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Mission Statement: Cosmetic Surgery Times is where the exchange on aesthetic perspective begins. It is your multimedia forum for accessing and discussing the leading technology, surgical and noninvasive techniques and practice management associated with cosmetic surgery. Perspectives, innovations and strategies are shared, debated and augmented by expert contributors and the larger community. The results are quality procedures and strong practices.

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Dear Editor,

I completely missed the image on the cover of the March issue of Cosmetic Surgery Times, turning instead to the content, as I usually do. It was only after another pair of eyes called it to my attention that I really LOOKED at the cover. The image of the crouched, naked model reflected in water was illustrating the cover story about cellulite treatment, yet this model certainly didn’t have anything to do with needing either cellulite treatment or liposuction or any other cosmetic procedure.

I engaged some of your editorial board members and other friends and acquaintances who are cosmetic surgeons in dialogue about the uses of nude female forms, finding some in agreement and some not that the cover was offensive.

As cosmetic surgeons doing bodywork, nudity is essential to any conversation about indications, treatment plans or results. Eroticized images are certainly NOT necessary. In fact, at a recent conference I was struck by how often frankly eroticized images appeared and how few audience members were even aware of it, much less offended. Clearly, we have been desensitized in some way.

Once the images were pointed out, I did find support for the opinion that I hold, that such uses are disrespectful to women as a class, demeaning to our patients as a whole, and certainly should play no role in education.

Although I recognize that Cosmetic Surgery Times has commercial interests, and provocative covers are marketing instruments, I would think that other images might be just as illustrative and attractive but less sexualized. I am certainly no prude, but I do have a pride in this profession that is bruised in some way.

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JANE A. PETRO, M.D.

Joe Niamtu III, D.M.D., F.A.A.C.S., responds: Dear Editor,

I would like to comment on the recent letter from Dr. Jane Petro. First, I want to say that Jane is one of my heroines and is an awesome clinician and surgeon and one of our literati.

Dr. Petro feels that eroticized images may be inappropriate for medical literature and meetings. I truly feel that she is correct in that we are all probably a bit “sensitized” by this and probably don’t think much of it. This does not make it good or bad, it just depends how it impacts one’s personal psyche.

Personally, I have appreciated these covers as “haute cosmetic art” and feel that they are provocative, not in a sexual way, but certainly in an artistic way. Some people like landscapes and still life images, which are indisputably art, and some journals use them on their covers. No one can dispute that the human body is art and can be found in any significant museum. I guess one question is, “When does the human body become erotic?” I am sure some people would find Michelangelo’s “David” to be erotic, but most see it as a work of art featuring a fit male specimen.

I think that the field of cosmetic surgery is predominantly female patients treated by male physicians. This must have a conscious or subconscious effect on what we, in the field, view as artistic. Since most cosmetic surgeons (regardless of gender) seek to emulate youth and perfection, these images seem appropriate to me. Are they erotic or exotic? I think the answer lies in the beholder, especially in a society like the United States, where the exposed breast is censored. I have noticed that Editor-in-Chief Amy Stankiewicz also uses provocative images of males when the publication discusses male procedures, so I don’t think it is one-sided.

“No one can dispute that the human body is art and can be found in any significant museum.”

Joe Niamtu III, D.M.D., F.A.A.C.S.
Richmond, Va.

I personally like these images and feel that they invite readers to explore the topics. We also have to remember that Cosmetic Surgery Times is not an index medicus medical journal, but rather a tabloid aimed at providing information to surgeons funded by advertisers. It is not the New England Journal of Medicine, and it is not Penthouse, and I believe the images are appropriate for this milieu.

One thing that Dr. Petro did was make me think about the use of female or male images and realize they are all around me in the cosmetic surgery world. I have paid more attention to this as a result of her letter. To me it is art, but I am sure that her letter will bring forth more views, including some that diametrically oppose mine.

Joe Niamtu III, D.M.D., F.A.A.C.S.
Editorial Advisory Board member, Cosmetic Surgery Times

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Letters to the editor can be a maximum of 700 words and may be edited for clarity, content, and/or grammatical correctness. Send letters, along with full name and title of the author, to Amy Stankiewicz, Editor in Chief, Cosmetic Surgery Times, 24950 Country Club Blvd., #200, Cleveland, OH 44070, or electronically to astankiewicz@advanstar.com.
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<th>With Scar Recovery Gel</th>
<th>Untreated</th>
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<td>Percentage (%)</td>
<td>80%</td>
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P < 0.0001

At 6 months

**DRAMATIC DIFFERENCE AT 6 MONTHS' RECONSTRUCTIVE SURGERY**

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<th>Study Design</th>
<th>Tape Alone</th>
<th>Tape with Scar Recovery Gel</th>
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<td>10 patients/20 areas of the body</td>
<td>1 side treated with gel and tape, 1 side treated with tape and no gel</td>
<td>Scars were evaluated by physicians at 1 month, 2 months, 4 months, and 6 months</td>
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Q: When developing a treatment plan for the face, we know that one size does not fit all. How do you approach each individual face to determine your aesthetic approach?

**Harris S. Hausen, M.D.**
Long Island, N.Y.

“I have heard it said that everyone has a double, a doppelgänger, another individual, somewhere on this planet, who could be that person’s long-lost twin. However, in my years of practicing cosmetic medicine, I have yet to see any two patients who are identical. One’s genetics, lifestyle, experiences, traumas, choices regarding diet and exercise, and countless other factors all exert subtle influences upon the structure of one’s face. Accordingly, bony and muscular architecture, the extent of subdermal adipose, and the quality of the skin vary dramatically among individuals, even between monozygotic (identical) twins.

“After obtaining a detailed medical and surgical history from a patient — but before examining her — I wish to get a better understanding of the cosmetic concerns my patient has come to address and what her goals and expectations of a proposed treatment plan might be. Consideration of a suitable plan for a given patient incorporates not only the anatomic structure of one’s face and the condition of the skin, but also the patient’s gender, age, occupation, the face’s cultural expectations for what is acceptable or desirable in terms of age-related changes to the shape of their face and the texture of their skin. The inherent thickness of either a man’s or woman’s skin contributes greatly to their resistance to rhytids and how they respond to many therapies.

“Similarly, as many cosmetic procedures can be feminizing, the approach I will offer a gentleman may be less aggressive than that offered to his female contemporary. Retaining masculinity to preserve a man being perceived as handsome, not pretty, is a necessary and fundamental aspect of selecting his proper plan of management.

“Frequently, patients present unsure of which procedures they may require to achieve certain effects and ends. Patients also present with misconceptions regarding the safety or efficacy of various cosmetic procedures, or they present misidentifying those procedures they think will most benefit them. As a physician, it is my responsibility to guide my patients toward the most valuable course of action or, conversely, to decline undertaking any course of action if I believe it to be unsafe or unnecessary for a given patient.

“My recommendations in addressing the needs of each patient vary as greatly as individuals vary. One constant, consistent component of my approach is the very recognition that each patient is a unique individual with unique structure and unique mindset and unique circumstances. My treatment must, therefore, be customized to fit that one patient, and only that one patient, seated before me in consultation.”

**Helen M. Torok, M.D.**
Medina, Ohio

Assessing the aging face best includes a twelve-step aesthetic assessment of the aging face:

1. The patient’s age. Complaints in younger patients generally reflect changes limited to the skin. With advancing age, the deeper, supportive structures of the face contribute increasingly to the aging changes.

2. The patient’s gender. Men experience changes to their hairline and have the ability to camouflage with facial hair. Men and women may also have differing cultural expectations for what is acceptable or desirable in terms of age-related changes to the shape of their face and the texture of their skin.

3. Skin pigment. Dyschromia gives clues to the patient’s past history concerning skincare (or lack thereof) and possibly their adherence to a skincare program in the future. The severity of the patient’s dyschromia also indicates their skin’s susceptibility to photodamage adjusted for their Fitzpatrick skin type.

4. The patient’s medical history. Always assess for factors that can accelerate aging or affect healing (smoking history, coexistent diseases and medications, past history of facial injury or surgery, history of large fluctuations in weight).

5. The patient’s occupation and avocations. Certain activities (marathons) can affect tissue aging. The patient’s occupation may influence how important appearance is to their success at work and how much recovery time can be tolerated.

6. Facial asymmetry. Is the patient’s asymmetry noticeable to them, and what is causing the asymmetry?

7. Expression lines. What is the dynamic component involved in creating facial lines, and are they fixed and are they a desirable expression or not?

8. The risk/reward calculation. Is the work that would be most helpful to the patient within their budget and tolerance for procedures?

9. Who sees what. Prioritize your evaluation and recommendations to what the patient sees and
observe during the consultation the range of the rejuvenating procedure will achieve the same and a content patient will look very different as well in assessing this.

Different volumes of muscle and subcutaneous fat

Different races/cultures/nationalities have different dislikes, not what you are seeing, to avoid an unhappy result.

10. Reconstructive vs. rejuvenating. For the patient over 35, a copy of a portrait of them from their late teens to early 20s should be brought to the initial consultation so you can return the patient to their previous youthful state that they recall and desire.

11. Appreciate the patient’s facial structure.

Different races/cultures/nationalities have different

12. The patient’s state of mind. A depressed patient and a content patient will look very different as well as respond differently to your treatment. Do not think a rejuvenating procedure will achieve the same result in a patient who feels bad and looks bad. This is a subjective assessment, but a valid one as you observe during the consultation the range of the patient’s expressions.”

Joe Niamtu III, D.M.D., F.A.A.C.S.
Richmond, Va.

“Faces, like snowflakes, are never the same, but they are all similar. All humans age predictably, but the way they age is very diverse due to a combination of intrinsic and extrinsic factors. I have the same conversation many times a day (mostly with women), because the basis of face and neck aging is similar for all of us. Having said that, we all individually have aging nuances that relate to our genetics, social habits and lifestyle. So everybody is the same, but no one is exactly the same.

“I believe that I could perform an accurate diagnosis from outside the consult room if the patient slid their driver’s license under the door. Most cosmetic surgeons could predict what aging a patient has and what procedures they may benefit from knowing their birth year! Obviously, that is a huge generalization, and the real art of diagnosis and treatment lies in identifying both the overt and the covert aspects of face and neck aging. Overt aging would be the grossly obvious factors such as brow ptosis, submental excess and severe actinic damage. Covert aging are the “hidden” factors that many patients and some doctors will miss. These are the little things like loss of cheek volume, temporal wasting, tear trough accentuation, earlobe shape and position, etc. These are the details that can make a big difference.

“By providing this organized structural thinking, patients can better relate and remember the discussion, as well as explain it to their spouse. Since most docs have the same conversation day in and out, we take it for granted that the patients understand our diagnosis and treatment plans. Too often, however, patients can leave the office confused, especially when multiple surgical diagnoses and procedures are discussed. It is imperative to insure in some way that the patient has a clear and concise appreciation of an accurate and comprehensive diagnosis, as well as the contemporary options. Some docs do this themselves, others have staff to simplify the discussion. I stress that a comprehensive evaluation is necessary to fully understand the total aging picture. Once in awhile, a patient presents for eyelid evaluation and may be surprised when we discuss their neck. “I just want my eyes done” may be the patient reaction, but it is important for them to understand the full impact of comprehensive aging and how the total can surpass the sum of the parts.

