

ISAPS NEWS

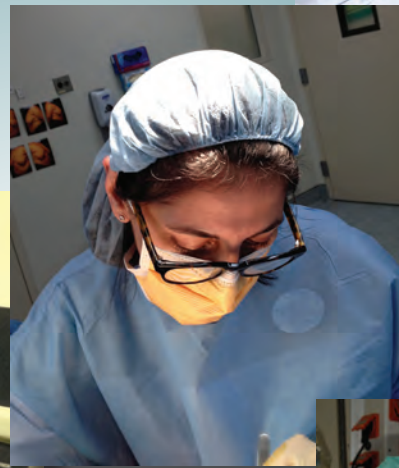
Official Newsletter of the International Society of Aesthetic Plastic Surgery

WOMEN OF ISAPS

Violeta Skorobac Asanin, MD – Serbia



Nina Naidu, MD – USA



Lina Triana, MD – Colombia



Ewa Anna Siolo, MD – South Africa



Maria Wiedner, MD – Germany

*Women Plastic Surgeons
Represent 14% of the
ISAPS Membership*

See article on page 43

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MESSAGE FROM THE EDITOR



Dear Members, Colleagues, and Friends,

Welcome to this Issue of *ISAPS News!*

It is hard to believe that more than half a year has passed since our wonderful Congress in Kyoto. We move forward with great enthusiasm with the planning of the 2018 World Congress in Miami. Under the leadership of Dr. Renato Saltz, our society continues to fulfill its mission of education, patient safety, and international excellence in aesthetic plastic surgery, joining together our colleagues from across the globe in this important pursuit.

There are many interesting features in this issue. Ashish Davalbahakta from India reports the outcome of an informal survey on cosmetic surgery taxes, giving perspectives from different regions. Clara Jimenez from Spain weighs in on the Spanish perspective on this topic. Scott Hackworth from the United States, CPA and Data Scientist, talks about the data integrity process for the ISAPS Procedural Survey in 2017. This data set is key in tracking procedures around the world, and we appreciate the thoughtful process that is being applied. Rick Read, also from the United States, presents a very informative piece on cyber security.

In our Global Alliance Spotlight section, we feature Francisco Menéndez-Graíño, MD, PhD, from Spain and the Spanish Society of Aesthetic Plastic Surgeons, as well as Chris Snijman, MD, of South Africa and the Association of Plastic Reconstructive and Aesthetic Surgeons of Southern Africa. Our Patient Safety Committee presents very useful material about the ISAPS Patient Safety Diamond, and prevention of operating room fires.

We see reports of our wonderful educational activities across the globe including ISAPS Symposia in Chile, Germany, Japan, Thailand and Argentina. Our ISAPS Visiting Professor Program remains very strong with recent activity in Ukraine and Chile. Dr. Bahman Guyuron presents an update of our International Journal and we encourage everyone to submit their best work for publication in this forum.

Our very popular Global Perspectives series features midface rejuvenation with insightful thoughts from members in Japan, Germany, United States, Ukraine, Brazil and Argentina.

Our cover feature highlights the establishment of a new committee: ISAPS Women Plastic Surgeons. Nina Naidu, MD from the United States chairs this new committee. It is important to note that 14% of our membership consists of women surgeons. Moreover, this is likely the largest group of women plastic surgeons in any society worldwide. Of course, we want to see this percentage grow even larger! We congratulate the ISAPS Board for establishing this important committee and we thank Dr. Naidu for her leadership of this group.

This issue is packed with additional useful and interesting information about ISAPS members' humanitarian efforts, the history of plastic surgery and the history of the executive office of ISAPS. We also find the very impressive calendar of upcoming educational events. Thank you for supporting our great international society.

Warm Regards,

J. Peter Rubin, MD

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MESSAGE FROM THE PRESIDENT



Dear Members, Colleagues and Friends,

It has been six months since the current Board of Directors took over in beautiful Kyoto after the great Presidency of my dear friend Dr. Susumu Takayanagi.

One of my goals for 2016-2018 was to take ISAPS to the next level as a modern, energized, highly functional organization that runs **as a business** - a model not very

different from how we run our private offices!

I outlined clear and transparent goals during my presentation at the business meeting in Kyoto last October: to move a busy agenda forward and not get caught up in bureaucracy, status quo, comfort zones, personalities and many other difficulties not uncommon in any large organization to insure *a Society based on Meritocracy, Hard Work and Service!*

Here are some of the most exciting activities and updates in the last six months:

Welcoming the New ISAPS

After 47 years since our founding, it was time to modernize our society and give ourselves a facelift. I asked key members of the board and our Chief Marketing Officer to go back to the drawing board and come up with modern concepts to better represent the New ISAPS as *the Global Authority on Aesthetics*. The growth of ISAPS over the past few years has been truly astonishing - and humbling. With over 3200 members in 102 countries, we have become the loudest and largest advocate for patient safety and defender of our specialty. We have the largest Facebook following of any society in aesthetics, and our public relations reach to connect with the top media outlets in the world is extensive. The time is now to take the public image of ISAPS to the next level by creating a new logo, and a new look and feel for our organization that is truly reflective of who we have grown to become.

We sent all members a short survey to determine your ideas for the "New ISAPS" and how we can serve you even better. Based on that feedback, the ISAPS Branding Task Force will finalize a new, more modern look for ISAPS, including a brand-new logo which will be shared with you first, before it is launched to globally.

The New ISAPS Website

I am pleased to advise that we have concluded months of negotiations with Advice Media to design a brand-new website for ISAPS that will provide sleek new functionality for our members, as well as continuing its role as the global authority for all things aesthetic for prospective patients and global media.

The Global Alliance continues to add National Societies and allows direct communication among Presidents expediting solutions for worldwide problems related to patient safety, education, media and patients. The latest National Society to join us is Thailand.

The Global Sponsorship Program has been completely revamped and expanded by Julie Guest and Hani Zeini. They took into account important industry feedback and have customized the packages making them more attractive to industry.

Education Council

New Policies - I have asked EC Chairs, Vakis Kontoes and Ozan Sozer, to modernize current EC policies to better structure our educational mission to fit a global organization like ours.

Upcoming ISAPS Courses - We have many excellent ISAPS events planned. Please take note of the calendar of courses, symposia and endorsed programs at the back of this issue. If you haven't yet attended one of our courses, I strongly encourage you to do so. Not only is the quality of the scientific presentations outstanding, but it is the best way to experience the fellowship of this great organization and develop new friendships among our specialty that can last for decades.

Aesthetic Plastic Surgery

Bahman Guyuron, Editor-in-Chief of our journal, has completed the transition in record time. The Blue Journal has a new Editorial Board and a beautiful new cover – and a growing number of submitted manuscripts.

Patient Safety First

The Patient Safety Committee under Foad Nahai's leadership has done a terrific job in a very short period of time. The partnership with ASAPS & ASPs in the Gluteal Fat Task Force and ALCL communications to members and media will certainly help patients worldwide.

The First ASAPS-ISAPS Gluteal Symposium took place during the ASAPS Annual Meeting in San Diego. It was a sold-out event attended by more than 150 colleagues.

The next European Standard 16708 Beauty Salon Services will be modified as a result of pressure that ISAPS applied together with other partner societies in the Global Alliance. The European Committee for Standardization, CEN, recognized its mistake to allow a standard to be published with serious dangers for patients and customers. As a result, on April 6th the CEN Technical Board decided to remove advanced beauty treatments from beauty salon standards. Please read the article by Dr. van Heijningen in this issue.

Global Aesthetic Survey

Results will be released worldwide soon. A big thank you to everyone who participated in the world's largest survey of its

MESSAGE FROM THE PRESIDENT

kind. This survey is also the single largest public relations initiative we undertake and it attracts a great deal of global media attention.

Cybersecurity

There is a growing concern at all levels of business regarding recent “hacking” going on, especially in the healthcare industry. I have personally contacted the company in charge of ISAPS cybersecurity and am assured that the ISAPS database is very well protected. Please review the article on cybersecurity in this issue by Rick Read and learn how to protect your data, your practice and your patients.

Women’s Chapter

Nina Naidu, our new National Secretary for the United States, has formed the ISAPS Women Surgeons Chapter – a first in our history. ISAPS has 500 women members representing over 14% of our membership. She is also leading the team in charge of organizing the First Women’s Symposium to be held during the Biennial Congress in Miami Beach in 2018. Please read her article in this issue and sign up.

ASAPS 50th Anniversary

This year marks the celebration of The American Society for Aesthetic Plastic Surgery’s 50th anniversary. It gives me great pleasure to congratulate them on this achievement and the many amazing contributions ASAPS has made not only to American Aesthetic Surgery, but to aesthetic surgery throughout the world.

The relationship between ISAPS and ASAPS continues to grow with a record number of joint shared by our two organizations. I would like to emphasize the following:

- ASAPS was one of the first societies to join the new ISAPS Global Alliance
- ASAPS Facial Rejuvenation Panel in Kyoto was the first ever at an ISAPS Biennial Congress
- ISAPS has endorsed the 2017 ASAPS that will be attended by a significant number of ISAPS Board Members
- ASAPS-ISAPS had their first Joint Symposium during this year’s Aesthetic Meeting
- ASAPS-ASPS-ISAPS developed great co-operation for the advancement of global patient safety during the ALCL Project
- ASAPS-ASPS-ISAPS are the leading societies participating at the Inter-Society Buttock Fat Grafting Safety Task Force
- ASAPS is the first society to endorse the ISAPS 24th Biennial Congress to be held in South Beach, Miami on October 31st – November 4th, 2018

Many of these amazing initiatives between our two societies would never have happened without the enthusiastic support and leadership of Dr. Dan Mills and his Board of Directors.

Personally, this is a very special occasion for me as Past-President of ASAPS to celebrate The Aesthetic Society’s 50th Anniversary and their continued dedication to excellence in aesthetic

education. Congratulations ASAPS, I am looking forward to the next 50 years!

Miami Beach 2018 Update

You can read an update about the upcoming Biennial Congress in this edition. Please follow every newsletter for information as we get closer to this great event. We already have a record number of 327 distinguished faculty confirmed. Other exciting innovations include simultaneous translation in Spanish and Portuguese, a full day of cadaver dissections and live injections, multi-disciplinary faculty, ISAPS Business School, ISAPS Skin, Residents & Fellows Forum, Women’s Symposium and 64 Master Classes by the best faculty in the world - all happening at the most exciting location in this country - South Beach Miami! A preliminary brochure was distributed during the ASAPS Annual Meeting in San Diego and will be available at ISAPS booths at other meetings. Please follow the updates at www.isapsmiami2018.com. **Have you registered yet?**

Enjoy reading this issue of *ISAPS News* and don’t forget to follow us monthly in the ISAPS E-Magazine!

These many accomplishments would not have been possible without the excellent work of your Board of Directors and Committees and the amazing dedication of our staff. My gratitude to them for the many conference calls late at night and on weekends.

As always, I appreciate hearing back from you and learning of your ideas about how we can make ISAPS serve you and your patients even better.

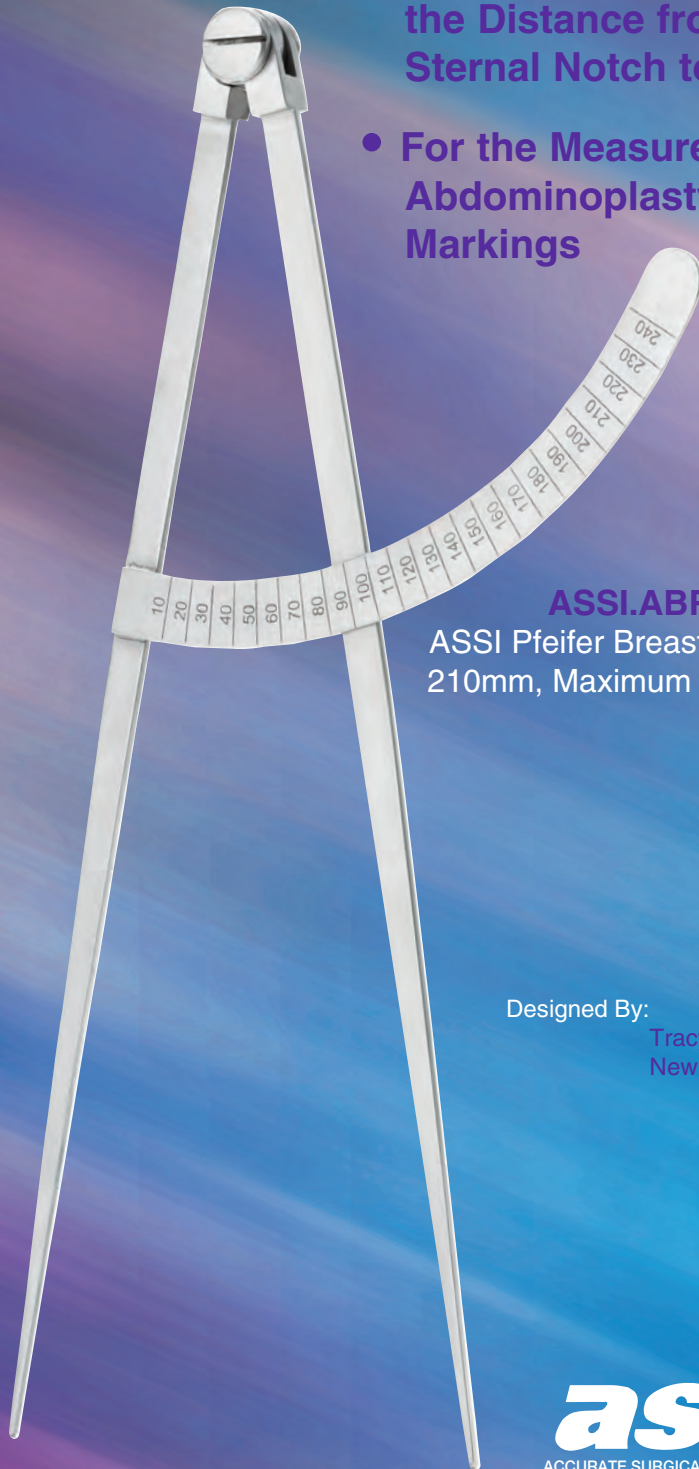
Please email me or call me at any time.

Best regards,
Renato

rsaltz@saltzplasticsurgery.com
cell – 801-910-4410 (I am also on WhatsApp)

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MIAMI UPDATE



Dear Members, Colleagues and Friends,

Your entire Board, Staff and I are working hard to produce a phenomenal ISAPS Congress in the United States.

Please review the preliminary brochure on our website and if you have not registered yet it is time to do it. The link to registration is: <http://www.isapsmiami2018.com/fees/> You should not miss this spectacular scientific and social event that will gather world aesthetic surgery in South Beach Miami in 2018.

We have over 327 confirmed faculty from all over the world with registrations already coming in. Industry and exhibitors are also registering with many booths already sold. All nights are booked with great social events. We will keep you very busy and happy during your week in South Beach.

The Scientific and Advisory Committees are now complete. You can review the distinguished group below. We are currently working on the Scientific Program and should have it available on the meeting website soon.

Please help me to promote the 2018 ISAPS Biennial Congress at every opportunity you can and refer your colleagues to <http://www.isapsmiami2018.com> It is your biennial congress!

ISAPS Congress 2018 Scientific Program Committee

Renato Saltz – 2018 Congress President
Nazim Cerkes – Scientific Co-Chair
Lina Triana – Scientific Co-Chair
Vakis Kontoes – Scientific Co-Chair
Ozan Sozer – Scientific Co-Chair
Susumu Takayanagi – Immediate Past-President
Catherine Foss – Congress Producer
Julie Guest – ISAPS Business School & ISAPS Skin Coordinator

ISAPS Congress 2018 Advisory Committee

Robert Singer – Chair
Jason Pozner – Local Host
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Foad Nahai – ASJ Editor

Rod Rohrich – PRS Editor
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Dirk Richter – Europe
Lee Pu – Asia

Joao Sampaio Goes – South America
Claudio DeLorenzi – North America
Randy Waldman – Multi-Specialty Faculty
Susan Wells – SPSSCS
Hani Zeini – ISAPS Industry Advisor

Best regards,

Renato Saltz, MD, FACS



FEATURES



Ashish Davalbahakta – India

ISAPS Education Council Regional Chair for Asia

SERVICE TAX ON COSMETIC SURGERY

In 2009, the government of India decided to levy a service tax on medical procedures. This was quickly reversed after a hue and cry from the public and only retained on cosmetic or plastic surgeries undertaken to enhance aesthetic beauty, for example: BONTA, tummy tuck, facelift, eyelid surgery, and liposuction. Cosmetic or plastic surgeries to restore or to reconstruct functions of the body affected by congenital defects, developmental abnormalities, injury or trauma were exempted.

Over the last eight years, we have been dealing with this legislation and struggling to comply with its complexities.

- i. The service tax is to be collected at the point of billing, but the surgeon who provides the service has to bill the hospital for a service tax on the professional fees he charges, and pay the government. This is to be offset, but is rarely done.
- ii. Many procedures have a combined benefit of cosmetic improvement and a functional improvement, e.g. rhinoplasty, where shape is improved along with the primary complaint of deviated nasal septum, or abdominoplasty, where the panniculus is corrected along with ventral divarication or hernias. Should we be charging service tax or not?
- iii. Government wants a service tax on the total billable amount; however, when the major component of the service is a product cost, on which VAT has already been paid, shouldn't we be paying tax only on the service component?

Due to these ongoing questions, the Indian Association of Aesthetic Plastic Surgeons decided to approach the government. There is a window of opportunity as the government is implementing GST all across the country. We therefore approached the ISAPS Executive Office for help in determining how many other countries were facing this discriminatory tax. We wanted to know what arguments were used in those countries where this tax was successfully refuted.

This is an issue that is faced by our community of surgeons and physicians all over the world and it is important to have a consensus amongst all of us. This is a discriminatory tax. Although it may be considered valid and reasonable if used purely for beautification or enhancement, there are a lot of psychological, physical and sexual benefits to aesthetic surgery.

The four-question survey that ISAPS recently conducted among our National Secretaries and presidents of ISAPS Global Alliance member societies revealed some interesting results. Responses came back from 49 countries with, in four countries, more than one response. Tax rates range from 5% to 30%. Of the 53 respondents, 26 reported that they do not have a service tax on cosmetic surgery. Six reported that their government had proposed a tax, but it was defeated. Diverse arguments were used to thwart the levying of service tax:

- i. Service tax is discriminatory to women (as more women have cosmetic surgery),
- ii. Difficulty in distinguishing between cosmetic and reconstructive indications,
- iii. Psychological benefits of cosmetic surgery cannot be considered as a mere service similar to hairdressers,
- iv. The WHO definition of health is complete physical, social and mental wellbeing, so the increase in self-esteem through cosmetic surgery is an important factor of health,
- v. If a person undergoes cosmetic surgery to increase his or her general wellbeing or sense of wellbeing, it should not be taxed,
- vi. It is a medical procedure and hence should not be taxed.

Thank you to our colleagues in the following countries around the world who contributed information: Argentina, Australia, Belgium, Bolivia, Brazil, Canada, China, Chinese Taipei, Colombia, Cyprus, Czech Republic, Denmark, Dominican Republic, Ecuador, Egypt, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Lebanon, Lithuania, Malaysia, New Zealand, Panama, Philippines, Poland, Portugal, Romania, Russian Federation, Saudi Arabia, Serbia, Singapore, Slovenia, South Africa, Spain, Sweden, Switzerland, The Netherlands, Tunisia, Turkey, Ukraine, United Arab Emirates, United Kingdom, United States, and Uruguay.

