecourse.org>

DATE: 16 OCTOBER 2015 – 18 OCTOBER 2015

Meeting: ISAPS Symposium – Australia ISAPS SYMPOSIUM
 Location: Sydney, AUSTRALIA
 Contact: Dr. Morris Ritz
 Email: morrisr@melbplastsurg.com
 Tel: 61-3-9508-9508
 Fax: 61-3-9508-9588

DATE: 28 OCTOBER 2015 – 1 NOVEMBER 2015

Meeting: Global Aesthetics Conference ISAPS-ENDORSED PROGRAM
 Location: Miami Beach, Florida, UNITED STATES
 Contact: Delphine Hepp
 Email: Delphine@multi-specialty.org
 Tel: 1-877-673-3273
 Fax: 1-859-422-5073
 Website: <http://www.globalaestheticsconference.com>

January 2016

DATE: 22 JANUARY 2016 – 24 JANUARY 2016

Meeting: ISAPS Course – India ISAPS-OFFICIAL COURSE
 Location: to be determined, INDIA
 Contact: Dr. Lokesh Kumar
 Email: drlokesh2903@gmail.com
 Tel: 91-112-922-8349/91-114-16-37-288
 Fax: 91-114-610-4541

March 2016

DATE: 10 MARCH 2016 – 12 MARCH 2016 ISAPS-OFFICIAL COURSE

Meeting: ISAPS Course – Qatar
 Location: Doha, QATAR
 Contact: Dr. Habib Al-Basti
 Email: halbasti@hotmail.com
 Tel: 974-493-5699
 Fax: 974-442-5550

April 2016

DATE: 12 APRIL 2016 ISAPS SYMPOSIUM

Meeting: ISAPS Symposium – Argentina
 Location: Buenos Aires, ARGENTINA
 Contact: Cristina Picon
 Email: mariacristinapicon@hotmail.com.ar
 Tel: 54-11-48032823
 Fax: 54-11-48074883

DATE: 22 APRIL 2016 – 24 APRIL 2016 ISAPS-ENDORSED PROGRAM

Meeting: 1st German Brazilian Aesthetic
 Meeting (GBAM)
 Location: Munich, GERMANY
 Contact: Dr. med. Joachim Graf von Finckenstein
 Email: dr.med@finckenstein.de
 Tel: 00 49 (0) 8151 29968
 Fax: 00 49 (0) 8151 29968

May 2016

DATE: 26 MAY 2016 – 27 MAY 2016 ISAPS-OFFICIAL COURSE

Meeting: ISAPS Course – Tunisia
 immediately preceding the International Meeting of the
 Société Tunisienne de Chirurgie Esthétique on May 28
 Location: Tunis, TUNISIA
 Contact: Dr. Atef Maherzi
 Email: amaherzi@hotmail.com
 Tel: 216-71-801-080
 Fax: 216-71-801-080

October 2016

DATE: 23 OCTOBER 2016 – 27 OCTOBER 2016

Meeting: 23rd Congress of ISAPS ISAPS OFFICIAL CONGRESS
 Location: Kyoto, JAPAN
 Contact: Catherine Foss
 Email: isaps@isaps.org
 Tel: 1-603-643-2325
 Fax: 1-603-643-1444

2016 date to be announced ISAPS-OFFICIAL COURSE

Meeting: ISAPS Course –
 United Arab Emirates
 Location: Dubai, UNITED ARAB EMIRATES
 Contact: Dr. Venkat Ratnam Bandikatla
 Email: bvratnam@emirates.net.ae
 Tel: 971-2-617-9741
 Fax: 971-2-631-7303

Admitted November 2014 – March 2015

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Kristoff VERDONCK, MD

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VENEZUELA

Linda RINCON, MD

* indicates Associate-Resident/Fellow Member

** indicates Associate Member

Where in the World?



Answer: National Secretaries Chair Peter Scott in Mali. The Dogon culture of the 14th and 15th centuries is animistic and relates to Sirius, the Dog Star, which they say has three parts. This was only confirmed by scientists in 1920. The cliff dwellings are listed as World Heritage Sites and symbolic paintings depict their beliefs. Dr. Scott, an avid amateur archeologist with a major interest in the paleoneuro-psychology of rock paintings and engravings, is pointing to a circle of life symbol.

Guess Who!



Answer: Renato and Flavia Saltz riding in the Grand Teton National Park, Wyoming, USA.



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YES, IT IS THAT SIMPLE | DEVELOPED BY A SURGEON FOR SURGEONS
It's Clear. It's Universal. It's Better Than Ever.
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