“Again, it is important to remember that what we say every hour may be the only time the patient ever hears it, so it is up to us and our staff to make sure the message gets through. Supplemental docs such as websites, blogs, YouTube videos and written information can also greatly assist. Always remember, an educated patient simplifies the entire cosmetic surgery process. Misunderstanding and related disappointments can fuel a litany of problems. For this reason, it is also important for the patient to understand what their procedure won’t do.”

Mary Lupo, M.D., F.A.A.D.
New Orleans

“The initial cosmetic consultation is critical to the long-term success of the patient’s treatment, as well as the long-term relationship of the doctor and patient. The dermatologist must balance the truth of what the patient needs (or does not need) with considerations of their feelings, expectations and their budget.

“At that initial consult, it is important to hand the patient a mirror and ask about their concerns and even to prioritize them for you. Then you must add your insight and observations based on your years of experience. For example, the patient may want their nasolabial folds gone when in fact they really need cheek augmentation and lift. Patients have been so conditioned to ask for their “parentheses” to be treated that they do not see the big global aging picture of their face. Remember, companies can only advertise what is an off-label FDA (Food and Drug Administration) approval. It is our job to responsibly use these tools to make the patient (not just the nasolabial fold) look better. And this means using products quite a bit ‘off-label.’ If patients are too far gone for my nonsurgical tools, I refer them to a plastic surgeon.

“All this makes the consult take longer. Patient education is the only way to have them make the best choices. If you do what a patient wants but you think it is wrong, you then own that result. So make sure every treatment used, every device employed and every filler injected is doing what your vision is for the patient. I often tell patients if you just inject the nasolabial fold, the fold will look better, but YOU won’t look better.

“I do not measure after so many years. I do a good job eyeballing the proportions. Photography is also an essential tool, as I see things in pictures. I also rely on watching the patient while they talk and animate. It is hard to articulate why I use what (products). I just “know” because I have been using fillers since 1983 and toxins and lasers since the mid-’90s.

“Finally, I always address skincare and the need for sun protection. After all, the canvas must look great and be even toned for the final painting to come out right.”

Doctors’ Bios:

Mary Lupo, M.D., F.A.A.D., is a board-certified dermatologist and clinical professor of dermatology at Tulane Medical School. She is the past-president of the Women’s Dermatologic Society, Louisiana vice-chair for the Dermatology Foundation and member of the Annenberg Circle.

Harris S. Hausen, M.D., specializes in cosmetic rehabilitative procedures of the face and body. He is the founding director of Medical Aesthetics of Woodbury, based on Long Island, New York.

Helen M. Torok, M.D., is the medical director for the Dermatology & Surgery Center at Trillium Creek. Dr. Torok, a nationally noted, board-certified dermatologist, has been practicing medicine for more than 33 years.

Joe Niamtu III, D.M.D., F.A.A.C.S., is a board-certified cosmetic facial surgeon specializing in oral and maxillofacial surgery. He is a fellow of the American Academy of Cosmetic Surgery and author of the textbook Cosmetic Facial Surgery.

Disclosures:

Dr. Lupo is a researcher/speaker/trainer and is on the advisory board for Allergan; a speaker/trainer and advisory board member for Medicis; a speaker/trainer for Valeant; an advisory board member for Merz; and a speaker for Lumenis, BTL and Syneron. Drs. Hausen, Niamtu and Torok report no relevant financial interests.
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Research is ongoing to identify how specific approaches for autologous fat grafting affect the results. Until true level 1 or 2 data are available to develop practice-changing, evidence-based recommendations, Rod J. Rohrich, M.D., says he believes it is best to keep it simple and efficient with a focus on minimizing the time between when the fat is extracted and replaced into the patient in order to minimize fat cell death.

He says his technique, which is based on his clinical and laboratory studies published in the Journal of Plastic and Reconstructive Surgery plus a decade of clinical experience, represents a rationale and effective approach for recontouring the face with autologous fat.
In addition to prompt reinjection of the fat, he says the components of his method include preferential fat harvesting from the inner thigh; one minute of centrifuge time; and reinjection of the fat in an anatomically based approach into well-defined deep facial compartments.

“When it comes to techniques for autologous fat augmentation, currently there are only data showing the value of minimizing centrifuge time and reinjecting the fat as quickly as possible after harvesting in order to reduce cell loss due to anoxia, and in my opinion, prompt reinjection is a consideration that has not been emphasized enough,” he says. “Otherwise, there are no good evidence-based medicine data demonstrating that any specific techniques for fat harvesting, processing or injection improve graft take and survival, and that includes a lack of data to support the use of costly devices that purportedly isolate stem cells for use in augmenting fat injections.”

Dr. Rohrich is professor of plastic surgery, Crystal Charity Ball Distinguished Chair in Plastic Surgery, and Warren and Betty Woodward Chair in Plastic and Reconstructive Surgery, University of Texas Southwestern Medical Center, Dallas.

“From a personal perspective based on my clinical outcomes of over 350 facelift patients, I can report that the approach I use works well, although I acknowledge it represents level 5 evidence-based medicine,” he says.

**Harvesting Technique**

Dr. Rohrich says he chooses the inner thigh for fat harvesting whenever possible, followed by the lateral flank as a secondary site, based on research he has conducted showing that fat cells in these anatomic regions tend to be smaller in size and are a closer match to those found in the face.

Harvesting is done with an atraumatic, manual technique with low-pressure suction without using any local anesthetic and epinephrine that can increase the loss of fat cells. Dr. Rohrich says he uses blunt, small (3 mm), multiple sideport hole cannulas and withdraws the aspirate into 10 cc syringes, filling them to 50 percent volume. The syringes are immediately centrifuged at 2,250 rpm for only one minute. Then the fat is immediately decanted and transferred to syringes for injection after removing the supernatant and draining the infranatant.

“The fat transfer procedure is usually done in conjunction with a facelift, but the fat is reinjected as soon as it is processed,” Dr. Rohrich says.

Entry sites for fat transfer are created with a 16-gauge needle at the alar base, and the material is delivered directly into the deep malar fat compartments. The area is massaged gently after injecting each cc, and the total volume injected per compartment ranges from 1 cc to 3 cc, depending on the preoperative facial analysis and degree of asymmetry noted, Dr. Rohrich says.

This anatomic approach is based on cadaver work done by Dr. Rohrich and Joel Pessa, M.D., which led to the description of discrete fat compartments in the face. Extrapolating this information to fat transfer procedures suggests that the material should be injected back into these specific compartments if the goal is to rejuvenate the face to a more youthful appearance, Dr. Rohrich says.

“This is a GPS technique of injecting fat based on our analyses demonstrating there are well-delineated facial fat compartments from which fat is lost in a predictable sequence over time that explains the pattern of facial aging due to volume loss,” he says. “This method of fat augmentation is in contrast to an approach in which the entire face is treated by delivering fat through multiple stab wounds and into multiple layers from superficial to deep.

“My conjecture is that targeted replenishment of fat at the sites from where it’s been lost will deliver results that are cosmetically more natural and also longer lasting,” he adds. “However, the theory needs to be borne out by studies providing higher-level evidence.”

**Disclosures:**

Dr. Rohrich reports no relevant financial interests.
IMPORTANT SAFETY INFORMATION, INCLUDING BOXED WARNING

Distant Spread of Toxin Effect
Postmarketing reports indicate that the effects of BOTOX® Cosmetic and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asthenia, generalized muscle weakness, diplopia, blurred vision, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening, and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity, but symptoms can also occur in adults treated for spasticity and other conditions, particularly in those patients who have underlying conditions that would predispose them to these symptoms. In unapproved uses, including spasticity in children and adults, and in approved indications, cases of spread of effect have occurred at doses comparable to those used to treat cervical dystonia and at lower doses.

CONTRAINDICATIONS
BOTOX® Cosmetic is contraindicated in the presence of infection at the proposed injection site(s) and in individuals with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation.

WARNINGS
The recommended dosage and frequency of administration for BOTOX® Cosmetic should not be exceeded. Risks resulting from administration at higher dosages are not known.

Lack of Interchangeability Between Botulinum Toxin Products
The potency Units of BOTOX® Cosmetic are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, Units of biological activity of BOTOX® Cosmetic cannot be compared to or converted into Units of any other botulinum toxin products assessed with any other specific assay method.

Spread of Toxin Effect
Please refer to Boxed Warning for Distant Spread of Toxin Effect. No definitive, serious adverse event reports of distant spread of toxin effect associated with dermatologic use of BOTOX® Cosmetic at the labeled dose of 20 Units (for glabellar lines) have been reported.

Hypersensitivity Reactions
Serious and/or immediate hypersensitivity reactions have been reported. These reactions include anaphylaxis, urticaria, soft-tissue edema, and dyspnea. If such reactions occur, further injection of BOTOX® Cosmetic should be discontinued and appropriate medical therapy immediately instituted. One fatal case of anaphylaxis has been reported in which lidocaine was used as the diluent and, consequently, the causal agent cannot be reliably determined.

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Individuals with peripheral motor neuropathic diseases, amyotrophic lateral sclerosis, or neuromuscular junctional disorders (eg, myasthenia gravis or Lambert-Eaton syndrome) should be monitored particularly closely when given botulinum toxin. Patients with neuromuscular disorders may be at increased risk of clinically significant effects including severe dysphagia and respiratory compromise from typical doses of BOTOX® Cosmetic.

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This product contains albumin, a derivative of human blood. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases. A theoretical risk for transmission of Creutzfeldt-Jakob disease (CJD) also is considered extremely remote. No cases of transmission of viral diseases or CJD have ever been identified for albumin.

PRECAUTIONS
Caution should be used when BOTOX® Cosmetic treatment is used in patients who have an inflammatory skin problem at the injection site, marked facial asymmetry, ptosis, excessive dermatochalasis, deep dermal scarring, thick sebaceous skin, or the inability to substantially lessen glabellar lines by physically spreading them apart.

Information for Patients
Patients should be counseled that if loss of strength, muscle weakness, or impaired vision occur, they should avoid driving a car or engaging in other potentially hazardous activities.

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Co-administration of BOTOX® Cosmetic and aminoglycosides or other agents interfering with neuromuscular transmission (eg, curare-like nondepolarizing blockers, lincomamides, polymyxins, quindine, magnesium sulfate, anticholinesterases, succinylcholine chloride) should only be performed with caution as the effect of the toxin may be potentiated. The effect of administering different botulinum neurotoxin serotypes at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin.

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Administration of BOTOX® Cosmetic is not recommended during pregnancy. There are no adequate and well-controlled studies of BOTOX® Cosmetic in pregnant women.

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ADVERSE REACTIONS
General
The most serious adverse events reported after treatment with botulinum toxin include spontaneous reports of death, sometimes associated with anaphylaxis, dysphagia, pneumonia, and/or other significant debility. There have also been reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including pre-existing cardiovascular disease. The most frequently reported adverse events following injection of BOTOX® Cosmetic include blepharoptosis and nausea.

