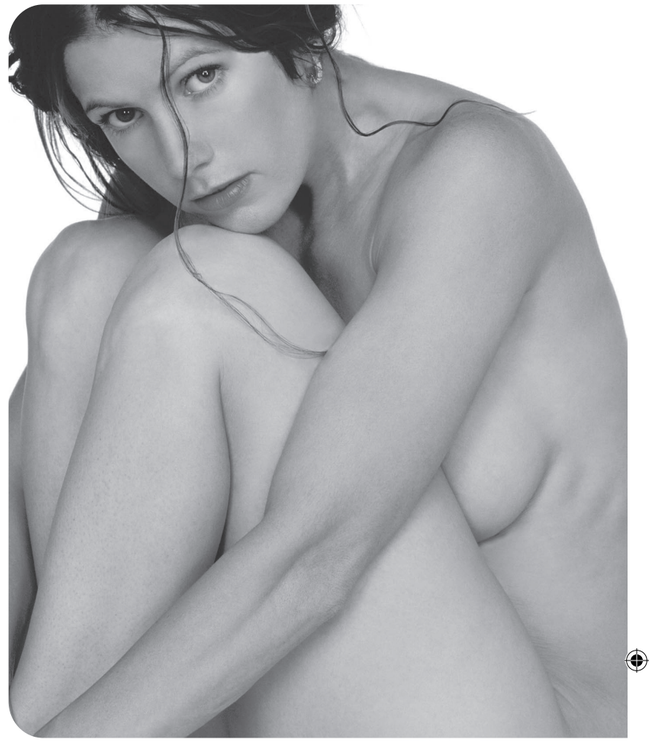
THE ART &

SCIENCE OF

COSMETIC

SURGERY



THE ART & SCIENCE OF COSMETIC SURGERY

FINAL PROGRAM

American Academy of Cosmetic Surgery

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AACS 21ST ANNUAL SCIENTIFIC MEETING

January 27 - 30, 2005

The Manchester Grand Hyatt, San Diego, California USA

Program Chairs: Claude H. Crockett, Jr., MD, and Patrick G. McMenamin, MD

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American Academy of Cosmetic Surgery

past

present

future

American Academy of Cosmetic Surgery
21st Annual Scientific Meeting
January 27 – 30, 2005
The Manchester Grand Hyatt
San Diego, California

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GENERAL INFORMATION

AACS Meeting Registration

Location: **Elizabeth Foyer**

Hours:		
	Wednesday, January 26	1:00 pm - 8:00 pm
	Thursday, January 27	6:30 am - 4:00 pm
	Friday, January 28	6:30 am - 1:00 pm
	Saturday, January 29	7:00 am - 4:00 pm
	Sunday, January 30	7:30 am - 12:00 pm

Exhibit Hall

Location: **Elizabeth Ballroom**

Hours:		
	Thursday, January 27	9:00 am – 7:30 pm
	Friday, January 28	9:00 am – 1:00 pm
	Saturday, January 29	9:00 am – 4:00 pm

Please note: As outlined in the program all food functions will be served in the Exhibit Hall.
**** Badge required for admittance.***

General Sessions – All general sessions are located in the **Elizabeth Ballroom F-H**, unless otherwise indicated.

Social Activities (Golf, Tennis & Fishing)

The deadline for purchasing tickets for the social activities is Friday, January 28, 2005 at 12 noon.

Video Library / Speaker Ready Room

Location: Betsy AB

Hours:		
	Wednesday, January 26	3:00 pm – 7:00 pm
	Thursday, January 27	7:00 am – 6:00 pm
	Friday, January 28	7:00 am – 2:00 pm
	Saturday, January 39	7:00 am – 6:00 pm
	Sunday, January 30	7:00 am – 12:00 pm

MEETING SPONSORS

AACS gratefully acknowledges the support of the following companies:

BOTOX® Cosmetic
Botulinum Toxin Type A

MERCK

CANFIELD Imaging Systems

ERCHONIA

LASERSCOPE®

SCHEDULE AT-A-GLANCE

Wednesday, January 26

1:00 – 8:00pm
Registration Open

7:00 – 9:00pm
Video Workshop

Thursday, January 27
6:30am – 4:00pm
Registration Open

7:00 – 9:00am
Bright Eye Conferences

9:00 – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session I: The Principals for a Beautiful Face
Facial & Forehead Rejuvenation

12:15pm
Lunch on Your Own (Exhibit Hall Open)

1:15pm
General Session II: The Principals for a Beautiful Face
Blepharoplasty

3:00 – 3:40pm
Coffee Break in Exhibit Hall

3:40pm
General Session III: The Principals for a Beautiful Face
Lasers & Botox®

6:00pm
Adjourn

6:00pm – 7:30pm
Welcome Reception in Exhibit Hall

Friday, January 28
6:30am – 1:00pm
Registration Open

7:00 – 9:00am
Bright Eye Conferences

9:00 – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session IV: Hair Restoration for the Cosmetic Surgeon

10:40am
American Medical Association
Keynote Presentation – Michael D. Maves, MD

11:00am
Election of Officers/Presidential Address

11:35am
Cosmetic Surgery Foundation: A Year in Review

12:00pm
Adjourn

12:00pm
Lunch on Your Own

12:30 – 5:00pm
Social Activities (golf, tennis & whale watching tour)

8:00 – 11:00pm
International Reception – America's Cup Terrace

Saturday, January 29
7:00am – 4:00pm
Registration Open

7:00 – 9:00am
Bright Eye Conferences

9:00 – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session V: The Principals for a Beautiful Body
Liposuction & Fat Transfers

12:00pm
Lunch in Exhibit Hall

1:10pm
Richard C. Webster Lecture
Leslie Bernstein, MD, DDS

2:00pm
General Session VI: The Principals for a Beautiful Body
Breast & Body

3:00 – 3:40pm
Coffee Break in Exhibit Hall

5:00pm
Richard C. Webster Resident Paper Presentation and Award
Adil Ceydeli, MD, MS

5:30pm
Adjourn

7:00 – 11:00pm
CSF Recognition Gala "Visionaries of the Past and Present"

Sunday, January 30
7:30am – 12:00pm
Registration Open

7:00 – 9:00am
Bright Eye Conferences

9:00 – 9:40am
Continental Breakfast in Exhibit Hall

9:40 – 12:00pm
General Session VII: New Horizons/Young Surgeons of Our Future

12:00pm
Adjourn

FACULTY DISCLOSURES

Disclaimer:
The views expressed and the techniques presented by the speakers at AACS-sponsored educational meetings are not necessarily shared or endorsed by the Academy. AACS requires faculty to disclose all relevant personal/professional relationships and any unapproved or "off-label" uses of medical devices or pharmaceutical agents that they discuss, describe, reference or demonstrate during their presentations. Registrants must use their independent judgment in applying the information discussed in AACS education sessions in the treatment of their patients.

No Disclosure to Make:
Victoria Belo-Henares, MD
Robert Burke, MD
Adil Ceydeli, MD
Angelo Cuzalina, MD, DDS
Patricia Dunwell, MD
Gerald Edds, MD
Andrew Fragen, MD
Ronald Fragen, MD
Mitchel P. Goldman, MD
Loek Habbema, MD
C. William Hanke, MD
Enrique Hernandez-Perez, MD
Steven Hopping, MD
Sandra Lee, MD
Mark Mandell-Brown, MD
Gary Monheit, MD
Patrick McMenamin, MD
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Curtis Perry, MD
Michael Rosenberg, MD
Jan Saether, MD
Gerhard, Sattler, MD
Robert Shumway, MD
Theodore Staahl, MD
Mario, Trelles, MD, PhD
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Disclosures Not Received:
William Beeson, MD
Leslie Bernstein, MD
Cat Burkat, MD
Robert Cattani, MD
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Susan Lim, FRCS PhD
Michael Maves, MD
Tanusin Ploysangam, MD
Cameron Rokhsar, MD
Robert Schwarcz, MD
Jeffrey Schafer, MD
Jeremiah Tao, MD
Clark Taylor, MD
Saied Vejdani, MD
Troy Williams, MD
Alan Wulc, MD
Longin Zurek, MD

Disclosure to Make:
Mark, Berman, MD - The Pocket Protector is my invention; I own a patent and have stock in Surgiform Co. that produces it. The material is FDA approved, but the device is not specifically approved for breast augmentation.
Steven Burres, MD - Fascian - Ownership interest will be mentioned with discussion.
Alastair Carruthers, MD – Allergan, Inc. consultant, stockholder & researcher. Artes Medical, Inc., consultant. Arthrocare, Inc. stockholder & researcher. Elan, Inc., consultant & researcher. Ferndale Labs. researcher. Inamed, Inc., researcher & consultant, Lumenis Medical Lasers, Inc., Medical Advisory Board. Q-med, Inc., researcher, Richard James, Inc., researcher. Glaxo Smith Kline, Inc., researcher.
Jean Carruthers, MD - Allergan Inc., consultant, stockholder & researcher. Artes Medical, Inc. consultant. Arthrocare, Inc., stockholder & researcher. Elan Inc., consultant & researcher. Ferndale Labs. Researcher. Inamed Inc., researcher & consultant, Lumenis Medical Lasers Inc., Medical Advisory Board. Q-med, Inc., researcher, Richard James, Inc., researcher. Glaxo Smith Kline, Inc., researcher.
Sorin Eremia, MD - I have applied for a patent on the suture and instrument used to insert the suture.
Robert Goldberg, MD - Medical consultant to Medicis Corp.
Robert Jackson, MD - The IRB for this study was sponsored by Erchonia, no financial support for investigation. FDA has given market approval of device.
E. Antonio Mangubat, MD - I have financial relationships with KMI.
Neil, Sadick, MD - I have consultant affiliations with the following: Candela, Laserscope, Syneron, Thermage, Mediderm, Medicis, CureLight, 3M, Allergan, BSN-Jobst, Cooltouch, Edge Systems, Ethicon, Radiancy & Dermik.

SCIENTIFIC ABSTRACTS

WEDNESDAY, JANUARY 26

7:00pm – 9:00pm
VIDEO WORKSHOP WITH THE EXPERTS
Experts in Cosmetic Surgery present video presentations of their latest techniques.
Moderator: Steven B. Hopping, MD & Robert F. Jackson, MD

7:00pm – 7:30pm
Abdominoplasty in the Massive Weight Loss Patient
Michael H. Rosenberg, MD & Jane Petro, MD

7:30pm – 8:00pm
An Overview of Breast Augmentation
Ronald A. Fragen, MD & Andrew Fragen, MD

8:00pm – 8:30pm
Advances in Lasers - An Update in Laser Resurfacing
Mitchel P. Goldman, MD

8:30pm – 9:00pm
Rejuvenation of the Periorbital Area
Robert M. Dryden, MD & Alan Wulc, MD

THURSDAY, JANUARY 27

7:00am – 9:00am
Bright Eye Conferences

Bright Eye Conference #1
Room – Edward A
An Overview of Liposuction Surgery – Complications
Loek Habbema, MD, Gerhard Sattler, MD & C. William Hanke, MD

Bright Eye Conference #2
Room – Edward B
The Basics & Advanced Use of Botulinum Toxin A in the Cosmetic Arena
Jean Carruthers, MD & Alastair Carruthers, MD

Purpose: To describe the basic and advanced use of Botulinum toxin A in the cosmetic arena.
Method: Clinical situations will be described and the audience will be asked to offer their opinions and suggestions in a dialogue facilitation format. Participants may wish to offer their own clinical case conundrum to us ahead of time for discussion.
Results: The participants will be able to appreciate a number of equally valid approaches to different but common clinical problems. At the end of the session, the key points will be summarized and can then be emailed to all the participants who wish to receive them. A list will be given to all participants for their email addresses during the session.

Bright Eye Conference #3
Room – Edward C
Lower Facial Surgery – Balance of Bone & Soft Tissue
Clark O. Taylor, MD, DDS & Angelo Cuzalina, MD, DDS

To discuss the different approaches to rejuvenation of the forehead based upon years of clinical experience and observations. The audience will be encouraged to engage in professional debate on the advantages of each unique approach.

Also discussed will be the clinician's current approach to chin augmentation including genioplasty and alloplastic augmentation. The problems of chin reduction will be discussed as it effects facial balance and contributes to the aging process.

Bright Eye Conference #4
Room – Edward C
Breast Augmentation - Benefits of the Axillary Approach
Jan Saether, MD

The following will be discussed in this session:
- Benefits of the axillary approach
- Technical finesses for the endoscopic procedure
- Pitfalls at surgery
- Pain reduction
- Keeping the breast soft

9:00am – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session: The Principals for a Beautiful Face
Facial & Forehead Rejuvenation
Moderators: Clark O. Taylor, MD, DDS & Gerald G. Edds, MD

9:40am
The Trichophyllic Subcutaneous Forehead/Brow Lift
Clark O. Taylor, MD, DDS

Objective: To present a technique of forehead rejuvenation utilized by the author over the past 15 years with excellent results and minimal complications.
Methods: Review of patient selection and technique of forehead rejuvenation utilizing the trichophyllic subcutaneous approach. Traditional Coronal incisions frequently yield long term results with noted relapse due to the distance from the brow and the performance in the subgaleal plane. Both Coronal and endoscopic approaches result in unavoidable posterior movement of the hairline and elongation of the forehead. In addition the coronal incision results in sensory nerve morbidity to the scalp posterior to the incision. Endoscopic techniques are limited in their applications due to variable long term stability. The only advantage to the endoscopic approach is the utilization of minimal incisions and the avoidance of nerve morbidity. The trichophyllic approach was utilized to eliminate the shortcomings of both coronal and endoscopic approaches. Patients are treated with an incision which preserves a normal hairline and allows maximal, stable elevation of the brow when performed in the subcutaneous plane, and yields an incision which is virtually unnoticeable. Resection of the Corrugator Supercilli is possible thru a midline inverted V subperiosteal incision, which preserves the sensory nerve supply to the forehead. The utilization of Fibrin Glue with closure minimizes swelling and eccymosis and contributes to stability of the result.
Results: Superior results are possible with good long term stability, preservation of a normal sensory nerve supply, and an incision well camouflaged due to regeneration of a normal hairline. In addition, cephalic migration of the hairline is avoided as well as secondary forehead lengthening.
Conclusions: The trichophyliic incision preserves a normal appearing hairline, with an inconspicuous scar, with long term stable results when performed in the subcutaneous plane. Muscle resection is possible, and minimal sensory nerve morbidity is encountered due to the superficial layer of dissection. This is the ideal approach in the vast majority of patients undergoing forehead rejuvenation.

9:50am
The Subcutaneous Forehead Lift Revisited
Gerald G. Edds, MD

Objective: The subcutaneous forehead lift was introduced early in the history of forehead rejuvenation. Over the past twenty-five years this procedure was essentially replaced by other, more aggressive procedures, including coronal and endoscopic approaches. The objective of this talk is to show the ease and versatility of the subcutaneous forehead lift, as well as its advantages over other approaches with specific clinical finding.
Methods: The history of forehead rejuvenation and a discussion of various incisional approaches to the subcutaneous forehead lift will be reviewed and photographs will demonstrate operative results. The subcutaneous forehead lift has been found to be an excellent approach to a variety of forehead problems with ease of performance and predictability of results.