It is important for all of us to have a unified stand on this issue and through ISAPS it may be possible to achieve a consensus. The arguments for and against will be the same in all countries. This initial, informal ISAPS survey has helped us understand what position Aesthetic Plastic Surgeons in other countries have taken. It will arm us with facts and figures prior to approaching our governments in the future.





Clara Jimenez – Spain

Tax Specialist and Partner at Perez-Llorca Lawyers

COSMETIC SURGERY TAX – THE SPANISH PERSPECTIVE

I. Introduction

These days there are a number of uncertainties in relation to the indirect taxation and data protection applicable to aesthetic plastic surgery. For this reason, the Spanish Society of Plastic, Reconstructive and Aesthetic Surgery (“**SECPRE**”) and the Spanish Association of Aesthetic Plastic Surgery (“**AECEP**”) together with the legal advice of the Spanish Law firm Pérez-Llorca, have tried to shed some light on these matters by submitting several queries to the Spanish General Directorate of Taxes (“**SGDT**”) and the Spanish Data Protection Agency (“**SDPA**”).

II. EU and national provisions and case law

According to Article 132(1)(b) and (c) of Council Directive 2006/112/EC of 28 November 2006 on the common system of Value Added Tax (the “**VAT Directive**”), Member States shall exempt the following transactions from tax:

(b) hospital and medical care and closely related activities undertaken by bodies governed by public law or, under social conditions comparable with those applicable to bodies governed by public law, by hospitals, centers for medical treatment or diagnosis and other duly recognized establishments of a similar nature;

(c) the provision of medical care in the exercise of the medical and paramedical professions as defined by the Member State concerned;”

This article has been interpreted by the Court of Justice of the European Union (“**EU**”), amongst others, in its Judgment of 21 March 2013 (Skatteverket vs PFC Clinic AB) in which the Court stated the requirements for tax exemption to apply.

According to this Judgment, services whose purpose is to treat or provide care for persons who, as a result of an illness, injury or a congenital physical impairment, are in need of plastic surgery may fall within the exemption. However, when the surgery is for purely cosmetic reasons it does not fall within this concept.

Article 132(1)(b) and (c) of VAT Directive was transposed into Article 20(1)(3^o) of Law 37/1992, of 28 December, of VAT (“**Spanish VAT Law**”). However, there were several doubts regarding the way that Spanish VAT Law should be interpreted when applied to aesthetic plastic surgery.

III. Initiative of SECPRE and the AECEP

In light of domestic and EU provisions, it was considered necessary to determine in which cases the service of aesthetic plastic surgery would be included in the VAT exemption.

With this purpose, two queries were submitted to the SGDT requesting criteria in the application of the VAT exemption. The SGDT issued two binding tax rulings in July 2015 and April 2016 (tax ruling V2075-15 and tax ruling V1709-16).

Once the existing uncertainties had been solved from a tax perspective, additional steps were taken in relation to the data protection of patients.

In this regard, as the burden of proof of the application of the VAT exemption lies with the medical practitioners (as they are responsible for justifying case-by-case that the requirements established in order for the VAT exemption to apply are met) a query was filed before the SDPA in relation to the data that can be provided to the Tax Authorities.

The query submitted to the SDPA was answered by a report issued in December 2016.

IV. Summary of the GDT binding tax rulings conclusions

According to the binding tax rulings issued by the GDT, in order to determine whether the VAT exemption applies to the services rendered in the field of aesthetic plastic surgery, the following requirements must be met:

- There must be a previous disease, injury or health disorder (including psychological diseases).
- The purpose of the services must be treating or, in so far as possible, curing said diseases or health disorders or to protect, maintain or restore human health. This concept also includes treatments carried out with the purpose of mitigating their effects or appearance.
- Medical practitioners shall determine, on a case-by-case basis and using their medical skills and knowledge, whether a medical intervention fulfills the mentioned requirements and should thus be included in the exemption or not.
- Medical practitioners shall be able to prove, case-by-case, that all requirements were met when applying the VAT exemption.

continued on page 9



Ivar van Heijningen, MD – Belgium

ISAPS National Secretary for Belgium

ISAPS Membership Committee Chair and Patient Safety Committee Member

President-Elect, European Association of Societies of Aesthetic Plastic Surgery (EASAPS)

BEAUTY SALON STANDARD MODIFIED THANKS TO JOINT PRESSURE

The soon to be published European Standard 16708 Beauty Salon Services was finally modified as a result of the pressure ISAPS applied together with a number of our Global Alliance partner societies.




European Committee for Standardization

Two claims of a defective standard were drafted by aesthetic doctors Dominique Debray and Sofia Del Cueto, plastic surgeons Claude LeLouarn and me, along with dermatologist Johan Snauwaert, to convince CEN of their mistake to allow a standard to be published with serious dangers for patients/customers. Numerous national and international societies recognized our concern and also filed claims with CEN against this standard.

As a result, the CEN Technical Board decided on April 6th to remove advanced beauty treatments including chemical peels, micropigmentation/semi-permanent make up, micro needling, IPL, laser and light treatments from EN 16708.

There remains the worrisome misuse of the terms disinfection and sterilization in the text, but this change is a big step forward. Unfortunately, the Technical Committee (TC-409) drafting this standard was dominated by people with a vested interest such as selling laser machines. Too few physicians (if any) were involved and attempts by us to point out the risks were initially ignored. This example shows how vigilant we must be when Standards are being drafted on a National, European, or International (ISO) level.

The imminent standard on Aesthetic Medicine-non-surgical treatments EN 16844, written mainly by doctors, is a good compromise with an emphasis on patient safety, similar to EN 16372 Aesthetic Surgery Services which was published in 2015 by the same group. It proves that standards are only as good as the people drafting them. This means that enough of us must sacrifice our time to be present when standards are being discussed and composed so that subjects that will impact our profession are addressed in time. 


Features – Jimenez continued

- The GDT established some general presumptions in relation to certain kinds of illnesses (for instance, breast enlargement due to agenesis or reconstruction after mastectomies are presumed to be exempt and liposuction is presumed to not be exempt).

V. Summary of the SDPA report's conclusions

According to this report, the SDPA established that the data requested by the Tax Administration in the course of a tax inspection is considered to have tax "significance", and consequently, the transfer of such data to the Tax Administration is allowed without the need to inform the affected party.

Additionally, the invoices issued by medical practitioners must include a minimum description of the service rendered in order for the Tax Administration to be able to determine whether the tax treatment applied to such services is correct, and the fact that the disease or treatment received is included does not constitute a violation of the patient's privacy.

Since the limits of such a description are not specifically mentioned in the SDPA Report, the decision of what is the minimum information which should be included should be down to the medical practitioner's judgment. 



Scott A. Hackworth – USA
 CPA and Data Scientist
 Senior Vice President, Industry Insights, Inc.

ISAPS PROCEDURAL SURVEY 2017 – DATA INTEGRITY PROCESSES

My team and I at Industry Insights recently completed this year’s ISAPS Procedural Study, which estimates the number of aesthetic procedures performed world-wide in 2016. This year’s project has been an overwhelming success, given its response rates and the number of countries for which we are able to report data. The results we’ve published compare well with the prior year’s figures, and the increased sample provides tighter overall confidence bands than experienced by any of our prior studies.

The methodology established for this project is fairly simple. We survey plastic surgeons from all areas of the world and extrapolate the results. However, several nuances exist within the process of confidently producing these findings. ISAPS requested that I list and describe some of the key methods we apply for reviewing and auditing the study’s data prior to publishing results. These steps (and several more) are necessary to ensure the final results are as accurate as possible.

Initial Data Review Procedures: these are the general steps followed to ensure the submissions are acceptable and the data values have been properly entered.

Completeness: We enforce general requirements for how complete a response must be for it to remain in our sample. Likewise, we also conduct tests to ensure that the response is logical. For example, it is highly unlikely that an individual surgeon would have performed every possible aesthetic procedure in 2016. Frequency patterns further help us detect invalid or incomplete submissions.

Errors: Error detection is a general process of ensuring that respondents followed instructions and didn’t make recurring mistakes that may indicate the response was rushed and/or not well considered. These issues are commonly found in areas where items should add to a set total or where combined values are expected to fall in an expected range.

Outliers: Data values that exceed several standard deviations from the mean are systematically pruned from the database. The process commonly detects data entry errors or possibly mischievous submissions. While some of these outlying values could potentially be valid, their inclusion would jeopardize the study’s overall accuracy and consistency.

Data Patterns (scatter plots and histograms): Graphing the data allows us to visually identify inconsistent patterns that may exist between years or among the given procedures. When issues are detected, our team reviews the specific data points to make corrections and ensure the anomalies are not systematic.

Integrity Audit Processes: these steps help insure the data are valid and trustworthy.

IP Origins: While the survey is purely anonymous, we collect Internet Protocol (IP) addresses of respondents in order to audit their country of origin. For instance, we generally expect that submissions from a Brazilian surgeon would have originated from a Brazilian IP address.

Completion Patterns: General patterns exist for most respondents’ overall submissions. We can generally anticipate and test for various relationships among surgeon’s answers. The existence of these patterns gives confidence that the accepted responses are valid.

Benford’s Law: This “first-digit” proportions rule allows us to easily audit the overall values to ensure the data were not randomly or fictitiously provided. Benford’s Law resolves that the proportions of the first digit (e.g. “2” in 254) in naturally-occurring data follow a distinct pattern, whereas fictitious or randomly-provided data result in proportions that are out of alignment with these standards. Determining that our sample generally complies with Benford’s Law helps rule out concerns about fictionalized data.

Final Review Processes:

Comparison with Prior Year: Comparing procedures of the 2 years’ datasets for their individual variances and statistically significant differences helps us verify comparability and identify key differences that should be reviewed for accuracy.

Industry “Gut Check”: After the initial results were prepared, ISAPS provided the draft tables to its Global Sponsor Presidents and other industry experts for their review and comment. This external inspection allowed us to calibrate our results against these experts’ global expectations. Overall, the data were approved, which reinforces the success of the above processes and the study’s overall methodology.

It is my hope that the above details have provided you with increased confidence in ISAPS’ annual statistics. Our unrelenting goal is to provide procedural counts that are as accurate as possible, given the project’s daunting scope. In addition to my team’s efforts, ISAPS’ leadership and its volunteers invest hundreds of hours each year, assisting with the survey’s participation efforts, communicating with the National Societies, and offering advice and perspectives during the survey review process. We work together to provide the only such study that exists in the world – and we value this responsibility.



Rick Read – USA
President – On Top of IT

CYBERSECURITY NOTES

As we've all made the transition to interconnectedness via the internet, opportunities have opened for the unscrupulous to exploit weaknesses in people and systems. The miraculous benefits of computers have become commonplace, but the resulting complacency plays into the hands of cybercriminals.

The following notes are meant to provide some guidance on what can be done to help harden systems under your watch against attackers. The list is not comprehensive.



Old fashioned email continues to be the method of choice for illicitly hacking computers. The reason for this is that email is ubiquitous and messages in an email can be socially engineered to take the upper hand of

trust. This tricks the recipient into opening the payload (an attachment or link) potentially infecting their computer.

It is useful to reiterate that the default position towards email should be one of distrust.

A common method for falsely gaining the recipient's trust is to make the message look like it came from someone the recipient knows. "Oh, it's from my mother, it must be fine." Think again, and again, especially if the message suggests an action such as downloading, clicking on a link or attachment, or logging in to a web site. Those actions should be taken as red warning signals in block capitals.

But how can someone fake being my trusted colleague?


Anyone can send messages that appear to come from someone else because a person's identity cannot be verified with standard email. Assume that attachments and unknown links are toxic.

Verify the identity and intent of the sender as necessary by way of alternate means (a separate message, text or phone call) and then act on the message accordingly.

Aside from maintaining raised awareness about messages that are not as they seem to be, here are some other preventive measures to help keep your data secure:

1. Use reputable email spam and malware filters. These provide an automated first-level security screen for incoming email.
2. Perform periodic system audits. Are security updates being installed automatically to your operating system?
3. Production machines should be run with standard (not administrative) privileges.
4. Create complex passwords, especially for accounts on public-facing servers, and do not repeat the same password across web sites.
5. Use secure web sites. The address should read with https: instead of http:. This encrypts data between your computer and the web site, improving security.
6. Use two-factor authentication where feasible. On your email account, for example, with two-factor authentication, a hacker will not be able to log in to your account without having access to your smartphone.
7. Using multiple backup media rotated off the network creates layers of protection against ransomware.

Ransomware attacks will quickly encrypt your data, making it inaccessible to you. Paying an exorbitant ransom will un-encrypt your data, but only if the ransomer cooperates. To keep from being beholden to the criminals, keep multiple days, or weeks, of backup on separate devices off network, and use a cloud backup service specifically designed to help recover from ransomware.

Cybersecurity is an ever-evolving threat. To keep up, it is best to employ a trusted technology specialist who can regularly monitor your communication systems to be sure that your office (and personal) devices are not only up to date, but more than adequately backed up and protected. This should not be one of your staff. Insurance will not cover you in the event of a seizure of your data. Invest in a specialist instead. As a busy surgeon, keeping up with technological threats is probably not a good use of your time, nor particularly effective. Find someone you can trust who will challenge, advise, update, monitor, and protect your very valuable assets. 

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WHERE IN THE WORLD?



See page 55 for the answer



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Send photos to: membership@conmx.net



MIAMI TRIVIA

The Best Place To Cruise

For those that want to take a cruise, Miami Beach is the place to be. Miami contains the largest cruise ship port in the entire world. Many cruise ships go in and out of this port on a daily basis.

GLOBAL ALLIANCE



S P O T L I G H T



Francisco Menéndez-Graño, MD, PhD – Spain

President of the Spanish Society of Aesthetic Plastic Surgeons (AECEP)



The Spanish Society of Aesthetic Plastic Surgeons was founded in 1989 in order to respond to the specific professional needs of plastic surgeons in Spain, specially those focused on Aesthetic Surgery.

The requirements for membership included being a member of the Spanish Society of Plastic, Aesthetic and Reconstructive Surgery (SECPRE) as well of the International Society of Aesthetic Plastic Surgery (ISAPS), in addition to having at least five years of professional experience as a plastic surgeon, and showing a special interest in Aesthetic Surgery.

The aims of the Spanish Society of Aesthetic Plastic Surgeons remains in force after twenty-eight years: contribute to raising the scientific level of Aesthetic Surgery, defend and solve the daily problems of the specialty, stimulate the scientific performance and professional improvement of its members through meetings, conferences, training courses, congresses and exhibitions related to the specialty, plus promote the exchange of know-how and cooperation with other medical specialties.


Currently, over 130 plastic surgeons are members of the Spanish Society of Aesthetic Plastic Surgeons (AECEP), probably the most prestigious and highly trained in Spain, all of them with great experience in the Aesthetic Surgery field, with remarkable professional ethics.

The Spanish Society of Aesthetic Plastic Surgeons (AECEP) has successfully raised the prestige of Aesthetic Surgery through the organization of anatomical courses, as well as other monographic training courses of specific medical topics, plus the organization of an important international meeting with the involvement of outstanding and well known international Aesthetic Surgery speakers.

This year we have organized a theoretical and practical training course in open rhinoplasty dissection with the Anatomical Professorship of the Universidad Autónoma de Madrid (February 18th), a training course on breast secondary aesthetic surgery in Oviedo (April 21st-22nd) and the AECEP International Meeting which will be held in Madrid (November 2nd-4th, 2017) with the participation of distinguished Spanish and international plastic surgeons like Dr. Foad Nahai, Dr. Sam Hamra, Dr. Dennis Hammond, Dr. Daniel del Vecchio, Dr. Benjamin Ascher, Dr. Nazim Cerkes, Dr. Constantino Mendieta, Dr. Aaron Kosins and Dr. Alfredo Hoyos.

Although the good relations between ISAPS and AECEP have been present during all these years, since all AECEP members are also ISAPS members, becoming part of the ISAPS GLOBAL ALLIANCE has seemed transcendent to us, since we consider a key factor of the alliance of all the aesthetic plastic surgeons worldwide to share opinions, knowledge and make joint decisions.

Living in a “global village” implies fluid communication and immediacy when making decisions, and this is only possible through unity. Furthermore, other factors like collaboration in the ISAPS journal, *Aesthetic Plastic Surgery*, or the organization of ISAPS training courses make even more attractive the participation, in fact, next February 2018 we will celebrate an ISAPS training course in Barcelona, organized by Dr. Jesús Benito.

There is no doubt that union makes force and a national society by itself would never have the same capacity or reaction of an international organization of national societies as the ISAPS GLOBAL ALLIANCE. Therefore, it is an honor for to be the President of the AECEP during its foundation. 



Chris Snijman, MD – South Africa

President, Association of Plastic Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)



As the newly elected President of the Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA), I am pleased and honoured to acquaint you with the history and development of our society.

The genesis of APRASSA was in 1956 when six registered plastic surgeons convened at the Brenthurst Clinic in Johannesburg to form an Association of Plastic Surgeons of South Africa. Dr. Jack Penn, the senior surgeon, had returned to South Africa in 1941 from England where he had worked with Sir Archibald McIndoe at the Queen Victoria Hospital in East Grinstead, Sussex doing pioneering work in the treatment and rehabilitation of Royal Air Force pilots who had been burnt during World War II. This led to the phoenix rising out of the ashes becoming the logo of our Society.


At this meeting, Dr. Penn was elected as the first President, Dr. Dennis Walker, Honorary Secretary and Treasurer and Dr. James Cuthbert was tasked with drafting our constitution. By 1962, we had ten full members of the association and well-established teaching units in all of the major centres in South Africa. It was during this year that we achieved recognition as a group by the Medical Association of South Africa. From these humble beginnings, our association started its explosive growth to its present-day membership of 162.

South Africa is a truly unique country with tremendous cultural and fiscal diversity. This is reflected in the spectrum of plastic surgery practised in our country that ranges from technically demanding microvascular reconstruction to high-end aesthetic surgery in the major urban centres. Our members undergo a rigorous standardised training program of a minimum of four years of plastic surgery residency in a recognized teaching facility, following which they are eligible to sit for the College of Plastic Surgery examination. Should the candidate be successful in this endeavour, he or she is then able to apply for membership to the association. In this way, standards are maintained from a grass roots level. In addition, we have a very strong peer review and ombudsman system in place. This allows for continued monitoring of our standards and, should a problem be identified, corrective measures are rapidly implemented.

Affiliations and mentorships are common in our country, with the older surgeons being more than willing to disseminate their knowledge and experience to their younger colleagues. Despite

being a relatively small and highly competitive community, we are a cohesive and tightly knit group.

Our hospitality and enjoyment of life and the great outdoors is infectious and our regular overseas guests, who are invited to attend our annual association and ISAPS congresses, will attest to this.

We look forward to ongoing interactions with all of you in the future and to welcoming you to our beautiful country. 