Please see brief summary of full Prescribing Information on following pages.
Confidence comes from experience

Proven to last up to 4 months in 25% of patients (102/403) vs 2% (2/128) for placebo per physician assessment

- Dosing and injection techniques you know well
- #1 prescribed Botulinum Toxin Type A in the US as of January 2012

Indication
BOTOX® Cosmetic is indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in patients 18 to 65 years of age.

Please see Important Safety Information, including Boxed Warning, on adjacent page.

There’s only one BOTOX® Cosmetic
**BOTOX® Cosmetic (onabotulinumtoxinA)**

for injection (Brief summary of full prescribing information)

Manufactured by: Allergan Pharmaceuticals Ireland

a subsidiary of: Allergan, Inc. 2525 Dupont Dr, Irvine, CA 92612

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**Distant Spread of Toxin Effect**

Postmarketing reports indicate that the effects of **BOTOX® Cosmetic** and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These may include asystole, generalized muscle weakness, diplopia, blurred vision, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for strabismus and other conditions, particularly in those patients who have underlying conditions that would predispose them to these symptoms. In unapproved uses, including spasticity in children and adults, and in approved indications, cases of spread of effect have occurred at doses comparable to those used to treat cervical dystonia and at lower doses.

**INDICATIONS AND USAGE**

**BOTOX® Cosmetic** is indicated for the temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in adult patients 65 years of age.

**CONTRAINDICATIONS**

**BOTOX® Cosmetic** is contraindicated in the presence of infection at the proposed injection site(s) and in individuals with known hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation.

**WARNINGS**

**BOTOX®** and **BOTOX® Cosmetic** contain the same active ingredient in the same formulation. Therefore, adverse events observed with the use of **BOTOX** also have the potential to be associated with the use of **BOTOX® Cosmetic**. The recommended dosage and frequency of administration for **BOTOX** Cosmetic should not be exceeded. Risks resulting from administration at higher dosages are not known.

**Lack of Interchangeability between Botulinum Toxin Products**

The potency Units of **BOTOX® Cosmetic** are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, units of biological activity of **BOTOX® Cosmetic** cannot be compared to or converted into units of any other botulinum toxin products assessed with any other specific assay method (see DESCRIPTION).

**Spread of Toxin Effect**

Postmarketing safety data from **BOTOX® Cosmetic** and other approved botulinum toxin products suggest that botulinum toxin effects may, in some cases, be observed beyond the site of local injection. The symptoms are consistent with the mechanism of action of botulinum toxin and may include asystole, generalized muscle weakness, diplopia, blurred vision, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, and breathing difficulties. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death related to spread of toxin effects. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults treated for strabismus and other conditions, particularly in those patients who have underlying conditions that would predispose them to these symptoms. In unapproved uses, including spasticity in children and adults, and in approved indications, symptoms consistent with spread of toxin effect have been reported at doses comparable to or lower than doses used to treat cervical dystonia.

No definitive adverse event reports of distant spread of toxin effect associated with dermatologic use of **BOTOX®**/**BOTOX® Cosmetic** at the labeled dose of 20 Units (for glabellar lines) or 100 Units (for severe primary axillary hyperhidrosis) have been reported.

No definitive adverse event reports of distant spread of toxin effect associated with **BOTOX® Cosmetic** at the recommended dose (30 Units and below) or for strabismus at approved indications have been reported.

**Injections In or Near Vulnerable Anatomical Structures**

Care should be taken when injecting in or near vulnerable anatomical structures. Serious adverse events including fatal outcomes have been reported in patients who have received **BOTOX®** injected directly into salivary glands, the orculo-lingual-pharyngeal region, esophagus and stomach. Some patients had pre-existing dysphagia or significant debility. (Safety and effectiveness have not been established for indications pertaining to these injection sites.) Pneumothorax associated with injection procedure has been reported following the administration of **BOTOX®** near the thorax. Caution is warranted when injecting in proximity to the lung, particularly the apices.

**Hypersensitivity Reactions**

Serious and/or immediate hypersensitivity reactions have been reported. These reactions include anaphylaxis, urticaria, soft tissue edema, and dyspnea. If such a reaction occurs, further injection of **BOTOX** Cosmetic should be discontinued and appropriate medical therapy immediately instituted. One fatal case of anaphylaxis has been reported in which lidocaine was used as the diluent, and consequently the causal agent cannot be reliably determined.

**Pre-Existing Neuromuscular Disorders**

Individuals with peripheral motor neuromuscular diseases, amyotrophic lateral sclerosis, or neuromuscular junctional disorders (e.g., myasthenia gravis or Lambert-Eaton syndrome) should be monitored particularly closely when given botulinum toxin. Patients with neuromuscular disorders may be at increased risk of clinically significant effects including severe dysphagia and respiratory compromise from typical doses of **BOTOX® Cosmetic** (see ADVERSE REACTIONS).

**Dysphagia and Breathing Difficulties in Treatment of Cervical Dystonia**

**BOTOX** and other botulinum toxin products can result in swallowing or breathing difficulties. Patients with pre-existing swallowing or breathing difficulties may be more susceptible to these complications. In most cases, this is a consequence of weakening of muscles in the area of injection that are involved in swallowing or breathing. When distant effects occur, additional respiratory muscles may be involved (see WARNINGS).

Deaths as a complication of severe dysphagia have been reported after treatment with botulinum toxin. Dysphagia may persist for several months, and require use of a feeding tube to maintain adequate nutrition and hydration. Aspiration may result from severe dysphagia and is a particular risk when treating patients in whom swallowing or respiratory function is already compromised.

Treatment of cervical dystonia with botulinum toxin may weaken neck muscles that serve as accessory muscles of ventilation. This may result in a critical loss of breathing capacity in patients with underlying conditions that would predispose them to these symptoms. In unapproved uses, there have been postmarketing reports of serious breathing difficulties, including respiratory failure, in cervical dystonia patients.

Patients treated with botulinum toxin may require immediate medical attention should they develop problems with swallowing, speech, or respiratory disorders. These reactions can occur within hours to weeks after injection with botulinum toxin (see WARNINGS and ADVERSE REACTIONS).

**Cardiovascular System**

There have been reports following administration of **BOTOX** of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including pre-existing cardiovascular disease.

**Human Albumin**

This product contains albumin, a derivative of human blood. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases. A theoretical risk for transmission of Creutzfeldt-Jakob disease (CJD) also is considered extremely remote. No cases of transmission of viral diseases or CJD have ever been identified for albumin.

**PRECAUTIONS**

The safe and effective use of **BOTOX® Cosmetic** depends upon proper storage of the product, selection of the correct dose, and proper reconstitution and administration techniques. Physicians administering **BOTOX® Cosmetic** must understand the relevant neuromuscular and/or oral/airway anatomy of the area involved, as well as any alterations to the anatomy due to prior surgical procedures (see WARNINGS).

Caution should be used when **BOTOX® Cosmetic** treatment is used in the presence of inflammation at the proposed injection site(s) or when excessive weakness or atrophy is present in the target muscle(s).

Reduced blinking from **BOTOX® Cosmetic** injection of the orbicularis muscle can lead to corneal exposure, persistent epithelial defect and corneal ulceration, especially in patients with dry eye conditions. The use of **BOTOX** for the treatment of blepharospasm, one case of corneal perforation in an aphakic eye requiring corneal grafting has occurred because of this effect. Careful testing of corneal sensation in eyes previously operated upon, avoidance of injection into the lower lid area to avoid ectropion, and vigorous treatment of any epithelial defect should be employed. This may require protective drops, ointment, therapeutic soft contact lenses, or closure of the eye by patching or other means.

Inducing paralysis in one or more extraocular muscles may produce spatial disorientation, double vision or palpebral ptosis. Covering the affected eye may alleviate these symptoms.

Caution should be used when **BOTOX® Cosmetic** treatment is used in patients who have an inflammatory skin problem at the injection site, marked facial asymmetry, ptosis, excessive dermatochalasis, deep dermal scarring, thick sebaceous skin or the inability to substantially lessen glabellar lines by physically spreading them apart as these patients were excluded from the Phase 3 safety and efficacy trials.

Needle-related pain and/or anxiety may result in vasovagal responses (including e.g., syncope, hypotension), which may require appropriate medical therapy.

Injection intervals of **BOTOX® Cosmetic** should be no more frequent than every three months and should be performed using the lowest effective dose (see ADVERSE REACTIONS, IMMUNOGENICITY).

**Information for Patients**

The physician should provide a copy of the FDA-Approved Patient Medication Guide and review the contents with the patient. Patients should be advised to inform their doctor or pharmacist if they develop any unusual symptoms (including difficulty with swallowing, speaking, or breathing), or if any existing symptoms worsen. Patients should be counseled that if loss of strength, muscle weakness, or impaired vision occur, they should avoid driving a car or engaging in other potentially hazardous activities.

**Drug Interactions**

Co-administration of **BOTOX® Cosmetic** and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like nondepolarizing blockers, lincosamides, polymyxins, quinidine, magnesium sulfate, anticholinesterases, succinylcholine chloride) should only be performed with caution as the effect of the toxin may be potentiated.

The effect of administering different botulinum neurotoxin serotypes at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin.

**Pregnancy: Pregnancy Category C**

Administration of **BOTOX® Cosmetic** is not recommended during pregnancy. There are no adequate and well-controlled studies of **BOTOX® Cosmetic** in pregnant women.
When pregnant mice and rats were injected intramuscularly during the period of organogenesis, the developmental NOEL (No Observed Effect Level) of BOTOX® Cosmetic was 4 Units/kg. Higher doses (8 Units/kg or 16 Units/kg) were associated with reductions in fetal body weights and/or delayed ossification. In a range-finding study in rabbits, daily injection of 0.125 Units/kg/day (days 6 to 18 of gestation) and 2 Units/kg (days 6 and 13 of gestation) produced severe maternal toxicity, abortions and/or fetal malformations. Higher doses resulted in death of the dams. The rabbit appears to be a very sensitive species to BOTOX® Cosmetic.

If the patient becomes pregnant after the administration of this drug, the patient should be apprised of the potential risks, including abortion or fetal malformations that have been observed in rabbits.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Long term studies in animals have not been performed to evaluate carcinogenic potential of BOTOX® Cosmetic.

The reproductive NOEL following intramuscular injection of 0, 4, 8, and 16 Units/kg was 4 Units/kg in male rats and 8 Units/kg in female rats. Higher doses were associated with dose-dependent reductions in fertility in male rats (where low weight resulted in the inability to mate), and testicular atrophy or an altered estrous cycle in female rats. There were no adverse effects on the viability of the embryos.

Nursing Mothers

It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when BOTOX® Cosmetic is administered to a nursing woman.

Pediatric Use

Use of BOTOX® Cosmetic is not recommended in children.

Geriatric Use

The two clinical studies of BOTOX® Cosmetic did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. However, the responder rates appeared to be higher for patients younger than age 65 than for patients 65 years or older.

There were too few patients (N=3) over the age of 75 to allow any meaningful comparisons.

ADVERSE REACTIONS

General

BOTOX® and BOTOX® Cosmetic contain the same active ingredient in the same formulation. Therefore adverse events associated with the use of BOTOX® also have the potential to be associated with the use of BOTOX® Cosmetic.