10:00am
Midface Augmentation with a Canine Fossa-based Implant
Steven A. Burres, MD

Objective: Restoration of volume in the midface has typically been devoted to implantation directly over the malar eminence or the adjacent submalar zone. Areas of bone concavity are more susceptible to volume loss than those of convexity. This study shows the feasibility of placing an implant in the canine fossa to correct the step-off of the maxillary eminence.
Methods: A custom-designed implant, titled the Maxout™ Implant, was created to suit this problem. The implant had a large, oval-shaped base to fill the fossa and a lateral phlange to hook around the lateral maxillary buttress into the infratemporal fossa. Under local anesthetic, either a transoral or intranasal approach was used. The transoral incision was vertically across the mucosa of the canine fossa, whereas the intranasal approach was through the nasal vestibular skin along the pyriform aperture. After the incision, the periosteum was elevated off the canine fossa and lateral buttress and the implant was inserted.
Results: Twelve implants were placed in six subjects, four transoral and eight intranasal. Three subjects were HIV-positive. One transoral implant placed in an HIV-positive patient became infected. It was removed and replaced 3 months later without complications. The remainder of imlants has been satisfactory 1 year later.
Conclusions: The canine-fossa based Maxout™ implant represents a new approach to mid-facial skeletal augmentation. Areas of concavity are more susceptible to age-related soft tissue wasting than areas of convexity since the volume loss of fat and the migration of fat are greater than that of bone. The step-off from the maxillary eminence to the canine fossa becomes more evident and is difficult to repair by only soft tissue manipulation alone. The canine fossa is an anatomically neutral site for an implant. Implant drift is prevented by the gingival ridge inferiorly and the maxillary eminence superiorly. The Maxout implant is a relatively easy and safe choice to repair this problem.

10:10am
Internal Midfacelift: The Foundation for Facial Rejuvenation
Carlos A. Morales-Ryan, MD

Objective: There are two essential aspects or components to consider when treatment planning or performing any type of facial rejuvenation operation. These are 1) attempt to work from the inside out and 2) attempt to reposition or add to before performing any type of "take away" procedure. The purpose of this study is to evaluate the aesthetic effect performing the internal midfacelift (which is always combined with an endoscopic forehead lift) concomitant with our conventional rhytidectomy as a facial rejuvenation comprehensive therapy.
Methods: This prospective study included 15 female patients that underwent the internal midfacelift (IML) concomitant with our conventional rhytidectomy approach. A second group of patients that underwent rhytidectomy alone were used as controls to compare the results. Clinical and photographic evaluations with VAS (Visual Analog Scale) by surgeons and nursing staff were performed at 3 time intervals: presurgery (T1), at surgery (T2) and postsurgical follow-up (T3). Evaluation criteria included 1) soft tissue projection in the malar and submalar area (increase, no change or decrease); 2) natural or unnatural appearance; 3) overall outcome between IML and non IML patients. We use t-test for the statistical analysis.
Results: We found statistical significant higher VAS scores for the IML group in all 3 parameters compared with the non IML group of patients. These results were similar between surgeons and nursing staff. IML group significantly increased soft tissue projection, while non IML group showed a no change or decrease in projection. The overall outcome was highly rated for the IML group as compared to the non IML group.
Conclusions: The results of this study showed by combining the internal midfacelift with our conventional rhytidoplasty, the aesthetic outcome is a more natural, longer lasting facelift than with a subcutaneous lift alone showing a significantly soft tissue projection in the malar and submalar area. It also eliminates the need for subSMAS dissection and hence decreases the chances for facial nerve damage.

10:20am
The Use of a Newly Designed Suspension Suture for "No", "Minimal", "Limited", and "Standard" Incisions Face Lifts
Sorin Eremia, MD

Objective: Presentation of a specially designed suture technique developed and practiced by the author since January 2004 that allows elevation and suspension of the mid face, malar fat pad, and lower face and jowls, either as an independent procedure, or as part of a more traditional face lift.
Methods: 20 patients have been enrolled in a study to determine the effectiveness of a specially designed suspension suture to lift and reposition the mid face, malar fat pad area, with correction of nasolabial folds and lateral oral commissural folds, and correction of lower face and jowls. Special, though relatively simple instrumentation is required to insert the special design suspension sutures, which are currently made of slowly absorbable material. The special design of the suspension suture allows for even distribution of suspension tension and reposition of the ptotic tissues. Two to five sutures are placed depending on the desired areas of correction and vectors. The results are followed with serial photographs. The study looks particularly at use of the suspension suture for a very minimally invasive, no skin excision, suspension lift, but we have also incorporated it as part of selected standard lifts, reducing the needed amount of undermining. Those results will be presented as well.
Results: The early results have been very promising. The procedure is relatively quick and can be easily performed under local anesthesia, though mild po/IM sedation is preferred by some patients. Most patients can camouflage and return to normal activities in 3-4 days. The redundant skin appears to spontaneously redrape, much like with endobrow lifts, after 10-20 days. A satisfactory degree of correction appears to be maintained, at least in the early follow up phase of this study. 8-12 month follow up will be

available at the time of the presentation. There have been no hematomas, infections, or nerve injuries, or any other complications so far. Patient satisfaction has been very high so far.
Conclusions: The use of a newly designed type of suspension suture appears to be a simple, safe, and at early stages of follow up, an effective method of correcting ptotic mid and lower face ageing changes.

10:30am
Question & Answer Session

10:40am
Seamless Facelift with Aptos Thread: The Belo Medical Group Experience
Victoria G. Belo-Henares, MD

Objective: With aging, the face loses volume and contour in all dimensions. The classic methods of face lifting would normally leave unsightly scars especially on Asian skin. APTOS threads are made of polypropelene sutures with dents or cogs. These were used by Sulamanidze (Russia) in restoring normal contours of the face and had excellent results without any visible scars.
Methods: From Nov. 2002-Nov. 2003, 257 patients with age ranges of 28 to 73 years were treated with this procedure. For the purpose of this study, we used threads with convergent cogs in order to fix tissues in their required position. Threads were inserted through the skin using a spinal needle. Most areas done were the cheeks and jowls. The procedure is easy and quick to perform with minimal damage to tissues. Outcome is seen as early as on the operating table. Rehabilitation time is as short as 5-7 days.
Results: The use of APTOS threads in successfully treating facial ptosis in 257 patients of The Belo Medical Group was a simple, conservative and time-saving procedure that left no visible scars even on Asian skin.
Conclusions: Our experience proved that this technique may be an alternative to the classic methods of lifting and contour plasty without leaving visible scars on Asian skin.

10:50am
SafFe Lift - Secure Anchoring Filaments for Facial Elevation
John H. Flynn, MBBS

Objective: The objective of this presentation is to present a comprehensive method of utilization of 'threads' lifting or 'suture' lift to apply to the whole face. Several types of threads and thread lifts have been described each with a specific objective; most popular recently have been the APTOS threads with the trademarked Feather lift.
Methods: Varieties of suture or thread techniques were researched to establish advantages and disadvantages and a process of usage designed to give a comprehensive lift to all areas of the face. Reference is made to APTOS threads, the Saylan sling technique, Gianpappa suture, Des Fernandes method of ectropion correction among others.
Results: Results are demonstrated photographically
Conclusions: APTOS threads provide good support to the tissue and form a scaffolding type structure to the tissues. Designed for brow, malar, jowl and neck however the effectiveness is limited by the lack of a secure anchorage. The thread is supported only by its dermal attachment. I consider this good for the malar area but less so for the brow and jowl where muscle forces and gravity overcome the effect of the threads. In the neck the Saylan and Gianpappa techniques perform better. The Fernandes ectropian technique can be adapted for a stable brow elevation and provides for a secure anchor to the periosteum of the skull. This format can also be used to elevate the malar pad and still provide stable anchoring to the temporalis or zygoma. In essence this paper shows how a variety of techniques can be assembled to provide a secure thread based (I use the term 'FILAMENT") lift without restricting oneself to a particular brand.

11:00am - To Evaluate the Effectiveness of the Skin Stitch in Non-Surgical Face Lifting
Cyntheia Weinstein, MD

Objective: To evaluate the effectiveness of the Skin Stitch in non-surgical face lifting.
Methods: 57 patients underwent the Skin Stitch to elevate the skin against gravity. 34 patients underwent full-face skin stitch to elevate multiple areas i.e. brows, midcheek, jowls, neck. 23 patients underwent treatment to only one or two areas. Procedures were performed either under local anesthetic alone or in conjunction with intravenous sedation. A small incision (0.5cm) was placed in the post auricular, preauricular, and temporal region. A 22-gauge spinal needle was introduced at the most distal point away from the incision, and exited at the incision. A 40 prolene suture was introduced into the belly of the spinal needle. The needle with the suture was pulled back to a point 1-2mm from the initial distal point where the spinal needle was introduced. At all times the needle was kept under the skin. The needle then did a U turn and exited at the incision site. The suture was removed from the belly of the spinal needle. The suture was then tied into the cartilage behind the ear, in front of the ear and the temporalis fascia. Several sutures were used along the same tract to create uniform traction. The incisions were not sutured, but healed in 48 hours. Oral antibiotics were used routinely. Oral analgesics were used for 24 hours.
Results: 94% of patients were either satisfied or very satisfied with the results when evaluated at 3 months. 34% of patients required further sutures after the first procedure to lift the skin further. 2 patients requested removal of the sutures; 1 patient decided to undergo a surgical face lift, and 1 patient could not cope with the puckering in the first 48 hours. 48% of patients developed initial puckering of the skin in the preauricular and post auricular area. In all patients the puckering settled within 4-6 weeks. There were no cases of infection. 6% of patients had extrusion of the sutures; 5% in the post auricular region and 1% in preauricular region.
Conclusion: The Skin Stitich is an effective and safe non-surgical "face lifting" which has high patient satisfaction and few complications.

11:10am - Elongated Deep SMAS Flap for Improved Cheek Lift in Rhytidectomy
Robert M. Dryden, MD

Objective: Rhytidectomy is a popular cosmetic surgery procedure for rejuvenation of the lower face and neck. Many variations have been described and utilized since first introduced almost 100 years ago. This abstract describes an innovative technique of an elongated inverted L-shaped deep SMAS flap that provides significant cheek elevation in addition to improving lower face and anterior cervical soft tissue ptosis.
Methods: 176 patients ranging in age from 26 to 85 have undergone rhytidectomy with this procedure since 1999. The overwhelming majority have been primary procedures, 59% (n=104) cervicofacial rhytidectomy ("full" facelifts), and 41% (n=72) facial rhytidectomy ("mini" facelifts). Pre and postoperative indexed images were obtained and compared with Canfield Mirror Imaging software, Fairfield, N.J. Technique Sedation, MAC, or general anesthesia are employed. Standard periauricular rhytidectomy incisions are made and undermined after local anesthesia infiltration and tumescent solution infusion. Monopolar cutting current with a Colorado Needle facilitates the SMAS flap dissection and provides a measure of safety with neuromuscular stimulation

as the electrocautery dissection plane nears facial nerve fibers. The SMAS flap orientation is an inverted L, the apex initiated 1 cm anterior to the skin incision, and 1 cm superior to the zygomatic arch. Superiorly, the horizontal limb is two to 3 mm deep and extends anteriorly as dictated by electrocautery neuromuscular stimulation, generally two to 3 cm. The vertical limb extends from the apex to two to 3 cm inferior to the mandibular angle, deeply to parotid capsule, and anteriorly as limited by electrocautery neuromuscular stimulation. Once elevated, generally 1.5 cm of SMAS overlap can be achieved. The overlapped portion is excised, and the SMAS is repaired with 4-0 prolene running suture directed superoposteriorly to enhance cheek lift. Hemostasis is obtained; the overlying skin is redraped, trimmed and closed with staples and sutures prior to bulky dressing placement. A J-P drain is utilized for cervicofacial rhytidectomy and generally removed on the first postoperative day.
Results: By comparing Canfield Mirror System indexed pre and postoperative images, all patients displayed significant cheek elevation as well as improvement in soft tissue ptosis and rhytids. The complication rate has been extremely low, with no incidence of motor nerve palsy, hematoma, infection, skin flap necrosis or SMAS flap fatigue. The procedure has been used concurrently with other procedures, and is commonly followed by blepharoplasty or CO_2 laser skin resurfacing.
Conclusions: Elongated inverted-L deep SMAS flap technique for rhytidectomy provides a safe and effective means for cheek elevation in addition to improvement of lower face and cervical soft tissue ptosis.

11:20am
The "Contour Lift" - Three Dimensional Facial Rejuvenation with Alloplastic Implants
Steven B. Hopping, MD

Objective: Traditional SMAS Facelifting provides two dimensional rejuvenation. Facial Rejuvenation with alloplastic facial implants gives a three dimensional rejuvenation. This study evaluates whether there are aesthetic advantages to three dimensional facelifting with implants and whether the technique offers greater longevity.
Methods: 50 consecutive "Contour Lifts", three dimensional facelifts with alloplastic facial implants, are retrospectively reviewed. Long term results are compared with traditional SMAS two dimensional facelifting. Techniques are compared. Complication of the procedures are compiled. Patient satisfaction with the procedure as evaluated by 6 month questionnaire are reviewed.
Results: The complication rate for the three dimensional facelift with alloplastic was 6%. The long term aesthetic results appear superior to traditional facelifting. Patient satisfaction with the procedure was high 93%.
Conclusions: Three dimensional facelifting with alloplastic implants ("Contour Lift") provide aesthetic and long term advantages over traditional facelifting techniques in properly selected patients requesting facial rejuvenation.

11:30am
Question & Answer Session

11:40am – 12:10pm
Scott McKain, PhD

Featured Speaker Scott McKain combines an understanding of clients needs with superior customer service to present a business philosophy that will enhance any practice. With experience as Vice Chairman of a diverse group of companies, spectacular speaking skills and a true understanding of business today, McKain has captivated audiences worldwide. His proven philosophy of profitably creating experiences that create loyalty is documented in his bestselling book, "All Business is Show Business," as well as several audio and visual programs. A phenomenally effective speaker, McKain has been recognized by his peers as a member of "Speakers Roundtable" and the Professional Speakers Hall of Fame. As a former broadcast journalist and television news anchor, he has made several recent appearances as an Analyst and Commentator on FOX News Network. Now serving as Chairman of McKain Performance Group, McKain is committed to providing educational presentations that stimulate professional and personal growth and enhance customer experiences. The Cosmetic Surgery Foundation is honored to welcome Scott McKain to the 2005 Annual Scientific Meeting.