ISAPS GLOBAL ALLIANCE PARTICIPATING SOCIETIES

ARGENTINA - Sociedad Argentina de Cirugía Plástica Estética y Reparadora (SACPER)
 AUSTRALIA - Australasian Society of Aesthetic Plastic Surgery (ASAPS)
 AZERBAIJAN - Society of Plastic Surgery Azerbaijan (SPSA)
 BELGIUM - Royal Belgian Society for Plastic Surgery (RBSPS)
 BOLIVIA - Sociedad Boliviana de Cirugía Plástica Estética y Reparadora (SBCPER)
 CANADA - Canadian Society for Aesthetic Plastic Surgery (CSAPS)
 CHILE - Sociedad Chilena de Cirugía Plástica, Reconstructiva y Estética (SCCPRE)
 COLOMBIA - Sociedad Colombiana de Cirugía Plástica, Estética y Reconstructiva (SCCP)
 DENMARK - Dansk Selskab for Kosmetisk Plastikkirurgi (DSKP)
 DOMINICAN REPUBLIC - Sociedad Dominicana de Cirugía Plástica Reconstructiva y Estética (SODOCIPRE)
 EASAPS - European Association of Societies of Aesthetic Plastic Surgery (EASAPS)
 EGYPT - Egyptian Society of Plastic and Reconstructive Surgeons (ESPRS)
 FINLAND - Suomen Esteettiset Plastiikkakirurgit r.y. (SEP)
 FRANCE - Société Française des Chirurgiens Esthétiques Plasticiens (SOFCEP)
 GERMANY - Vereinigung der Deutschen Aesthetisch Plastischen Chirurgen (VDAPC)
 GREECE - Hellenic Society of Plastic, Reconstructive and Aesthetic Surgery (HESPRAS)
 INDIA - Indian Association of Aesthetic Plastic Surgeons (IAAPS)
 IRAN - Iranian Society of Plastic and Aesthetic Surgeons (ISPAS)
 ISAPS - International Society of Aesthetic Plastic Surgery
 ITALY - Associazione Italiana di Chirurgia Plastica Estetica (AICPE)
 ITALY - Società Italiana di Chirurgia Plastica Ricostruttiva ed Estetica (SICPRE)
 JAPAN - Japan Society of Aesthetic Plastic Surgery (JSAPS)
 KOREA - Korean Society of Aesthetic Plastic Surgery (KSAPS)
 LEBANON - Lebanese Society of Plastic, Reconstructive, and Aesthetic Surgery (LSPRAS)
 OSAPS - Oriental Society of Aesthetic Plastic Surgery (OSAPS)
 PERU - Sociedad Peruana de Cirugía Plástica (SPCP)
 PHILIPPINES - Philippine Association of Plastic, Reconstructive and Aesthetic Surgeons (PAPRAS)
 PORTUGAL - Sociedade Portuguesa de Cirurgia Plástica Reconstructiva e Estética (SPCPRE)
 ROMANIA - Romanian Aesthetic Surgery Society (RASS)
 SERBIA - Serbian Society of Aesthetic Surgeons (SRBSAS)
 SERBIA - Serbian Society of Plastic, Reconstructive, and Aesthetic Surgery (SRBPAS)
 SINGAPORE - Singapore Association of Plastic Surgeons (SAPS)
 SPAIN - Asociación Española de Cirugía Estética Plástica (AECEP)
 SPAIN - Sociedad Española de Cirugía Plástica Reparadora y Estética (SECPRE)
 SOUTH AFRICA - Association of Plastic, Reconstructive and Aesthetic Surgeons of Southern Africa (APRASSA)
 SWEDEN - Svensk Förening för Estetisk Plastikkirurgi (SFEK)
 SWITZERLAND - Schweizerische Gesellschaft für Aesthetische Chirurgie (SGAC)
 THAILAND - Society of Aesthetic Plastic Surgeons of Thailand (THSAPS)
 TURKEY - Turkish Society of Aesthetic Plastic Surgery (TSAPS)
 UNITED KINGDOM - British Association of Aesthetic Plastic Surgeons (BAAPS)
 UNITED KINGDOM - United Kingdom Association of Aesthetic Plastic Surgeons (UKAAPS)
 UNITED STATES - American Society for Aesthetic Plastic Surgery, Inc. (ASAPS)
 VENEZUELA - Sociedad Venezolana de Cirugía Plástica, Reconstructiva, Estética y Maxilofacial (SVCPREM)

PATIENT SAFETY



Ivar van Heijningen, MD – Belgium
ISAPS Membership Committee Chair and Patient Safety Committee Member

PATIENT SAFETY & STANDARDS

The four facets of the ISAPS Patient Safety diamond describe how to provide patient safety:

1. A competent well trained specialist (SURGEON)
2. Checks the health of a patient and manages their expectations to be sure they are realistic (PATIENT)
3. Then chooses the right procedure for this patient (PROCEDURE)
4. And executes that procedure in a safe, accredited environment (FACILITY)

That sounds like something that could be accomplished for every patient; nevertheless, we see lots of violations of this process which brings us to the core question:

Who checks this?

We would expect that university training produces competent, ethical medical specialists, but then we see maxillofacial surgeons doing breast augmentations, radiologists doing Botox™ injections and GP's doing liposuction.

Arguably, if we do not stay within the core competencies for which we were trained, that will have a big impact on patient management and procedure selection.

Facility control varies enormously for country to country. Some need government licensing and formal accreditation by official groups such as the American Association for the Accreditation of Ambulatory Surgical Facilities (AAAASF) and AAAASF International while in other countries no facility licensure or certification is necessary.

Thus, there is a worldwide lack of control!

How can we solve this?

Ideally, this would be enforced by law, but few countries have laws on aesthetic procedures, and those that do have such laws see that these are not always well written by the politicians.

Second best are universal standards. Everybody knows the International Standards Organization (ISO) has standards on lots of products that apply in every country in the world. Nobody needs to follow these standards (they are not laws), but most will do so anyway since these rules are written by experts in the

field and are considered the gold standard. Service standards that describe how a particular service should be provided are becoming more and more important.

Standards are written by those with an interest in a particular service and have a neutral status. They must be implemented in all countries creating the standard, so for example a European Standard will be published in all European and ESTA countries. Because they are used by lawyers, standards can have legal implications. This is all good, but on the negative side is the fact that the standard is only as strong as the stakeholders who write it and if it is not good, the legal implications still stand.

The European Standard EN 16372 Aesthetic Surgery Services was published in 2015. We worked for more than 6 years on this standard. You can find articles about it in previous ISAPS newsletters. It describes competencies needed to provide these services such as:

3.1.3 *A registration for all practitioners performing aesthetic surgical procedures is highly recommended...*

How to manage and communicate with patients, such as:

4.1.2 *Financial inducements shall not be used to entice patients*

It describes the basic recommendations for facilities such as:

5.1.1 d) *The procedure room shall have an **emergency power source**, (e.g. a generator or battery powered inverter), with sufficient capacity to operate monitoring, anesthesia, surgical device, cautery and lighting a minimum of two hours.*

And it describes the procedures:

6.1 General

Aesthetic surgical procedures are subject to change. This clause sets out current practice and the generic groups of these treatments. For exact definitions of procedures, peer reviewed journals, European and national competent organizations, and authorities should be consulted.

This European Standard is a consensus document and not all of it is what we as plastic surgeons would have preferred, but it puts the bar sufficiently high for all who aspire to perform these procedures to protect the patient.

continued on page 19



James Fernau, MD – United States
Member, ISAPS Patient Safety Committee

PREVENTION OF OPERATING ROOM FIRES

Hundreds of surgical fires occur each year. Preventing these fires requires teamwork and an understanding of the very real hazards of using oxygen in the operating room. The new recommendations focus on eliminating open delivery of supplemental oxygen during sedation or securing the airway if a patient requires an increased oxygen concentration.

Surgical fires can be prevented in the vast majority of cases. It is all about careful attention to oxygen delivery. Based on Eckerd Institutes analysis of extensive state based medical adverse event reporting data, there are an estimated 600 surgical fires in the US per year. Most are minor; however, some result in serious injury, disfigurement, or even death. Every surgery poses a risk of fire. Some procedures are riskier than others. Plastic surgeons perform many of these high risk cases.

Surgical fires have occurred in or on all parts of the body and the majority of such fires involve areas where high oxygen concentrations were present. These potentially oxygen enriched areas include the head, face, neck and upper chest which account for approximately 65% of surgical fires, the remaining 35% occur elsewhere on or in the body. Fires occur when an ignition source; a fuel, and oxygen come together. Each member of the surgical team should be aware of these three elements and their related fire risks. Surgeons typically use ignition sources such as electro surgical pencils or lasers. OR nurses help apply prep solutions and other potential fuels. Anesthesia professionals control the delivery of oxygen and nitrous oxide. The entire surgical team should discuss the risk of fire for every patient. A prep timeout is the ideal time to identify fire risks and coordinate preventive methods. Oxygen enrichment is the most significant factor contributing to surgical fires, especially for surgery to the head, neck, face, airway and upper chest. Many items that will not burn in room air will easily ignite and burn in the presence of an oxygen enriched atmosphere. In the surgical setting, nitrous oxide is as dangerous as oxygen in supporting fires. Fires burn hotter and faster in the presence of increased oxygen concentrations or nitrous oxide.

To reduce the risk of excess oxidizers, the patient's oxygen needs must be considered. Routine delivery of supplemental oxygen using an open source like a nasal cannula during head and neck

surgery increases the oxygen concentration in the surgical field and increases the chance of fire. To prevent fires during sedation with a natural airway, we need to ask is supplemental oxygen necessary for this patient? Many patients can be sedated safely and effectively without supplemental oxygen. For patient comfort in these cases, air can be delivered to the patient via a nasal cannula or mask. Oxygen saturation monitoring with a pulse oximeter should be used to insure adequate oxygenation. If supplemental oxygen is required to maintain adequate patient oxygenation then the airway must be secured with a tracheal tube or laryngeal mask airway to keep oxygen from entering the surgical field.

There are, however, some surgical procedures around the head, neck and upper chest where conscious sedation is required and oxygen delivered by nasal cannula or mask may be needed to maintain adequate oxygen saturation. There also may be unusual cases where the risk of securing the airway for a minor procedure is greater than the risk of careful open delivery. When delivering oxygen by nasal cannula or mask in such exceptional cases, you should not use the axillary oxygen flowmeter which is only capable of delivering 100% oxygen. The goal is to deliver the minimum concentration of oxygen necessary to maintain adequate oxyhemoglobin saturation. Restricting the delivered oxygen concentration to 30% or less will minimize fire risks during exceptional surgeries and may provide an acceptable oxyhemoglobin saturation. Room air is preferred whenever possible. There is no risk of a flash fire if the oxygen concentration is less than 30%, but many items that do not burn in air will burn in 30% oxygen.

Three options are recommended during exceptional surgical cases where open oxygen delivery is essential. The most reliable approach is to use an air/oxygen blender to provide the gas to the nasal cannula or mask. The primary advantages are that the oxygen concentration is selected directly and that these devices are accurate. Although commonly available in other areas of the hospital, blenders may not be present in many anesthetizing locations. Alternatively use a three gas anesthesia machine, one with air oxygen and nitrous oxide that has a readily available common gas outlet and take the blended gas directly from the outlet.

continued on next page

Be careful about the ratio of oxygen and air used. You must remember that it takes very little oxygen added to air to enrich the oxygen concentration beyond 30%. For example, adding only 200 millimeters per minute of oxygen to 1.8 liters of air creates an oxygen concentration of 29%.

Newer anesthesia machines may not have an available common gas outlet. For three gas anesthesia machines without an available common gas outlet, delivery of blended air and oxygen via the patient WYE is possible. For faster changes in oxygen concentration delivery, close the APL valve. This technique has the advantage of being able to measure the concentration of oxygen delivered by the flow meters using the oxygen concentration monitor.


Regardless of which open delivery method is used, if you first deliver 100% oxygen with the intent of later lowering the concentration prior to using an ignition source it may require several minutes (wait at least one minute before use of electrocautery) to reduce the oxygen concentration delivered to the patient and accumulating under the drapes. Furthermore, the actual oxygen concentration at the surgical site is not known when using open oxygen delivery. You should always start with the lowest oxygen concentration required to keep the patient safe. The delivery of five to ten liters per minute of air under the drapes can wash out excess oxygen. Use of alternate surgical modalities such as a scalpel, bipolar electro surgery or harmonic scalpel can remove the ignition risk. Draping techniques such as open draping where the face is only partially covered or not covered at all have been advocated to reduce the risk of oxygen accumulating under the drapes and flowing into the surgical site. Be aware these techniques should only be used for exceptional cases since they do not fully eliminate the surgical fire risk when delivering oxygen above 30%.

To summarize the preventive methods that can be used for exceptional cases include blending air and oxygen, diluting the under drape space with air, using alternative surgical modalities and using modified draping techniques.

Like oxygen enriched fires, alcohol related fires can cause serious injury. Alcohol based prep solutions burn readily in room air and the fires are hard to see. If you use a prep solution containing alcohol, it must be allowed to dry completely before draping (3 minutes). The same holds true for any flammable dressing. They must be allowed to dry before use of an electro surgical pencil or other ignition source near them. Many other surgical items burn vigorously in the presence of enriched oxygen. If you ensure that excess oxygen is not enriching the surgical site and allow alcohol prep solutions to dry completely (3 minutes), you will be able to prevent most surgical fires. Many commonly used surgical instruments produce heat but must be used to accomplish the procedure. Since the potential ignition source often cannot be eliminated, it is essential to control the oxygen concentration at the surgical site so the risk of fuel ignition is reduced.

You should be able to prevent surgical fires if you eliminate an increased oxygen concentration and any alcohol vapors from the surgical site. However, if a fire occurs, rapid team work is required to minimize injury. The anesthesia professional should remove any source of oxygen from the fire, the surgeon and scrub nurse can pull off the burning drapes while another staff member pours saline on and around patient to douse the fire. The circulator can use a fire extinguisher to put out the burning drapes once they are removed from the patient.

It is a rare occasion when a fire extinguisher needs to be discharged directly on the patient. Airway fires are especially hazardous and require a rapid response to remove the burning materials and minimize patient injury. For a fire in the airway or breathing circuit, saline should be poured into the patient's airway to extinguish any residual embers and cool the tissues.

Surgical fires are preventable. The risk of surgical fire should be discussed by the operating room team. Communication between surgeon and anesthesia is essential. With attention to teamwork and knowledge of the causes of fires, prevention should be successful. 

CHECK YOUR ADDRESS ON THE ISAPS WEBSITE



Have you looked at your listing on our website lately?

Patients will find you if your contact information is correct. Be sure the email, telephone and address are up to date. If you have not added your practice website link to your isaps.org profile, you can do that when you pay your dues. To update your information, send an email to Membership@isaps.org

Patient Safety – van Heijningen continued


This year the European Standard for Aesthetic Medicine Services – Non-surgical medical treatments EN 16844 will be published by the same working group. It is a good document that restricts these procedures to medical doctors or supervised health care professionals. It has the same layout as the surgical documents and provides rules to protect the patient.

Beauty Salon Standard

Not all standards are good. They can only be as good as the people who develop them, and if a working group or technical committee includes people with other interests at heart, then that can result in very dangerous documents. The proposed EN 16708 allows beauticians to do laser treatments without supervision. It confuses disinfection and sterilization throughout the document and as such is not written with the best interests of the customer at heart. We have tried to reason with them but in vain. A claim for a defective standard was proposed and overturned so now we are making a second claim for a defective

standard to hopefully stop the publication. Every International and European Scientific Society can make such a claim, and the more that do this the better. For more information, contact me at: info@duinbergen-clinic.be

Standards are good, useful documents that can help provide patient safety.

We as plastic surgeons must be vigilant when standards are developed and make sure we are involved. It is best when we initiate them ourselves, but if others do so, we must act and actively influence the process to protect patients. ISAPS must continue to lead and to promote patient safety in aesthetic surgery worldwide. We have standards to qualify for membership in our organization and now is the time to go beyond the surgeon qualifications and mandate our members operate in accredited facilities. 

MIAMI TRIVIA Vizcaya Museum



The Vizcaya Museum calls Miami Beach home. It has an exquisite orchid collection and has artwork displays that are over 2,000 year old. More than 170,000 visitors come to the Vizcaya Museum each year.

ISAPS EDUCATION



Montserrat Fontbona, MD – Chile
ISAPS member/Course-Co-Director

ISAPS SYMPOSIUM – CHILE


The Chilean Plastic Surgery Society held the ISAPS Symposium – Chile from March 31 to April 1 in Santiago. The Scientific Program encompassed most of the aesthetic and also many reconstructive topics of our specialty (oculoplastic, facial rejuvenation, abdominoplasty, mastopexy, liposuction, gluteal reshaping, post-bariatric surgery, fillers and marketing) with an outstanding invited faculty: Dr. Dirk Richter (Germany), Dr. Lina Triana (Colombia), Dr. Fabián Cortiñas (Argentina) and Dr. Ricardo Ribeiro (Brazil).

We had 96 attendees from the entire country including all the Plastic Surgery Residents of our Society.

The very high quality of the invited faculty offered us the opportunity to learn, share experiences and enjoy moments for which we are grateful. The social activities included a faculty dinner hosted by the ISAPS National Secretary, Dr. Teresa de la Cerda, with spectacular culinary specialties, and the Symposium dinner featuring Chilean food specialties, wine and dance music. On the last day, the faculty enjoyed a city tour during the afternoon.

The day before the Symposium, Dr. Dirk Richter held the first Visiting Professor Program ever in Chile with all the Residents of

the Chilean Plastic Surgery Society and Universities. His excellent teaching ability was highly valued by all who attended as it gave them the opportunity to learn and discuss in detail many topics in Oculoplastics and Facial Rejuvenation with clinical cases, master classes and previously recorded videos in an extraordinary meeting. On his arrival, we had the opportunity to invite him to a very special dinner at Restaurant Boragó that features “endemic molecular” food.

The Visiting Professor Program and Symposium were assessed by everyone as a magnificent scientific and social meeting. 



Dr. Fabián Cortiñas, Dr. Gustavo Abrile, Claudio Valdivia, Dr. Montserrat Fontbona, Dr. Teresa de La Cerda, Dr. Dirk Richter, Dr. Lina Triana, Dr. Ricardo Ribeiro



Dr. Sergio Sepúlveda, Dr. Ricardo Ribeiro, Dr. Lina Triana, Dr. Montserrat Fontbona, Dr. Dirk Richter, Dr. Fabián Cortiñas, Dr. Teresa de La Cerda, Sergio Reyes



ISAPS Symposium Chile at the Hotel Plaza El Bosque Nueva Las Condes, Santiago



Dirk Richter, MD, PhD – Germany
ISAPS President-Elect

ISAPS SYMPOSIUM – GERMANY

Learn from each other - and from the best. This is the basic idea behind the International SOS Symposium that was organized for the sixth time this year. On 10 and 11 March 2017, more than 200 plastic and aesthetic surgeons from all over the world followed the livestream from operating rooms at the Trinity Hospital in Wesseling.

Together with Prof. Wolfgang Gubisch and Prof. Axel-Mario Feller, we founded the SOS Symposium in 2011 and once again developed a challenging program for this year. SOS stands for Secondary Optimizing Surgery, or the improvement of surgical results after complications. On Friday, surgery of the breast, eyelids, face, and body were analyzed live, commented on, and corrected. These sequences were broadcast to the congress participants seated in the Cologne Hyatt Regency Hotel. Invited experts from Canada, America and England shared with colleagues many tricks and tips based on their special knowledge and decades of experience.


The international specialist audience represented 35 countries. The longest journeys had participants arriving from Australia, Colombia and Korea. They were rewarded with an exciting and varied operating program.

Nine, sometimes very complex, operations were carried out. Dr. Bryant Toth from San Francisco was invited as a specialist in oculo-facial procedures and operated a facelift, which had been previously operated five times, with corresponding deformities. Dr. Mitch Brown from Toronto and Dr. Pat Mallucci from London operated on several of the most difficult breasts. A correction of the abdomen with a high-riding scar and umbilicus stenosis was also operated by Dr. Mark Soldin from London. Prof. Wolfgang Gubisch impressively demonstrated the correction of a severe nose deformity after several prior corrections. I operated a bilateral ectropium as well as pre-operated hollowed upper and lower eyelids. Throughout the operations, Dr.

Sebastian Haack from Stuttgart and Professors Heitmann and Fansa from Munich served as moderators.