The most serious adverse events reported after treatment with botulinum toxin include spontaneous reports of death, sometimes associated with anaphylaxis, dysphagia, pneumonia, and/or other significant debility.

There have also been reports of adverse events involving the cardiovascular system, including arrhythmia and myocardial infarction, some with fatal outcomes. Some of these patients had risk factors including pre-existing cardiovascular disease (see WARNINGS).

New onset or recurrent seizures have also been reported, typically in patients who are predisposed to experiencing these events. The exact relationship of these events to the botulinum toxin injection has not been established. Additionally, a report of acute angle closure glaucoma one day after receiving an injection of botulinum toxin for blepharospasm was received, with recovery four days later after laser iridotomy and trabeculectomy. Focal facial paralysis, syncope and exacerbation of myasthenia gravis have also been reported after treatment of blepharospasm.

In general, adverse events occur within the first week following injection of BOTOX® Cosmetic and while generally transient may have a duration of several months or longer. Localized pain, infection, inflammation, tenderness, swelling, erythema and/or bleeding/bruising may be associated with the injection. Local weakness of the injected muscle(s) represents the expected pharmacological action of botulinum toxin. However, weakness of adjacent muscles may also occur due to spread of toxin.

Glabellar Lines

In clinical trials of BOTOX® Cosmetic the most frequently reported adverse events following injection of BOTOX® Cosmetic were headache,* respiratory infection,* flu syndrome,* blepharoptosis and nausea.

Less frequently occurring (<3%) adverse reactions included pain in the face, erythema at the injection site,* parasthesia* and muscle weakness. While local weakness of the injected muscle(s) is representative of the expected pharmacological action of botulinum toxin, weakness of adjacent muscles may occur as a result of the spread of toxin. These events are thought to be associated with the injection and occurred within the first week. The events were generally transient but may last several months or longer.

* incidence not different from Placebo

The data described in Table 1 reflect exposure to BOTOX® Cosmetic in 405 subjects aged 18 to 75 who were evaluated in the randomized, placebo-controlled clinical studies to assess the use of BOTOX® Cosmetic in the improvement of the appearance of glabellar lines. Adverse events of any cause were reported for 44% of the BOTOX® Cosmetic treated subjects and 42% of the placebo treated subjects. The incidence of blepharoptosis was higher in the BOTOX® Cosmetic treated arm than in placebo (3% vs. 0).

In the open-label, repeat injection study, blepharoptosis was reported for 2% (8/373) of subjects in the first treatment cycle and 1% (4/434) of subjects in the second treatment cycle. Adverse events of any type were reported for 49% (103/273) of subjects overall. The most frequently reported of these adverse events in the open-label study included respiratory infection, headache, flu syndrome, blepharoptosis, pain and nausea.

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not be predictive of rates observed in practice.

<table>
<thead>
<tr>
<th>TABLE 1. Adverse Events Reported at Higher Frequency (&gt;1%) in the BOTOX® Cosmetic Group Compared to the Placebo Group</th>
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<tbody>
<tr>
<td><strong>Adverse Events by Body System</strong></td>
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<tr>
<td>Muscle Weakness</td>
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<td>Cardiovascular</td>
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Immunogenicity

Treatment with BOTOX® Cosmetic may result in the formation of neutralizing antibodies that may reduce the effectiveness of subsequent treatments with BOTOX® Cosmetic by inactivating the biological activity of the toxin. The rate of formation of neutralizing antibodies in patients receiving BOTOX® Cosmetic has not been well studied.

The critical factors for neutralizing antibody formation have not been well characterized. The results from some studies suggest that botulinum toxin injections at more frequent intervals or at higher doses may lead to greater incidence of antibody formation. The potential for antibody formation may be minimized by injecting the lowest effective dose given at the longest feasible intervals between injections.

Overdose

Excessive doses of BOTOX® Cosmetic may be expected to produce neuromuscular weakness with a variety of symptoms.

Symptoms of overdose are likely not to be present immediately following injection. Should accidental injection or oral ingestion occur or overdose be suspected, the person should be medically supervised for several weeks for signs and symptoms of systemic muscular weakness which could be local, or distant from the site of injection (see BOXED WARNING and WARNINGS). These patients should be considered for further medical evaluation and appropriate medical therapy immediately instituted, which may include hospitalization.

If the musculature of the oropharynx and esophagus are affected, aspiration may occur which may lead to development of aspiration pneumonia. If the respiratory muscles become paralyzed or sufficiently weakened, intubation and assisted respiration may be necessary until recovery takes place. Supportive care should include the need for a tracheostomy and/or prolonged mechanical ventilation, in addition to other general supportive care.

In the event of overdose, antitoxin raised against botulinum toxin is available from the Centers for Disease Control and Prevention (CDC) in Atlanta, GA. However, the antitoxin will not reverse any botulinum toxin-induced effects already apparent by the time of antitoxin administration. In the event of suspected or actual cases of botulinum toxin poisoning, please contact your local or state Health Department to process a request for antitoxin through the CDC. If you do not receive a response within 30 minutes, please contact the CDC directly at 1-770-488-7100. More information can be obtained at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5232a8.htm.

Rx Only

Single use vial.

Storage

Unopened vials of BOTOX® Cosmetic should be stored in a refrigerator (2° to 8°C) for up to 36 months for the 50 Units and 100 Units vial.

Administer BOTOX® Cosmetic within 24 hours of reconstitution; during this period reconstituted BOTOX® Cosmetic should be stored in a refrigerator (2° to 8°C). Reconstituted BOTOX® Cosmetic should be clear, colorless and free of particulate matter.

Do not use after the expiration date on the vial. All vials, including expired vials, or equipment used with the drug should be disposed of carefully as is done with all medical waste.

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Reference:


71823015C APCR85L11
A validated facial laxity rating scale proves to accurately document the changes and improvements achieved following facial cosmetic surgery procedures, introducing a more scientific approach and objective evaluation of aesthetic outcomes, according to Craig Jonov, M.D., D.M.D.

Various facial rating scales can be used to document facial measurement changes achieved following cosmetic surgery, and their implementation can offer much more objectivity in the assessment of outcomes, Dr. Jonov says.

"Today, we really do not have any objective data to say if a patient looks better or improved after cosmetic surgery. Commenting on improvements or even the absence of them is very subjective, underscoring the need for such rating scales," says Dr. Jonov, the Gallery of Cosmetic Surgery, Seattle.

**FLRS in Action** Recently, Dr. Jonov and colleagues developed a facial laxity rating scale (FLRS) in order to facilitate quick and accurate reproducible assessments of laxity in all the facial regions. According to Dr. Jonov, the FLRS is based on the evaluation of four main signs, each located in one of the four facial compartmental regions that divide the face and the neck for laxity assessment proposes.

The four regions include the upper face (frontal), middle face (malar), lower face (mandibular), and the upper neck. The representative signs for each region to be evaluated are the eyelid fold, nasojugal fold, jowls and profile of the neck angle, respectively.

Based on standard patient photographs and line drawings, the designated FLRS signs are analyzed, compared or measured to establish its position in relation to neighboring facial structures. So that the scale could be applied to the widest range of patients, Dr. Jonov says the gold standard chosen for the FLRS is the ideal facial aesthetic positioning of youth and not a treatment effect such as surgical facelift.

For the assessment of facial laxity, evaluations are classified on a 10-point scale, namely, stage 0 (or no facial laxity), stages 1 to 3 (mild laxity), stages 4 to 6 (moderate laxity) and stages 7 to 9 (severe laxity).

After a given cosmetic procedure is performed, photographs and measurements taken at baseline can then be compared to those taken...
after the procedure to measure and assess the improvements made, Dr. Jonov says. The FLRS system can be implemented for any facial rejuvenation procedure that addresses skin laxity, including surgical procedures such as facelifts, blepharoplasties and necklifts, as well as less invasive procedures such as volume enhancements using filler techniques, botulinum toxin treatments and energy-based treatments including radiofrequency, and laser and light modalities, he says.

“Gauging the effectiveness of cosmetic treatments to reduce the sagging of facial skin and deep tissue can be challenging for both physicians and their patients. There are multiple characteristics of different facial types that combine to determine varying degrees or stages of deep facial flaccidity. These characteristics are difficult to group, as objective data for the purpose of determining the degrees of sagging and even degrees of improvement or worsening of deep facial laxity,” Dr. Jonov says.

OBJECTIVITY COUNTS

According to Dr. Jonov, the FLRS offers both physicians and patients an objective way to assess the efficacy of the rejuvenation treatments chosen for a defined goal, rather than a subjective assessment, which differs from observer to observer.

“Sometimes you may have a cosmetic patient where technically, you did an outstanding job and by all standards the cosmetic surgery was a success, however the patient may not really be happy with the outcome. In the search of objective criteria, one can use the rating scale to evaluate improvements,” Dr. Jonov says.

Dr. Jonov says he often will incorporate the facial rating scale data into the overall evaluation of the patient, offering an “identification of baseline” from which potential improvements can be planned and realistic goals set. The FLRS not only serves to document the improvements made; it can also point out the potential improvements that could still be achieved with other adjunctive cosmetic interventions, he says.

“The FLRS combines all of the methodology that we have to provide facial rejuvenation surgery today. With the proper training, cosmetic physicians can apply the FLRS in a consistent and reproducible manner in the grading of facial laxity,” Dr. Jonov says.

Disclosures:
The facial laxity study was sponsored by Solta Medical.

A 36-year-old female patient before (top images) and two-and-a-half months after upper and lower blepharoplasties, necklift and fat transfer to the midface region. From baseline, the eyes, midface, lower face and neck region showed improvement in the facial laxity scale by 3 points, 1 point, 2 points and 2 points, respectively, Dr. Jonov says. (Photos credit: Craig Jonov, M.D., D.M.D.)

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Tried & true

In the case of new-age facelift procedures, less is definitely not more, one surgeon says

Ilya Petrou, M.D.
Senior Staff Correspondent

There is an ever-growing popularity among physicians and their patients in the use of minimally invasive facelift surgery techniques. However, these supposedly new and innovative techniques will often prove to be insufficient in achieving comprehensive and lasting results in patients. In fact, one surgeon says the majority of patients would benefit most from traditional facelift procedures.

“In my opinion, the vast majority of the purported new and innovative facelift techniques, which are frequently used today and touted as ‘miracle facelifts,’ are mostly just hype, and I have yet to see any of these ‘new’ facelift techniques to be truly an innovation in facelift surgery. More often than not, they are, in fact, a step backwards,” says Joe Niamtu III, D.M.D., F.A.A.C.S., a board-certified oral and maxillofacial surgeon with a practice limited to cosmetic facial surgery in Richmond, Va.

Facelift surgery has been around for a century, and most of the variations in the techniques have come and gone without making a significant impact in the art or the outcomes of the procedure, Dr. Niamtu says. Though it is not impossible for a surgeon or corporate entity to develop an advancement in the procedure, more often than not, the newer techniques are simply a rehashing of older techniques, and they hardly ever achieve the results that they claim, he adds.