12:15pm – 1:15pm
Lunch on Own (Exhibit Hall Open)

1:15pm
General Session: The Principles for a Beautiful Face
Blepharoplasty & Facial Rejuvenation
Moderators: Mark Berman, MD & Robert M. Dryden, MD

1:15pm
Dermis Graft for Lower Eyelid Retraction
Allan E. Wulc, MD

Introduction: Eyelid retraction is commonly seen following lower blepharoplasty or transeyelid midface lifting.[1,2,3] It is often exceedingly difficult to correct, requiring the addition of either skin grafts, hard palate or ear cartilage, or exogenous Alloderm grafts in conjunction with horizontal eyelid shortening.[1,2,3] We describe our experience with a novel supporting substance for the posterior lamella, an autogenous dermis graft. Dermis can be used to support the posterior lamella of the eyelid in postblepharoplasty roundeye and in the eyelid retraction of thyroid eye disease as well.
Methods: 34 cases of patients with Grave's disease and lower eyelid retraction were reviewed. After the lower eyelid was infused with local anesthesia, unipolar cautery was used to incise through conjunctiva and eyelid retractors. A dermis graft was harvested from the abdomen and sewn into place with a 6-0 absorbable suture. Two frost sutures were placed to relieve tension and keep the graft on stretch.
Results: All patients experienced clinical improvement in their eyelid retraction. There was minimal shrinkage of the grafts and 100% take of all grafts. One patient had minimal improvement and had to have the procedure repeated. Total improvement occurred after the second procedure.
Conclusions: Thirty four patients with lower eyelid retraction secondary to post blepharoplasty roundeye or Graves' disease underwent a new procedure where a dermis graft was used to replace or lengthen the posterior lamella. As opposed to the use of exogenous spacers such as Alloderm which resorb over time, a one to one ratio between harvested dermis and amount of lid retraction that is observed can be employed with dermis grafting. While hard palate grafts and ear cartilage can produce fullness in the lower eyelid, dermis grafts do not. Use of a dermis graft as a spacer to improve lower eyelid retraction from any etiology is successful and resulted in only one failure. The most common donor site was the abdomen. The procedure was well tolerated. There was minimal contraction of the graft compared to other material such as alloderm and minimal discomfort from the donor site unlike in hard palate grafts.
References:

1. Aldave AJ, Maus M, Rubin PA. Advances in the management of lower eyelid retraction. Facial Plast Surg. 1999; 15:213-24.

2. Sullivan SA, Dailey RA. Graft contraction: a comparison of acellular dermis versus hard palate mucosa in lower eyelid surgery. Ophthal Plast Reconstr Surg. 2003; 19:14-24.
3. Patipa M, Patel BC, McLeish W, Anderson RL. Use of hard palate grafts for treatment of postsurgical lower eyelid retraction: a technical overview. J Craniomaxillofac Trauma. 1996; 2:18-28.

1:25pm
A Comparison of Midface Lifting Techniques
Robert M. Schwarcz, MD

Objective: To analyze methods used in midface lifting techniques.
Methods: A review of 10 years experience of senior authors cases of subperiosteal as compared to SOOF lifting techniques and outcomes. Both approaches were performed transconjunctively with a concomitant lateral canthoplasty. They both utilized 4-0 Prolene suture anchored to the arcus marginalis as the structure area used to harness the lifted midface. The subperiosteal approach involved a transconjuctival route with a subperiosteal dissection down the midface, including a distal periosteotomy. The midface was then fastened to the arcus marginalis.
Results: SOOF lifting involving the pre-periosteal approach accomplishes a greater lift without as much dissection needed. Complications of nerve injury or bleeding were more likely with this technique, as well as skin dimpling and contour irregularities irregularities. Pre-periosteal lifting was performed with more ease and allowed a greater lift superiorly. Subperiosteal midface lifting displayed a more even contour and the new subperiosteal adhesion that developed allowed for a longer lasting lift on average. The subperiosteal lift also an opportunity for placement of a midface implant if necessary.
Conclusions: Midface lifting is an integral part in addressing the rejuvenation and rehabilitation of the lower eyelid midface continuum. Pre and sub-periosteal approaches have been evaluated. Both have pros and cons, yet there is need for knowledge of both methods. In the authors experiences, subperiosteal midface lifting allows for a longer lasting midface lift with a more even contour, with the opportunity for placement of malar augmentation devices. The pre-periosteal midface lift allows for less of a dissection with the opportunity for a slightly greater lift, but a risk for skin depressions. Both techniques could be combined with a posterior lamella eyelid graft as well if further rehabilitation is needed for eyelid architecture to address middle lamella cicatrix.

1:35pm
A Comparison of Healing Parameters in Upper and Lower Eyelid Blepharoplasty Using the CO_2 Laser versus the Colorado Needle and Electrocautery
Cameron K. Rokhsar, MD

Objective: In performing upper or lower lid blepharoplasties, cold steel, CO_2 laser and electrocautery devices have all been used. The subject of the efficacy of the CO_2 laser vs. cold steel has been well debated. However, many surgeons who currently perform this procedure use the electrocautery device in conjunction with the Colorado needle tip. The CO_2 laser has never been studied head to head with the Colorado needle device. The purpose of this study was to compare healing parameters including edema, erythema and ecchymosis following blepharoplasty using the two devices.
Method: 10 subjects requesting upper or lower blepharoplasties were enrolled in this study. One eyelid was operated using the CO_2 laser for excising eyelid skin, orbicularis and fats pads and the other eyelid was operated using the Colorado fine needle tip. Subjects were evaluated on post op day 1, 3, 7, 14 and 30 in a blinded fashion for edema, erythema, ecchymosis and pain both through a patient questionnaire and through a blinded assessor and scored according to a scale of 1-10. Scar width at the widest portion was also measured at 1 month post op.
Results: There appeared to be no difference in edema, erythema and ecchymoses in the eyelids operated with the electrocautery vs. the CO_2 laser at day 7 and day 30. Patients reported minimal post-op pain with either technique. Intraoperative time was similar utilizing both techniques. The similar healing time is probably related to coagulative properties for both techniques. Patients rated the appearance of the eyes to be the same on day 30. The excised tissue for comparison of zones of thermal necrosis is currently under histopathologic study.
Conclusion: There appears to be no significant difference in healing time when performing blepharoplasties with the CO_2 laser and electrocautery.

1:45pm
New and Unresolved Complications after Upper Lid Blepharoplasty and Full Face CO_2 Laser Resurfacing
Sandra S. Lee, MD

Objective: To inform cosmetic surgeons of a new, as yet unreported and unresolved complication following upper eyelid blepharoplasty and full face CO_2 laser resurfacing.
Methods: Upper lid blepharoplasties were performed due to dermatochalasis, using the transcutaneous approach, with the Ultrapulse CO_2 laser utilized to remove the skin, the orbicularis oculi muscle, provide hemostasis, and further tighten the tissue of the upper eyelid. 6-0 nylon suture was used to oppose the skin edges and recreate the upper eyelid crease. There were no post-operative complications in the 7 cases we are reporting and the patients were very pleased with the results. An ultrapulse CO_2 laser was used to perform full face laser resurfacing for improvement in photodamage and rhytides in 2 patients. Our technique is composed of one full face pass with the CO_2 laser, using the CPG hand piece, and one to two further passes in areas with more significant photo damage or deeper rhytides, depending on the need. Post-operative course was nonremarkable in the 2 patients reported and the patients were pleased with the outcomes.
Results: We report 7 cases of foreign body granulomas occurring along the suture line in patients 1-3 months after receiving upper lid blepharoplasty, and 2 cases of foreign body granulomas occurring 1-3 months after full face CO_2 laser resurfacing. Histological, the lesions biopsies from areas after blepharoplasty and facial laser resurfacing are similar, showing the presence of foreign bodies. Oil Red O stains were positive, suggesting the presence of mineral oil.
Conclusions: We suspect that the granulomatous reactions were caused by the use of a bacitracin topical antibiotic ointment applied to the areas after surgery. Although initially disputed by the drug manufacturer, we have discovered that this ointment contains mineral oil which is likely the cause of the foreign body reactions, namely, parafinnomas. Topical Aldara (imiquimod) cream and oral allopurinol have both been reported to resolve cuntaneous foreign body reactions. However, neither has proven successful in our patients when administered over the course of a few months. Other than excision of focal areas, there appears to be no other reliable treatment option.

1:55pm - Autogenous Dermis and Fascia for Prominent Glabellar Furrows
Allan E. Wulc, MD

Introduction: While botulinum toxin and surgical disruption and denervation are useful in ameliorating glabellar furrows, these techniques are often inadequate for patients with deeply established wrinkles.[1,2] Numerous filler materials have been described for treating glabellar furrows associated with dermal remodeling.[2] Laser resurfacing can be performed as well, but the risks and the recovery time associated with laser preclude that option in many candidates.[3] We propose the use of subcision followed by fascia or dermis grafts placed subcutaneously as an alternative to glabellar rhytid reduction.
Methods: A study reviewing patients who underwent endoscopic browlifts between 2000 and 2003 was performed. Preoperative and postoperative photographs were compared by an independent observer. The preoperative glabellar furrows were rated from 1 to 4 with 1 being minimal furrow, 2 being somewhat furrow, 3 being moderate furrow and 4 deep furrow. Postoperative change was also rated from 1 to 4 scale with 1 being no/very minimal change, 2 being moderate change, 3 being good change, and 4 being superb change. Patients undergoing endoscopic brow lifts in a similar time period not receiving glabellar grafts were used as controls. Other parameters noted was whether or not botulinum injections were necessary after the graft procedure.
Results: The average age of patients receiving glabellar grafts was 56.4 years with an age range of 39 to 71 years. The average rating for the preoperative furrow was 2.95 with a postoperative improvement rating of 3.3. 22.5% received botulinum toxin to the glabellar area after surgery secondary to recurrence of the furrows. No complications of placing the glabellar grafts were noted. The average age control patients who did not receive a glabellar graft was 47.6 years with a range of 38 to 73 years. As in the graft group, all patients underwent an endoscopic browlift. The average preoperative furrow was rated a 1.8 and the average postoperative improvement rating was 1. 45.4% of these patients received botulinum toxin to the glabellar area after surgery for recurrence of the furrows.
Conclusions: Rhytides of the glabellar area are difficult to manage because of the high recurrence rate after fillers, myotomies or myectomies. Our control group is similar with other studies in which patients underwent myotomies of the glabellar muscles in that there was only little improvement in the furrows. Furthermore, over 44% of the patients in the control group had to receive botulinum I injections postoperatively to improve the appearance of the glabellar furrows. With the glabellar grafts in place, the appearance of the glabellar furrows improved on average 75%. In addition, the need of botulinum toxin postoperatively was reduced to 22% of our browlift patients.
References:
1. Vecchione TR. Glabellar frown lines: direct excision, an evaluation of the scars. Plast Reconstr Surg 86:46, 1990.
2. Carruthers J and Carruthers A. Treatment of severe glabellar rhytides with a hyaluronic acid derivative compared with a derivative and BTX-A. Dermatol Surg 29:802, 2003.
3. Alster TS and Garg S. Treatment of facial rhytides with a high-energy pulsed carbon dioxide laser. Plast Reconstr Surg 98:791, 1996.

2:05pm
Question & Answers

2:15pm - A Review of Lateral Canthoplasty Techniques
Robert M. Schwarcz, MD

Objective: To investigate the strengths and weaknesses of different methods of performing a lateral canthoplasty.
Methods: We reviewed the charts of patients referred for evaluation after lateral canthoplasty. Five techniques have been reviewed and either directly performed, treated postoperatively as a referral, or re-created with a cadaver. The lateral canthoplasty techniques reviewed were the dermal orbicular pennant, the lateral tarsal strip, lateral canthal suspension sutures, inferior retinacular canthoplasty, and the lateral retinacular suspension. Each of these techniques are described and shown on digital still photos.
Results: The dermal pennant appears to preserve the lateral canthal angle, yet disrupt the lateral rectus check ligaments causing malposition of the lateral canthus affecting its dynamic movement. The disruption of the anatomy could also lead to lymphatic drainage disruption. The lateral tarsal strip allows placement of the lateral canthus in a more normal anatomic position. Lateral canthal suspension sutures appear to cause least trauma to the area, leaving the canthus in an anatomic position. The Lateral retinacular resuspension, may result in lagophthalmos and persistent overcorrection. The inferior retinacular lateral canthoplasty allows preservation of the lateral canthal angle, although technically easy to perform, it could allow for overriding of the lower over the upper eyelid.
Conclusions: Indications for lateral canthoplasty include lasteral canthal dystopia, entropion, ectropion, horizontal eyelid laxity, floppy eyelid syndrome, and aesthetic rejuvenation. The lateral tarsal strip and lateral canthal suspension sutures appear to restore anatomic function and appearance as compared to other options reviewed.

2:25pm
Advanta (cross linked-ePTFE) an Advanced Permanent Alternative to Biodegradable Peri-oral/Lip Implants
Jim E. Gilmore, MD

Advanta (new cross linked ePTFE) by Atrium Medical Corporation, a scientific company with many years of experience in arterial grafts, provides a permanent and reversible alternative to known lip and perioral -facial fillers. The comparison is made to injectable fillers (hyaluronidase, bovine and human derived collagen) with limited shelf life and potential for foreign body reactions that are not easily reversible. In this presentation the attendees will receive information on the risks/benefits of permanent fillers (e.g. Advanta) that allows for decreased morbidity with ease of surgical implantation in a retrospective study of 700 implant sites over a two plus year period. In this period the following observations were made in the case study:
>nerve injury/dysfunction----0.0%
>extrusion----<0.5%
>infection-----<1.0%
>irregularity and lumpiness---<1.0%
>foreign body reaction----------<0.0%
>patient satisfaction--->90%
The actual details of careful assessment, implant placement, and surgical management will be presented in digital and streaming video format. This will define for the surgeon the proper and exact steps for a successful outcome without complications in a new and emerging technology.

2:35pm
Simultaneous Laser Resurfacing with Facelift
Joseph Niamtu, III, DDS

Objective: Laser skin resurfacing has revolutionized cosmetic facial treatment. Facelift surgery primarily addresses ptotic tissues and does little for skin rhytids. Facelift and CO_2 laser resurfacing are synergistic in clinical outcome to provide improvement beyond what either modality could do alone. Controversy exists over the safety of concomitant facelift and full face laser resurfacing. Some authors report the combination as safe while the literature shows complications including flap and skin necrosis from simultaneous facelift and laser. The author will present a literature review coupled with pearls of experience from the aforementioned cases to illustrate a technique to safely perform full face CO_2 laser resurfacing with concomitant facelift.
Methods: The author will present a multimedia presentation of his experience with simultaneous facelift and CO_2 laser resurfacing in a series of 25 cases performed over the past 30 months. A review of the anatomy and importance of the preservation of vascular perforators as they relate to flap vialbility is reviewed. Safe facelift surgical approaches and laser settings are discussed and the literature reviewed.
Results: 25 cases of simultaneous facelift with full face CO_2 laser resurfacing treated over a 30 month period are presented along with a review of current literature and technical pearls to illustrate the safety of this procedure when basic clinical guidelines are followed.
Conclusions: Simultaneous facelift and full face CO_2 laser resurfacing is a safe and effective procedure. This combination of procedures can offer the patient a greater degree of rejuvenation than either of the procedures alone.

2:45pm
Reducing Complications in Facial Fat Grafting
Curtis Perry, MD

Objective: Fat injection surgery can be among the most dramatically successful and gratifying procedures a cosmetic surgeon performs. Unfortunately many surgeons have avoided or abandoned fat grafting because of complications including nodules, inconsistent results or the often cited concern over longevity of the grafted tissue. Occasionally even when excellent results are obtained there may be ambivalent or negative reactions from the patient due to changes in body image.
Methods: Causes and prevention of the above complications are reviewed. Treatments are also discussed. The author's "cobblestone" injection technique to prevent nodules is explained. Examples demonstrate patient analysis and selection. Grafting as a primary procedure versus adjunctive procedure is presented. Strategies for staging injections and site selection to facilitate the patient's psychological adjustment are reviewed.
Results: Careful preoperative analysis and injection technique greatly increase patient satisfaction and reduce complications.
Conclusion: Fat grafting can achieve slight enhancement to a single area or dramatic contouring and rejuvenation of the entire face. However it presents many pitfalls to the unwary surgeon. The author presents his experiences which will hopefully assist other surgeons to achieve consistent results and avoid many complications.