I would stress that this process was in no way a question of reprimanding or exposing other colleagues. Rather, we created a team of experts to determine if and how a mistake could have been avoided and showed appropriate solutions and corrections. The goal is to pass on best practice approaches and thus create a solid basis for steady improvement in patient safety. This follows exactly the two missions of ISAPS: patient safety and aesthetic education worldwide.

On Saturday, the program focused more on theoretical work in the form of expert panels. The results from SOS courses of recent years were demonstrated.

The overwhelmingly positive feedback by the participants and their satisfied faces were our greatest reward as we celebrated the successful symposium with our international guests in the evening in Cologne. 





Susumu Takayanagi, MD – Japan
ISAPS Immediate Past President

ISAPS SYMPOSIUM – JAPAN

From April 12 to 14, 2017, the 60th Annual Meeting of Japan Society of Plastic and Reconstructive Surgery (JSPRS) took place in Osaka, Japan under the direction of JSPRS President, Dr. Ko Hosokawa. He is a Professor in the Department of Plastic Surgery at Osaka University. An ISAPS Symposium was held for the second year in succession during this meeting.

Last year, the 59th Annual Meeting of JSPRS was convened in Fukuoka, Japan, when Professor Ohjimi from Fukuoka University was in the position of JSPRS President. Serving as a National Secretary of ISAPS, he had suggested that the JSPRS Annual Meeting should include an ISAPS Symposium as a session, and it gained a high reputation.

Following the success of this session, Dr. Hosokawa, current president of JSPRS, requested that another ISAPS Symposium should be held as a part of the 60th Annual Meeting of JSPRS in 2017. The JSPRS Annual Meeting in April 2017 attracted approximately 3,000 plastic surgeons from across Japan, and the ISAPS Symposium took place on the first day.

As a Course Director, I had invited ISAPS members from all over the world to organize a superb faculty, and the symposium earned an excellent reputation. Speakers were Chang-Chien Yang (Chinese Taipei), Man Koon Suh (South Korea), Arturo Ramirez-Montanana (Mexico), Ryosuke Fujimori (Japan), Bertha Torres Gomez (Mexico) and James Grotting (USA). Moderators



Faculty Members James Grotting, Man Koon Suh, Yu-Yi Liu, Chang-Chien Yang, Dirk Richter, Susumu Takayanagi, Bertha Torres Gomes and Arturo Ramirez-Montanana.

were Ryuichi Utsugi (Japan), Yasushi Sugawara (Japan), Kunihiko Nohira (Japan) and me.

In that one-day symposium, I incorporated three sessions – Periobital and Rhinoplasty in the morning, and

Facial Rejuvenation in the afternoon. Each lecture was at the highest level, and we received appreciative words from many plastic surgeons who participated in those sessions.

The Faculty Dinner was held in a *Teppan-yaki* (a style of Japanese cuisine that uses a large-sized griddle to cook food) restaurant, where everyone enjoyed Japanese beef of high quality.




Right in front of their eyes, they had a glorious view with the lighting of Osaka Castle surrounded by cherry trees in full bloom.

Every year, cherry blossoms are expected to be at their best around the end of March here in Japan. This year, however, due to an unusually long spell of cool weather, cherry trees were late to blossom out and reached full bloom in the middle of April – just when we were having the 60th Annual Meeting of JSPRS. So, many participants enjoyed beautiful cherry blossoms around Osaka.



Each member of the faculty took time from his/her busy schedule to come to Japan and deliver those high-level lectures. I would like to express my sincerest appreciation for their contribution.

The membership of the Japan Society of Plastic and Reconstructive Surgery includes many doctors who are expected to become aesthetic plastic surgeons in the future. It gave me great pleasure to take the excellent opportunity to promote ISAPS to those young plastic surgeons in Japan. 



Sanguan Kunaporn, MD – Thailand
Course Director
Member, ISAPS Patient Safety Committee

ISAPS SYMPOSIUM – THAILAND

Background

Thailand is recognized as one of the most popular destinations in the medical tourism industry. The fact is that most of the revenue generated by this industry comes from people who seek and get serious medical services in large hospitals in Bangkok, but the image of people who fly across the continents to have aesthetic plastic surgery service, including gender reassignment surgery, is more dominant in the global media.

Fortunately, most medical tourists are still smart and well-advised to seek services from qualified and well-trained surgeons. As in other countries, aesthetic plastic surgery is not only in the hands of qualified plastic surgeons. General practitioners and other non-core specialists are also offering cosmetic surgery to people and the number is increasing significantly every year. Both national plastic surgery societies in Thailand have used strategies similar to those of ISAPS, advising that we educate the public and the government about Patient Safety and that we are different from those other medical practitioners. Both societies have also organized regular national and regional academic meetings every year for their members. Thailand currently has more than 300 qualified plastic surgeons.

The Symposium

The first ISAPS Symposium in Thailand was held in Pattaya in 2014 combined with the 14th OSAPS Congress.

ISAPS Symposium Bangkok 2017, the second event, was held on March 8-10 and was combined with the 18th Association of South East Asia Nations (ASEAN) Congress of Plastic Surgery. ASEAN is composed of ten countries. The venue was the Avani Bangkok Riverside Hotel.



I served as the Course Director under the supervision of the 1st Vice President of ISAPS, Dr. Nazim Cerkes (Turkey). Immediate Past President, Dr. Susumu

Takayanagi (Japan), was the top key leader of ISAPS in this symposium. The President of the 18th ASEAN Congress was Prof. Dr. Apirag Chuangsuwanich. Ten main ISAPS speakers and another fourteen guest speakers from the USA, Australia,


Turkey, Japan, Korea, India, Singapore, Chinese Taipei, Vietnam, and Thailand participated in the program.

There were more than 300 doctors from all ten ASEAN countries attending this event. The Symposium was run in three rooms simultaneously. In total, 47 topics were covered including ISAPS Introduction, Patient Safety and Medical Tourism, Rhinoplasty, Breast Aesthetic Surgery, Body Contouring, Hair Transplantation and Surgery for LGBT.

The most popular topic was rhinoplasty, especially several presentations with videos of surgery given by Dr. Cerkes. This Symposium was also a good opportunity for the attendees to learn the difference between rhinoplasty for Caucasians and Orientals. Dr. Takayanagi, Dr. Lokesh Kumar (India) and I introduced ISAPS and stressed our Patient Safety mission.

The second room featured breast aesthetic surgery. Dr. Takayanagi, Dr. Kumar, Dr. Li Yu (China) and Dr. Cemal Senyuva (Turkey) were among the main speakers. The issue of ALCL was presented by Dr. Roger Wixtrom (US) to alert the surgeons about the need for close surveillance.

The third room was devoted to body contouring in the morning as shared by Dr. Murat Turegan (Turkey). In the afternoon, I presented on the topic of LGBT gender reassignment surgery with distinguished Thai plastic surgeons who are experts in this field including Dr. Suporn Watanyusakul, Dr. Sukit Worathamrong, and Dr. Kamol Pansritum.

The Organizing Committee had worked excellently. All speakers were very impressed with their hotel rooms with stunning views of Chao Phraya River. The hospitality, welcome reception, dinner cruise and post symposium downtown boat and sky train rides and dinner in the huge shopping center were all memorable. Every ISAPS speaker was very happy and satisfied with this Symposium. 





Fabian Cortiñas, MD - Argentina
National Secretary Argentina

ISAPS SYMPOSIUM – ARGENTINA

On May 9th in Buenos Aires at the time of the 47th Annual Congress of the Argentinean Society of Aesthetic and Reconstructive Plastic Surgery, a half-day ISAPS Symposium was held.

We would like to express our gratitude to Drs. Boris Henriquez from Colombia, Daniel Mills from the United States, Arturo Ramirez-Montañana from Mexico, Sebastien Garson from France and Luis Perin from Brazil.

This successful Symposium consisted of two panels about the difficult breast and facelift. In the first panel, the presenters

discussed a variety of breast deformities including: asymmetries, tuberous breast, high position of the submammary crease, secondary, tertiary and quaternary surgery.


Presenters showed interesting and innovative approaches to those areas of our practice. ISAPS confirmed our advocacy through education showing the state-of-the-art of our practice through his faculty and the program they presented. 



Figure 1 - Drs. Perin, Garson, Cortinas, Mills and Ramirez-Montanana

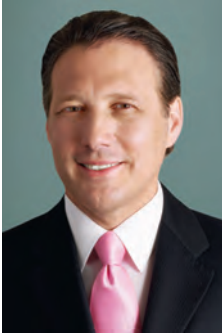


Figure 2 - Drs. Boris Henriquez, Arturo Ramirez-Montañana, Liliana Odone, Jorge Herrera, Daniel Mills, Sebastien Garson, Cortinas, Luis Perin and Abel Chajchir.

The ISAPS Global Survey results will be released at the end of June.

Thank you to all those who participated.
We had the best response rate in the history of the survey.

VISITING PROFESSOR PROGRAM



Renato Saltz, MD, FACS – United States
ISAPS President & Visiting Professor Program Chair

This program was designed to share Aesthetic Surgery Education by the best educators in the world.
-- Renato Saltz, MD, FACS – Chair, Visiting Professor Program

The Visiting Professor Program (VPP) was established in 2013 with one primary goal: to bring aesthetic education to young surgeons in any of our member countries.

So far, we have sent out 27 Visiting Professor trips and they have all found the experience to be very rewarding by both sides: the recipient countries and the ISAPS Visiting Professors.

In this issue, you will find two VPP reports, one by our President-Elect, Dirk Richter, about his recent visit to Chile and one by Pavol Denyshchuk about Tino Mendieta's visit to Ukraine.


Rhinoplasty

Nazim Cerkes – Turkey
Enrico Robotti – Italy

Face

Gianluca Campiglio – Italy
Philip Chen – Chinese Taipei
Vakis Kontoes – Greece
Apostolos Mandrekas – Greece
Bryan Mendelson – Australia
Foad Nahai – US
Mario Pelle-Ceravolo – Italy
Lee Pu – US
Dirk Richter – Germany
Lorne Rosenfield – US
Renato Saltz – US

Below you find the updated list of ISAPS Visiting Professors for 2016–2018. Nominations are now being accepted for the 2018-2020 period. Please contact me.

If you want to apply for an ISAPS Professor to visit your country and/or your institution please visit the Visiting Professor Guidelines on our website or contact Catherine Foss or myself directly. 

Breast & Body Contouring

Al Aly – UAE
Thomas Biggs – US
Stephano Bruschi – Italy
Joao Erfon Ramos – Brazil
Ruth Graf – Brazil
Moustapha Hamdi – Belgium
Joseph Hunstad – US
Constantino Mendieta – US
Joao Sampaio Goes – Brazil
Arturo Ramirez-Montanana – Mexico
Cemal Senuya – Turkey
Ozan Sozer – US
Grant Stevens – US
Susumu Takayanagi – Japan
Lina Triana – Colombia

Non-Invasive

Barry DiBernado – US
J. Peter Rubin – US
Woffles Wu – Singapore



Pavlo Denyshchuk, MD – Ukraine
ISAPS National Secretary for Ukraine

ISAPS VISITING PROFESSOR PROGRAM UKRAINE

The ISAPS Visiting Professor Program (VPP) has become a very good tradition in Ukraine. The third international Ukraine-Baltic Program took place on April 7 and 8 in Kiev. The topic was “Modern Trends in Breast, Buttock and Calf Correction.” Dr. Constantino Mendieta of the United States visited Ukraine and charmed us with superbly presented reports and videos from the operating room about breast augmentation and buttocks fat grafting. Dr. Mendieta not only shared his knowledge and experience, but also moderated a live surgery broadcast for Congress participants.



The third Visiting Professor Program (VPP3) became the most prominent event in Ukrainian plastic surgery for many reasons. Primarily, thanks to collaboration by colleagues from the Baltic States, the program was

appropriately titled “International Ukraine-Baltic”. Unique clinical cases of breast augmentation were presented by Paolo Montemurro (Sweden) and Janis Gilis (Latvia) shared his cases of secondary breast augmentations after complications. ISAPS National Secretary for Estonia Peep Pree and National Secretary for Belarus Vladzimir Padhaiski also visited the Congress.



National Secretary for Estonia, Peep Pree, and me

The number of Congress participants reached a new high: more than 120 doctors from Ukraine, Belarus, Latvia, Estonia and Moldova participated. The Program raised very intense interest from the mass media. Two Ukrainian nationwide television channels and 14 published and online newspapers highlighted the visit of Dr. Mendieta as an ambassador for ISAPS and its educational mission.



Dr. Constantino Mendieta on Ukrainian TV

For the first time, live surgeries were demonstrated by Ukrainian specialists. I shared my experience in tubular breast

reconstruction with augmentation and subfascial placement of the implant. Prof. Vasily Khrapach demonstrated buttock augmentation and calf augmentation with implants. The feature of live surgery, moderated and supervised by Dr. Mendieta, produced genuine interest and active discussion among audience members.



Televised live surgery

The round table discussion was a very important part of the Congress during which surgeons presented different cases of complications after breast augmentation. Together with the board of experts that included Drs. Mendieta, Montemurro, Pree, Padhaiski and Khrapach, we found the most optimal solutions and also discussed ways of avoiding such complications in future.



acquaintances and discussions of different clinical cases in this informal, friendly environment.

The interesting and very useful scientific program on the first day concluded with a gala dinner devoted to VPP3. Surrounded by famous Ukrainian artists and sculptors in the Art Ukraine Gallery, we continued our

Throughout the program, I presented ISAPS, its education programs and the future Congress in Miami Beach with great pleasure. Member benefits and possibilities of membership in ISAPS were noted. There is an interest among specialists. We are waiting to welcome new members into ISAPS and at present are getting ready for Visiting Professor Program 4 when we can welcome another ISAPS Professor to Ukraine.



Opera singing during gala dinner



Dirk Richter, MD, PhD – Germany
ISAPS President-Elect

ISAPS VISITING PROFESSOR PROGRAM CHILE


This was not only the first ISAPS Visiting Professor Program ever held in Chile, but it was also my first Visiting Professor Program and my first visit to Chile.

I was invited by the President of the Chilean plastic surgery society, Dr. Montserrat Fontbona, who herself spent six months at my unit about ten years ago. At that time, she had a stipend to improve her knowledge of oculoplastic surgery. She asked me to come to her country to provide a deep dive into oculoplastic surgery for the residents in Chile. This is a perfect format for the ISAPS Visiting Professor Program that was inaugurated by Dr. Renato Saltz four years ago and since then has been a huge success.

All 19 Chilean Residents who are taking part in a program at the two universities and the military hospital in Santiago were present. Not even one missed the event. I was deeply impressed by their already profound knowledge – and their tireless thirst for more knowledge.

We spent a whole day together with not only lectures, but also very interactive sessions including learning via operative videos about complication management. The Residents had prepared many nice cases they wanted to demonstrate or had questions about. Also, complication cases were analyzed, discussed and

solutions worked out. After a long day, we were very happy to have a nice dinner with all the participants.

The next day, the ISAPS Course took place and was a great success with almost 100 participants. I was proud to be there and to be chosen as a Visiting Professor. I left with a good feeling that we all learned a lot from each other. Special thanks to all the Residents, to Dr. Fontbona and to our ISAPS National Secretary, Dr. Teresa de la Cerda, all of whom made my stay so unforgettable. 



Dr. Dirk Richter and Dr. Montserrat Fontbona with the Plastic Surgery Residents

MIAMI TRIVIA Bordered By Two National Parks



Miami Beach is surrounded by both the Biscayne National Park and the Everglades National Park. It's the only city in the United States that has two different national parks as part of its borders. Both parks offer a wide array of activities for visitors to partake in including wildlife watching and canoeing.

NATIONAL SECRETARIES



Peter Scott, MD – South Africa
Chair – ISAPS National Secretaries

MESSAGE FROM THE CHAIR OF NATIONAL SECRETARIES

I recently attended the ISAPS Symposium attached to the Aesthetics at The Red Sea Meeting in Eilat, Israel where our President, Renato Saltz, and EC Chair, Vakis Kontoes, led an international faculty who provided high quality lectures to the delegates present. Prior to this I attended the ISAPS Board Meeting at ABAM in Park City, Utah. Again, another excellent meeting organised by Renato Saltz where we had an informal lunch and fruitful discussion with the various NSs who were present and with members of the Board. Meetings like this allow us to interact and discuss relevant issues more frequently rather than waiting for the biennial NS meeting at the Congress. Another NS lunch was attended by about 15 NS and several Board members on 29 April during the ASAPS meeting in San Diego.

I encourage all NS to plan to attend the 24th Congress of ISAPS, 31 October - 4 November 2018 in Miami Beach, Florida USA. Registration is already open on our website. Let's see if we can have as successful a meeting as we did in Kyoto, Japan. At this meeting, we will be electing a new National Secretaries Chair and Assistant Chair, as my two terms will be coming to an end. Consider placing your name in nomination for these positions. To do so, please contact Catherine Foss in our Executive Office.

Catherine and I will be involved in several more NS elections in the coming year. The NSs of Cyprus, Norway and the United States have completed two terms amounting to eight years and the new NSs will have to be elected for those countries this year. We thank these three NSs, Lefteris Demitriou, Petter Amland and Mark Jewell, for their long service and would ask them to help facilitate the transition and election in their respective countries.

Three NSs are due for either re-election or for new candidates to be proposed. These are Slovenia, Uruguay and Venezuela. Finally, Dominican Republic and Panama are due for elections this year. Either a re-election or new candidates will be required as they are both entering into their 5th year.

Montenegro recently re-joined our family where we now have two members.

I am very pleased to report that Panama recently added 23 new members using the fast track system. Unfortunately, several other countries have had major losses in membership and I hope that the NSs in those countries will be able to contact each of the

defaulters personally and encourage them to pay their annual fee. We have a goal of 5,000 members in ISAPS by the Miami Congress. Presently, ISAPS has 3,080 members.

With Bahman Guyuron as our new Editor-in-Chief of Aesthetic Plastic Surgery, many changes are taking place in our official journal. I encourage you to submit articles and support our society's publications.

The Education Council has new policies regarding ISAPS Symposia and Courses and I remind you to read the requirements carefully and contact our EC Chairs, Vakis Kontoes and Ozan Sozer, for further discussion if you are planning an educational event in your country.

Finally, we ran a very successful Global Alliance meeting in Cape Town in March with a safari for the international keynote speakers who included: James Grotting (Past President, ASAPS), Joseph Hunstad (ISAPS Visiting Professor, USA), Mark Jewell (NS-USA) and Klaus Ueberreiter (ISAPS Member from Germany). As the meeting Chairman, I enjoyed the post-congress safari that allowed us all to interact on a social level and also allowed husbands and wives to enjoy relaxing quality time at the end of a busy meeting. I would encourage anyone organising an ISAPS Symposium or Course to consider showing your overseas guests the highlights of your country.

The three elections completed this year were:

Mexico Bertha Torres Gomez NS
Gustavo Jimenez Munoz Ledo ANS

Dra. Torres Gomez replaced Arturo Ramirez-Montanana who was appointed to the ISAPS Board of Directors as Parliamentarian.

Spain Jesus Benito-Ruiz NS
Patricia Gutierrez-Ontalvilla ANS

USA Nina Naidu, MD
Alan Matarasso, MD

We welcome our new NSs and ANSs and as always thank their predecessors for their outstanding efforts during their terms.