“There is a trend for surgeons to make the smallest changes in techniques that have been documented for decades and attempt to take credit for advancement or invention of an operation. I think this is unfortunate, especially for the public who may make a poor decision to have a ‘new’ procedure just to find out it provided much less result and longevity and cost just as much as traditional techniques,” Dr. Niamtu says. “It really bothers me when I see a senior citizen that clearly needed a larger lift but was sold a minimally invasive lift and now feels embarrassed and cheated.”

So-called minimally invasive “filler-facelifts” are a glaring example of this trend, Dr. Niamtu says. “Filler-facelifts” and facelift techniques that center on technologies like endoscopy, laser and ultrasound are great examples of marketing hype that can lure patients into a procedure that may ultimately result in disappointment, he explains.

“In my personal experience, over the years, I find that I have always gravitated away from ‘shortcut’ techniques and gotten back to the basics; back to performing more traditional facelift procedures,” he says.

LESS IS NOT MORE “Less is more” is a common mantra from advocates of shortcut facelifts, Dr. Niamtu says, and one with which he strongly disagrees.

“When the hype of shortcut facelifts gets twisted around that a small lift can suffice for advanced aging or is somehow preferable, patients can be subjected to uninformed choice and expect traditional results with a nontraditional lift,” Dr. Niamtu says.

According to Dr. Niamtu, proponents of short scar techniques will strive to avoid and otherwise compensate for not using this incision. Techniques that do not include the posterior auricular incision can result in half of a facelift and subsequently achieve less favorable results and longevity of traditional lifts that include this incision, he says. The short scar facelift procedure should be reserved for younger patients (late 30s to early 40s) who may typically have minor jowling and very little submental laxity.

The vast majority of patients who need a facelift will require both anterior and posterior auricular incisions, Dr. Niamtu says. In a typical case, he will perform a traditional postauricular incision that traverses the entire posterior auricular sulcus, which then tapers off approximately 6 cm to 10 cm into the posterior scalp.

“I have started out with a short scar lift on young patients with minor skin excess and converted to conventional facelift because of the impressive skin excess that was evident intraoperatively but not clinically,” Dr. Niamtu says. “On the rare occasion that I perform a short scar lift, I always have the patient’s consent to convert to a larger lift at my discretion.”

OMISSION OF PLATYSMAPLASTY A platysmaplasty is a crucial component of a true facelift, Dr. Niamtu says, but many surgeons choose not to do it. According to Dr. Niamtu, it takes approximately 15 to 20 minutes to undermine the submental and anterior cervical skin and plicate the platysma in the midline. This step is critical in achieving better facelift outcomes, he says, particularly in those patients who exhibit platysmal banding.

Though the procedure may extend recovery when compared to procedures that do not include platysmaplasty, it is an important trade-off, as it contributes to the youthful neck and longevity of procedure results, he says.
"Many of these new facelifts simply omit midline platysmaplasty. Though these procedures are quicker and easier to perform with faster recoveries, sacrificing several days of recovery for several years of result is not good math," he says.

In those patients where a platysmaplasty is not performed, Dr. Niamtu says it is not uncommon that they will soon present with a recurrence of neck and band laxity. This underscores the importance of performing the procedure at baseline.

"In my hands, my results are better and last longer when performing significant undermining of the submental and anterior cervical skin and plicating the platysma midline. Although many surgeons advocate platysma cutbacks in the hiod region in order to avoid bowstringing, I have never done this, as I feel it is unnecessary and can lessen the effect of the platysmal sling," Dr. Niamtu says.

Addressing the posterior platysma is also important when performing a comprehensive facelift, and here, Dr. Niamtu says that suspending the lateral-posterior platysma is essential in achieving a natural, longer-lasting facelift outcome. In his technique, Dr. Niamtu will place about seven or eight 2-0 braided nylon sutures in the midline and several mattress sutures in the posterior platysma that attach in the mastoid region, effectively creating a sling around the entire submental region.

"Using this technique, I am not worried about pulling the center repair apart, as it is well bolstered," he says. "Also, I believe that the fear of nerve damage resulting from the pressure of sutures traversing over the greater auricular nerve is generally not a significant factor that would contribute to permanent nerve damage."

ADDRESSING SMAS

Performing facelifts that only pull back the skin are considered outdated procedures due to the poor longevity of results. As a result, Dr. Niamtu says, virtually all modern facelift techniques will address the SMAS.

According to Dr. Niamtu, techniques geared at pulling on and tightening the fibroadipose tissue overlying the parotid, cheek and upper platysma in a sheet-like manner are instrumental in achieving a tighter, more youthful look in these areas. Pulling on this tissue at key areas can tighten the jowls and neck, and to a lesser extent the cheeks.

"This suspension provides a more natural-looking lift that lasts longer due to the fact that the foundation is addressed along with the skin," Dr. Niamtu says.

Though purse strings are commonly used when addressing the SMAS, Dr. Niamtu says he often prefers to use "belt and suspenders" multiple suture methods. A simple SMAS placation is a safe and easy technique to perform, especially for beginners, which could consist of six to eight 2-0 braided nylon sutures placed in the jowl, upper neck, and cheek regions, he says.

When addressing the SMAS, Dr. Niamtu says he prefers to perform an elliptical SMASectomy in which a strip of the SMAS is removed from the malar eminence to below the mandibular border into the neck. The width of the excised SMAS is commensurate with the amount of laxity but is usually 3 cm to 5 cm. Dr. Niamtu says he typically uses scissors in the technique and is careful to stay superior to the parotidomasseteric fascia. He will usually begin with suspending the jowl and neck before moving on to the cheeks, and he will often place seven or eight 2-0 braided nylon sutures from the malar region to the upper neck.

CREATING A SYNERGY

In addition to performing more traditional facelifts, Dr. Niamtu says that cosmetic outcomes can be enhanced with the combination of other techniques. These can include the use of cheek or chin implants and fat or filler injections to help restore youthful volume.

"Synergy occurs when the total is greater than the sum of the parts, and this relates to facial rejuvenation. If a patient is old enough to have a facelift, they more than likely have aging changes in their upper face, midface and skin. Therefore, I will often perform a facelift as well as other simultaneous procedures in order to address all aspects of the aging face," Dr. Niamtu says.

Of the 71 facelifts Dr. Niamtu performed last year, just under half of those patients received simultaneous CO2 laser resurfacing. Approximately 85 percent of his facelift patients also receive upper and/or lower blepharoplasty. Though combination procedures will typically result in a longer recovery period, he says that the final aesthetic outcome will be enhanced, so many patients will opt for such combination approaches.

Some surgeons can achieve extremely good results using a given technique, Dr. Niamtu says, results that may be challenging to reproduce for a different surgeon. But in the end, all surgeons should embrace advances with skepticism until they're proven or dispelled, he adds.

Disclosures:
Dr. Niamtu reports no relevant financial interests.

IN ACTION

See Dr. Niamtu's SMASectomy procedure in action by visiting cosmesurgerytimes.com/scissorsSMAS today!

This image shows a patient after SMASectomy and lateral platysma suspension.

A 66-year-old female patient before (left) and 90 days after a traditional facelift with SMASectomy, platysmaplasty, four quadrant blepharoplasty, cheek implants and simultaneous full-face CO2 laser resurfacing, in one single session.

Figure A shows the SMAS being undermined for the SMASectomy procedure; figure B shows the SMAS strip removed; figure C shows the angled SMASectomy where the cheek and neck can be tightened in multiple favorable vectors.
Getting even

Better blepharoplasty outcomes depend on appreciation of asymmetry

Cheryl Guttman Krader
Senior Staff Correspondent

The ability to recognize pre-existing asymmetry and address it with an asymmetric approach to surgery is important for achieving satisfaction in patients presenting for cosmetic upper eyelid blepharoplasty, says Robert A. Goldberg, M.D.

Speaking at the 2012 meeting of the American Academy of Cosmetic Surgery, Dr. Goldberg discussed detection and management of subtle asymmetry in upper blepharoplasty.

"Most people are not aware of differences between one side of their face and the other, even though facial asymmetry is ubiquitous. However, patients are likely to spot unevenness after cosmetic surgery, particularly as they concentrate on their appearance in a magnifying mirror and partly because a procedure that removes skin, fat and soft tissue can unveil pre-existing deep asymmetry," says Dr. Goldberg, chief, orbital and ophthalmic plastic surgery, Jules Stein Eye Institute, and Karen and Frank Dabby Professor of Ophthalmology.
David Geffen School of Medicine, University of California, Los Angeles.

“In my referral practice, I commonly see patients who are very unhappy because of asymmetry after upper blepharoplasty and who are convinced it is the fault of the surgeon,” Dr. Goldberg says. “This information underscores that it is incumbent on surgeons venturing into procedures addressing the aesthetics of the periorbital area to be able to understand the nuances of asymmetry existing around the eyes and to discuss the preoperative findings so that the patient understands the situation. Then, unless the patient chooses against it, surgeons must be prepared to surgically treat the asymmetry, which usually requires operating more on one side than the other.”

Dr. Goldberg adds that in undertaking asymmetric surgery to optimize the cosmetic outcome, surgeons and patients must recognize what he calls the “Goldberg Principle,” which cautions that pre-existing asymmetry is usually only partially addressed.

“In my experience, pre-existing asymmetry can usually be improved when it is approached based on careful preoperative analysis, surgical planning and surgical technique. However, even with purposely asymmetric surgery, perfection is rarely achieved. Asymmetry in nature is so powerful, it is difficult to overcome,” he explains.

EVALUATING THE EYES

The preoperative evaluation takes into account that there are multiple sources of upper eyelid asymmetry. It may be bony in origin, arise from differences in soft tissue or be the consequence of a dynamic element. Although bony asymmetry is not something that will be addressed in cosmetic blepharoplasty, it is possible to mask some of the discrepancy between the two eyes by doing asymmetric surgery manipulating the skin, fat and soft tissue, Dr. Goldberg says.

Assessment of soft tissue asymmetry is done by measuring two parameters — tarsal platform show (TPS) and brow fat span (BFS), represented as the distance from the top of the tarsus to the eyebrow. Between the two parameters, achieving symmetry in the TPS should be the main target of surgery, Dr. Goldberg says.

Dr. Goldberg says his preference for focusing on the TPS is based on the finding that small differences between eyes in the TPS were more noticeable to lay people than small amounts of asymmetry in the BFS.

“In our study where lay people were shown different facial configurations, we found they were able to detect 1 to 2 mm of TPS asymmetry, whereas such small amounts of BFS asymmetry were less noticeable,” he explains. “For this reason, I recommend the surgical goal should be to make the TPS as symmetric as possible, especially if there are limitations and compromises that need to be made because of bony asymmetry. Even if the bony asymmetry remains, the outcome of the surgery will still appear fairly symmetric to the patient and other lay people if the TPS is similar for both eyes.”

UPPER EYELID PTOSIS

Subtle upper eyelid ptosis, identified preoperatively by measuring the distance from the eyelashes to the center of the cornea, is another cause of upper eyelid asymmetry, and it has a powerful effect because it creates a dynamic component, Dr. Goldberg says. For example, drooping of the eyelid margin results in a compensatory muscle drive that raises the eyebrow on the ptotic side. Correction of subtle eyelid ptosis is one of the most important maneuvers performed to address upper eyelid asymmetry, but this feature is often overlooked by inexperienced surgeons, he says.