2:55pm
Question & Answer Session

3:00pm – 3:40pm
Coffee Break in Exhibit Hall

3:40pm
General Session: The Principles for a Beautiful Face
Lasers & Botox®
Moderators: Edward B. Lack, MD & Neil S. Sadick, MD

3:40pm – 4:15pm
Expert Botox® Panel
Jean Carruthers, MD & Alastair Carruthers, MD

4:15pm – 4:45pm
Featured Presentation
An Overview of Ablative and Non-Ablative Resurfacing Techniques
Mario Trelles, MD, PhD

Resurfacing is a popular procedure for the rejuvenation of aged skin. Until very recently, laser resurfacing was the method of choice with strong debate as to which, the CO_2 or the Er:YAG, is 'the best' resurfacing laser. Reports have also appeared on a combination of these laser modalities in the one system. The aims of all these methods are: the total removal of the epidermis to induce the growth of new, young epithelium; and the creation of a controlled zone of Residual Dermal Damage from which angiogenesis and collagenesis produce a tight, superficial dermis. Ablative laser resurfacing produces very good results, but the associated downtime, the persistent erythema, and the risk of complications and side effects present negative factors for patients. In the past few years, nonablative skin rejuvenation has been introduced with a variety of modalities in the treatment of photoaged skin. The aim of nonablative skin rejuvenation is to deliver a controlled dermal wound without harming the overlying epidermis, so that all stages of wound healing occur under the biologic protection of an intact epidermis. Early attempts to achieve this involved the Q-switched Nd:YAG laser at the 1064 nm wavelength, used with and without cooling and absorption accelerators. A non-laser source, electrosurgery using radio frequency, has recently been reported in noninvasive dermal remodeling. The 1320 nm line of the pulsed Nd:YAG in conjunction with epidermal cooling has also been presented as being efficacious and reports that the pulsed dye laser at 585 nm might well offer improvements in dermal remodeling for skin rejuvenation. The development of intense pulsed light (IPL) sources provides another method to deliver the required dermal damage without harming the epidermis. IPL is a powerful pulse of broad spectrum 'white' light from a flashlamp from around 500 nm (in the visible green/yellow band) to around 1200 nm in the near infrared band. IPL has been communicated as being successful in the treatment of vascular and pigmented lesions superficially located, which is a common sign of aged skin. The use of a sequential series of cut-off filters can irradiate dermal tissue through the epidermis, sequentially cutting off the shorter wavelengths while allowing the emission of longer wavelengths to treat vascular, pigmentary and dyschromic conditions. Furthermore, lasers and IPL sources have been reported to be effective in nonablative skin rejuvenation. The excellent histological findings obtained after a series of treatments do not always coincide with the clinical results and patient satisfaction index. We have noticed that a combination of various wavelengths in the same treatment regimen can obtain a visible improvement in the skin condition, and the histological results are often reflected in strong patient satisfaction.

4:50pm
Noninvasive Facial Rejuvenation of Photodamaged Skin in Thai Patients Using Serial, Full-face Fluorescent Pulsed Light Treatments, a Series of 400 Patients with a 12 Month Follow-Up
Tanusin Ploysangam, MD

Background: Photodamaged skin is characterized by rhytids, irregular abnormal hyperpigmentation, epidermal and dermal atrophy, rough skin texture, telangiectasias, laxity and enlarged pores. Nonablative lasers and pulsed light methods have been proven to significantly improve photodamaged skin. This study was to evaluate the role of fluorescent pulsed light (FPL) in the rejuvenation of photodamaged skin.
Objective: The aim of this study was to evaluate and quantify the degree of visible improvement in photodamaged skin following a series of full-face, FPL treatments.
Methods: Four hundred subjects with varying degrees of photodamage were treated with a series of four or more full-face treatments at 2-week intervals using a non-ablative FPL. The treated skin conditions included wrinkles, irregular hyperpigmentation, telangiectasias, rough skin texture, skin laxity and enlarged pores. Fluences varied from 25 to 33 J/cm^2 . Pre and post skin cooling procedure was also implemented. Objective evaluation by dermatologists and subjective evaluation by patients were also conducted to assess treatment results.
Results: All aspects of photodamage including wrinkles, skin roughness, irregular abnormal hyperpigmentation, telangiectasias and pore size showed clinically significant improvement in more than 90% of patients. There was no downtime and scarring. Eighty-five percent of patients were satisfied with the overall results of their treatments.
Conclusion: Treatment of photodamaged facial skin using a serial full face treatments with FPL is an alternative effective noninvasive method for facial skin rejuvenation with no downtime and

5:00pm
Management of Post Inflammatory Hyperpigmentation in the Dark Skin Fitzpatrick IV, V and VI Patient
Patricia A. Dunwell, MD

Objective: To outline safe, proven methods of treating P.I.H.
Methods: 1. Inhibit the formation of more melanin.
2. Exfoliate the epidermis to decrease the number of melanin granules present.
3. Avoid inflammation.
4. Early treatment since recently laid down pigment is easier to clear.
5. Combination therapy with feathering to the surrounding areas to produce better cosmetic results.
Results: Presentation of mismanaged and effectively managed cases.
Conclusions: Scientific, methodical management of P.I.H will result in prevention of unnecessary.

5:10pm
Treatment of Acne Scars with an Advanced Technique of Laser Resurfacing
Saied Vejdani, MD

Objective: Acne scars were treated from the past with many kinds of procedures such as Chemical Peeling, Dermabrasion, Micro dermabrasion, Punch Elevation, Laser resurfacing, non-ablative lasers with deferent efficacies. In this paper we have experienced a highly effective technique with an Erbium yag laser.
Methods: 85 patients (49 Females and 36 Males) were treated from 1999 until 2002. They were in range of 18 to 46 years old and they have a follow up of 4 to 36 months. Resurfacing has held on the edge of the depressed scar with adjusting of laser energy and spot size. First pass has done with lowest energy per pulse (100mj) and with smallest spot size (1mm2) on the edge of the scars with 40% overlap. econd pass with the same energy and with spot size of 2.5mm2 again with 40% overlap. Third pass with the energy of 200 mj with the spot size of 5 mm2. Fourth pass with the energy of 300 and the spot size of 10 mm2 between the islands of scars. Last pass was the total resurfacing with the energy of 800-1200 mj all over the area, all the passes was held with repetition rate of 20 pulse per second.
Results: The pictures of all patients were taken before, 2 days after, 15 days after, 2 months after, and in some cases some months after the surgery. Between 70-85 % of scars were disappeared in all cases after first session of treatment. 95% of patients were satisfied.
Conclusions: This technique offers a different concept of treating acne scar with laser resurfacing. One of the most effective ways for treating acne scars is laser resurfacing with specified method.

5:20pm
The Effectiveness of Laserbrasion to Treat Peri-oral Wrinkles
John P. Fezza, MD

Objective: Laser resurfacing alone can yield disappointing results in the peri-oral area of heavily wrinkled patients. This study assesses combining CO_2 laser with dermasanding (Laserbrasion) to treat deep peri-oral wrinkles.
Methods: 60 patients underwent Laserbrasion in the peri-oral area. CO_2 laser was performed with 3-4 passes followed by dermasanding with sterile silicone carbide 220 grade sandpaper. Outcomes and complication were assessed and compared to laser or sanding alone.
Results: Laserbrasion patients had superior results than laser or sanding alone. Wrinkles reduction was far greater in Laserbrasion patients, and healing was more rapid by 3 days on average. No cases of scarring or infection were noted with Laserbrasion.
Conclusions: Laserbrasion combines laser and dermasanding for superior results to laser alone in the perioral area. The procedure is safe and healing appears to be faster than laser alone. Sandpaper is an inexpensive and easy addition for laser surgeons.

5:30pm
The Treatment of Photodamage and Facial Rhytides with Fraxel (Fractional Photothermolysis)
Cameron K. Rokhsar, MD

Objective: CO_2 laser resurfacing has been the gold standard in the treatment of facial wrinkles and photodamage. However, patients' acceptance of this modality is negatively influenced by long recovery periods. The results of non-ablative laser procedures in reversal of photodamage have been modest at best. We report for the first time the use of a new laser technology, Fraxel (Reliant Technologies, Palo Alto, CA) in the treatment of facial wrinkles. This new laser system achieves its results through a new concept, termed fractional photothermolysis, producing an array of microscopic zones of thermal injury in the skin inter-dispersed within islands of normal skin. Healing time is minimized because in essence only about 20% of the skin surface area is treated in each session.
Methods: 12 patients with facial rhythides corresponding to Fitzpatrick scale 4-9 were treated with the Fraxel laser using fluences of 7-20 joules at 1-4 week intervals. Anesthesia was achieved through a topical 30% lidocaine formulation. Each patient received an average of 4-5 treatments. The areas

were treated so that 2000 Micro-epidermal necrotic debris (MEND) were placed per each square centimeter. Patients were assessed for improvement in texture, dyschromia and wrinkles on the face, neck and the chest.
Results: Significant improvement was seen in all parameters. Biopsies demonstrated new collagen formation. Side effects were minimal and were limited to post treatment erythema lasting a few days, mild edema, and small linear abrasions which healed uneventfully. Patients reported an average pain score of 4-5 out of 10.
Conclusion: Fractional photothermolysis results in significant improvement of facial rhytides and photodamage.

5:40pm
ELOS Technology for Cellulite and Fat Treatment - Combination of Conducted Radiofrequency, Infrared and Vacuum
Neil S. Sadick, MD

Background: Cellulite is a skin condition that appears as dimpled irregularities in the skin. This unsightly condition tends to gather around the thighs, hips and buttocks of women. Cellulite affects 80% of the women world wide, and usually is more of anesthetic problem to those who have low percentages of body fat.
Objective: To determine the safety and efficacy of combined infrared and radiofrequency energy, suction and mechanical manipulation on cellulite.
Methods: Fifteen female patients (age range 25-64) with skin type II-IV with cellulite on the hips, buttocks and thighs were treated two times per week for four weeks with combined infrared and radiofrequency energy, suction and manipulation (Vela Smooth, Syneron Medical Ltd., Yokneam Illit, Israel) - IR power level 2-3, RF power level 2-3, suction level 2-3. Patients were assessed at baseline and at 3-4 weeks after the last treatment using global photography (Nikon S70-Canfield Clinical Systems, Fairfield, NJ), via diameter measurements of the treatment area, histopathologic analysis, and a patient diary. Additionally, a physician evaluation and patient evaluation was performed based on the following scale: 0-25% improvement, 26-50% improvement, 51-75% improvement and 76-100% improvement.
Results: All patients demonstrated improvement in the cellulite appearance as well as reduction in the circumference of the treated site. Average improvement for all patients on the appearance of cellulite was 65%. The perimeter of the hips was reduced by 3.2cm on average and all patients reported skin contraction as an effect of the treatment. No complications were noted and there was not any discomfort noted during or after the treatment. Biopsy analysis and ultrasound studies are ongoing.
Conclusions: Combined infrared and radiofrequency energy, suction and manipulation appears to be an effective and safe treatment approach for the reduction of cellulite.

5:50pm
Enhanced Full-Face Skin Rejuvenation Using Synchronous Intense Pulsed Optical and Conducted, Bipolar Radiofrequency Energy, (ELOS): Introducing Selective RadioPhotoThermolysis
Neil S. Sadick, MD

Background: The authors have previously reported their experience achieving non-ablative skin enhancement performing serial, full-face, intense pulsed light treatments in a large series of patients. Radiofrequency (RF) energy has been used in dermatologic surgery for many decades. A new method for skin renewal electro optical synergy (ELOS), which combines intense pulsed optical energy and conducted bipolar RF energy into a single pulse has been recently introduced.
Objective: The authors report their experience using an intense pulsed light and bipolar, conducted RF energy system on 108 consecutive patients treated with a series of full-face procedures.
Methods: Patients received a full-face treatment every 3 weeks for a total of 5 treatments over 15 weeks. Each treatment consisted of 1-8 full-face and segmental passes using patient-specific optical and RF energies. The number of passes, specific wavelength of pulsed optical energy, and RF energy was determined by the patient's skin type, clinical dyschromia and wrinkle pathology and level of current sun exposure. A total of 540 treatments were performed on 108 subjects. All patients had pre-procedural and post-procedural photographs.
Results: All patients completed a patient-based survey, rating improvement and satisfaction. In addition, results assessment were done by two physicians evaluating the before and after pictures. Overall skin improvement was rated at 75.3%. The overall average wrinkle improvement was 41.2%, with an average Class 1 wrinkle improvement of 64.7%, Class II wrinkle improvement of 38.6% and Class III wrinkle improvement of 20.4%. Improvement in skin laxity was rated at 62.9%. Skin texture was reported improved by 74.1%. Improvement in the appearance of pore size was rated at 65.1%. Average improvement in erythema and telangiectasia was 68.4%. Average improvement in hyperpigmentation and dyschromia was 79.3%. Overall patient satisfaction was 92%. Complications observed were temporary. The overall minor complication rate, including blistering, crusting and stripping, was 8.3%, and major complication rate less than 1%. One small, depressed nasal scar was observed in one patient.
Conclusions: This study demonstrates the safety and efficacy of a new technology using combined intense pulsed light and conducted RF energies for non-invasive skin rejuvenation. The results reported show improvement in wrinkle reduction compared to other non-ablative laser and light-based treatments, and comparable improvement in erythema, telangiectasia and hyperpigmentation to that reported for other intense pulsed light technologies.

6:00pm – 7:30pm
Welcome Reception in Exhibit Hall

FRIDAY, JANUARY 28

7:00am – 9:00am
Bright Eye Conferences

Bright Eye Conference #1
Room – Edward A
An Overview of Ablative and Nonablative Resurfacing Techniques
Mario Trelles, MD

Bright Eye Conference #2
Room – Edward B
New Innovations in Botox®
Jean Carruthers, MD & Alastair Carruthers, MD

Purpose: To enhance awareness of the different new innovations in the field of aesthetic Botox.
Method: A combination of lecture style presentation with 25% session time devoted to discussion. Microphones will be available for the participants from the floor. An examination will be projected before the session starts and again at the conclusion of the session to enhance the learning experience.
Results: The participants will be able to discuss the most recent and significant advances in the field of aesthetic Botox®.

Bright Eye Conference #3
Room – Edward C
Introduction to Computers in Digital Photography, Imaging, and Medical Presentations: Computer Lab
E. Antonio Mangubat, MD & Curtis Perry, MD

This hands-on computer workshop will delve into more advanced uses of computers for presentation and multimedia including: digital photography, computer imaging, archiving, communication and professional presentation. Digital photography is a cornerstone of the electronic office. Is 35mm-photography dead or dying? No more negatives to lose, get reprints on demand, send photos to a colleague via email and use your pictures in a PowerPoint presentation. Computer imaging can be a useful communication tool if used correctly. Seeing how to perform a procedure is vastly superior to a verbal or written description. Finally, integrating all of these technologies into a workable and cohesive system can be overwhelming. We will examine various ways of bringing all of these components together into a workable and efficient system. Come experience the powerful ways that these new and evolving technologies can be used in patient care. Having basic computer knowledge is very important to get the most out of this workshop. For physicians who have little or no experience, please practice with you computer typing in Microsoft Word and know how to open and close files. With these basics, you will come away with a wealth of knowledge and skills. This is a hands-on workshop and you will be taking the photos, importing the photos to the computer, and creating a PowerPoint presentation. This promises to be a true cutting edge workshop on the state-of-the-art of digital imaging and computers in medicine. The wave of the future has arrived. Be there to experience it.