Richard Hamilton, MD, FRACS – Australia
ISAPS Assistant National Secretary for Australia

THE FACE 2017 - FINAL COMMUNIQUE

An inaugural international meeting, THE FACE 2017, held in beautiful Queenstown, New Zealand, attracted 36 plastic and maxillofacial surgeons and staff (including several ISAPS members) from New Zealand, Australia, the US and the UK over three days: April 6 - 8th, 2017. It was sponsored by the University of Otago Medical School. <http://theface2017.co.nz>

Retirement

Dr. Patrick Beehan, a retired New Zealand Plastic Surgeon, now a Queenstown resident, welcomed us all to his town with an informative and humorous overview of when to stop as a surgeon and how to plan for a different non-clinical future. For “life beyond the knife” it is important to plan early, with a gradual withdrawal and increasing engagement in new hobbies and activities.

War & The Third World

Col. Prof. Darryl Tong (Dunedin, New Zealand), Dr. Darryl Hodgkinson (Sydney, Australia) and Dr. Mark Moore (Adelaide, Australia) presented inspirational lectures on the realities of modern facial injury from warfare and historical perspectives together with the challenges of delivering humanitarian plastic and craniofacial surgery to a sometimes desperate and dangerous third world. Lessons learned from battlefield trauma can be transferred to civilian practice. Asymmetric warfare has presented new injury patterns and adapting to this with rapid medical evacuation, damage control resuscitation and surgery plus pre-deployment trauma training are key strategies. Control of airway and bleeding remain the priorities for maxillofacial injuries (head and neck). Humanitarian surgery in foreign countries requires a huge commitment to long term service, clinical prioritisation and building trust with foreign nationals. There are often no safety nets.

Scientific

A wide range of science specific to plastic and reconstructive surgery was considered by the invited speakers. Advanced Applied Anatomy for facial restoration was graphically presented by Dr. Bryan Mendelson (Melbourne, Australia) including his long-term experience using Hydroxyapatite derived from coral for bony augmentation. Bio-engineering concepts for interpreting functional anatomy was summarised by Dr. Kumar Mithraratne (Auckland, New Zealand). Dr. James Newman (Palo Alto,

California, US) presented his experience with new energy-based technology for precise and longer lasting facial motor nerve modulation (SERENE) and skin rejuvenation. The role of stem cells, diseased, and cancer stem cells in reconsidering the prevailing concepts of clinical pathology and reconstructive challenges were brilliantly reviewed by Dr. Swee Tan (Wellington, New Zealand). The oVio360 patient imaging tool was also presented by Dr. Greg Mueller (Los Angeles, California, US) via video.

Reconstructive

The devastating problem of facial palsy and a strategy based on extensive clinical experience was presented by Dr. Swee Tan. Skin cancer and cutaneous defects of the face, and whether to graft



Figure 2- Mike Klaassen with his wife, Karen

or to flap were considered by Dr. Michael Klaassen (Auckland, New Zealand). Dr. James Newman mentioned the use of fractionated LASERS by VA hospitals for scars and contractures in post war trauma.


Aesthetic Facial Restoration

In a modern world increasingly dictated to and influenced by social media, younger and younger patients are seeking aesthetic treatments. Non-surgical techniques are evolving and changing with a move towards combination therapies. This was clearly summarised by Dr. Vic Narurkar (San Francisco, California, US) from the first and pivotal FDA trial - the HARMONY study. Web-based and Cloud-based patient information and informative discussion media vehicles are defining a new market place. We need to consider which market we are in and adapt our practices to that. Dr. Tristan de Chalain (Auckland, New Zealand) gave an extensive review of the history of facial rejuvenation from the 19th century until the present. His multiplanar approach to face lifting and the social implications of aesthetic surgery were considered. Dr. James Newman reviewed his scientific study of fractionated LASER resurfacing at light,

continued on page 30

National Secretaries – Hamilton continued

medium and deep levels, which proved that the latter two groups are the most satisfied. Dr. Bryan Mendelson illustrated his complete composite facelift approach with detailed and up-close video imagery of the anatomical approaches utilising the deep facial spaces and protecting the vital facial nerves. Prof. James Frame (Cambridge, UK) reported on his experience with the oVio360 Imaging System and multiple minimally-invasive facelift techniques adapted for his patient demographic. The Anterior Flicklift in particular was very interesting. The intra-nasal route for cannula-placed fat grafting was novel. Total neck rejuvenation with Fogli’s tri-cable suture and fascio-platysmal flap offered another improvement for the lower third of the neck

by Dr. Darryl Hodgkinson. Dr. Stephen Gilbert (Auckland, New Zealand) presented his volumetric approach to face lifting and defined the arcs of beauty so often desired. Dr. Lawrence Ho (Sydney, Australia) presented his concepts for contour congruent facelift based on original 3D evaluation of facial planes, aesthetics and balance between the face and neck. Dr. Michael Klaassen showed his early results with Dr. Ho’s method and emphasised the use of the Essential Tool - the Ho facelift needle. Aesthetic surgery principles include careful informed consent, compromise and matching treatment methods to patient expectations. 



MIAMI TRIVIA
Transportation Central

Miami is a major transportation center. There are a number of airports in the area, of which the most important is the Miami International Airport, on the western edge of the city, with flights to Latin America and Europe, as well as to cities in the United States.

**ISAPS Premier
Global Sponsor
Program**




JOURNAL UPDATE



Bahman Guyuron, MD – United States
Editor-in-Chief, *Aesthetic Plastic Surgery*

With the cooperation of everyone involved, we have achieved great progress with a speed that can be a source of pride for all of us. I certainly hope you like the cover change and see that the content has improved as well. I will continue improving the journal relentlessly. In addition to changing the cover, we have also included some individuals on the Editorial Board who have been serving the journal for a long time as expert reviewers to demonstrate our appreciation of their invaluable services. Furthermore, you will see some names on the Editorial Board that may not be recognizable to you. These are upcoming superstars. The journal has already been the beneficiary of their contributions in a very short period of time. We currently have a very dynamic, eager, and extremely enthusiastic Board.

My promise remains unwavering. I hope those of you who have been submitting articles have observed the speed with which we review them. We will continue processing your articles as fast as humanly possible. Our Editorial Board and reviewers are keenly aware that we cannot suggest new changes after the initial review, meaning that all requested changes must be included in the first round. What sometimes delays the publication is the authors not understanding the initial suggestions or not following the recommendations fully, mandating additional revisions and reviews. Delays are minimized to the best of our capabilities while maintaining the scientific integrity of the articles.

I invite every one of you who is interested in reviewing manuscripts and have expertise with original research and an understanding of how you can help authors improve their articles to participate. I treasure the passion of individuals who volunteer and enjoy helping the journal and prefer to use their services rather than imposing reviews on those who may or may not show interest. I also have an open mind and welcome any suggestions that you believe would improve the journal.

This publication belongs to you. Its mission is to help improve your plastic surgery knowledge and patient care. If you think this mission can be more successful with a new and different idea, please feel free to share your thoughts with me.

bahman.guyuron@gmail.com



You are going to see frequent invited discussions involving experts across the aesthetics specialty. We will also be involving specialists from the other disciplines whose expertise could be valuable to readers. The journal now has a vast supply of articles ready for publication. My team is grateful to you for submitting the articles and to the Editorial Board and the reviewers for their timely reviews.

ISAPS News has moved to quarterly publication. We ask that submissions for each issue follow the copy deadline schedule and invite readers to send articles to the Managing Editor at this address: ISAPS@isaps.org

Kindly include all graphics and photos as attached high resolution JPG files, not photos imbedded in the email, and be sure to send head shots of all authors.

ISSUE

September
December

COPY DEADLINE

July 15
October 15



Julie Guest – United States
ISAPS Chief Marketing Officer
CEO, Premier Physician Marketing

WHICH FACEBOOK ADS ARE THE MOST EFFECTIVE TO MARKET YOUR PRACTICE?

Flying back home from New York last night, my plane was delayed three hours due to thunderstorms. To my left was a 60-something year old man checking out his newsfeed on Facebook. And to my right was a Mother of three who appeared to be instant messaging someone on Facebook while her children ran rampant through the terminal playing a heated game of tag. As I'm sure you already know by now, advertising your practice on Facebook is no longer optional. It's mandatory. It's still the #1 social media frequented by women ages 35 - 65 (which is very likely your target market) and the platform continues to grow and expand each year. But HOW are you using this incredibly powerful way to engage with patients and prospective patients? Are you just using it "organically" by posting updates and bits of news. Or are you also actually investing in Facebook ads as a way to grow your following and connect with new prospective patients?

As a marketer I love running ads for our clients on Facebook because there is no other advertising platform that provides such precise micro-targeting. For example if you wanted to run a campaign on Facebook that only reached women the ages of 35-45 years old, who earned over \$100,000 USD a year, who had an interest in revision rhinoplasty, spent over \$10,000 a year on skincare products and who lived within a 5 mile radius of your medical practice in Bangalore, India – you could! Throughout the world there are over 1.8 billion people using Facebook every month which means there is a ton of untapped opportunity for your practice – no matter where in the world you're located.

Which Facebook Ad type is best for your practice?

Whenever you run an ad for your practice, the first thing you have to do is be clear about it's objective. Obviously the point of running ads is to attract new patients to your clinic, but which kinds of ads are going to be the most effective for this? Let's discuss the different kinds of ads you can place

1) Running an ad to raise "awareness" of your practice (also known as a brand ad)

There have been many studies done that show it takes an average of "7 touches" before a new patient will pick up a phone and make a call to your clinic. This means that on average a new patient has to have seen your ads, or your brand an average of seven times before they finally pick up the phone. Facebook's brand awareness ad type could technically be used for any kind of campaign – such as promoting a webinar you're holding, or a new technology or



service. But it works best when you have a really great blog post that drives brand awareness by enticing Facebook users to view it and then want to know more about your brand.

In the example above, this marketing company's ad uses a creative, attention grabbing offer and a free special offer

that is specifically written for real estate agents, and will only be shown to people who have identified themselves as real estate agents. A Facebook user might see the advertisement and decide to call the agency immediately. This is a good example of using a brand awareness ad to create compelling content to attract the user's attention.

2) Store Visit Facebook Ads

While some brand awareness campaigns can be set to raise the profile of your brand across the country (if that is your goal), however in terms of getting new patients to call your practice today audience, your medical practice is going to get much better results focusing on attracting patients within your geographic location.

Store visit ads are a great way to do this and if you have a clinic in multiple locations, you can use the same creative template and target Facebook users who are spending time in each of your locations.

3) Local Awareness Facebook Ads

Whether you have a new clinic opening or just want to boost awareness for one of your clinic's existing locations, use the local awareness ad type to drive brand awareness in specific geographic regions. This ad type is basically the same as brand awareness ads, but will be more oriented and targeted via location than large, far-reaching audiences.





engage with Facebook users and grab attention.

4) Website Conversion (for example signing up for your newsletter or monthly specials)

While brand awareness campaigns encourage “likes” and tend to be more high-level website conversion campaigns encourage prospective patients to take a specific action which then takes them to your website immediately.



for a Facebook user to take a specific action such as calling your office, or filling out a form, there are other ad-campaigns that are targeted at specifically attracting more people to your website – known as “driving traffic”.

For traffic-oriented campaigns, use the clicks to website ad type. This ad type allows you to send users to specific blog posts, site pages, or product offers in a number of different ways. For example you can include a rotating carousel of images to send users to different links, or run what’s known as a “canvas mobile ad feature” to tell a story with your ad.

6) Event Ads

Do you have an important event coming up that you want to generate some buzz and attendance for? Use the event ads type to promote a Facebook event and get more responses!



For example, Cold Stone Creamery used a local awareness ad to target people in a geographic area when their store in Bangladesh opened. Notice how in this ad Cold Stone uses video as a great way to

For example, take a look at this Uber advertisement. It encourages a viewer to become an Uber driver with a specific call to action “sign up.”

5) Traffic to Your Website (clicks)

While many of your Facebook campaigns will have the objective

So How Do You Choose Which Facebook Ad Type to Use?

Follow this simple formula to help you decide – but there’s no reason why you can’t run multiple styles of ads at the same time and test them – see which ones do better!

1) Start with your objective

Are you trying to drive conversions on your website? Get more registrations for an upcoming event? Simply get more patients to pick up the phone and call your practice? Don’t just come up with a campaign around which ad type you want to use. Instead, start with your own marketing needs and then choose the right kind of ad to use.

2) Choose which ad types you could use.

Once you’ve defined the goal of your ad campaign, then take a look at the different Facebook Ad types and choose the kind most relevant to your goals. You probably noticed Facebook has multiple ad types you could use for a single objective. If your goal is to drive attendance at your event, for example, you could use any one of the following options:

- 1. Clicks to Website
- 2. Brand Awareness
- 3. Event Ads

Once you’ve chosen which ad types are most applicable to your needs, choose the one you think will work best for you campaign. Or, use the same creative, copy, and targeting options to set up a campaign test using different ad types and see if one performs better than the other!

4) Create the Ad

Facebook gives you lots of choices – should you use a photo or a video, one image or multiple images, should your ads be customized for mobile and desktop audiences (yes!)

5) Target the right audience.

This step is extremely important – you want to ensure the right people will be see your ads and exclude the wrong people (for example showing an ad for plastic surgery to men – but using an ad that is clearly targeting women, is going to result in a low response rate and a waste of your money.)

8) Test, tweak, and repeat.

Remember: digital advertising is all about testing, analyzing, and optimizing future ad campaigns over time. Make sure you follow this important final important step, and you’ll be on your way to implementing a high-ROI ads strategy in no time – or asking the right questions of your digital marketing agency to ensure that they do! 



Hiroko Yanaga, MD, PhD – Japan

Global Perspectives: Japan Mid-Face Rejuvenation Using Micro Lipo-Injection

EAST ASIA



JAPAN

Why has lipo-injection become popular around the world?

“Structural Fat Grafting”, which was advocated by Dr. Sydney Coleman, completely changed the conventional concept of fat grafting. Cell assisted transfer is now used to enrich lipo-aspirate. Adipose-derived stem cell (ASC) and stromal vascular

fraction (AVF) are added to enhance the absorption and holding properties of fat grafts. It has also been found that a key point of the grafting method is to graft fat in tiny amounts at multiple locations. The treatment method thus has become reliable and attractive.

When focusing on mid-face rejuvenation, there are problems that cannot be solved by just lifting the sagging or drooping skin. This is because aging of the mid-face is accompanied with atrophy of the subcutaneous fat. Fat grafting is an ideal filler, that it is autologous, naturally integrates with recipient tissues, and it is potentially permanent. We therefore concluded it would be ideal to apply micro lipo-injection for mid-face rejuvenation.

Our technique and procedure

The procedure consists of taking donor fat from the abdominal region or thigh, centrifuging it for 5 min at 1200 rpm, the liquid components are discarded and the ASC+SFC in the sediment is mixed with the fat in the upper layer. We use a small Tulip™ cannula of 2 mm or 1.2 mm to perform suction and this enables us to obtain fine small fat particles.

The micro fat is injected into deep fat layers or on the periosteum in places such as the medial cheek fat, lateral and medial SOOF, tear trough deformity, nasojugal groove or nasolabial fold.

At the lower eyelid or the temporal region, a 0.7mm cannula is used because the subcutaneous tissue in this area is thin. When injecting around the eyes, we do not centrifuge so the micro fat can spread more easily. If the level of placement is superficial, I use massage to finalize the desired shape.

Most suitable candidates

Anti-aging of the mid face is equivalent to providing a 3-dimensional contour. With micro lipo-injections, fat can be overlaid as in a sculpture. This procedure is most suitable for patients in their forties or early fifties with no pronounced sagging who might be hesitant to have a facelift. Facelift patients are also good candidates to receive lipo-injections primarily or secondarily for touch up purposes.

Summary

Micro lipo-injections provide three dimensional contours that facelifts alone cannot. They can provide significant improvements to treat wrinkling and sagging brought in by aging which is always accompanied by subcutaneous tissue and fat atrophy at the midface. Micro lipo-injection is thus considered to be extremely useful. A key point to obtain the best results is to inject the micro lip into a deep fat layer so that irregularities on the surface can be prevented and it can be shaped like a volumetric sculpture.

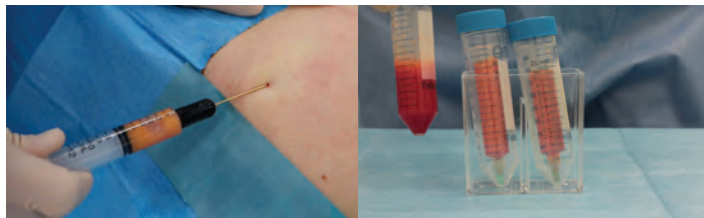


Figure 1a - Micro fat being harvested from the abdomen using 1.2 mm cannulas with 10 cc syringe.

Figure 1b - Micro fat before centrifuging (left) and the mix ready for injection (right).

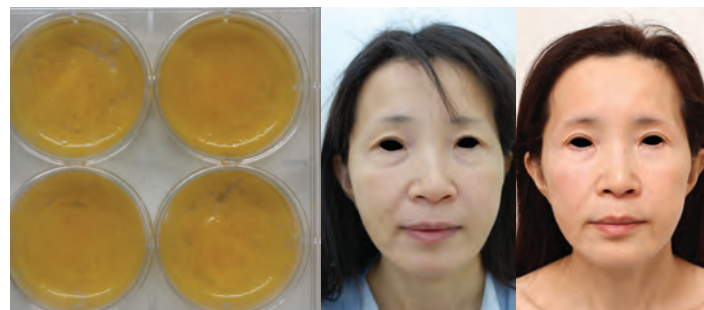


Figure 2 - Notice the consistency of the fat particles.

Figure 3 - Left preoperative image 45-years-old, right post-operative image 51-years-old.

The left shows the mid face laxity and volume loss of cheek. The right shows a correction of sagging mid face and a stable volume shift in the cheek region with a more youthful state. The corrections of cheek, lower eyelid and nasolabial fold, show the volumetric rejuvenation of the mid face. The volumetric rejuvenation has been maintained six years after the operation.

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



Dirk Richter, MD, PhD – Germany
ISAPS President-Elect

Global Perspectives: Germany

European Perspective on Mid-Face Lifts

EUROPE



GERMANY

Times and perspectives in periocular rejuvenation have significantly changed in recent years.

Micro- and nano-fat grafting have become very important options and the development of available techniques and procedures is on a fast track.

During the global economic crisis, many patients looked for minimally invasive treatments and fillers gained popularity especially treating tear trough deformities and volume loss in the upper lid. Micro-fat grafting was also used as a solo treatment in the periocular region and midface. Not only financial aspects were important, but also the simplicity of the procedure.

Nowadays, it has become a safe additional procedure to surgical approaches such as the sliding procedures in lower lid blepharoplasties or midface lifts. Fast-moving blunt cannulas with small diameters are key to success and patient safety. Lumps have become rare complications, but we have to dampen the euphoria because the outcome of fat graft is still dependent on the surgeon's skills and the individual patient. We know that the uptake of fat in smokers may be very variable and some surgeons refuse to operate on smokers at all.

I personally use the midface lift as the first place to treat severe lower lid deformities, especially when it comes to malar bags as you have to use a significant amount of fat when using fat grafting

alone. Implants are very helpful to treat bony resorption during the aging process. In combination with the midface lift, it is still the most powerful tool in terms of stability and longevity. However, the complication rate is higher even in experienced hands. Prolonged swelling, as in subperiosteal midface lifts, can also be seen in fat grafting procedures and if lumps occur they are hard to treat.

The most commonly used fillers in Europe are hyaluronic acids as they are pretty safe for the periocular area. We observed a lot of disasters with non-resolvable fillers due to the thin skin and delicate tissues which are sensitive to any manipulation.

Surgically, the safest approach seems to be transconjunctival and in easy cases this approach can be safely used also for distributing the fat over the orbital rim. If there is any additional skin excess, the pinch excision can be helpful as well as a laser or peeling. Even the subperiosteal midface lift can be done through this approach in order not to harm the anterior lamellar.