EXPERIENCE REQUIRED

Dr. Goldberg notes that when planning to address ptosis, surgeons must recognize that cosmetic ptosis surgery is different than surgery to treat ptosis causing a functional problem, and they must either be skilled in the minimally invasive techniques used for cosmetic ptosis surgery or be able to work with a colleague who is adept at methods for achieving subtle cosmetic changes in eyelid position.

To address subtle ptosis in cosmetic blepharoplasty, Dr. Goldberg says posterior surgical approaches are preferred because they do not involve any skin incision and are more reliable than anterior surgery for treating small amounts of ptosis in a predictable fashion.
Patients who desire the benefits of an early-maintenance facelift want to stop the clock at a time when they feel they look their best, says Timothy J. Marten, M.D.

"It’s also a common misconception that all patients seeking surgical facial rejuvenation want to look as young as possible," says Dr. Marten, director and chief of the Marten Clinic of Plastic Surgery in San Francisco. "In fact, many patients think they look their best in the third and fourth decade of their lives."

Traditionally, facelifts were reserved for older patients and regarded as a way to "repair" an advanced aging deformity, Dr. Marten says. But today, many patients are requesting procedures to rejuvenate the face at a younger age, all with the goal of maintaining — not regaining — a youthful appearance.

Early-aging deformity is characterized chiefly by a subtle but distinct sagging of the deep facial tissue and loss of facial contour that is typically evident as perioral laxity, jowl formation and cheek flattening, Dr. Marten says. Varying degrees of forehead ptosis and loss of neck contour are also usually present, but skin wrinkling, skin laxity and skin redundancy are usually minimal.

"Although the early-aging deformity of the face has been overlooked and underappreciated by all but the most observant and artistically sensitive plastic surgeons, it has been recognized by and has been a cause of concern for many of our patients for some time," he says.

A NEW PARADIGM Early-maintenance facelifts typically include SMAS repositioning of the midface, cheek and jowl; minimal or no skin tension; a precise incision plan and meticulous execution of skin excision closure; and some form of forehead, neck and eyelid surgery, Dr. Marten says. Skin resurfacing is not usually needed and fat injections are generally not indicated, although they are sometimes helpful because "the younger patient typically has minimal skin wrinkling and facial atrophy," he says.

The early-maintenance facelift approach is based on the concept that aging is a continuum and that younger patients have a microform of the same problems older patients have. Thus, they should be treated by more or less the same means, but the procedures must be performed less aggressively and in a very meticulous fashion.

"Patients with forehead ptosis are often best served with a forehead lift even..."
if the ptosis is modest; patients with sagging of
the cheek and jowl and loss of a smooth jawline
need a facelift that includes SMAS support to
correct these problems if a meaningful and
sustained improvement free of secondary
deforomities is to be obtained; and patients
with neck problems often are not adequately or
attractively rejuvenated with liposuction or by
limited surgical or nonsurgical means," Dr. Marten
says. "Skin resurfacing, ‘skin shrinking’ and facial
filling may be of help but don’t actually address
these problems."

Dr. Marten says it can be difficult
to define exactly what constitutes an
“early” facelift because
some patients in their 40s are
already “emergencies,” while
other patients in their 50s could
arguably be defined as undergoing
eary procedures.

“As a general rule, I would say most surgeons
regard a patient to traditionally be ready for a
facelift and related procedures in their 50s or
60s, and that an ‘early’ facelift would be one
performed in one’s 30s or 40s,” Dr. Marten says.
“We don’t track numbers specifically, but the
average age of facelift patients in our practice is
early-to-mid 40s.”

**SCAR SUBTERFUGE**

Concealing scars is
of paramount importance in the young patient,
Dr. Marten points out. “If we see a bit of a scar
on a 60- or 70-year-old we smile to ourselves and
think ‘she’s had a facelift,’ but typically don’t
pass judgment or cast aspersions on her. If we
see a scar on a 30- or 40-year-old, however, this
somehow carries more of a stigma. In this sense,
operating on a younger patient arguably carries a
heightened responsibility. There is no room for
error, and every effort must be made to obtain a
well-concealed scar,” Dr. Marten says.

“The fallacy of most ‘short scar’ procedures
is that they move the scar from a concealed
location behind the ear to a much more visible
and objectionable location in front of the
temporal hairline,” he adds. “While this is often
a necessary and worthwhile compromise in the
older patient, it is a considerable burden to the
younger patient who wears less makeup, leads a
more active lifestyle, and who is subject to more
shame when this scar is seen by others.

“The ‘early-maintenance’ technique, by
comparison, avoids a scar along the temporal
hairline,” and the scar behind the ear is situated
in a way that allows the patient to wear her hair
up or back, or in a ponytail, he says.

The second problem with most short scar
techniques is that little, if any, meaningful and
sustained support from deep-layer tissues is
obtained, and unavoidable skin tension incites
hypertrophic healing and poor scar formation.

“This is avoided when a full SMAS lift is
performed and tension is diverted from the skin to
the SMAS layer,” Dr. Marten says. “Finally, most
proponents of mini-lifts and short scar procedures
view the fact that they can be completed quickly
as an advantage to both the patient and surgeon,
but in reality, this rushing through the procedure
is the typical source of a low quality, poorly
situated and poorly concealed scar in many cases.

“In an early-maintenance procedure, 45 minutes
or more is often spent concealing the scar on
each side, totaling an hour and a half on that
part of the procedure alone,” Dr. Marten says.

“Many surgeons performing mini-lifts and short
scar procedures are trying to complete the entire
facelift in that same amount of time. Ultimately,
it is incumbent on surgeons performing facelift
procedures to remember that it is someone’s face
we have been entrusted with, and that it deserves
our best effort, not a compromised or half-hearted
one.”

Dr. Marten says that patients who have early-
maintenance procedures typically recover quickly
and can return to their work and social lives in 10
to 14 days. This is due to the fact that they are
young and heal well, as well as the fact that pull
was placed on the SMAS and not the skin and
that the patients have well-concealed incisions
(no incision along the temporal hairline).

In addition, they typically don’t need fat injections
or skin resurfacing, both of which increase
swelling and prolong recovery. “Ultimately,
however, no one judges a facelift by how long
it took to perform or how fast the patient
recovered,” Dr. Marten says. “In the end, what
is remembered and what really matters is that
the patient looks natural and has no signs that
surgery has been performed.”

**LESS IS RARELY MORE**

The “early-
maintenance” concept is not limited to just
the cheeklift, as are some minimally invasive
procedures. “The whole face ages — not just part
of it — even in younger patients,” Dr. Marten
says. “To achieve a balanced, harmonious and
natural appearance, the forehead, eyes and neck
often have to be refreshed using a ‘combination’
approach. This is the inherent weakness in any
attempt to spot-rejuvenate or refresh the face
in a limited way — one part of the face can end
up looking younger than the others, and this is
something that subliminally, at least, suggests to
others that something has been ‘done’ or ‘is not
right.’ It is a bit of a paradox and can be difficult
to accept at first, but skillfully performed, doing
more surgery can actually look more natural …
because a balanced and harmonious outcome is
achieved.”

Dr. Marten stresses that the early-maintenance
technique is not new, but it is also not something
that can be adopted by the surgeon performing
the occasional facelift.

“The early-maintenance concept is not new
or a specific technique of mine,” Dr. Marten
says. “A committed group of skilled surgeons
have used or are employing a similar approach.
However, I published one of the first detailed and
comprehensive scientific articles on the technique
and the concepts behind it, and as such it has
served as a point of reference for surgeons
seeking to meet the increased demand we have
seen for early-maintenance procedures.

“It has also provided important counterpoint to the
often-misguided and overly simplistic approaches
advocated by those asserting that the younger
patient can be effectively treated by nonsurgical or
limited surgical means,” he says.

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Australasian fat grafting is a safe, effective and durable technique for soft-tissue augmentation, but more importantly, the fat grafts also have regenerative activity that has implications for restoring aged and damaged skin, says Sydney R. Coleman, M.D.

“Fat grafts are much more than fillers that add volume and recreate fullness. They also stimulate tissue repair and rejuvenate skin quality,
and my observations are that these benefits are progressive and long-lasting,” says Dr. Coleman, clinical assistant professor, department of plastic surgery, New York University Medical Center, New York.

Noting that the regenerative properties of fat grafting were first described in the literature about a century ago, Dr. Coleman says his interest in this aspect of the practice was raised when a patient of his who received a 1 cc fat graft to augment a defect in the nose benefited with resolution of a long-standing scar.

Patients receiving autologous fat grafts into different areas of the face as a cosmetic procedure for volume restoration also developed improvements in skin color and reductions in pore size and wrinkles, he says. Another patient had remarkable improvement of chemical peeling-induced scarring on the hands and forearms, and fat injection around the coccyx to provide cushioning in a patient with idiopathic lipodystrophy benefited with healing of a longstanding ulcer over her coccyx. Another patient who had undergone radical local excision and radiation therapy for rhabdomyosarcoma of the masseter showed improvement in skin quality and regrowth of beard hair after receiving a series of three fat injections.

“I think this latter case provides the most concrete clinical evidence that fat grafting has regenerative properties because radiation therapy causes progressive, unremitting tissue damage that does not heal with time. Whereas the irradiated tissue in this patient had been hard and sclerotic, after fat grafting, it became pliable and felt natural to touch,” Dr. Coleman says.

**ANIMAL EXPERIMENTS** Supported by a research grant from the National Endowment for Plastic Surgery, Dr. Coleman established the regenerative effects of fat grafting in laboratory experiments. First, he investigated the effects of human fat grafts on irradiated tissue in an animal model (Sultan SM, Stern CS, Allen RJ Jr, et al. Plast Reconstr Surg. 2011;128(2):363-372). Dorsal skin of wild-type immunocompetent mice was distracted from the body and then exposed to 45 Gy radiation.

During four weeks of follow-up, the animals developed visible damage, including tissue thickening, hyperpigmentation and progressive ulceration, Dr. Coleman says. The dorsal areas were then injected with either human fat grafts or saline as a control; the grafting was performed using Dr. Coleman’s structural fat grafting technique in which small aliquots of fat are diffusely delivered into the subcutaneous space. The animals were followed with serial photography and divided into two groups for sacrifice and histological evaluation at four and eight weeks.

Dr. Coleman reports that only animals receiving the fat injections exhibited clinical improvement in their skin appearance that was manifested by reduction of alopecia, normalization of skin color and texture, and ulceration healing. Histological studies provided evidence of the molecular basis for the observed changes. Compared with controls, fat injection was associated with downregulation of the expression of Smad3, a profibrotic protein, and CD31 staining showed a decrease in pathologic angiogenesis that occurs in response to radiation. However, animals receiving the fat grafts had an increase in normal vascularity and reductions in both epidermal thickening and the scar index as measured by picrosirius red staining, Dr. Coleman says.