Bright Eye Conference #4
Room – Edward D
The Essential Steps of Rhinoplasty
Leslie Bernstein, MD

9:00am – 9:40am
Continental Breakfast in Exhibit Hall

9:40am – 10:40am
Hair Restoration for the Cosmetic Surgeon
Moderators: E. Antonio Mangubat, MD & Robert V. Cattani, MD

9:40am
Loek Habbema, MD
Hair Transplantation – An Overview of Alopecia Evaluation, Treatment Plans, Mini and Follicular Unit Grafting

9:50am
Martin Unger, MD
An Overview of Scalp Surgery (Reduction, Lifts and Flaps)

10:00am
Robert V. Cattani, MD
Integrating Hair into the Cosmetic Surgery Office

10:10am
E. Antonio Mangubat, MD
Effectiveness of Medical Therapy in Hair Restoration (effects on results and patient retention)

10:20am
Saskia Dejong, MD
Non-Surgical Hair Replacement – When Surgery is Not Possible

10:30am
Neil S. Sadick, MD
Hair Removal Modalities – Effectiveness and Safety

10:40am – 11:00am
AMA Keynote Presentation
The State of Medicine in the United States
Michael D. Maves, MD

11:00am – 11:35am
Election of Officers / Presidential Address

11:35am – 12:00pm
Cosmetic Surgery Foundation: A Year in Review
Capital Campaign - Overview

12:00 – 5:00pm
Social Activities (Golf, Tennis & Whale Watching Tour)

8:00 – 10:00pm
International Reception – Manchester Grand Hyatt
America's Cup Terrace

SATURDAY, JANUARY 29

7:00am – 9:00am
Bright Eye Conferences

Bright Eye Conference #1
Room – Edward A
Periorbital Rejuvenation: Advanced Tutorial
Robert A. Goldberg, MD

Bright Eye Conference #2
Room – Edward B
Chemical Peeling for Photoaging Skin
Gary Monheit, MD & Suzan Obagi, MD

Resurfacing procedures are classified as superficial, medium depth and deep based on depth of injury pattern and resultant degree of skin rejuvenation. Medium depth combination peeling has become the gold standard for safe facial rejuvenation. This can be combined with deeper peeling or laser procedures for more advanced photo injury in the periobital and perioral areas and superficial peeling agents to be used simultaneously on the neck and chest. Combining the various levels of agents for individual cosmetic units will benefit the patient with a safe, natural result. This session will cover the basics of chemical peels varying from light to deep peels. Patient selection, various peeling techniques, and management of complications will be reviewed. Additionally, advances in lasers and light-based technologies will briefly be discussed. Emphasis will be placed on the role of these newer modalities alone or in combination with peels.

Bright Eye Conference #3
Room – Edward C
Introduction to Computers in Digital Photography, Imaging, and Medical Presentations: Computer Lab
E. Antonio Mangubat, MD & Curtis Perry, MD

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Bright Eye Conference #4
Room – Edward D
The Essential Steps of Rhinoplasty
Leslie Bernstein, MD

SATURDAY, JANUARY 29

9:00 – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session: The Principals for a Beautiful Body Liposuction/Fat Transfers
Moderators: Robert F. Jackson, MD & Richard L. Dolsky, MD

9:40am – 10:10am
Featured Presentation
Rethinking Blepharoplasty: Creating Contours That Rejuvenate - Robert Goldberg, MD

Objective: Traditional blepharoplasty techniques are, by themselves, inadequate in many cases to optimally rejuvenate the periorbital complex. Traditional blepharoplasty removes bulges, but hollow contours are often more significant than bulges in creating the appearance of aging.
Methods: An individualized approach to analysis of the upper face involves assessment of bony contour and globe position, skin quality, muscle prominence, orbital fat and fluid bulges, and hollow contours. Hollow contours (which are based anatomically on ligamentous attachments to the skin) include the orbital rim hollow, the septal confluence hollow, and the zygomatic hollow.
Results: A customized individual plan to address periorbital contour problems might include upper face lift, blepharoplasty, skin treatments, Botox®, implants, fillers, and midface lift. Minimal incision techniques are available for all of these interventions.
Conclusions: Surgeries that remove skin, muscle and fat only address a portion of the contours that make the upper face appear aged. Customized analysis of the bony and soft tissue contours of each patient provides a basis for an individualized rejuvenation that may require adding volume rather than debulking.

10:10am
Fat Disruption: A Significant Adjunct to Large Volume Liposuction Efficiency
E. Antonio Mangubat, MD

Objective: The concept of fat disruption is not new. Ultrasonic assisted liposuction (UAL) is an example, but significant equipment expense has decreased its widespread use. In addition, its effectiveness in large volume liposuction (LVL) has not been quantified. This paper describes new instrumentation that permits faster procedures with smoother results with considerably less expense. Last year I reported the use of the Blugerman liposhifting instrument to perform fat disruption and demonstrated it to be comparable to UAL at a fraction of the expense. The new instrumentation presented now makes the process simpler, faster, and more effective.
Methods: 10 patients were selected to compare fat disruption to standard liposuction technique. After adequate anesthesia and tumescent infusion, a unilateral side of the patient underwent fat disruption using the new instrumentation. Then liposuction was performed for exactly 1 minute comparing the disrupted side with the standard side. We then evaluated fat quantities, subjective resistance, subjective smoothness, and cannula sizes that would yield optimal results.
Results: The fat disrupted side was subjectively smoother and provided less resistance intraoperatively in all cases. The disrupted side also provided an average of 39% greater fat aspiration speed than the non-disrupted side. Cannulas ranging from 3mm-8mm in diameter were used to determine efficacy. Surprisingly, the size of aspiration cannula was not significant to yielding smooth results on the disrupted side. This was not true for the non-disrupted side. Fat disruption provided massive improvements in speed without sacrificing smoothness. The average speed of aspiration during this study was 523ml/min of supernatant fat. The maximum speed of aspiration was over 900ml/min using the 8mm diameter cannula.
Conclusions: Fat disruption is a significant improvement in liposuction efficiency providing considerably faster aspiration volumes with smooth results, less fatigue, less expense. The aspiration speeds achieved in this study could only be reliably achieved with fat disruption. Attempted aspiration using large diameter cannulas produced lumpy and unsatisfactory results in the non-disrupted side. Faster liposuction speed has been demonstrated to limit blood loss and thus fat disruption may be thought of as an adjunct to liposuction safety. Moreover, fat disruption is a significant tool for the liposuction beginner, providing a method to produce smoother results without the steep learning curve. The new tools presented provide a cost efficient method for performing fat disruption.

10:20am
Suction, Infrared and Radio Wave: A New Device for the Treatment of Cellulite
Loek Habbema, MD

The treatment of cellulite can be unrewarding. Despite an enormous variety of existing methods of treatment, one clear dominant solution has yet to be found. In the quest for better results in cellulite removal a device has been developed through which both infrared and radio wave frequencies are jointly administered to the tissue and simultaneously retracted in the treatment head. In theory, the re-contouring of skin surface is achieved via a controlled increase of the metabolism in adipose tissue caused by:

- Increasing the blood supply by localized reduction of atmospheric pressure on blood vessels
- Increasing oxygen dissociation from oxy-hemoglobin by superficial heating with infrared

light
- Increasing oxygen intracellular diffusion by deep heating with conductive RF

Additionally, the retraction of skin and subcutaneous tissue in the treatment head mechanically breaks the connective bonds and causes a redistribution of liquids.

A prospective, blinded study is underway applying the treatment on one leg, with the other leg serving as control. A non-involved investigator will grade each leg without knowledge of the treated extremity. We are attempting to provide an accurate photographic method to document the differences in the treated versus untreated leg.

The initial results will be presented. The side effects are mild and consistent primarily of temporary redness, slight tingling sensation, and a short-lived, red-papular eruption immediately following the treatment.

10:30am
Infiltration Techniques of Tumescent Local Anesthesia and their effects
Gerhard Sattler, MD

Since its introduction by Jeffrey Klein in 1985, tumescent local anesthesia has changed and dramatically improved liposuction surgery. Due to different teaching backgrounds this young method has developed worldwide silmultaneously with specific individual features. Since the early 1990s the understanding has grown that tumescent local anesthesia has additional effects to the simple fact of local anesthesia. The change of tissue structure and consistency of the fat, which alterates the mechanical forces developing during the surgery, is an example for the importance, how the fluid is introduced into the surgical site. This relates to the infiltration time, infiltration pressure, infiltration instruments (needles, pump), etc. The steps of infiltration will be demonstrated and discussed as well as their effects.

10:40am
Tumescent Local Anesthesia Peak Serum Lidocaine Concentrations Without Liposuction
Jeffrey A. Klein, MD

Aim: It is desirable to have a safe estimate of the maximum recommended mg/kg dosage of lidocaine (MaxD) for TLA. Current estimates of MaxD are based on data obtained from liposuction patients. One cannot assume all patients will have liposuction after infiltration of TLA. For technical or medical reasons it is possible that liposuction surgery might have to be cancelled after a patient has been given a complete dosage of TLA but before liposuction can be initiated. Furthermore, there are a number of surgical procedures which rely on TLA but do not involve liposuction. Thus estimates of MaxD for tumescent liposuction should be based on patients who have not had liposuction.
Background: In tumescent local anesthesia (TLA) the peak serum concentration lidocaine (P) is a function of the mg/kg dosage of lidocaine, and the concentration of lidocaine and epinephrine in the solution of TLA. Liposuction removes lidocaine before it can be absorbed into the systemic circulation and thereby reduces P. P is correlated with the risk lidocaine toxicity.
Methods: Six adult female volunteers received dilute lidocaine and epinephrine injected by the Monty infiltration technique for TLA. P was determined from sequential serum samples which were taken at times = 0, 1, 4, 6, 8, 10, 12, 14, 18, 24 and 30 hours after completion of infiltration. After the infiltration there was no liposuction. The mg/kg dosage and concentrations of lidocaine and epinephrine in the TLA solution varied between patients.
Results: The maximum of all the peak lidocaine concentrations was 2.9 micrograms/ml. The ranges of dosages of tumescent lidocaine was 30 to 40.4 mg/kg. The mean time of the peak serum concentration of lidocaine was 13.2 hours, range 10 to 18 hours.
Conclusion: A tentative estimate for maximum recommended dosage (MaxD) of tumescent lidocaine is approximately 45 mg/kg without or with liposuction.

10:50am
Why Not to Use IV Sedation in Liposuction Surgery?
Enrique Hernandez-Perez, MD

Objective: We try to prove that this principle is not true when working under ideal conditions.
Methods: A survey was performed between 100 cosmetic surgeons in the USA, Spain and Latin America investigating the use of IV sedation during their procedures, along as the equipment used and the morbidity observed.
Results: All of them currently use IV sedation combined with tumescent local anesthesia in liposuction surgery. On reviewing more than 4,000 cases (carefully chosen patient, anesthesiologist, fully equipped operating room, training of the surgeon on the use of IV drugs) we have not seen any single sedation-anesthesia related complication.
Conclusion: The use of IV sedation plus tumescent anesthesia seems to be safe and comfortable for the patient when working under the conditions mentioned above. We certainly respect the point of view of those surgeons who do not want to use IV sedation in their procedures.

11:00am
The Results of Erchonia Low-Level Laser Treatment on Post-Surgical Pain & Ease of Extraction of Fat in Liposuction Patients
Robert F. Jackson, MD

Neira et al (2002) showed that if surgical sites were irradiated for 6 minutes with the Erchonia low-level laser prior to liposuction, the extraction of fat from adipose tissue surgery was easier. Scanning Electronic Micrographs showed that cell membranes of adipocytes became porous, allowing the intracellular contents to move from inside cells to extracellular spaces, collapsing the cell, and making it easier for mechanical extraction through a liposuction cannula. The result of this research prompted this second multi-center, double blinded, randomized, clinical study with the primary purpose of reproducing Neira's initial results in the ease of fat extraction while collecting data on additional post operative parameters such as pain, swelling and wound healing. Erchonia low-level laser was used on the treatment of patients who underwent liposuction for body contouring in the hip, thigh, stomach and neck and were studied for the low-level laser's effects on ameliorating post-surgical discomfort. Subjects were assigned equally to either the test group who actually received the Erchonia laser treatment; or the placebo group which received "fake" treatment with an inactivated Erchonia laser. VAS pain data was recorded at 24 hours, 1 week, 2 week and 4 week intervals. Individual subjects success criteria (ISC) was defined as a score of less than 30 on a Degree of Discomfort VAS scale at 24 hours post-procedure. Overall study success criteria was defined as a 30% difference between test and placebo groups, comparing the proportion of successes in each group. It was anticipated that at least 50% of the test group would meet the ISC and 20% of the placebo group would meet the ISC. At the time of submission of this abstract, the results showed that 75% in the test group met the ISC criteria of a score less than 30 on the VAS Degree of Discomfort scale; and 32% in the placebo group met the success criteria at post-operative 24-hours. The difference of 43% currently exceeds the overall study success criteria of 30% by 13%. In addition, the other parameter results; "Ease of Fat Extraction", "Emulsification of Extracted Fat", and "Degree of Swelling" were equally impressive and exceeded projected

values and were statistically significant ($p<0.0001$)
Neira R et al, "Fat liquefaction: effect of low-level laser energy on adipose tissue," Plastic & Reconstructive Surgery Sept 2002; 110(3): 912-22.

11:10am
The Effect of Low-Level Laser on the Adipocyte
Susan Mey Lee Lim, MD

The Low-Level Laser has contributed greatly to the efficacy of liposuction. The Lipoaspirate obtained was noted to be emulsified and extracted with ease. Samples of adipose tissue were studied at various time intervals (following exposure to Tumescent and Low-Level Laser). The samples were studied using:
1)Light Microscopy
2)Conventional and Scanning Electron Microscopy
3)Transmission Electron Microscopy
Findings were similar on all 3 modalities and revealed initial swelling of the adipocyte followed by formation of a transitory pore at the cell membrane. Progressive disruption of the cell membranes then gave rise to release of fat into the interstices.

11:20am
Question & Answer Session

11:30am – 12:00pm
Featured Presentation
Recent Developments in Liposuction Surgery
Loek Habbema, MD

The removal of fat tissue is a rewarding procedure producing for the most part highly successful results. For that reason liposuction has been one of the most popular cosmetic surgical procedures for many years. Despite the enormous amount of performed procedures, relatively little research in the field of liposuction has been done. In many publications and presentations even basic clinical data is lacking. Simple documentation of observations can help to better understand the principles and will hopefully lead to enhanced safety, improved cosmetic results, and the development of new indications for the future.
• Monitoring the results of the liposuction with the patient in a standing position during an operation improves the cosmetic result. The disadvantages being the prolonged operating time, the additional time required to maintain sterile conditions and the leakage of tumescent solution whilst the patient is upright.
• Measuring the amount of aspirated supernatant fat is considered to be relatively easy. However, studies have shown that the separation time of the aspirate can be much longer then the generally assumed period of thirty minutes.
• A lower lidocaine concentration in the tumescent solution reduces the plasma lidocaine level. Care should be taken not to use higher lidocaine concentrations than necessary, thus requiring a more precise and accurate method of infiltration of the tumescent solution.
Greater experience has turned up further possibilities to expand the role of liposuction in both medical and cosmetic procedures:
• Breast reduction by liposuction now seems to be an adequate treatment in selected patients, with a higher safety profile and less scarring when compared to excision.
• Lipedema patients, an all too rarely diagnosed condition, seem to benefit enormously from liposuction.
With these indications cosmetic surgery penetrates the field of medical indications, bringing the cosmetic and medical oriented communities closer together, and hopefully expanding the potential for further scientific research in the field of liposuction surgery in the future.