Fat grafting has also taken on an important role in reconstructive periorbital procedures and the treatment of bad outcomes. A touch up can easily be performed under local anesthesia with low cost.

In conclusion, fillers are observed as a starter procedure in periocular rejuvenation mostly followed by fat grafting in easy cases. More severe deformities are still treated surgically by a subperiosteal midface lift with good and stable results. Fat grafting has gained popularity and it is not possible to imagine one without the other.



Global Perspectives - Future Themes

September 2017

Blepharoplasty

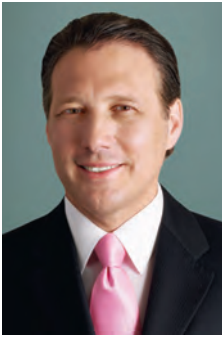
Deadline: July 15

December 2017

Rhinoplasty

Deadline: October 15

To contribute an article of 500-750 words, please forward it to ISAPS@isaps.org with the subject line: ISAPS NL Series. This should be a non-referenced opinion piece of several paragraphs giving your observations and perspectives on the topic. What do you do in your practice? What unique approaches do you use? What do you see your colleagues doing in your country or region? Photos are welcome, but must be high resolution JPG files and limited in number.



Renato Saltz, MD, FACS – United States
ISAPS President

Global Perspectives: United States

Endoscopic Midface Rejuvenation

N. AMERICA



UNITED STATES

Introduction

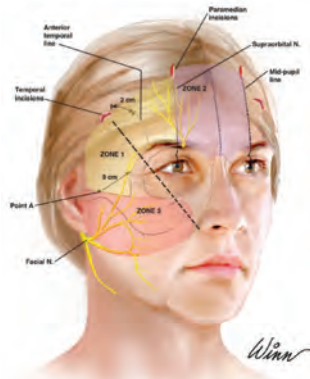
Since the introduction of the endoscopic approach in 1993 by Luis Vasconez, I have not performed one open coronal brow lift. Almost all of my facial rejuvenation cases today that do not require rhytidectomy include brow and midface rejuvenation through an endoscopic approach. I have been using my endoscopic midface technique since 1998 (see references below).

Other techniques for midface rejuvenation include fat grafting, filler injections and SMAS treatments during facelift surgery. During patient selection, the key problem to be addressed are decreased midface volume often accompanied by brow ptosis due to volume depletion and descend of the soft tissues.

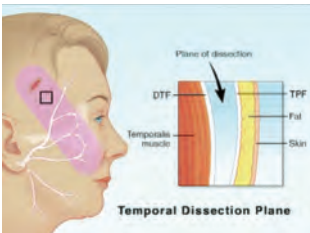
OPERATIVE TECHNIQUE

Anesthesia

The patient is placed most commonly under general anesthesia using an endotracheal tube secured to the upper teeth with dental floss and wrapped with sterile plastic drape so it is inside the sterile field and easily manipulated when the head is turned to either side.



Renato Saltz, MD, Bianca Ohana, MD, Thirteen Years of Experience with the Endoscopic Midface Lift, *Aesthetic Surgery J*, 2012, 32 (8), 927-936, by permission of American Society for Aesthetic Plastic Surgery.



Infiltration is achieved using a mixture of 20ml of 2% Lidocaine, 20ml of 0.25% Marcaine, 1ml of Epinephrine solution in 140cc of normal saline. Infiltration is done using a 20 gauge spinal needle in a tumescent fashion.

Incisions

The incisions are the same as for the endoscopic browlift. A temporal incision is made along a superior lateral vector line from the nasal ala crossing the lateral canthus and continues to a point approximately 2cm behind the temporal hairline. A two centimeter curved line is then marked medial to that point in both temporal areas. One cm paramedian incisions below the hairline are made at midline from the mid-

pupil superiorly to the anterior frontal hairline. The location of the supratrochlear and supraorbital nerves are also identified and marked.

Technique

The brow and midface lift is divided into these key steps:

1. Blunt subperiosteal dissection over the frontal bone down to the supraorbital rim.
2. Meticulous division and spreading of the supraorbital rim periosteum under endovisualization.
3. Corrugator muscle resection under endoscopic visualization.
4. Subperiosteal dissection over the lateral orbital rim extending medially over the infraorbital rim.
5. Subperiosteal dissection over the maxilla avoiding the infraorbital nerve.
6. Midface fixation using the endotine device.
7. Brow fixation with sutures and endotines.



Summary

I have performed endoscopic forehead rejuvenation in over 1500 patients since 1994 and endoscopic midface rejuvenation in over 200 cases since 1998. The endoscopic approach for forehead and midface rejuvenation has many advantages. It provides excellent exposure for release of periorbital tissues combined with endoscopic magnification, shorter scars and reduced risk of alopecia and scalp



Renato Saltz, MD, Bianca Ohana, MD, Thirteen Years of Experience with the Endoscopic Midface Lift, *Aesthetic Surgery J*, 2012, 32 (8), 927-936, by permission of American Society for Aesthetic Plastic Surgery.

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Pavlo Denyshchuk, MD, PhD
 ISAPS National Secretary for Ukraine
Kurinnyi SI, MD
Baranov TJ, MD
Slyusarev IY, MD, PhD

Global Perspectives: Ukraine

Complex Minimally Invasive Rejuvenation of the Mid-Face



Elimination of the signs of aging in the mid-face is a very important part of facial rejuvenation surgeries and procedures. At present, there is a broad spectrum of operative procedures targeted at facial contour enhancement and rejuvenation. In our practice, we use a combination of minimally invasive surgical interventions

and procedures either alone or in addition to classical rejuvenation surgical operations. In an attempt to sort out existing methods of surgical approaches with optimal impact in terms of age, weight and severity of tissue alterations in the mid-face zone, we have developed a complex approach to minimally invasive rejuvenation procedures.



Figure 1 - Fat harvesting (patented method), manual centrifugation, lipofiling

The use of various minimally invasive approaches, such as thread lifting techniques, volumizing fillers (e.g. hyaluronic acid, calcium hydroxylapatite, autologous fat tissue) (Fig.1), and Bichat's fat pad removal offer substantial, harmonious, consistent and long-lasting outcomes in mid-face rejuvenation. The advantages of the above mentioned minimally invasive methods are the possibility of using them on patients without pronounced indications for operative face-lift or in those who are not yet ready for the "big surgery". Complex minimally invasive interventions and procedures are perfect for the outpatient office setting under local anesthesia.

A complex approach to mid-face rejuvenation requires not only general patient assessment, but also thorough mid-face skin evaluation. The use of "lightening" surgical interventions (Bichat's fat pad removal) enables thread tissue translocation with intense

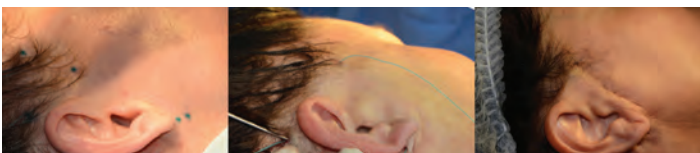


Figure 2 - Stages of mid-face thread lifting technique

lifting effects avoiding rhythidectomy. For additional soft tissue fixation, we use sutures (modified Serdev's technique) (Fig.2) that significantly strengthen and prolong the obtained rejuvenation effect.

Volumizing plasty and lipofiling in the mid-face usually enhances lost volume in the malar area, and corrects the nasolabial zone. We enhance tear troughs with Loeb's technique. Among helpful minimally invasive mid-face procedures, it is worth mentioning the local surgical nasolabial fold excision in cases of severe visualization (Fig.3).



Figure 3 - Nasolabial fold surgical excision

We consider that Bichat's fat pads play a significant role in relation to additional cheek volume build up that results in progressive tissue ptosis. Therefore, Bichat's fat pad removal is pathogenetically justified. The fat pad is composed of the main body and several extensions: buccal, pterygoid and temporal (deep and superficial). Our goal is reduction of buccal extension of Bichat's fat pad. By lightening the cheek by 8-15 grams on average, we substantially decrease cheek volume and prevent gravitational ptosis impact in the future. We perform Bichat's fat pad removal using an oral approach either as a mono procedure or simultaneously with thread lifting. The landmark for the incision is Stensen's papilla of the parotid duct or first molar of the maxillary teeth (Fig.4). The procedure can be successfully carried out under local anesthesia.

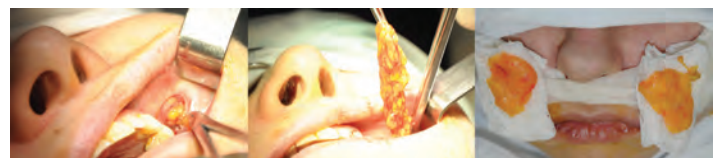


Figure 4 - Bichat's fat pad removal

After a 1cm incision of the oral mucosa 1cm away from mucogingival junction, bluntly separating fibers of cheek muscle, the Bichat's fat pad capsule can be reached.

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Marcelo Olivan, MD, PhD – Brazil

Global Perspectives: Brazil

Outpatient Reverse Triangle Suspension Technique to Midface Rejuvenation

S. AMERICA



BRAZIL

Introduction

The aging of the middle third of the face due to loss of volume, ptosis and laxity of the skin and the SMAS is visible by the accentuation of the nasogenian sulcus and loss of malar projection^{1,2,3}. There are well-established techniques for coping with this problem, such as fillings, non-invasive suspension sutures and surgeries^{1,2}. Fillings and suspension sutures demonstrate limited results and their indication is restricted to patients presenting low sagging and discrete sulcus^{1,3}. Face lifting surgery is indicated in moderate or large sagging, when the cervical, mandibular and malar regions may also be considered. Yet it is sometimes associated with blepharoplasty^{1,2}. Between these two groups, the younger patients who are satisfied with ancillary procedures and the older ones who require full face surgeries, there is a category of patients that is not satisfied with the inexpressive results of filling and/or suspension sutures, but feel too young to undergo a face lifting^{4,5}. These patients are between the ages of 35 and 45 with optimal body care and when they switch from sedentary lifestyle to an active one, carrying excess weight and body fat losses there is an accentuation of the malar flaccidity translated by the pronounced nasogenian sulcus. For these patients, we indicate an outpatient mini-lifting of the middle third.

Methods and Results

A pre-capillary area about 1.5 to 2.0 cm around the sideburns is delimited. According to the flaccidity presented by the patient, we determine a traction point between the sideburn and nasogenian sulcus strong enough to promote a cranial and lateral traction of the middle third. From this point, a triangle based on the sideburn is drawn (Fig1). Under local anesthesia, the skin of this area is removed exposing the SMAS. Plication points with non-absorbable sutures are made to traction the middle third of the face, repositioning the malar projection and attenuating the nasogenian sulcus. The skin is tightly sutured.



Figure 1 - Reverse triangle based on the sideburn and pointing the nasogenian sulcus is drawn. The vertex of the triangle determines a point that is strong enough to move the middle of the face upwards and laterally.

The patient is discharged with a prescription of analgesics and instructions for applying topical ice.

In the immediate postoperative period, the middle third correction of the face is already visible. A swollen area is also visible around the incision. After the completion of 30 procedures, we had no cases of hematoma or local infection and only 3 cases of unilateral cutaneous bruising, resolved in 7 to 10 days. There was no case of nerve damage since all the approach is supra SMAS. All the scars are easily covered by the hair and are very discreet after complete healing. (Fig 2)



Figure 2 - On the left side, the image shows the patient face before the procedure. On the right side, it is possible to see the results three months after the surgical procedure.

Discussion

The face is the body region about which patients demonstrate the greatest concern. From youth, when the first anti-aging care of this region begins through the use of sunscreen, until elder age, when people no longer care as much about body appearance, everyone wants to have a pleasant face. Later in life, patients undergo a series of procedures aiming to slow down, ameliorate or correct signs of aging. Botulinum toxin, filling, non-invasive suspension sutures, laser, peeling, and radiofrequency are the initial procedures and last for years in the Dermatology and Plastic Surgery offices until the patient comes across a surgical procedure for face lifting. In this transition time, some patients will no longer have satisfactory results with non-surgical procedures and at the same time consider

continued on page 39

Global Perspectives – Saltz continued


sensory changes compared to traditional open coronal brow lift. The technique has improved over the last 24 years with better fixation devices, a better understanding of the long-term results and decreased complications. It offers a much easier, safer and long-term solution for the aging forehead and the ptotic/flat midface often seen in young patients who are not yet candidates for facelift surgery or that want long term results that fillers/fat often do not provide.

Endoscopic midface lift is a time-tested method of providing highly accurate, precise, safe, long lasting and aesthetically focused rejuvenation of the entire forehead and midface regions in a short time when done by a well-trained surgeon.

The recent criticism of endoscopic facial rejuvenation and the increase of “non-endoscopic” procedures (which I consider “blind surgery”) has to do with a lack of understanding and unwillingness to learn the endoscopic technique. In my view, the better you can see, the more precise you can be and non-endoscopic procedures

are “blind surgeries”. Can you imagine a “new” type of cholecystectomy just for surgeons who don’t have access to an endoscope, don’t want to learn, don’t need to see the anatomy, don’t mind the complications and just want to go faster at the sacrifice of visualization and precision – *Benefit to the patient or to the surgeon?*

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Global Perspectives – Denyshchuk continued

The important condition for long-term effect (2-3 years) of the above mentioned surgical interventions and procedures is the patient’s intention to maintain a steady weight afterwards.

In most cases, our patients undergo a rehabilitation program in the post-operative period which impacts both local structures and general patient condition. In order to enhance tissue microcirculation and decreasing edema, skin tone restitution, we use mesotherapy, hirudotherapy, microcurrent therapy, oxymesotherapy, ozone- and carboxytherapy. For detoxication reasons and general microcirculation improvement, we use intravenous infusions and plasmapheresis.

In conclusion, we want to point out that use of minimally invasive surgical interventions and procedures can become an optimal choice in the pursuit of sustained and long-term rejuvenation results. Patients with mid-face soft tissue excess require “lightening” surgical interventions in order to get optimal results. Application of volumizing fillers and autologous fat tissue is a reasonable option for the volume depleted areas of the mid-face and age related wrinkles and folds. Rehabilitation serves an important role in timely wound healing and a comfortable post-operative period.



Global Perspectives – Olivan continued

themselves too young to undergo a surgical intervention, hospitalization and extended rest. For this group of patients, we propose an outpatient approach that fetches objective results, such as the suspension of the middle third of the face, which demonstrates longer lasting results when compared to non-surgical procedures, but with the same recovery time to resume normal activities.

The technique is indicated not only for patients who demand suspension of the middle third since it may be applied to the cervical or frontal regions with the same principle. Moreover, it is indicated for patients who have already lost partial results of a first facelift and would like to have a local, isolated, outpatient, fast and more effective intervention than non-surgical procedures.


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Juan Martin Chavanne, MD – Argentina

Nestor Vincent, MD – Argentina

Global Perspectives: Argentina Contemporary Midface Facial Rejuvenation

S. AMERICA



ARGENTINA

Clinical approach towards the midface is one of the most popular interventions for practitioners in Argentina when treating age-related changes of the face. Presently, a plethora of procedures, invasive and non-invasive, are used and practiced in midface rejuvenation.

However, few of these approaches have been validated or passed review board assigned evaluations.

Recent work has shown that the local cosmetic surgery market follows the standard laws of economics. The increase in local density of practitioners associated with lower adjusted fees for aesthetic operations, excessive costs of hospital facilities for surgical procedures, increasing numbers of price-sensitive patients and the wide spectrum of soft tissue substitutes available in the market have increased the number of non-invasive procedures to treat midface problems. Dermal fillers, neuromodulators, PDO thread lifts and fat injections are currently used to the detriment of the classical midface lift rejuvenation. As many of these non-invasive methods are being performed in office-based and free standing ambulatory surgical facilities, there is a propensity to reduce the complexity of the surgical procedures and to opt for them.

To understand this trend and its effects on the practice of local plastic surgeons, it is necessary to take into account the economic aspects of cosmetic surgery, plastic surgery settings and some consequences of the business of health care companies in Argentina, some of which offer aesthetic procedures to their associates.

Regarding local surgical perspectives on aging midface treatment, these include an increased tendency to combined short scar midface lifts and fat graft transfer focused on restoring volume and proportion around the eyes, according to conventional golden rules and to fill nasolabial folds. By means of the volumizing of certain sectors of the middle third of the face, theoretically less soft tissue manipulation is required reducing time and cost of the procedure. At this point, and for the same reason, there is a marked inclination of local colleagues to plicate or invaginate soft tissues more than current SMAS or High SMAS techniques. Additional stimulation of collagen by means of radiofrequency therapy to recover the tone of the skin with

retraction and elasticity is often performed complementary or prior surgery. Photo stimulation resources when available are used to improve the texture and surface of the skin as well.

Endoscopic assisted midface lift is not a technique frequently used in our country except by a handful of surgeons. Many of them prefer mini temporal approaches for browpey or direct botulinum toxin to raise the eyebrow. The combination of minimally invasive treatment with surgical procedures is the current trend in search of safe and effective fast results.



Pre- and postop: Short Scar Hi SMAS facelift, blepharoplasty and structural fat grafting.

Local plastic surgeons face several strongly negative market forces as in other parts of the world. In addition to dealing with the problems mentioned above, we face great rivalry from existing providers of cosmetic facial surgery including surgeons in training in plastic surgery and members of other specialties offering cosmetic procedures. Even more, patients do have bargaining power over plastic surgeons because they are price-sensitive and willing to shop around for surgeons on the basis of price. Substitutes include alternative procedures such as laser blepharoplasty or weekend face lifts and again, to some extent, by members of other specialties.

Lastly, the facial aesthetic surgery market in our country is basically wide open to new entrants and thus additional competition. From a strategic perspective, it is essential that plastic surgeons know the entire spectrum of techniques available, from the non-invasive to open approaches, offering the safe and best result for patients seeking midface rejuvenation. ISAPS members should be at the forefront.

ISAPS NEWS



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COMMITTEE REPORTS




Nina Naidu, MD – United States
ISAPS National Secretary for the United States
Chair, Women Plastic Surgeons Committee

NEW COMMITTEE: ISAPS WOMEN PLASTIC SURGEONS

ISAPS Women Plastic Surgeons was recently created to empower and advocate for women plastic surgeons at all stages of their careers. Participation is open to both women and men plastic surgeons who are members of ISAPS. As of this writing, 14% of our membership consists of women surgeons, which to our knowledge is the largest group of women plastic surgeons in any society worldwide. This number includes many world-renowned surgeons who have contributed enormously to the field of plastic surgery.

ISAPS Women Plastic Surgeons will hold its inaugural symposium on the day preceding the next Congress in Miami Beach on Wednesday, October 31, 2018. This will be a five-hour symposium during which we will honor and learn from some of our renowned women plastic surgeon leaders; present the challenges of being a woman plastic surgeon; discuss how to ethically leverage being a woman surgeon in a traditionally masculine field; and present a roundtable discussion on how to work more effectively with our men plastic surgeon colleagues for the benefit of our patients and our specialty. We will finish with a networking reception prior to joining the opening reception of the full Congress.

We have been very encouraged by the enthusiasm for this project from both women and men surgeons in so many of our member countries. Women plastic surgeons from around the world have begun approaching us with great interest in becoming members of ISAPS, and in being a part of this group. Please visit our new Facebook page [include the link] for ISAPS Women Plastic Surgeons and join our closed group where questions can be raised and answered in a private forum.