**BURN-SCAR STUDIES** Dr. Coleman and colleagues performed a similar experiment in an animal model of burn scars (Sultan et al. Aesthet Surg J. 2012;65(2):219-227). Full-thickness injury was created using Dr. Coleman’s established murine model of thermal injury, and two weeks later, fat or saline was injected subcutaneously at the site of injury. The animals were divided into two groups for evaluation after four or eight weeks. Doppler scanning established there was significantly greater blood flow in the fat-grafted animals compared with the controls. Histological evaluations of tissue from sacrificed animals showed that compared with the control group, tissue from the fat-treated animals had significantly higher levels of vasculogenic proteins and significantly lower levels of molecular markers of fibrosis.

Consistent with these findings, tissue staining showed significantly upregulated vascularity at four weeks in the fat-treated animals and a significantly lower scar index at eight weeks compared with the controls.

Dr. Coleman says he attributes the regenerative benefits of fat grafting to the presence of adipose-derived stem cells and growth factors in the fat grafts.

“Every time we graft fat, we are grafting stem cells. Therefore, we are now focusing on trying to isolate these primitive cells from fat tissue and investigating their therapeutic use,” he says.
Enhancing blepharoplasty results requires addressing laxity of the eyelids and ptosis of the eyelashes or brow during the blepharoplasty when needed, says Bradley N. Lemke, M.D. For laxity of the medial canthal tendon (MCT) in particular, he recommends a subcaruncular approach over more complex surgeries.

“The key is to do a careful examination before you do the surgery, so that you can recognize problems such as a drooping eyelid, drooping eyelashes, or drooping brow and forehead before performing the surgery,” says Dr. Lemke, clinical professor of oculofacial plastic surgery, volunteer faculty, department of ophthalmology and visual sciences, University of Wisconsin-Madison. He is also an oculofacial plastic and facial cosmetic surgeon in private practice.

“If you don’t educate the patient about these problems beforehand, you might have to explain why they exist afterwards,” he says, adding that, fortunately, surgeons can address such problems during the course of blepharoplasty.

To fix a droopy eyelid, Dr. Lemke says he prefers an external levator repair. Some surgeons repair a droopy eyelid from a posterior approach, performing a conjunctival Müller’s muscle resection. Physicians taking this approach will need a Putterman clamp, which is used to grasp the tissue to be excised, he says.

However, Dr. Lemke says, “My preferred technique is to raise the lid from the front. I make an incision through the orbital septum to expose the levator aponeurosis, and I clean the external surface of the levator and tarsus. Then I place sutures between the aponeurosis and the tarsus to raise the lid.”

For drooping lashes, “Oftentimes when one closes the blepharoplasty incision, the lashes will rotate upward,” he explains. “If one needs to produce more of a lift, one can bluntly undermine the pretarsal muscle to free the orbicularis muscle from the tarsus. That allows the eyelid margin to rotate better.”

To raise the brow, Dr. Lemke says techniques include the coronal, the pretrichial or the small-incision endoscopic browlift. He says he personally prefers the pretrichial lift.

**PRETRICHIAL LIFT** To perform a pretrichial lift, “I make an incision along the hairline. Often, I spare the central aspect of the hairline, beginning the incision paracentrally above the medial canthus or pupil and extending laterally into the temporal hair. Make a meandering incision following the hairline, rather than a straight incision,” Dr. Lemke says, adding that this incision is beveled and trichophytic.

Dr. Lemke also says that dissecting subcutaneously allows one to preserve the frontal muscle, along with its nerves. “Sensory nerves
The key is to do a careful examination before you do the surgery, so that you can recognize problems such as a drooping eyelid, drooping eyelashes, or drooping brow and forehead before performing the surgery.

Bradley N. Lemke, M.D.
University of Wisconsin-Madison

travel upwards along the posterior aspect of the muscle until they perforate. And the motor nerve is on the anterior aspect of the frontalis," he says.

The next steps include elevating the brow, trimming the excess skin and closing the incision. In the medial area, "I use a running subcuticular 5-0 Monocryl suture (poliglecaprone 25, Ethicon) buried knot. And in the hair laterally, we use staples," Dr. Lemke explains.

A drooping brow can cause patients to have excess eyelid skin that will be apparent laterally after a standard blepharoplasty. If a blepharoplasty patient appears likely to have this problem, "The patient should be told about that, and maybe the patient should have a browlift — or at least that discussion should be had," Dr. Lemke says. "Otherwise, the patient would not understand that he or she will not have the perfect result because of the drooping brow that causes the skin in the upper lid to hang down."

Upper eyelid problems stem primarily from vertical vectors: drooping of the lid, lashes and brow, Dr. Lemke says. In the lower lid, however, "The structural factors are horizontal. Horizontal eyelid laxity can be medial, lateral or in both places," he says.

If one does not correct lower lid laxity at the time of cosmetic lower-lid blepharoplasty, the patient might develop an ectropion or retraction of the lid, or possibly both. The result of retraction is scleral show. Conversely, "If you do a horizontal tightening, you’re less likely to have those two complications," he says.

**MINDING THE MCT** For MCT laxity, Dr. Lemke uses the subcaruncular approach, which he says is a simple and minimally invasive MCT repair that involves securing the medial eyelid to the anterior central portion of the MCT via a subcaruncular approach that does not disturb the normal eyelid position or lacrimal system.

"The idea is to use a 5-0 Vicryl suture (poligactin 910, Ethicon) on a small half-circle needle (P-2, Ethicon)," he says.

Dr. Lemke says he performs the procedure using local anesthesia infiltrated into the medial tarsus and conjunctiva of the upper and lower lids. The first step involves evertting the lower lid to expose the medial tarsus and palpebral conjunctiva area. He then creates a 5 mm by 3 mm vertical elliptical excision of the conjunctiva, along with the lower lid retractors, tarsus and MCT. "The incision is made halfway between the tarsus and the caruncle on the underside of the eyelid," he explains. To anchor the medial tarsus and lower retractors, "Grab a good bite of solid tissue just under the caruncle. There’s fibrous tissue under the caruncle you can suture to."

Using a buried-knot technique, Dr. Lemke then sutures this tissue to the medial border of the lower lid tarsus. "Cinch the suture down only enough to prevent the lid from being dragged laterally from its normal position. Don’t overtighten the suture so that it drags the lid medially away from its normal position," he says. To tighten the entire MCT complex, Dr. Lemke says he performs a subcaruncular procedure on the upper lid as well.

Repairing the MCTs of the upper and lower lids adds approximately 15 minutes to a typical blepharoplasty, Dr. Lemke says. "Since it’s an extra procedure for a cosmetic case, we will tell the patient that it’s a necessary part of the blepharoplasty, and we will sometimes charge the patient more if they’re having this reconstructive structural problem fixed."

Laterally, "The tightening is done either with a tarsal strip procedure or a reinforcing suture between the lateral border of the tarsus and the periosteum within the orbital rim," Dr. Lemke says. A reinforcing suture through the lateral aspect of the upper eyelid blepharoplasty incision represents another option. Dr. Lemke says he uses a 5-0 Vicryl for that also.

To fix any residual lateral laxity left after the medial repair, Dr. Lemke says physicians can perform a lateral canthopexy for mild residual laxity or use a lateral tarsal strip for moderate to severe residual laxity.

**MCT STUDY** In a retrospective series of 30 patients with moderate-to-severe MCT laxity treated with the subcaruncular procedure on both the upper and lower eyelids, upper and lower MCT laxity in all patients went from greater than 4 mm pre-surgically to an average of 1 mm (Goel S, Lemke BN, Burkat CN. Am J Cos Surg. 2011;28(4):227-234).

Upper lid distraction also improved in this study — from a range of 8 mm to 20 mm bilaterally (mean: 13 mm) presurgically to 1 mm to 2 mm in 22 patients, and 3 mm to 4 mm in four patients postsurgically. These 26 patients experienced relief of their initial presenting symptoms, which included tearing, irritation, eyelash mattering and foreign body sensation, Dr. Lemke says.

The four remaining patients continued to experience watering postsurgically. Three of these patients underwent successful reoperation with the same MCT repair technique and lateral canthopexy; the fourth chose observation over reoperation, Dr. Lemke says.

Disclosures: Dr. Lemke reports no relevant financial interests.
Cosmetic surgery times

Resuspension of the SMAS with permanent fixation sutures through minimal incisions offers patients the “pick-me-up” of a facelift without the scars, anesthesia and recovery that are typically associated with a traditional surgical facelift procedure, says Steven B. Hopping, M.D., director of the Center for Cosmetic Surgery, Washington, and a clinical professor of surgery at George Washington University.

According to Dr. Hopping, this permanent suture fixation technique is particularly appealing to men and younger patients because they are most sensitive about wanting to avoid a “surgical” look and visible scars.

“They’re a little nervous about looking as if they’ve had a facelift, but they still want to get improved tightness in their jaw line and improved tightness in the neck,” he says. “The younger patients, the...
Ultherapy® is a new category of treatment that uses micro-focused ultrasound to non-invasively lift lax facial tissue. It is the ONLY technology with an FDA indication for non-invasive tissue lifting. During treatment, energy is discretely and precisely deposited at multiple depths (1.5, 3.0, 1.5 mm), heating tissue to the optimal temperature for neocollagenesis. Unlike lasers and radio-frequency, the ultrasound energy is focused below the skin’s surface, so treatments are typically completed in a single 60-minute session with no patient downtime. The result is multi-dimensional tissue lifting that begins at the skin’s foundation.

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male patients and patients who have already had some surgeries and now want to tighten up their neck because that area has aged a little faster, are all good candidates for these permanent fixation sutures."

**NEW TWIST** “The newest twist to facial rejuvenation in our practice that seems to be very popular and effective is the use of permanent resuspension sutures to tighten the SMAS. The advantage of these sutures is that they can be placed through extremely small incisions,” Dr. Hopping says. “Obviously, the SMAS is the system that we have traditionally tightened whenever we’re doing facelift surgery, but today’s patients tend to be looking for facelift results without the risks, recovery and operated ‘look’ of a facelift, and that’s what they like about the lower and mid-face SMAS suspension technique.”

The attraction to this technique falls in line with the current paradigm shift in aesthetic surgery, Dr. Hopping says. “Now, it’s all about earlier intervention with less invasive procedures. So rather than letting people age and then trying to reverse the aging, which usually requires a substantial surgical procedure, the paradigm shift is that we are trying to extend patients’ youthfulness with less invasive interventions so that they don’t ever need to resort to the big cut that inevitably looks ‘done,’” he says.

Dr. Hopping has taken the popularity of these minimally invasive permanent suture SMAS tightening procedures a step further by introducing the use of micro incisions to minimize scarring. “We’ve been using permanent sutures in facelifts for a long time, and we’ve been tightening the SMAS for a long time. My contribution to this is the addition of tightening the SMAS through minimal incision access so we accomplish substantial tightening with minor incisions,” he explains.

**LOWER AND MIDFACE** The “suture necklift” is best for patients with platysma banding and skin laxity who do not want a formal facelift, Dr. Hopping says. These would include men, younger patients and previous facelift patients who have developed neck laxity.

“In the neck, we’re actually doing a suspension that goes from ear to ear with a permanent fixation suture. It’s helpful for patients who have hanging platysma bands, and (it) appeals particularly to men because it is minimally invasive,” he says.