12:00pm – 1:10pm – Lunch in Exhibit Hall

1:10pm – 2:00pm
Richard C. Webster Lecture
Leslie Bernstein, MD
Early History of Facial Plastic Surgery

COSMETIC SURGERY FOUNDATION

2:00pm
General Session: The Principals of a Beautiful Body Breast & Body
Moderators: Michael H. Rosenberg, MD & Robert A. Shumway, MD

2:00pm - Subpectoral TUBA
Robert A. Shumway, MD

Objective: Transumbilical Breast Augmentation (TUBA) was first described in 1991 by Dr. Johnson in which he explained the subglandular approach. Since then, the subpectoral placement of saline implants via the TUBA method has become popular. My objective is to show physicians that the subpectoral approach using the TUBA procedure gives excellent results and can be a powerful alternative to subglandular augmentation.
Methods: This is a retrospective chart and photographic review of the last one thousand TUBA procedures performed by the author. The 1,000 cases are divided into 557 subpectoral and 443 prepectoral operations. The cosmetic results were reviewed photographically and by patient satisfaction through chart review. Any complications were noted and documented for each approach. The age range was females between seventeen and sixty-seven years of age.
Results: There were relatively few complications which included 3.6% capsular contracture in the subglandular approach and 3.1% capsular contracture for the subpectoral group. There were two implant extrusions, one subglandular and one subpectoral. Asymmetry was generally improved postoperatively in over 99% of both types of TUBA. Patient satisfaction was very high in both groups. The mean age of prepectoral patients was 38.1 years of age which the mean age of the subpectoral cohort was 25.3 years of age.
Conclusions: TUBA is a very viable alternative to other breast augmentation approaches whether implant placement is performed above or below the muscle. The cosmetic results are superb, but younger patients tend to favor the subpectoral position of their implants. The capsular contracture rate is slightly lower with the subpectoral implants while healing time was short with both approaches. In summary, with low complication rates and high patient satisfaction, the subpectoral TUBA is an excellent procedure, especially for younger patients.

2:10pm
Transaxillary Sub-Pectoral Fascia Augmentation Mammaplasty
Craig M. Davis, MD

Objective: Augmentation mammaplasty is one of the most popular cosmetic surgery procedures and is generally associated with a high degree of patient satisfaction. Traditionally, implant position has been subglandular or submuscular. A subglandular pocket is useful in active patients with concerns of potential implant movement during pectoral muscle contraction and in patients with fuller, ptotic breasts. Submuscular placement is thought to result in less capsular contraction, rippling and postoperative hematomas than subglandular placement. This abstract describes over five years experience from two centers with the sub-pectoral fascia augmentation mammaplasty technique.
Methods: Following a detailed evaluation, patients are started on Levaquin 500 mg p.o. the night before surgery and continued b.i.d. for five days following surgery. Patients are instructed to bathe with anti-infective soap the night

prior and the morning of surgery. The planned inframammary creases are measured and marked seven to 8 cm inferior to the center of the nipple. The thorax is circumferentially prepped with Technicare, and general anesthesia or conscious sedation employed. From the axillary approach, the superolateral pectoralis major muscle fascia is opened from lateral to medial for 2-3 cm with large Metzenbaum scissors. Blunt finger dissection initiates the implant pocket, freeing pectoralis fascia anteriorly from the underlying muscle fibers. The pocket is enlarged and tailored with MacCollum and Agris-Dingman dissectors. Sizers are inserted into the pockets and inflated 1.5 times the planned implant size, then removed. Adjustments are made; the pockets irrigated with gentamicin solution, the axillary incisions painted with Technicare and fresh gloves donned prior to placement and inflation of Mentor Smooth Round High Profile Saline Mammary Implants. Position and symmetry are evaluated in the supine and upright positions. Adjustments are made and the axillary incisions closed after diligently checking for and achieving hemostasis. Patients are placed in a supportive crease establishing garment for at least 24 hours, and seen the following day.
Results: Since 1998, 2535 primary augmentation mammaplasty procedures have been performed on patients ranging in age from 18-75, utilizing the sub-pectoral fascia position for implant placement. Postoperatively, patients have done well with this technique achieving esthetically pleasing results with no alteration of function. The pectoralis major muscle fascia provides a strong, stable tissue layer over the implant, which lessens the likelihood of rippling, prevents implant movement with muscle contraction, and can be useful for subsequent lifting procedures. The complication rate has proven to be equal to or better than other techniques with less incidence of capsular contraction, rippling, infections, and hematomas; while postoperative pain, incidence of Mondor's disease and deflations are comparable to other techniques.
Conclusions: Transaxillary subpectoral fascia augmentation mammaplasty offers benefits of submuscular and subglandular techniques, with a comparable or lower complication rate.

2:20pm
Subfascial versus Subpectoral Breast Augmentation
Patrick G. McMenamin, MD

The placement of saline breast implants in the subpectoral pocket is done to decrease scarring, improve mammography, and decrease rippling. However, many more suboptimal results occur with subpectoral placement due to implant settling, variable healing, tethering, movement dynamics, and other considerations. Developed by Dr. J. Dan Metcalf in the 1990s, subfascial placement of the implants greatly improves the appearance, recovery process, controlled healing, and long-term results of saline breast augmentation. Dr. Howard Tobin has demonstrated almost 50 percent occurrence of rippling with subpectoral placement. We have not experienced an increase in rippling with subfascial placement. Approximately 200 subfascial implant patients over three years comprise the data for this comparison. Photo analysis of postoperative results will be used to compare the techniques. Our results lead us to conclude that subfascial placement of saline breast implants are better than subpectoral placement.

2:30pm
Six Year Study of Teardrop Saline Textured Mammary Implant
Robert H. Burke, MD

Objective: Examine the six year experience of the Michigan Center for Cosmetic Surgery with the Inamed style 468, tear drop shaped saline textured implant.
Methods: A retrospective chart review was conducted. This included only those women in whom bilateral augmentation mammaplasty was performed utilizing the style 468 implant. A total of 107 patients were treated (214 implants placed). All implants were placed submuscularly through a lateral inframammary incision of 4 cm. or less. The implant pocket was irrigated with 1% betadine solution followed by two irrigations with normal saline. All implants were soaked in dilute gentamycin solution prior to placement (none of the patients were allergic to betadine or gentamycin). One dose of antibiotic solution was administered intravenously prior to implant placement (either cephalozin or cleocin depending on the history of allergy). Postoperatively, elastic tape was placed circumferentially. This tape was removed at the 7th postoperative day. A support garment was placed and worn by the patient for the first postoperative month.
Results: The age range was 19-54 years. The average age was 36.3 years. Implant sizes ranged from 195-495cc. The average size placed was 308.5cc. There were no infections. There were no cases of permanent nipple or breast numbness. There were no cases of implant malposition not associated with capsular contracture. There were no postoperative malrotations. 4 deflations occurred, requiring implant replacement. There were 6 grade III capsular contractions, significant enough at 1 year postop that capsulectomy and implant replacement were performed. 4 patients desired larger implants (1.9%). The overall complication rate was 4.6%. The deflation rate was 1.9%. The capsular contracture rate (grade III) was 2.8%.
Conclusions: This study confirms the 6 year effectiveness of this implant at the Michigan Center for Cosmetic Surgery. Complications were minimal, and compare favorably with other implant styles. Of significance is the lack of malposition and postoperative implant movement or malrotation, which may be related to meticulous submuscular pocket development and placement. The combined prophylactic antibiotic protocol, implant pocket irrigation, and irrigation of the implant with antibiotic solution was 100% effective as no infections were encountered.

2:40pm
The Pocket Protector: 100 Cases
Mark Berman, MD

Objective: A new e-PTFE breast implant device - the Pocket Protector - was developed to optimize results in breast augmentation. The device prevents capsular contraction while allowing for placement of smooth gel or saline implants thereby providing soft, more natural feeling breasts while providing an integrated barrier with the body. The device has been used in both primary and revision breast augmentation.
Methods: Primary breast augmentation or revision augmentation, usually with total capsulectomy, was performed in 100 patients utilizing an e-PTFE bladder (the Pocket Protector) and smooth gel or saline implants. Many of the patients had previously undergone multiple procedures and failed to ever maintain soft breasts. Data was collected on all patients to determine their breast type, pre-operative status, operative materials, and post-operative status.
Results: All of the patients had improved results with the Pocket Protector. There were three patients that had bothersome rippling of moderate profile gel implants under very thin skin. At least one of them has been successfully treated by replacing her implant with a high profile gel

implant. Two patients developed "flu" syndrome in the immediate post-operative period with subsequent intractable seromas necessitating removal of the Pocket Protector. Both patients were subsequently successfully revised with the Pocket Protector several months later. One patient, who had ruptured gel implants with multiple silicone granulomas, developed a Class II capsule contracture that necessitated revision with a Pocket Protector six months later.
Conclusions: The Pocket Protector maintains integrity of the breast pocket by integrating with the body without scar tissue formation. This prevents the pocket from sealing down on itself, thus maintaining patency. This thus allows for placement of a smooth gel or saline implant. The breast remains soft and more natural than current saline implants, submuscular implants, or textured implants. A smooth implant helps minimize rippling (though softer shells would help even more). The Pocket Protector provides a barrier against potential rupture and possibly even systemic infection. It serves as an internal brassiere. It allows for easy exchange of implants without the need for capsulectomy or capsulotomy. It also is useful in traditionally difficult reconstructive cases, such as subcutaneous mastectomy. It has become the optimal treatment of choice in my breast augmentation practice.

2:50pm
Question & Answer Session

3:00pm – 3:40pm
Coffee Break in Exhibit Hall

3:40pm – 4:10pm
Featured Presentation
Breast Augmentation - Benefits of the Axillary Approach
Jan Saether, MD

Methods: Careful education of the patients before surgery, routine in axillary endoscopic breast augmentation, and supporting the patients after surgery.
Results: Very happy and satisfied patients will increase your reputation among your patients.
Conclusions: The breast augmentation patients are very demanding, and need a lot of information and support, before during and after surgery. But if you manage the task, you will have many very faithful patients for a long period.

4:10pm
Preventing Thromboembolism During Abdominoplasty
Michael H. Rosenberg, MD

Thromboembolism is a well-described risk of surgery, and it is estimated that there are more than 150,000 deaths from pulmonary embolism each year in the United States. Abdominoplasty, alone or in combination with other abdominal procedures, has been shown to have an incidence of deep venous thrombosis of greater than 1%. It has been theorized that abdominoplasty interferes with the superficial venous drainage from the pelvis and lower extremities, and thus increases the chance of deep venous thrombosis and pulmonary embolism. We present our experience with abdominoplasty without the use of general anesthesia as a means of significantly decreasing the risk of a thromboembolic event. A recent study of deep venous thrombosis and pulmonary embolus after facelift showed a five fold higher incidence when general anesthesia was used, compared with patients under local anesthesia. We recently published our experience with abdominoplasty with procedural sedation and analgesia, and decided to retrospectively compare our group of patients utilizing this anesthesia method compared to patients of ours undergoing general anesthesia. We compared 125 patients who had their abdominoplasty under local anesthesia with procedural sedation with 300 matched patients who had general anesthesia. All procedures were performed with an anesthesiologist providing sedation and intra-operative monitoring of our patients. Our sedation protocol utilizes procedural sedation and analgesia, which results in a depressed level of consciousness, but one that allows the patient to maintain airway control independently and continuously. For purposes of this study, a deep venous thrombosis or pulmonary embolus was recorded only when a combination of clinical findings (calf pain, shortness of breath) and diagnostic testing (positive duplex scan, VQ scan, venogram, or pulmonary angiogram) confirmed the diagnosis. Patients were matched for age and sex, length of surgery, anesthetic agents used, and what, if any, ancillary procedures were performed. Thromboembolic events were counted if they occurred within three months of surgery. There were no thromboembolic events in the 125 patients who underwent abdominoplasty, including full fascial plication of the rectus and external oblique aponeurosis, with or without ancillary procedures, under local anesthesia. There were three cases of deep venous thrombosis in the general anesthesia group, and no documented pulmonary emboli. There was no mortality in either group. All patients in both groups had flowtron stockings used for prophylaxis. We suggest that another advantage of our technique of performing abdominoplasty without general anesthesia is a statistically significant decreased incidence of thromboembolic events ($p<0.05$).

4:20pm
Experiences with the Vertical Breast Reduction and Mastopexy
Theodore E. Staahl, MD

Objective: The vertical breast reduction technique and long term results will be presented.
Methods: Patient preoperative and postoperative photos are used to show the incision choices and modifications in vertical breast reduction. The use of liposuction is an integral part of the procedure.
Results: The long term results will show the stability of this surgery.
Conclusions: There are many techniques for breast reduction. The vertical breast reduction creates incisions only on the breast and eliminates the anchor scar which can be problematic in the Wise pattern.

4:30pm
Radiology and its Application to Planning Lipoplasty
John H. Flynn, MBBS

Objective: Lipoplasty is one of the most commonly requested cosmetic procedures in Australia and most likely in the USA as well. An intimate knowledge of surface anatomy is essential in the practice of lipoplasty and to this end I present a review of the relevant anatomy of neck, abdomen and lower limbs.
Methods: A series of CT scans of selected patients is presented to show a different perspective of the internal anatomy of particular patients. When we view a patient in assessment for surgery it is helpful to have an idea of the appearance of the adipose layers and how they relate to external appearance. The location and appearance of adipose collection provided a surprise for me when I embarked on this survey. This series was prompted by difficulties in assessing patients for lipoplasty of the calves and ankles and also of the neck. What extent is lymphoedema a factor in thick ankles and what role does subtle changes in muscular anatomy play a part in the external appearance of legs? In the neck, what are the relationships of the larnyx, hyoid, platysma. How much

adipose is pre platysma and how much is post?
Results: Review of CT films.
Conclusions: Radiology is a useful tool in the planning of lipoplasty and also a good educational aid in visualizing anatomy.

4:40pm
Episcan Ultrasound in Plastic Surgery
Brenda C. Edmonson, MD

Introduction: Ultrasound has not had the resolution to evaluate the skin adequately until recently.[1] The Episcan ultrasound instrument has been developed and uses a 20 Megahertz probe to evaluate the epidermis, dermis, subcutaneous tissue, including muscle and collagen, and blood vessels in real time up to a depth of 15 millimeters. [1] Current uses of this technology include the evaluation of skin wounds and surface changes in wounds preceding ulceration. [1] Ultrasound also has been used to assess skin changes including collagen remodeling after skin resurfacing.[1,2]
Methods: The Episcan ultrasound has proven useful in a busy cosmetic surgery practice. It can be used to document changes in the skin before and after the application of various cosmeceuticals and injectables.
Results: Use of the ultrasound provides great correlation with skin changes that occur from topical cosmeceutical applications. Skin thickness beyond qualitative judgment of surface appearance or photographic documentation is possible with the Episcan. Ultrasonic changes can be seen earlier than surface appearance changes and thus can be used to demonstrate the effectiveness of the resurfacing and cosmeceuticals to patients. We present representative examples of skin changes visible with the ultrasound in pre- and posttreatment patients.
Conclusion: Ultrasound technology provides a noninvasive tool to examine pre- and post-treatment skin changes after laser and cosmeceutical application. It is also beneficial in postsurgical evaluation of patients to distinguish edema from hemorrhage.
References:
1. Aguilar N, and Feste JR. The evolution of ultrasound imaging. Skin,Inc. 2003:60-68.
2. Moody BR, McCarthy JE, and Hruza GJ. Collagen remodeling after 585-nm pulsed dye laser irradiation: an ultrasonographic analysis. Dermatol Surg 2003; 29:997-1000.