For more information, please contact Dr. Nina Naidu at drnaidu@naiduplasticsurgery.com 

Currently, the committee includes the following members:

Nina Naidu, MD – New York, NY, USA - Chair

Lina Triana, MD – Cali, Colombia

Maria Wiedner, MD – Bonn, Germany

Dana Jianu, MD – Bucharest, Romania

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Adriana Pozzi, MD – Italy
ISAPS Assistant National Secretary for Italy

The Road to Afagnan: Diary of a Humanitarian Mission

The first impact in Togo is the road from Lomè to Afagnan, travelling on the St. Jean de Dieu Hospital minibus. From the capital, there is half an hour of “normal” road, which the locals call “autoroute,” and two hours of beaten red earth track, full of holes, but still preferable to the tarmacked road which runs parallel to it.

Then there are all of us: Claudio, our former AICPE Onlus President leading the expedition; Paola, a plastic surgeon on her third mission; Marie Christine (a Parisian friend) who works for the FAO and for an alliance that deals with malnutrition in underdeveloped populations; and the girls, fourth year medical students Greta and Marialuisa (the latter is my daughter) full of enthusiasm and curiosity which infects us all, right from the start of the journey! And me, on my second mission to Togo.

The mood of the group is high. Already at the airport, the first Togolese mosquitoes throw a welcome party for us. “The uneven road towards Afagnan cannot bring our morale down!” A request to make a stop to “pee because I’m bursting...” in the middle of the hot humid forest. “Are there any snakes?” ask the girls before venturing into the unknown area. “Yes, we often see them in the hospital garden, too” answers Augustine, our driver. Everything is done in great haste to avoid nasty surprises, and then back on the minibus to bounce around on the seats. The road never seems to end . . . the moon, already high, illuminates our route, and the shiny mangoes that hang from the trees reflect its white light. A little further to go along the difficult road, but our stomachs seem to withstand it.

We finally arrive at the hospital which in our eyes seems like paradise in the middle of nowhere. The temperature is 30°C; the air is hot and humid; the nocturnal sound is the song of bats, never heard before, which starts at about half past five in the afternoon and accompanies us all night long.

The rooms, simple but decent, are next to those of our mission companions. I can say “Good morning” and every one of them replies from their room, “Bonjour mon amie!” says Christine, “Good morning, Mum”, this is my daughter. “What shall we do? Let’s go!” This is Claudio, or rather “Doctor Feel Good” – a nickname given to him by Marie Christine.

I wake up on my first day in Togo, at six o’clock on a Sunday, to a joyous chorus accompanied by the rhythm of the tam-tam . . . when I discover that Mass begins very early and it is a celebration of almost two hours with songs, dancing and many colors. Everyone is elegant and beautiful at Mass! It reminds me of Harlem, a few years back, when I heard Gospel songs for the first time. Actually, the Mass I am seeing now is older than the Gospel in Harlem.

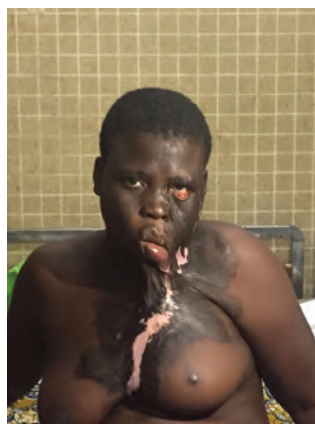


Figure 1 - This woman, who suffers from epilepsy, was burned in a cooking fire. In Africa, cooking fires are on the floor of the huts.

From the first day of work, our desire to give our all is huge. Our patients come from faraway villages. When we do rounds in the wards with Sister Simona – the hospital’s general surgeon – they greet us with a smile and the respect of people who have absolute faith in doctors. There are desperate cases, never seen before. Children with severe burns. Little hands closed by retracting scars. Syndactylies and enormous lipomas and sarcomas, a little baby with a double mouth and a facial cleft. And just when, in the late afternoon, we think we

have finished, the operating list gets longer with some unprogrammed debridement. African infections destroy the skin and the subcutaneous layer, leaving the muscles uncovered. With the operating room nurses, Felicienne and Agnese, very willing to satisfy all our requests, the operating room is a work environment which is spartan, but familiar and welcoming. It is also the best place in the hospital to be: we have air-conditioning!

At the end of the day, we all meet in “Mango Square” to talk about the next day’s surgical cases, and then everyone goes to the bar “la Buvette” where cold beers and cacahuètes (peanuts) are waiting for us.

When we go to do dressings in the pediatric rooms, the mothers are sleeping with their children, lying on the floor on their colorful cloths. As we pass by, many of them smile and others continue to rest, with the smallest children wrapped in the cotton covers.




Figure 2 - Member of our mission team with a small patient with a double mouth.

In the pediatric ward, there is also a small school room where Marie Christine teaches the language of Molière to the children. Finding the school is easy: you only have to listen for the voices and songs of the children.

One evening, Marie Christine organizes a meeting for us with an advisor of the President of Benin: Tekpon, a friend of hers for years, who comes specially to meet us by car for a two-hour journey crossing the new bridge built on the border between Togo and Benin. It is a great step forward! Benin is a more

advanced nation than Togo. You only need to look at the bridge that connects the two countries. Towards Benin, modern streetlights illuminate the road at night while towards Togo there are no lights! If missions are realized in Benin, it would be the fourth country in the world to be assisted by the charitable arm of AICPE, in addition to Togo, Guatemala and Paraguay. At present, it is still in an organizational phase.

One Sunday, Sister Simona takes us to the villages where she goes to visit and examine the children, leaving medicine for intestinal infections with the mothers. The village we visit is unknown to the Sister. The families live in huts with straw roofs; there are no lavatories; one woman has nine children, the two smallest ones hold on to her by the arm, dangling as if they are little monkeys! The second stop we make is at the House of Happiness, which the Sister has built, thanks to assistance from our organization, to take in children with difficult family situations. As soon as we ring the bell, the little ones jump into our arms and welcome us, singing and dancing!

Ten days later, when we return along the road from Afagnan on the hospital's minibus going towards the airport, the holes in the road are the same as they were on our arrival. We are full of nostalgia for the Togo to which we are saying goodbye. Then Marialuisa says "Mum, when we get home and we meet people in the street, nobody will smile at us anymore!" 

Dr. Pozzi is Vice President of AICPE Onlus, founded by Dr. Giovanni Botti in 2013 during the Second National AICPE Meeting. The current president is Dr. Marco Stabile, who is a very active and smart person.*

*** Associazione Italiana di Chirurgia Plastica Estetica (AICPE)**

MIAMI TRIVIA

The Home of Suntan Lotion



The inventor of suntan lotion was from Miami Beach. He was a pharmacist named Benjamin Green and came up with the useful concoction in 1944. Now visitors of Miami Beach can safely protect themselves from the sun thanks to Benjamin Green's invention.

HISTORY

THE HISTORY OF NOMA DISEASE AND ITS SURGICAL TREATMENT



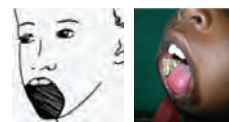
Denys Montandon, MD - Switzerland

It is not uncommon for plastic surgeons engaged in humanitarian aid in poor countries of Africa, South America or the Asia-Pacific region to encounter children affected with severe facial disfigurement due to a disease known as noma. This name was given to this particular disease in the 18th century and derives from the ancient Greek word νομή, meaning feeding from the devouring of pasture by herds and by extension a spreading lesion or a devouring ulcer.

Several other names like “water kanker” or “cancrum oris” have been abandoned, as they might suggest cancer-like lesions. Although little is known about the origin of the disease (see text box), for those who have seen a few cases who survived the initial stages, the diagnosis can be made almost immediately by the typical appearance of the residual lesions. Initially located in the gingiva, the sloughing of the necrotic tissues leaves a defect which always affects the mucosa, but may spread to the soft tissues and bones of the whole middle and lower third of the face.

Four types of sequelae are usually encountered:

- Type I is a localized cheek defect, sometimes involving part of the lips.
- Type II is a centro-facial defect, which affects mainly the nose and upper lip. It may involve the whole palate, nasal septum and nasal bones.
- Type III is a midline defect of the lower third of the face. It can affect only the lip or the chin or presents itself as a complete loss of the mandible.
- Type IV is a major cheek and maxillary defect that sometimes can spread to the orbit and the nose and destroy the whole hemiface.



always a difficult task. Another important feature of noma sequelae is the contraction of the tissues following the initial necrosis and the sloughing of the eschar. This retraction induces a forceful closure of the mouth, a lockjaw that should be differentiated from a TM joint ankylosis or trismus, that require different treatments.

Once the healing process is achieved, reconstructive surgery is usually delayed for one to four years depending of the type of lesion, the age of the child and the medical facilities. If in some minor cases it can be achieved by one operation (i.e. Estlander or submental flap), staged reconstruction is often indispensable. Complex defects represent the most difficult challenges in reconstructive plastic surgery of the face. They may necessitate the combined use of cranio-maxillo-facial procedures, free composite flaps, nasal reconstruction with forehead skin expansion, bone distraction and the whole panoply of local and distant flaps in multiple staged operations. Moreover, as this surgery is usually performed during childhood, a long-term follow-up is necessary leading sometimes to other corrections at a more advanced age.



The History

Although the people (mostly children) affected by noma are nowadays almost exclusively found in tropical or subtropical regions, the disease is not related to climate as demonstrated by the history showing that it was quite common in Europe up to the 19th Century. Even during the Second World War, a series of Gypsy children suffered from noma in the concentration camp of Auschwitz. Interested by this disease, which he thought was genetically or racially induced, the notorious doctor Josef Mengele approached a Jewish prisoner pediatrician, Professor Berthold Epstein, proposing that, in return for “an extension of his life,” he helps to carry out research that Mengele could publish under his own name. Epstein was granted a day to think the

matter over. He was indignant that Mengele “wanted to rob him of his soul.” But his colleagues convinced him that an attitude of this kind at a distance of three hundred meters from a crematorium was far from being realistic and that, under the pretext of “scientific research,” he could do a great deal of good for these inmates. Epstein then proposed a research project on the treatment of noma. Mengele agreed, and a “Noma ward” (*Nomaabteilung*) was established where forty-five to seventy children were kept and given a special nutritious diet, vitamins and sulfa drugs, as requested by Epstein. The children were photographed before, during and after treatment and SS doctors were brought to the ward to observe the work. A few of these children made good recoveries, the others died and their heads were sent for postmortem examination. The results of this “experiment” were never published. Having survived the war, Epstein later testified in the Soviet war crimes trials on genocide. He lived in Prague for the remainder of his life, serving as chair of the city Hospital pediatric clinic until his death in 1962. The excessively high number of children affected by noma in Auschwitz clearly shows the link of this disease to extreme malnutrition and debilitation.

If numerous papers are nowadays published on noma by plastic and maxillofacial surgeons, we are indebted to the British plastic surgeon Michael N. Tempest for having drawn the attention of our specialty to this disease in 1966. During his three and a half year stay in Ibadan, Nigeria, he treated more than 300 children and related his experience in a classical essay under the title *Cancrum oris*. He also gave a historical introduction and description of the state of the art as regards the etiology and treatment of this mutilating disease 50 years ago. In 2003, K.W. Marck, a Dutch plastic surgeon, published a book entitled *Noma the face of poverty* with an extensive chapter on the history of this disease, but failed to find the first descriptions of this pathology in antiquity.

Although the incidence of this impressive illness that devours beauty and life is relatively rare, it has been described a number of times throughout the ages. Already in the Egyptian Smith papyrus (1650 BC), translated by Breasted, one may find the following account corresponding to Type I sequelae.

Case 15: A cheek wound

Title: Practice for a perforation in his cheek.

Examination and prognosis: If you treat a man for a perforation in his cheek and you find a swelling on his cheek risen, black, and gone off, then you say about him: «One who has a perforation in his cheek: an ailment I will handle».

Treatment: You have to bandage him with alum and treat him afterward with oil and honey every day until he gets well.

In Hippocrates (400 BC), we find a typical description of a Type II sequela:

Τὸ παιδίω τῷ φαγεδαίνωθέντι...

“In the child suffering from phagedenic affection, the teeth of below and above, in front, have fallen down, the bone being eroded. The exposure of the palatine bone induced the collapse of the nose in the middle; the fall of the front teeth above induced the flattening of the tip of the nose.”

During the Middle Ages, physicians like the Arab Avicenna (980-1037) or the Flemish Jehan Yperman (1260-1301) mention in their books this spreading ulcer starting from the gums. The first author to describe noma as a clinical entity was the Flemish surgeon Carolus Battus in 1590 in a four-page chapter of his book *Handboeck der Chirurgien*:

“These ulcerations in the mouth of children, beginning as a little spark, can devour the lips, the jaws and even the tongue, leaving in the course of a month the children horribly disfigured if they stay alive.”

During the next two centuries, similar descriptions of the disease can be found in the English, French, Dutch, Swedish, German and Italian medical literature, accompanied sometimes with suggestive and dramatic illustrations.

First Operations

While working in Switzerland as a protestant refugee, the famous surgeon Pierre Franco (see ISAPS News: vol. 8/1, 2016) described in 1561 very precisely how he was able to cure a man suffering most certainly from noma sequelae. His account is a model surgical report as it includes diagnosis, previous medical history, methods used for surgery (skin and mucosal flaps), follow up, functional and cosmetic result.

“A certain Jacques Janot Savagny who lived near Neuchâtel-on-the-Lake in Switzerland was afflicted with a cantabris (ulcer) which penetrated his cheek, so much so that the largest part of the cheek had been destroyed. The ulcer was so large and round that a goose egg would fit through it. The two mandibles showed no flesh and there were no teeth in the ulcerated side of his face.

The patient had to wear a dressing and a leather strap. Even with this bandaging he still could not prevent some of his food and beverage falling through the hole in his cheek. As a result, he did not dare to socialize; especially since the saliva was always oozing through the wound. During the seven or eight-year period of his disease, he searched for someone who would be able to cure him. However, when I first saw him, he had not yet found anyone willing to touch it, and had been told that he was incurable, for flesh could not be generated, nor could the edges of the hole be brought together.

He asked if I could cure him. I told him I would heal him with the help of God. I placed the patient against the trunk of a tree and attached his thighs firmly to it. I advised that he be tied well. I had my *cautereres* nearby in a basin on a fire, ready to be used.

I took a small razor and cut all around the edges of the ulcer. I split the skin near the eye, towards the ear and towards the inferior mandible as quickly as I could, while making sure not to cut too far (so as not to create further damage and cut transverse muscles). I then cut the flesh around the ear and eye as much as I could, yet still the edges could not be joined. Next I cut the flesh inside the cheek sidewise and lengthwise, lacerating it, paying attention not to reach the outside area because one should not cut the skin. Where there was bleeding or a vein cut-off, I cauterized with the *cauterer* mentioned above. I pulled the edges together and managed to join them. I then immediately applied seven needles in the same manner as for cleft lips. After four or five days, three of them fell out and did not need to be replaced because the edges were pulling. I used dressings and little cushions with bandages around the wound to draw the flesh to the center so that the edges would not break and the remaining needles would not fall out. I also applied a cloth soaked in *oxicatron* and used my *restraintifs* in a way that they would not interfere with the needles.

Within fourteen days, I had cured him. Some said that his cheek would pull and he would not be able to open his mouth; in fact, the flesh was abundant enough that he even grew a beard, which made the wound hardly noticeable.”

Since Franco's time, one has to wait until the end of the 17th century to find other attempts to reconstruct the lips and the cheeks in noma cases. The most comprehensive reports on various aspects of the disease and their surgical treatment can be found in Von Brun's *Chirurgische Atlas* (1857), with a series of very realistic illustrations.



Conclusion

Although the disease was and is still infrequent compared to epidemics like leprosy, tuberculosis or plague, noma has haunted generations of people by the terrible disfigurement it may produce. The fact that it has disappeared nowadays in the wealthy countries should not let us forget that thousands of children are still possible victims among the undernourished populations of the globe. In addition to their functional and cosmetic burdens, they are sometimes considered as a malediction for their family and deprived of schooling and social relationships. Plastic surgery has a lot to offer to these children if fully trained surgeons in the cranio-maxillo-facial field provide it.


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 Montandon Denys: *Surgery of noma: a 20-year experience*. Stomatology 104, 1-9, 2007

Noma is a gangrenous stomatitis causing high mortality and devastating facial lesions with severe functional and aesthetic consequences, affecting mostly children age 2 to 10. It starts from a gingival lesion that spreads to the underlying bone. The corresponding facial region develops edema and becomes necrotic, leading to the destruction of large parts of the soft and hard facial tissues. Findings from observational studies suggest several risk factors such as poverty, stunting and malnutrition, low birth weight, poor sanitation, endemic infections (measles, malaria, AIDS), high number of previous pregnancies in the mother, poor oral hygiene and proximity of livestock. Although these factors might play a role in a cascade of events leading to a catastrophic derailment, this disorder is essentially an opportunistic infection to poor health status. In 2013, the Gesnoma (Geneva Study Group on Noma) published the result of a six year, prospective, matched case control study in a rural region of Niger. The sample consisted of 82 children younger than 12 years presenting a typical initial noma infection, that is exposure of the maxillary bone, edema or initial facial necrosis. For each case of noma, 4 children of similar age from the same village were included in the study and had similar investigations. Structured interviews took place with the children's family members, demographic, clinical and nutritional data were collected, as well as viral and microbiological samples of gingiva and blood. Acute necrotizing gingivitis (ANG) appears to be a precursor of the lesion. Analysis of bacterial composition showed that the flora present in the lesion and in the healthy mouth harbor fundamentally the same bacterial communities, but differ in the prevalence of a limited number of species. *Prevotella intermedia* and members of the *Peptostreptococcus* genus are associated with both diseases (noma and ANG). This study did not provide evidence for the existence of one bacterial pathogen as a cause for the disease, but strongly suggests that an altered oral microbiota increases the risk of the disease, independently of socio-demographic and environmental factors.

Baratti-Mayer D, Gayet-Ageron A, Hugonnet S, François P, Pittet-Cuenod B, Huyghe A, Bornand JE, Gervaix A, Montandon D, Schrenzel J, Mombelli A, Pittet D; Geneva Study Group on Noma (GESNOMA) : *Risk factors for noma disease: a 6-year, prospective, matched case-control study in Niger*. Lancet Glob Health. 2013 Aug;1(2): 87-96.

The history of noma: Illustrations

1. Type I defect
2. Type II defect
3. Type III defect
4. Type IV defect
5. Example of type II reconstruction of nose and upper lip with various skin and mucosal flaps and calvarial bone graft to the nose.
6. Von Brun's atlas: type I sequel
7. Von Brun's atlas: type IV sequel
8. Von Brun's atlas: bone loss in noma
9. Von Brun's atlas: surgical cure of a cheek fistula 



Thomas S. Davis, MD – United States
ISAPS Historian

ISAPS HISTORY: THE EVOLUTION OF THE EXECUTIVE OFFICE

On February 12, 1970, Mario Gonzalez-Ulloa, David Serson, Ulrich Hinderer, Jose Vinas, and Salvatore Castanares gathered at the United Nations in New York City to organize a new aesthetic plastic surgery society that they named the International Society of Aesthetic Plastic Surgery (ISAPS). A Steering Committee chaired by Mario Gonzalez-Ulloa met in May of 1970 to create a list of potential members who would be invited to form the nucleus of this new organization. The first membership meeting was held in Boston, Massachusetts in May 1971 and invited surgeons who had elected to join became the Founding Members. Plans were initiated for the First International Congress of Aesthetic Plastic Surgery in Rio de Janeiro on February 6-11, 1972.


The initial years of the society were similar to a “travel club.” The “central office” was, in reality, the practice office of the Secretary General who was the functional head of the Society, not the President, reflecting the society’s formation at the United Nations.