The “suture midface lift” can provide subtle improvement to the midface and jowl region without the need for an anterior facelift scar, Dr. Hopping says. Often, the "suture midface lift" is combined with the "suture necklift" and midface volume enhancement with autologous fat to achieve the best results for patients wanting to avoid visible scars and protracted recovery.

**STEP BY STEP** Permanent sutures stabilize the SMAS and platysma layers in their new position in both “suture lift” procedures, ensuring long-term results. These procedures can be readily performed with tumescent anesthesia with or without sedation, depending on patient and surgeon preference, Dr. Hopping says.

He describes the surgical process as such: The technique involves generously infusing 250 cc to 400 cc of a modified tumescent anesthesia (500 cc saline, 50 cc 1 percent lidocaine, 1 cc adrenaline) into the neck, midface and temple. After 20 minutes, criss-cross liposuction via submental and bilateral posterior earlobe incisions are performed with 1 mm and 2 mm cannula.

The neck flap is then bluntly undermined with a 1 cm spatula dissector from the submental approach. The posterior border of the platysma SMAS is exposed from the 2 cm postauricular incision by wide undermining with scissor dissection. Once exposed, the platysma SMAS is lifted posterior-superiorly by securing it to the postauricular mastoid fascia with a permanent 2-0 Ethibond (Ethicon) horizontal mattress suture, and this is completed on both sides.

Next, a 2-0 Prolene and 3-0 Vicryl sutures are passed simultaneously on a blunt trocar or cannula from the temple incision through the 2 cm temple incision placed 2 cm posterior to the hairline and carried down to the deep temporalis fascia. Two stab incisions are made preauricularly at the edge of the temple hair tuft spaced 3 cm apart with a No. 15 blade. A hemostat blade is used to undermine and create tunnels for the sutures.

Next, 2-0 Prolene and 3-0 Vicryl sutures are passed simultaneously on a blunt trocar or cannula from the temple incision through the two stab incisions incorporating the midface SMAS in a rhomboid design. The 3-0 Vicryl suture can be used to “saw” any soft tissue attachments tethered to the scalp skin, if needed. The sutures are returned to the temple incision and secured tightly to the immobile deep layer of the temporalis fascia, thereby lifting the midface SMAS in a superior vector.

The temple flap is then further moved superiorly as well by securing it at a more superior level on the deep temporalis fascia using a 2-0 Ethibond horizontal mattress suture, and the temple incision is closed in layers. Midface volume enhancement with autologous fat is then performed as needed.

The final step could include fractional laser resurfacing or chemical peel resurfacing as indicated, Dr. Hopping says. A light pressure dressing is applied for 24 hours, and patients may wash their hair the day after surgery.

Bruising is generally mild due to the generous use of tumescent anesthesia, and it is limited to the neck. Patients can usually return to work and exercise in one week, offering a dramatically shorter recovery period than formal facelifting, Dr. Hopping explains.

The suture lift techniques produce significant results, especially in combination with full-face liposculpture and fat grafting, according to Dr. Hopping.

“The sum is greater than the individual parts,” he says. “If we use soft tissue fillers to restore some volume and perform laser or chemical resurfacing to rejuvenate the skin and also tighten the SMAS in the neck — which has historically been a real problem to accomplish nonsurgically — the patient can end up with a very nice result.”

The “suture midface lift” can provide subtle improvement to the midface and jowl region without the need for an anterior facelift scar, Dr. Hopping says.
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Addressing defects

Soft-tissue sculpting restores contours in face, scalp

John Jesitus
Senior Staff Correspondent

Tucson, Ariz. — Template-guided repairs that incorporate soft-tissue sculpting can help restore facial contours that have been removed or altered by skin cancer excision, according to Frederick J. Menick, M.D., a Tucson, Ariz., plastic and reconstructive surgeon in private practice.

“IT SEEMS THAT WE AS PLASTIC SURGEONS DON’T APPRECIATE THE IMPORTANCE OF SOFT-TISSUE SCULPTING. WE THINK ABOUT SKIN, LINING AND CARTILAGE GRAFTS, BUT WHAT ABOUT THE SOFT TISSUE?” DR. MENICK SAYS.

Soft-tissue sculpting adds finesse and solves many difficult problems in facial and scalp reconstruction, he says. “THE ISSUES ARE: WHERE DO YOU MAKE YOUR INCISIONS, HOW MIGHT YOU APPROACH IT, AND WHY MIGHT YOU NEED TO DO THESE THINGS?”

Dr. Menick says that in his approach to reconstructive surgery, “INCISIONS AND ECISIONS ARE GUIDED BY EXACT TEMPLATES BASED ON THE NORMAL FEATURES. PROCEDURES ARE PERFORMED UNDER GENERAL ANESTHESIA TO AVOID THE DISTURBANCE OF BULK OR BLANCHING THAT LOCAL ANESTHETICS CAN CAUSE.” Additionally, he says that underlying facial contour — NOT SCAR SOARING — IS THE PRIMARY DETERMINANT OF A NORMAL APPEARANCE.

CASE STUDIES Dr. Menick points to a case in which a 56-year-old female patient’s post-Mohs surgery defect included most of her left ala. At first glance, it appeared she had a subunit defect of the ala, he says, but on closer inspection, “SHE HAD A DEFECT THAT EXTENDED ABOVE THE ALAR CREASE ACROSS THE SIDE WALL. SHE HAD UNDERGONE A SUBUNIT INCISION OF THE RESIDUAL ALAR SKIN, FOLLOWED BY A PRIMARY CARTILAGE GRAFT AND A TWO-STAGE FOREHEAD FLAP.”

Although this approach produced an aesthetically satisfactory result, it left her with a bulky ala, Dr. Menick says. More precisely, the surgery failed to recreate the convexity of the superior ala, or to recreate a deep alar crease, he says. In her case, “THE SUPERIOR ASPECT OR FLAP INSET LOOKED LIKE A FULL ALAR CREASE.”

To improve this patient’s results, Dr. Menick says he chose direct incision, disregarding the patient’s existing scars to allow precise soft-tissue contouring. In particular, “SHE HAD AN EXACT PATTERN OF THE RIGHT CONTRALATERAL ALA MARKED. ON THE ABNORMAL SIDE, DIRECT INCISION ADDED A NEW SCAR TO THE NOSE.” This incision allowed Dr. Menick to elevate superiorly and inferiorly the excess alar tissue in a thin layer, including 1 mm or 2 mm of fat.

Dr. Menick also excised excess soft tissue to make a flat sidewall, a deep alar crease and a convex alar margin. “INCISIONS HIDDEN IN CONTOUR LINES BETWEEN SUBUNITs PERMIT PRECISE SOFT-TISSUE INCISION AND ARE UNSEEN, NOT JUST BECAUSE THEY’RE HIDDEN, BUT BECAUSE THE CONTOUR IS CORRECT,” he says.

In another case, a 62-year-old female patient that Dr. Menick treated had a composite defect that extended onto her upper lip, medial cheek and nose. Dr. Menick says her nose required cartilage replacement and a forehead flap.

“We repaired her incision by making an incision in the right nasolabial fold, undermining the cheek skin, pulling it medially and using that excess advancement or dog ear lateral to the commissure to fill in her upper lip,” he says, adding that he also marked where her alar crease should fall based on a pattern made from her contralateral alar crease.

“She then underwent nose reconstruction with a separate flap,” Dr. Menick says. At the time her pedicle was divided, “SHE HAD A VISIBLE SCAR ACROSS HER LATERAL UPPER LIP UNIT, AND NO NASOLABIAL FOLD.” Dr. Menick says that when he divided her pedicle, he inserted it superficially as a small inverted V at the brow. He also sculpted her nasal sidewall and deepened her alar crease by elevating the inferior flap inset.

Again using a pattern drawn from the contralateral side, he then thinly elevated skin over the area where her alar crease would be and excised soft tissue and subcutaneous fat down to her intact orbicularis muscle, creating a flat plane. Finally, he re-inset the elevated skin with quilting sutures for deep closure and skin closure, he says.

Several months after this procedure, Dr. Menick says that from a front view, the patient’s lip scar had disappeared. From an oblique view, her new nasolabial fold was visible. “We obliterated her old scar and recreated an alar crease and nasolabial fold by adding new scars on her face and causing the eye to disregard the old cheek advancement,” he says.

Dr. Menick says he used similar principles to treat a 48-year-old female patient with a Mohs defect that encompassed part of her left ala, her cheek and the hairless triangle of her upper lip. “IT HAD BEEN CLOSED BY SIMPLE ADVANCEMENT WITHOUT ANY SUPPORT,” he says, adding that the patient had adequate skin coverage but needed her underlying contour and facial landmarks restored.

“To perform gross debulking, you approach it through peripheral incisions along the border of the old flap, knowing that you’ll have to come back later to make ‘finesse’ landmarks such as an alar crease through a direct incision,” Dr. Menick says. This is what he did for the patient, again patterning the reconstructed landmarks in accordance with those on the unaffected side of her face. This required making an incision along the border of her old incision, sculpting a round cheek and a flat nasal sidewall, and placing a secondary cartilage graft along the alar margin. “A COUPLE MONTHS LATER, SHE HAD A SECOND PROEDURE TO CREATE AN ALAR CREASE THROUGH DIRECT INCISION,” he says.

For a patient with a small, superficial Mohs defect of the nasal tip, Dr. Menick says he would not choose a bilobe flap or a V-Y flap. “I HATE LOCAL FLAPS IN THE NOSE,” he says. “I SEE MANY PATIENTS WITH A LOT OF DISTORTION OF THE NOSE ORRIM CREATED BY LOCAL FLAPS.”

Instead, he says he allows the excision area to heal for 10 days before he places a full-thickness forehead skin graft. “THIS IS MY ROUTINE METHOD OF TREATMENT FOR ALL SMALL DEFECTS AT THE END OF THE NOSE. IT’S SHORT, SWEET AND SIMPLE,” he says.

To perform the procedure, “PINCH A LITTLE ELLIPSE OFF TO ONE SIDE OR ANOTHER OF THE FOREHEAD JUST UNDER THE HAIRLINE AND APPLY IT TO THE NOW-GRANULATING BED; SUTURE IT IN WITH A FEW QUILTING SUTURES AND APPLY LIGHT BOLUS DRESSING, WHICH I LEAVE ON FOR A WEEK. THESE GRAFTS OFTEN HEAL EXTREMELY WELL,” Dr. Menick says.

Such grafts almost invariably “TAKE” if the surgeon allows the defect area to granulate before applying them, Dr. Menick says. Moreover, “THE CONTOUR IS ALWAYS PERFECT. AND ALTHOUGH YOU CAN HAVE A LITTLE UNPREDICTABLE COLOR AND TEXTURE, IT CAN BE EASILY CAMOUFLAGED WITH MAKEUP.”

Most women are quite satisfied with this type of outcome, he says, whereas they are extremely unhappy if a local flap excessively scars the nose or distorts the nasal rim./welcome.

Disclosures: Dr. Menick receives royalties from a book he wrote titled “Nasal Reconstruction Art and Practice.”

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