4:50pm
TUBA Safety
Robert A. Shumway, MD

Objective: Safety is the prime objective of any "new" procedure. After ten years of experience with transumbilical breast augmentation (TUBA), this study is a review of how TUBA is performed safely with excellent results.
Methods: A recent group of five hundred consecutive cases were reviewed and divided between subglandular and subpectoral TUBA approaches (36% subglandular, 64% subpectoral). All cases were performed using tumescent anesthesia techniques. Implant sizes ranged from 210 cc to 850 cc. TUBA was performed with McGhan (Inamed) smooth shell saline implants. A safety checklist was created and followed to ensure uniformity and safety compliance. Any complications were documented. Patient follow-up was weekly or monthly for at least six months.
Results: This consecutive retrospective chart review of a recent cohort of patients undergoing TUBA procedures reveled several important safety concerns. Specifically, patient screening for general health, appropriate expectation and augmentation size, prior breast surgery and family history, any prior upper abdominal liposculpture, breast shape and symmetry, pregnancy history, congenital issues, tolerance to local anesthesia, medication use, ASA levels, and a patient's ability to be thoroughly consented were initial screening factors that were considered prior to TUBA. If patients did not pass this initial safety screening for TUBA, they were not considered for surgery. Anesthesia safety with the tumescent technique was discussed with each patient and used as appropriate. Most importantly, there were three TUBA safety pearls that I gleaned from this study that must be understood by all TUBA surgeons.
Conclusions: TUBA is an extremely safe procedure when the proper safety protocol is in place and followed by safe tumescent anesthesia techniques. The three most important intra-operative safety issues that I have found from this study are: 1) how to stop any TUBA bleeding, 2) how to preserve nipple sensation for your patients, and 3) how to virtually eliminate the chance of infection from augmentation. These three extremely important safety factors will be presented in full detail.

5:00pm
Abdominoplasty Following Gastric Bypass Surgery
Michael H. Rosenberg, MD

Goals/Purpose: Gastric bypass surgery for morbid obesity is increasing dramatically, and many of these patients may request body-contouring surgery after massive weight-loss. It is estimated that more than 145,000 patients will have some form of gastric bypass surgery in 2004, which is up from 103,000 in 2003, and 65,000 in 2002. It is our opinion that this specific population may be at increased risk for complications following cosmetic surgical procedures. The purpose of this paper is to discuss our approach to this group of patients, as regards abdominoplasty, and to quantify that risk.
Methods/Techniques: We identified 50 post-bariatric patients in our practice that underwent a panniculectomy or abdominoplasty (with or without hernia repair) between 1999 and 2003. All charts were reviewed and pre-surgical data, operative techniques, post-op course, wound and medical complications were noted. The operative technique and approach to these patients were reviewed. All abdominoplasty patients were at least 1 year beyond their gastric bypass. These included 38 females and 12 males, aged between 28 and 57 years. They lost an average of 175 pounds. Patients weight at the time of surgery ranged between 125 and 304 pounds. All co-existent medical conditions were under control. Nutritional status was normal, based on routine preoperative lab studies.
Results/Complications: 25 of 50 patients (50%) had no complication. 16 patients (32%) presented with seromas requiring drainage. 7 (14%) had partial dehiscence of their abdominal wound and 2 (4%) required debridement and closure. One patient returned to the operating room for delayed closure 4 weeks after surgery. Two patients (10%) received prolonged oral antibiotics for superficial cellulitis but none were rehospitalised. No patient presented with systemic medical complications, including deep venous thrombosis or pulmonary embolus, and there was no mortality in this series of patients. The reported complication rate for elective abdominoplasty ranges from 0.3 to 5% dehiscence rate, 7% infection, and from 6% to almost 50% occurrence of seromas. Obesity is a known cofactor in complications, but the rate for abdominoplasty in the massive weight loss population is not well defined.
Conclusion: In our experience, post-bariatric patients can safely have reconstructive cosmetic abdominal surgery. Although our gastric bypass patients were more likely to develop complications than cosmetic abdominoplasty patients, none of them regretted the decision to have their procedure.

5:10pm
Resident Paper Contest Winner
Adil Ceydeli, MD, MS
'Tear Drop' Augmentation Mastopexy: A Technique to Augment Superior Pole Hollow

COSMETIC SURGERY FOUNDATION

Goals/Purposes: Breast ptosis classification systems focus on the inferior descent of the nipple, as well as the descent and distribution of the breast parenchyma below the inframammary fold. Common problems, such as the development of a superior pole hollow and an excessive width of the superior pole, extending into the axilla, are not addressed. Here, we present a technique – "Tear-drop" augmentation mastopexy – that addresses superior pole hollow, excess superior pole width, as well as breast ptosis and hypomastia.
Methods/Techniques: Patients with moderate to severe breast ptosis (Regnault's classification), tubular breast deformity, and deformities secondary to previous breast surgery are included in the study. Skin is deepithelialized through a circumareolar incision, and a skin-fat flap is elevated completely encircling the breast. A 2-cm area of parenchyma is left attached to the skin in the lower half of the breast. Breast parenchyma in the superior half of the breast is then advanced and plicated in a superiomedial direction to move the nipple areolar complex to the desired new position. Care is taken to redefine the pectoralis major muscle at its axillary border. A 3-cm incision is then placed in the inferior part of the parenchyma at 6 o'clock position to create a subpectoral pocket for placement of the implant. The tunnel is then closed to separate the implant pocket from the subcutaneous dissection. Residual dermal flap is used to define, and add durability to the parenchyma reshaping procedure. A 3-0 mersiline (Ethicon) blocking suture is used for a uniform circumareolar skin closure.
Results/Complications: Patients (n:35), ages 17-48 underwent "tear-drop" augmentation mastopexy between 1999-2002. The average follow-up was one year. All patients displayed type 1 or 2 capsules. One subcutaneous hematoma and one subcutaneous seroma were seen. No submuscular hematomas, infections, skin or nipple losses, or hypertrophic scars were noted. A more natural "tear-drop" breast shape was created with an improvement in the superior pole hollow and narrowing of the superior breast.
Conclusions: The "tear-drop" augmentation mastopexy is a novel technique for the correction of the breast ptosis with augmentation, avoiding problematic development of superior pole hollow and excess superior width. This technique is also well applied to tubular breast deformity as well as to secondary breast procedures.

5:30pm
Adjourn

7:00am – 11:00pm
CSF Recognition Gala "Visionaries of the Past and Present"
(invitation only)

SUNDAY, JANUARY 30

7:00am – 9:00am
Bright Eye Conferences

Bright Eye Conference #1
Room – Edward A
Male Cosmetic Surgery
Jeffrey B. Schafer, MD

Male cosmetic surgery is on the rise. It is an excellent addition to your practice - half of the people out there in need of your skills are men. Men want treatment for their gynecomastia, excess fat deposits and lack of masculine shapes. This is the age of the "Metrosexual" (Girlie Men in California). This presentation/discussion will highlight: 1. Marketing to the male 2. Surgical techniques for male breast reduction or pectoral implants, tummy tucks and quick recovery facial surgeries. 3. Spa procedures and cosmedeutical products geared to the male. 4. Proper equipment for the surgery to get the correct result.

Bright Eye Conference #2
Room – Edward B
Facelifts
William Beeson, MD

Bright Eye Conference #3
Room – Edward C
Veins & Sclerotherapy
Neil Sadick, MD & Mitchel P. Goldman, MD

Bright Eye Conference #4
Room – Edward D
Breast Augmentation – Benefits of the Axillary Approach
Jan Saether, MD

9:00am – 9:40am
Continental Breakfast in Exhibit Hall

9:40am
General Session: New Horizons in Cosmetic Surgery Young Surgeons of Our Future
Moderators: Suzan Obagi, MD, Angelo Cuzalina, MD, DDS & Patrick G. McMenamin, MD

9:40am
Mid-Face Enhancement by Autologous Fat Augmentation
Suzan Obagi, MD

Objective: Proper evaluation of the aging patient shows that many of the "stigmata" of an aging face is related to volume loss rather than to gravitational changes. Addressing facial volume is critical to optimizing cosmetic surgery results.
Methods: The author will review current methods of mid-face rejuvenation. The author will present a representative sample of patients in whom autologous fat augmentation was used to rejuvenate the mid-face region. The surgical technique will be briefly described.
Results: Long term results of patients will be shown. Patients requiring more than one session of fat augmentation will also be shown.
Conclusions: Using stringent evaluation criteria, the use of fat augmentation as described above can be shown to effectively achieve rejuvenation of the mid-face.

9:55am
Pearls and Pitfalls of Clinical Digital Photography and Imaging
Joseph Niamtu, III, DDS

Objective: Clinical photography is a mainstay of cosmetic surgery. Accurate clinical images are paramount to assess ones outcomes and skills, serve as a legal record as well as to use for publications, lectures, marketing and patient education. Even some of the most renowned lecturers and authors exhibit poor quality, unstandardized clinical images which detract from their ability, credibility and professionalism. It has never been easier to take accurate, standardized and reproducible clinical images and make them work for you and your practice.
Methods: The author will illustrate simple clinical methods to use off the shelf digital cameras and computers to take better and more accurate clinical images. Pearls and pitfalls

of proper digital photographic technique will be discussed as well as common photographic mistakes. Choice of background, lighting, cameras, digital media, downloading, archiving, emergency data recovery, back up strategies, marketing, patient education and new frontiers in imaging will be discussed.
Results: Excellent digital clinical photography is possible when basic guidelines are followed. There are simple pearls that if followed ensure accurate and standardized clinical images. These images can be useful to the doctor, staff, office and patients in many ways.
Conclusions: Taking accurate clinical images has never been easier. By following simple rules and understanding some of the differences between digital photography and older film photography methods every doctor can take standardized and useful images. Computer technology has made using images very easy and valuable to enhance any cosmetic surgery practice.

10:05am
Investigation of a Novel Cross-linked Hyaluronan Hydrogel For Use As a Soft-tissue Filler
James Chan, MD

Objective: To investigate an innovative tyramine-based hyaluronan (TB-HA) biomaterial for soft-tissue augmentation. Specifically to test: 1) the ability of the TB-HA biomaterial to be injected subcutaneously; and 2) to test the in vivo response of the TB-HA biomaterial in an animal model.
Background: Hyaluronan (HA) is a normal component of most tissues and as such is non-immunogenic, non-toxic and non-inflammatory. Cross-linked hydrogels are formed from HA by substitution (~5%) with tyramine followed by enzymatic cross-linking with peroxidase in the presence of very dilute hydrogen peroxide. From a single formulation of tyramine substituted HA (TS-HA), a full spectrum of biomaterial properties can be produced by varying the HA concentration prior to cross-linking. The properties of these biomaterials ranged from a soft, optically clear hydrogel (6.25 mg/ml) suitable for soft-tissue augmentation as an injectable, to a paste-like material (12.5-25 mg/ml).
Methods: The hydrogel was evaluated in vivo as an injectable (6.25 mg/ml). The material was injected into the subcutaneous tissue of an adult Sprague-Dawley rat, harvested at 8 weeks, and evaluated grossly and histologically. The specimens were paraffin embedded, sectioned on a microtome and stained with hematoxylin and eosin.
Results: In vivo analysis of the TB-HA hydrogels at 8 weeks revealed that they were resistant to degradation. Histologic analysis revealed no evidence of rejection or tissue inflammatory response.
Conclusions: Novel enzymatic cross-linking of HA enables the development of a versatile new biomaterial that can be used for soft-tissue augmentation. Preliminary in vivo analysis in an immunocompetent rat model revealed that the hydrogel material resisted degradation and did not elicit a host inflammatory response.

10:15am
A New Paradigm of Surgical Management of the Atonic Face
Robert Schwartz, MD

Consequences of facial paralysis are functionally and cosmetically debilitating. Surgical facial suspension in patients with facial nerve palsy is characterized by inexorable recurrent descent of the atonic tissues. Over the years, numerous variations on techniques including muscle and fascia flaps, deep plane or periosteal dissection, and multiple vector fixation, have proved disappointing with regards to substantial long term improvement. This experience has allowed us to reassess the basic philosophy of rehabilitation in facial paralysis. The more invasive surgeries are not permanent and frequently require re-operation. An alternative approach accepts and anticipates the need for repeat procedures, and utilizes minimally invasive techniques designed for maintenance re-operation. We report our experience with a layered multivector cable suture suspension technique to address the atonic descent of the eyebrow, eyelid, midface, and lower face in facial palsy. Two approaches are described: a keith needle with gortex or nylon suture passed from the nasolabial fold to the deep temporalis fascia; this can be performed in a multi vectored manner securing the cables in the deep dermis. To address the ocular complications in the atonic face, upper and lower eyelid adjunctive techniques are briefly reviewed. This paper will highlight experiences with cable suspension sutures addressing many aspects of facial paralysis including its ocular manifestations. Finally, to address the lateral oral commissure droop we discuss a localized technique involving upward positioning of the area via removal of an ellipse of tissue extending to the level of the orbicularis oris muscle.

10:25am
Submentoplasty and Advanced Chin/Neck Rejuvenation
Angelo Cuzalina, MD, DDS

Achieving a beautiful and youthful jaw line and neck contour is a common desire for many cosmetic surgery patients. Often, isolated facelift surgery performed by an assortment of lateral pulling or lifting techniques is performed as an isolated procedure to improve the jowls and neck. A submentoplasty may be mentioned briefly as part of the procedure, but it is not well described and not given the credit it deserves for its role in long term aesthetic neck improvement. In addition, the role of chin augmentation to improve a weak chin projection is critical to obtain good facial proportion as well as maximum neck aesthetics particularly when a patient has an anterior or low hyoid position. Arguments over whether to do a 'mini' facelift versus a deep plane technique often are irrelevant if a weak chin is not addressed or a good submentoplasty is not performed. Submentoplasty and chin augmentation can be invaluable tools to enhance lower face and neck rejuvenation with or without a facelift. In fact, there are many instances where proper treatment planning can yield exceptional neck results with isolated submentoplasty and/or chin enhancement. Most patients want a nice chin neck angle, and many prefer to avoid a 'facelift' if possible. A variety of surgical techniques may be performed through a small one inch submental crease incision including partial submandibular gland resection for gland ptosis or hyperplastic fullness. This discussion will focus on how to obtain dramatic lower facial and neck improvement not only with facelift surgery, but in many cases with only a submental crease incision. Appropriate patient selection and fundamental techniques are described. Avoiding common mistakes and management of complications is also addressed. Specific techniques for advanced submentoplasty maneuvers will be addressed to improve the chin neck angle even in extremely ptotic necks, along with achieving long-term stability with minimal relapse.