During the twenty-eight years from the founding of the society until the Board of Directors decided to hire an “Executive Secretary” in May, 1998, the central office would change with each biennial election of a new Secretary General. In the beginning, with a small membership, this arrangement worked well enough, but was not very efficient. It was increasingly difficult to maintain records, manage incoming membership applications, or manage the day to day activities required to run an international organization. The Secretary General was also responsible for all correspondence with the members and the National Secretaries, scheduling and running Board meetings and recording the minutes, and organizing the

Biennial Business Meeting at each Congress. With the inevitable growth of the society, the workload for the Secretary General became very difficult to manage from the office of a practicing surgeon. At the Congress in New York City in September of 1995, Freddie Nicolle, a Board Trustee, first suggested that the Board consider hiring someone to maintain a permanent office for the society.

Three years later, at the Board meeting held during the annual ASAPS meeting in Los Angeles, interviews were conducted with three individuals under consideration to establish the first ISAPS central office. Catherine Foss, then Executive Director of the Northeastern Society of Plastic Surgeons, was selected by the Board under Secretary General, Bill Little, who had served as President of the Northeastern Society and knew Catherine well. At the time, the Board would only agree to the title of Executive Secretary, and Bill relinquished his salary as Secretary General in order to pay for our new administrator.

Catherine’s first official assignment was to assist Tom Biggs with the production of an ISAPS Course in Napa Valley, California in September of 1999 just prior to the IPRAS Congress in San Francisco. She began attending our Board meetings at this Congress. The following year, during the ISAPS Congress in Tokyo, she was responsible for organizing the Board and Biennial Business meetings, but not the Congress.

Over the next nineteen years since she was first asked to take on the management of ISAPS, Catherine’s title changed to Executive Director, the staff grew, and the responsibilities of the Executive Office have expanded exponentially. 


IN MEMORIAM



Michel Rubeiz, MD – Lebanon
1937-2017

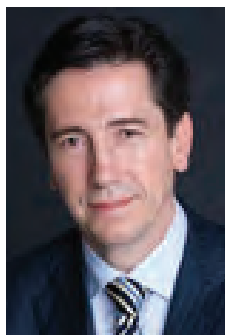
On Sunday, May 31 2017, Dr. Michel Rubeiz passed away at AUBMC (American University of Beirut Medical Center) after a long battle with disease. The news came as a shock to the AUB community and especially to the Faculty of the School of Medicine, his students and residents. Dr. Rubeiz was a well-trained and a prominent plastic surgeon and was highly regarded for his service and expertise.

Dr. Rubeiz was born at the American University Hospital in 1932 and graduated from its Medical School where he also received his General Surgery training. Later he

travelled to the United States to complete his training in Plastic Surgery at Saint Louis University School of Medicine. After returning to Lebanon he engaged in private practice for a few years until he joined the Division of Plastic Surgery in 1978 where he spent the next forty years teaching and mentoring generations of plastic surgeons. Dr. Rubeiz is survived by his wife Simone, his sons Tony and Nadim and his daughter Tania 

Paul Audi, MD
National Secretary for Lebanon

IN MEMORIAM



Dr. Enrique Etxeberria Olañeta – Spain
1963-2017

A very well known “sevillana” (a Spanish folk song) says: *Something dies in our soul when a friend leaves. When a friend leaves, something dies in our soul, when a friend leaves something dies in our soul, when a friend leaves, he leaves behind a mark that can't be erased, he leaves behind a mark that can't be erased. Don't go away yet, don't go away please, don't go away yet because even my guitar cries when you say good-bye.*

Enrique left us. The news of his death was shocking because it was completely unexpected. I can only recall a big, funny Basque man when he was away from work, and very hard working and committed to his job as the Spanish National Secretary of ISAPS. He had moved recently to Riyadh to start a new project in his career in the Plastic Surgery Clinic of the SULAIMAN AL HABIB-HMG/OLAYA MEDICAL CENTER. I had spoken with him several times after he left Spain and he was as friendly and positive as ever.

Thanks to Enrique, I became first Assistant National Secretary of ISAPS and when he resigned to move to Riyadh he encouraged me to “upgrade” to continue with his task. I shared very good moments with him. What I could not imagine is that one of my duties would be to write these words for him.

He studied medicine at the University of Leioa (Lejona) in Bilbao. He trained in Plastic Surgery in the Hospital Nuestra Señora de Aranzazu, now Donostia Hospital from 1991 to 1995. After that he went to the USA for a few months for a fellowship in Plastic and Reconstructive Surgery.

He dedicated himself exclusively to private practice. He worked approximately one year in the Policlínica of Guipúzcoa of San Sebastián since his first wife was originally from San Sebastián. They had no children from the first marriage.


Then he settled in Bilbao in a magnificent office in the heart of Bilbao, on Gran Vía in an emblematic building: Palacio de Sota.

His second wife, with whom he had 3 children, was involved in the activity of the office.

He liked the USA and traveled a lot to this country, for leisure or due to professional commitments. In fact, he was a member of the American Society of Plastic Surgery, the American Society of Aesthetic Plastic Surgery and the New England Surgical Society. And he was very active in international scientific societies, being a member of the most important. He was a founding member of the European Association of Aesthetic Plastic Surgery (EURAPS). His main academic appointment was Professor at the Stanford University School of Medicine from 1997 to 2016. He was the only surgeon in Spain who achieved Fellowship in the American College of Surgeons.

Hence also his position in ISAPS. He served as National Secretary until early 2017 when he resigned to move to Riyadh. He was deeply involved in trying to enhance the presence of Spanish plastic surgeons in ISAPS and abroad. Thanks to his efforts, both the Spanish Society of Plastic, Reconstructive and Aesthetic Surgery (SECPRE) and the Spanish Association of Aesthetic Plastic Surgery (AECEP) are members of the ISAPS Global Alliance.

He was proud of being Basque. Bilbaino to the marrow and a fan of the local football team, the Athletics of Bilbao, he had a permanent seat in the stadium known as The Cathedral (San Mames stadium). He played golf and he liked to live life with his family and friends.

Our deepest condolences to his wife Monica and children Mario, Pablo and Jorge, to his large family and all his friends and colleagues. We will miss him. *Agur, Enrique.* 

Jesus Benitor-Ruiz, MD
National Secretary for Spain

ISAPS *Calendar* of International Meetings



JUNE 2017

21 June 2017 - 23 June 2017

ISAPS ENDORSED PROGRAM

Body Sculpting

Location: Panama City, PANAMA

Contact: Dr. Joseph Setton

Email: info@bodysculptingpanama.com

Tel: 507-6747-0300

Fax: 507-204-8459

Website: <http://www.bodysculptingpanama.com>

22 June 2017 - 25 June 2017

GLOBAL ALLIANCE - Non-Surgical Symposium

Location: Gold Coast, AUSTRALIA

Contact: The Production House Events

Email: gina@tphe.com.au

Website: <http://www.asapsevents.org.au>

22 June 2017 - 24 June 2017

MIPSS 2017 - Marbella International Plastic Surgery

Summer School

ISAPS ENDORSED PROGRAM

Location: Marbella, SPAIN

Contact: Vanessa Garcia

Email: info@oceanclinic.net

Tel: 34-951-775518

Fax: 34-952-868827

Website: <http://www.mipss.eu>

23 June 2017 - 24 June 2017

ISAPS OFFICIAL COURSE

ISAPS Course - Romania in conjunction with the
Conference of the Romanian Aesthetic Surgery Society
(RASS)

Location: Poiana Brasov, ROMANIA

Contact: Simona Raia

Email: djianu02@gmail.com

Website: <http://www.isapscourse.ro>

30 June 2017 - 01 July 2017

8th Body Lift Course

ISAPS ENDORSED PROGRAM

Location: Geneva, SWITZERLAND

Contact: Géraldine Buffa

Email: contact@docteur-pascal.com

Tel: 33-4-7824-5927

Fax: 33-4-7824-6158

Website: <http://www.jfpascalmd.com/meetings>

JULY 2017

14 July 2017 - 15 July 2017

ISAPS Course - Ecuador - Current Trends in Aesthetic
Surgery

ISAPS OFFICIAL COURSE

Location: Guayaquil, ECUADOR

Contact: Dr. Marcela Yépez

Email: isapsecuador@gmail.com

Tel: 5934-999266455

Website: <http://www.isapscourse-ecuador.com>

21 July 2017 - 01 August 2017

GLOBAL ALLIANCE - ASAPS-ISAPS Cruise 2017

Location: North Sea, NORWAY ISAPS ENDORSED PROGRAM

Contact: Bob Newman

Email: BNewman@CruiseBrothers.com

Tel: 1-401-223-4711

Website: <http://www.surgery.org/downloads/microsite/cruise2017/index.php>

AUGUST 2017

18 August 2017 - 20 August 2017

Aesthetic Conference and Hands On Workshop

Location: Islamabad, PAKISTAN ISAPS ENDORSED PROGRAM

Contact: Dr. Huhammad Humayun Mohmand

Email: humayunmohmand@hotmail.com

Tel: 92-300-856-5300

Fax: 92-51-844-1444

Website: <http://www.aamsp.com.pk>

31 August 2017 - 02 September 2017

GLOBAL ALLIANCE - XV Chilean Congress of Plastic
Surgery

Location: Viña del Mar, CHILE

Contact: Dr. Stefan Danilla

Email: soccpchile@gmail.com

Tel: 56-2-2632-0714

Website: <http://www.sccp.cl>

SEPTEMBER 2017

14 September 2017 - 15 September 2017

Meeting: ISAPS Course - China

ISAPS OFFICIAL COURSE

Location: Tianjin, CHINA

Contact: Ying Zhang

Email: isaps2017@163.com

Tel: 86-21-6280-1061

Fax: 86-21-6280-3177

Website: <http://www.2017isaps.org>

21 September 2017 - 23 September 2017

GLOBAL ALLIANCE - 66th Congress of SICPRE and 1st Joint Meeting with the Brazilian Society of Plastic Surgery
 Location: Modena, ITALY
 Contact: nord est congressi
 Email: info@nordestcongressi.it
 Tel: 39-0432 21391
 Fax: 39-0432 506687
 Website: <http://www.sicpre2017.it>

22 September 2017 - 23 September 2017

ISAPS Course - Lebanon ISAPS OFFICIAL COURSE
 Location: Beirut, LEBANON
 Contact: Dr. Elie Abdelhak
 Email: elie.abdelhak@gmail.com
 Tel: 961-371-6706
 Website: <http://www.lspras.com/wp-content/uploads/2017/05/Plastic-Surgery-2nd-Announcement-2017-2.pdf>

22 September 2017 - 23 September 2017

BEAULI 2017 ISAPS ENDORSED PROGRAM
 Location: Starnberg, GERMANY
 Contact: Dr. med. Joachim Graf von Finckenstein
 Email: dr.med@finckenstein.de
 Tel: 49-0-8151-29968
 Fax: 49-0-8151-89149
 Website: <http://www.beauli.de>

22 September 2017 - 23 September 2017

São Paulo Breast Symposium 2017 ISAPS ENDORSED PROGRAM
 Location: São Paulo, BRAZIL
 Contact: Dr. Joao Sampaio Goes
 Email: clinica@sampaiogoes.com
 Tel: 55-11-3167-2200
 Fax: 55-11-3167-5535
 Website: <http://www.saopaulobreastsymposium.com>

28 September 2017 - 29 September 2017

ISAPS Lisbon Symposium – Aesthetic Breast Surgery and Body Contouring ISAPS SYMPOSIUM
 Location: Lisbon, PORTUGAL
 Contact: Margarida Ferreira
 Email: isaps-spcpre2017@aimgroup.eu
 Website: <http://www.isaps-spcpre2017.com>

OCTOBER 2017

05 October 2017 - 07 October 2017

ISAPS Symposium - Romania Immediately preceding the EASAPS Congress ISAPS SYMPOSIUM
 Location: Bucharest, ROMANIA

06 October 2017 - 07 October 2017

GLOBAL ALLIANCE - EASAPS Congress
 Location: Bucharest, ROMANIA
 Contact: Karen Rogerson
 Email: easaps@mzcongressi.com
 Tel: 39-02-6680-2323 ext 933
 Fax: 39-02-668-6699
 Website: <http://easapsbucharest.ro>

07 October 2017

ISAPS Symposium UK, in collaboration with CCR Expo 2017 and BAAPS ISAPS SYMPOSIUM
 Location: London, UNITED KINGDOM
 Contact: Alison Willis
 Email: alison.willis@easyfairs.com
 Tel: 44-20-3196-4300
 Fax: 44-20-8892-1929

11 October 2017 - 13 October 2017

ISAPS Course - Jordan ISAPS OFFICIAL COURSE
 Location: Amman, JORDAN
 Contact: Dr. Kusai Elmusa
 Email: elmusa.inbox@gmail.com
 Website: <http://www.isapscoursejordan.com>

12 October 2017

ISAPS Symposium - Canada immediately preceding the 44th Annual Meeting of the Canadian Society for Aesthetic Plastic Surgery ISAPS SYMPOSIUM
 Location: Toronto, Ontario, CANADA
 Contact: Tara Hewitt
 Email: csapsoffice@gmail.com
 Tel: 1-905-655-9889
 Fax: 1-905-655-7319
 Website: <http://www.csaps.ca>

13 October 2017 - 14 October 2017

GLOBAL ALLIANCE - Canadian Society for Aesthetic Plastic Surgery
 Location: Toronto, Ontario, CANADA
 Contact: Tara Hewitt
 Email: csapsoffice@gmail.com
 Tel: 1-905-655-9889
 Fax: 1-905-655-7319
 Website: <http://www.csaps.ca>

19 October 2017 - 22 October 2017

GLOBAL ALLIANCE - 40th Annual ASAPS Conference
 Location: Melbourne, AUSTRALIA
 Contact: The Production House Events
 Email: gina@tphe.com.au
 Tel: 61-03-9020-7056
 Website: <http://asapsevents.org.au>

19 October 2017

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

27 October 2017**2nd Norwegian-American Aesthetic Surgery Meeting**

Location: Oslo, NORWAY

ISAPS ENDORSED PROGRAM

Contact: Dr. Amin Kalaaji

Email: osloaestheticmeeting@gmail.com

Website: <http://osloaestheticmeeting.hostmotet.no>**NOVEMBER 2017****02 November 2017 - 04 November 2017****GLOBAL ALLIANCE - II International Congress AECEP 2017**

Location: Madrid, SPAIN

Contact: Carlos Lázaro

Email: c.lazaro@bnyco.com

Tel: 34-91-571-9390

Fax: 34-91-571-9206

DECEMBER 2017**01 December 2017 - 02 December 2017****The End of the World ISAPS Immersion Course in****Periorbital Rejuvenation**

ISAPS OFFICIAL COURSE

Location: Patagonia, ARGENTINA

Contact: Dr Fabian Cortiñas

Email: endoftheworldcourse@gmail.com

Tel: 54-911-4444-4375

Website: <http://www.isapsendoftheworldcourse.com>**JANUARY 2018****18 January 2018 - 20 January 2018****ISAPS Cadaver Dissection Course - Belgium**

Location: Liege, BELGIUM

ISAPS OFFICIAL COURSE

FEBRUARY 2018**02 February 2018 - 04 February 2018****ISAPS Course - India**

ISAPS OFFICIAL COURSE

Location: Udaipur, INDIA

MARCH 2018**09 March 2018 - 10 March 2018****ISAPS Course - Spain**

ISAPS OFFICIAL COURSE

Location: Barcelona, SPAIN

Contact: Dr. Jesus Benito-Ruiz

Email: drbenito@antiaginggroupbarcelona.com

Tel: 34-932-522-349

23 March 2018 - 25 March 2018**ISAPS Course - South Africa**

ISAPS OFFICIAL COURSE

Location: Cape Town, SOUTH AFRICA

APRIL 2018**07 April 2018 - 08 April 2018****GLOBAL ALLIANCE - Aesthetic Plastic Surgery 2018 - Korean Society for Aesthetic Plastic Surgery**

Location: Seoul, SOUTH KOREA

Contact: Prof. Seung-Kyu Han

Email: ksaps@ksaps.or.kr

Tel: +82-2-3472-4243

Fax: +82-2-3472-4243

Website: <http://www.aps-iae.com>**26 April 2018 - 30 April 2018****GLOBAL ALLIANCE - The Aesthetic Meeting - American Society for Aesthetic Plastic Surgery**

Location: New York, NY, UNITED STATES

Website: <http://www.surgery.org>**JUNE 2018****31 May 2018 - 02 June 2018****ISAPS Symposium - France - Immediately preceding 2018 SOFCEP meeting**

ISAPS SYMPOSIUM

Location: Lyon, FRANCE

Contact: SOFCEP

Email: sofcep@vous-et-nous.com

Tel: 33-5-3431-0134

Website: <http://www.congres-sofcep.org>**NOVEMBER 2018****31 October 2018 - 04 November 2018****24th Congress of ISAPS**

ISAPS CONGRESS

Location: Miami Beach, FL, UNITED STATES

Contact: Catherine Foss

Email: isaps@isaps.org

Tel: 1-603-643-2325

Fax: 1-603-643-1444

Website: <http://www.isapsmiami2018.com>

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Admitted February 2017 – May 2017

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Vietnam

Richard HUY, MD

* indicates Associate Member

** indicates Associate Resident/Fellow Member

WHERE IN THE WORLD?



Answer: On Safari, Thornybush Game Reserve, South Africa after the Global Alliance meeting in Cape Town, 18-20 March 2017

Joe Hunstad (ISAPS Visiting Professor), Peter Scott (Chair of NS and NS South Africa), Mark Jewell (Past President of ASAPS) and Jim Grotting (Past President of ASAPS)

ISAPS JOURNAL



The aesthetic journal, with a global circulation reaching over 10,000 readers, disseminates state-of-the-art techniques after careful editorial scrutiny. Selected articles and those open to controversy are discussed by respected experts expressing their frank independent views.

--Bahman Guyuron, MD - Editor-in-Chief

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Thank you to all our valued readers and authors.

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as of 6/1/2017



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Vakis Kontoes, Greece – Chair	Ozan Sozer, USA – Vice Chair
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ARE YOU COMING?



24TH CONGRESS

OCTOBER 31 - NOVEMBER 4, 2018

South Beach Miami, Florida, United States



#ISAPSMIAMI2018





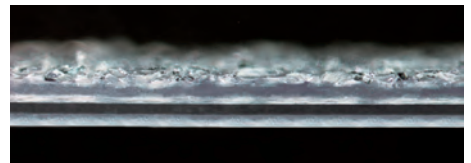
Did you know?

POLYTECH Health & Aesthetics currently is the only breast implant manufacturer offering **4** different shell surfaces.

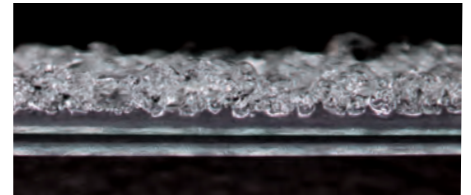
POLYsmooth™
Standard smooth surface



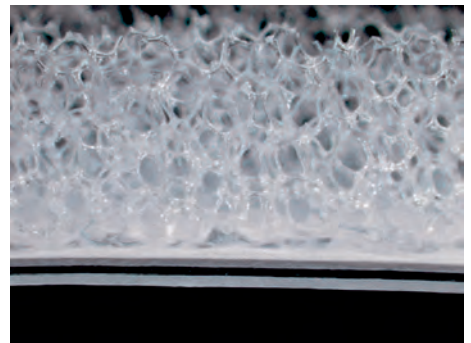
MESMO®sensitive
Micro-textured surface



POLYtxt®
Standard textured surface



Microthane®
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