10:40am
Autologus Pedal Extensor Tendon for Frontalis Suspension Correction of Blepharoptsois with Poor Levator Function
Jeremiah Tao, MD

Blepharoptosis with poor levator function is commonly repaired with a frontalis suspension procedure. A variety of suspension materials have been used, including autologous fascia lata, banked fascia lata, Supramid (S. Jackson, Inc., Alexandria, Virginia), Gortex (WL Gore & Associates, Inc., Flagstaff, Arizona), Silicone (Dynarod, Palmer, Puerto Rico), and Mersilene (Ethicon, Inc., Somerville, New Jersey). Autologous materials offer the advantage of less rejection and granuloma formation, and lower rates of ptosis recurrence. Autologous fascia lata, although commonly used, has been associated with hemorrhage, scar problems, pain, and muscle herniation over the harvest fascia site. In addition, sufficiently long autogenous fascia is sometimes not readily available. We describe the use of autologous pedal extensor tendon for frontalis suspension.
Methods: In a retrospective study, the authors evaluated 8 frontalis sling suspension surgeries using pedal extensor tendon in 8 consecutive children with congenital ptosis. The method of harvesting the pedal extensor tendon is described in detail.
Results: All ptotis eyelids were successfully corrected with good final lid position. No recurrence of ptosis was encountered. No exposure keratitis, wound infection, eyelid contour abnormality, or ptosis overcorrection occurred. There were no complications associated with the pedal extensor tendon donor site.
Conclusions: Frontalis suspension with autogenous pedal extensor tendon appears to be cosmetically sound and effective treatment for congenital ptosis with poor levator function in children. Its use as an alternative material to fascia lata for sling surgery can be considered.

10:50am
Comprehensive Glabellar Anatomy for the Cosmetic Surgeon
Cat Burkat, MD

Purpose: To clarify controversies in motor innervation to the glabellar muscles in order to create a comprehensive guide of anatomic relationships within the glabella for the cosmetic surgeon performing surgery or injections in this aesthetic region.
Methods: Microdissection was performed on 28 sides of 14 preserved cadaver heads and 10 sides of 5 fresh-frozen cadaver heads. Dissection proceeded anterograde from the main trunk of the facial nerve to its terminal branches in the glabellar muscles. Measurements were made with calipers to record the locations of the motor nerve entry into the corresponding muscle, and the locations of the sensory nerves, vessels, and orbital landmarks.
Results: The temporal branch of the facial nerve did not terminate after supplying the posterolateral transverse corrugator muscle, but continued medially to innervate the oblique head of the corrugator muscle, entering 4 mm inferior to the superior edge (range 2-6.5 mm). This pattern was identified in 26/38 dissections (68.4%). In 74% of dissections, a small artery coursed with the nerve towards the corrugator muscle that should be anticipated to avoid bleeding. In 4 specimens (10.5%), the temporal facial nerve supplied a branch to the depressor supercilii muscle, which continued to enter the posterior procerus muscle. The supratrochlear nerve exited between, rather than lateral to, the two heads of the corrugator supercilii muscle near the muscle origin before dividing into 2-3 branches, and measured 17 mm from midline. A sensory branch was located in the procerus muscle 5 mm inferior to the motor nerve entering the muscle. The supraorbital notch/foramen was 26 mm from midline. Prominent angular vessels were located between the heads of the corrugator supercilii muscle and between the heads of the depressor supercilii muscle.
Conclusions: With a thorough understanding of the anatomic relationships of the muscles to their associated innervation and vascular supply, complications such as prolonged paresthesia or dysesthesia from sensory nerve injury, eyebrow asymmetry from motor nerve damage, traumatic neuromas, and visual loss from vascular emboli from cosmetic injections may be avoided.

11:00am
Ambulatory Abdominoplasty Tailored to Patients with an Appropriate Body Mass Index
Troy C. Williams, MD

Objective: In our clinical experience, we would like to present 22 patients that underwent ambulatory abdominoplasty over a one year time span. These patients were carefully examined and assigned to have either abdominoplasty with intravenous sedation or general anesthesia. Many factors were considered and body mass index played a significant role in the ultimate decision. Our goal then became to define these selection guidelines to increase utilization of this technique.
Study Design: Our study was designed in the format of a retrospective case review. The information gathered came from detailed charting in the office setting pre-operatively and post-operatively. We also had the benefit of first hand accounts of details and decision making from all of the consultants involved in the management of our patients.
Results: Each of the patients had a body mass index between 22 and 34. All of our patients had an ASA I or II classification based on having no health concerns or one health matter that was well controlled. All twenty-two of our patients returned home the same day and there were no surgical or sedation related complications reported after several months of clinical observation.
Conclusion: Proper patient assignment to tumescent abdominoplasty under intravenous sedation when deemed appropriate can be safe and effective policy for plastic surgeons. Using body mass index as a standard of judgment gives surgeons a reliable guideline for evaluating their patient's body habitus. As more ambulatory abdominoplasties are performed under IV sedation after BMI charting, we will be able to further delineate the apparently achievable decreased complication rate that our study has elucidated.

11:10am
Adding Breast Augmentation To Your Practice Analysis of First 50 Augmentations
Mark K. Mandell-Brown, MD

Objective: The author has 16 years experience practicing facial plastic surgery. By taking American Academy of Cosmetic Surgery courses, the author added breast augmentation procedures to his cosmetic practice. Review of the first 50 patients provides helpful information for those considering adding breast augmentation to their practice.
Methods: Fifty patients undergoing breast augmentation surgery from December 2003 to June, 2004 were reviewed. The patients filled out questionares relating to satisfaction with size, incision approach, and complications. Additionally, the patients were measured to compare pre-operative and post-operative changes from breast augmentation.
Results: The 50 patients reported a high satisfaction rate with the size, incision approach, and a low complication rate. On average, the bust measurement increased 2 inches and the nipple to Inferior Mammary Fold (IMF) averaged 8cm. One patient developed Mondor's Syndrome, one patient had nipple numbness 3 months postop, and one patient was

diagnosed with a pheochromocytoma 3 days after her augmentation surgery. Two patients showed evidence of a double bubble while one patient had borderline synmastia.
Conclusions: Breast Augmentation procedures can be added to the physician's cosmetic practice. The benefits of the American Academy of Cosmetic Surgery courses and observing cosmetic surgeons help the physician transition to adding breast augmentation surgery. Review of patient outcomes shows a high satisfaction rate.

11:20am
Bone Augmentation with Injectable Demineralized Bone Powder
Steven A. Burres, MD

Objective: Demineralized bone powder has been shown to be osteoinductive in animal studies and numerous human applications. This study is intended to demonstrate its feasibility for implantation as an injectable, through a closed technique. Furthermore, this study is the first evaluation its potential benefit for facial skeletal augmentation in humans.
Methods: Twenty injections were made of demineralized bone powder in 10 subjects. Injections were made with 50-125 micron particle size and 250-500 micron particle size suspensions, hydrated in saline. After appropriate subcision of the recipient bed, implantation was performed under local anesthetic. Test injections were made in the mastoid area in several subjects. Treatments were made over the malar eminence and in the canine fossa. Two subjects were HIV positive on protease-inhibitors.
Results: All subjects tolerated the injections well. There were no incidence of infection or granuloma. Approximately half of the 50-125 micron injections had persistent evidence of implant that was obvious at 4 months, whereas of 10 250-500 micron particle injections, 7 showed persistence. Biopsy of several implants showed histology indicative of osteogenesis.
Conclusions: Demineralized bone powder has the potential to be the first truly permanent injectable filler. Since 1965, it has been proven to be osteogenic under specific circumstances. In monkeys, it has been shown to induce bone even when implanted subcutaneous, inramuscular, and periosteal locations. This is the first report of a closed injection technique of bone powder and, furthermore, the first description of its application for facial skeletal augmentation. Potentially, it could provide the injectable cheek or chin implant, as well as add volume when fat has failed.

11:30am
Infusion Pump Sedation in Cosmetic Surgery
Gerald G. Edds, MD

Objective: Intravenous sedation with concomitant local anesthesia has long been an accepted approach in cosmetic surgery procedures. Problems associated with the use of non-reversible anesthetic induction agents such as propofol have led to a joint position statement from the American Society of Anesthesiologists and the American Association of Nurse Anesthetists proposing restrictions on such agents. Some accrediting organizations now restrict the use of such agents to anesthesia providers. Other considerations, such as the "porpoise" effect of intermittent IV sedation during cosmetic surgery procedures have led to the development of protocols for IV sedation using an infusion pump in a wide range of cosmetic surgery procedures using reversible sedating agents.
Methods: After preoperative medication with oral diazepam, prednisone and Dramamine, IV sedation is administered per infusion pump using midazolam, ketamine and meperidine. Protocols for infusion pump sedation will be presented for multiple procedures to include dosages of medications, rates of infusion and practical condiderations, including anesthetic costs for various procedures.
Results: In over 4000 cases using infusion pump sedation, none have required intubation or experienced intoward sequellae.
Conclusions: Infusion pump sedation has proven to be an excellent modality in maintaining a steady rate of sedation without the highs and lows seen with intermittent administration of medication. There is an added measure of comfort in using two agents which are reversible (midazolam and meperidine), and ketamine, which does not cause significant respiratory depression.

11:40am
Building A Free Standing Office Based Surgery Center--Avoiding the Pitfalls And Escaping the Money Pit
Mark K. Mandell-Brown, MD

Objective: As state medical boards develop more stringent codes and regulations for office based cosmetic surgery emphasis on accredited surgery centers will become increasingly important. The co-authors will describe their experience designing, building and gaining state and AAAHC (Accreditation Association of Ambulatory Health Care) accreditation.
Methods: The authors will discuss the four phases of developing an office based surgery center. During the first phase key attention to design and architects with surgery center experience are critical. The second phase focuses on selecting a builder, building materials, Operating Room design, and general code issues. The third phase emphasizes the materials and manuals required for AAAHC and state licensure. The fourth phase will focus on financial and legal issues.
Results: By learning from the authors' experience, those seeking similar accreditation may benefit cost savings as well as legal protection in the complex maze of building construction, medical regulations, and legal regulations.
Conclusions: This presentation will highlight ways to decrease costs and assist those interested in gaining office based surgery accreditation.

11:50am
Question & Answer Session

12:00pm
Adjournment

EXHIBITORS

AAAHC - F4
Aesthetic Buyers Guide - F3
Aesthetic Internet Marketing Corp. - 513
Aesthetic Marketing Concepts - 308/310
Allergan, Inc. - F19
Allied Biomedical Corporation - 319
American Medical BioCare - F1
Annette International Corporation - 216
Anthony Products, Inc. - 201/202
ASSI - Accurate Surgical - 302
Atrium Medical Corporation - 321
Biodermis - 408/410
BioForm - 121
Body Care Resort, Inc. - 113
Boiron – 411
Caleel-Hayden, LLC - 311
Candela Corporation - 205
Canfield Clinical Systems - 305
Cardinal Health - 107
Care Credit - 109
Care-Tech Laboratories, Inc. - 312
Church & Dwight, Co, Inc. - 211
Coapt Systems - 419
CosMedix - 325
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Cosmetic Surgery Times - 412
Crescent Products - 314
Cutera - 105
Dermik Laboratories, Inc. - 318
Design Veronique - 518
Dexta Corporation - 506
DUSA Pharmaceuticals, Inc. - 208
Ellman International, Inc. - 504
Erchonia Medical Lasers - 307/309
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G. R. Industries - 115
GE Insurance Solutions - 514
Genesis BioSystems - 413
Henry Schein, Inc. - 508
HK Surgical - 108
I-Flow Corp. - F18
Ienhance.com / Cosmeticsurgery.com - 102/200
Implantech Associates, Inc. - F13
Inamed Aesthetics - F6/F7
Iridex - 517
IS Clinical by Innovative Skincare - 421
Jan Marini Skin Research, Inc. - 220
KLS-Martin, LP - F22
KMI (Kolster Methods, Inc) – F21
La Roche-Posay/Biomedic - F17
Laserscope Surgical Systems - F15/F16
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MedNet Technologies - 204
Mentor Corporation - 400/401/402/500
Merck Human Health - 103
Mesoestetic Laboratories - 519
MicroAire Surgical Instruments - F23
Microsurgery Instruments, Inc. - 313
Miller Medical - 122
MJD Patient Communication - F8/F9
Myotonology, Inc. - 213/215
Nextech Inc. - F5
Obagi Medical Products - 316
Page 1 Solutions, LLC - 521
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Plastic Surgery Products - 515
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Reliant Technologies - 326
Robbins Instruments, Inc. - 507
Saunders / Mosby / Churchill - 509
Sciton, Inc. - 418/420
Seattle Software Design - F12
Shippert Medical Technologies Corp. - F10
Silimed, Inc. - 104
Skinceuticals, Inc. - 210
SkinMedica, Inc. - 315
Smiths Medical PM, Inc. - 414
Surgical Specialties Corporation - F14
Surgitel/General Scientific Corp. - 226
Syneron, Inc. - F11
Thermage, Inc. - 405/407/409
Thorne Research, Inc. - 511
Topix Pharmaceuticals, Inc. - 520
Tulip Medical Products - 225
Valeant Pharmaceuticals - 117/119
Wells Johnson Company - 207/209
Whittmore Enterprises, Inc. - 111

EXHIBITOR DESCRIPTIONS

AAAHC
Booth # F4
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The Accreditation Association was established in 1979 to assist ambulatory healthcare organizations achieve accreditation. The AAAHC is the leader in ambulatory healthcare accreditation, having accredited over 2000 organizations nationwide. Throughout the ambulatory community, the AAAHC certificate of accreditation has become a symbol of commitment to quality in healthcare.

Aesthetic Buyers Guide
Booth # F3
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Valeant Pharmaceuticals International offers a wide range of dermatologic products. Efudex® (fluorouracil) is available in a 5% cream and solution. Kinerase® (N6-furfuryladenine) for diminishing the appearance of fine lines and wrinkles. Oxsoralen-Ultra® (methoxsalen Capsules, USP, 10mg) is available for use in combination with PUVA Phototherapy. GLYQUIN XM™ (hydroquinone USP, 4%) 10% glycolic acid, SPF 15 and hyaluronic acid for melasma.

Wells Johnson Company
Booth # 207/209
Elaine B. Wells
8000 South Kolb Road
P.O. Box 18230
Tucson, AZ
(520) 298-6069
(520) 885-1189
E-mail: sales@wellsgrp.com
Website: www.wellsgrp.com
Wells Johnson Company sells the finest in aspirators, infusion pumps, cannulas, disposables and powered assist cannulas. Since 1983, Wells Johnson has sold over 9,000 aspirators worldwide, and is dedicated to deliver quality, reliability and great customer service.

Whittemore Enterprises Inc.
Booth # 111
Chris Lazalde
11149 Arrow Rte
Rancho Cucamanga, CA 91730
(800) 999-989-2452
(909) 989-9976
E-mail: clazalde@wemed1.com
Website: www.wemed1.com
Whittemore Enterprises equals value and savings. Providing used refurbished, liquidation and new medical equipment worldwide since 1983. Surgery Center Surgical Equipment has been our specialty and we stock everything you need to equip your entire facility with savings of 40%-70%. www.wemed1.com.

EXHIBITORS BY BOOTH NUMBER

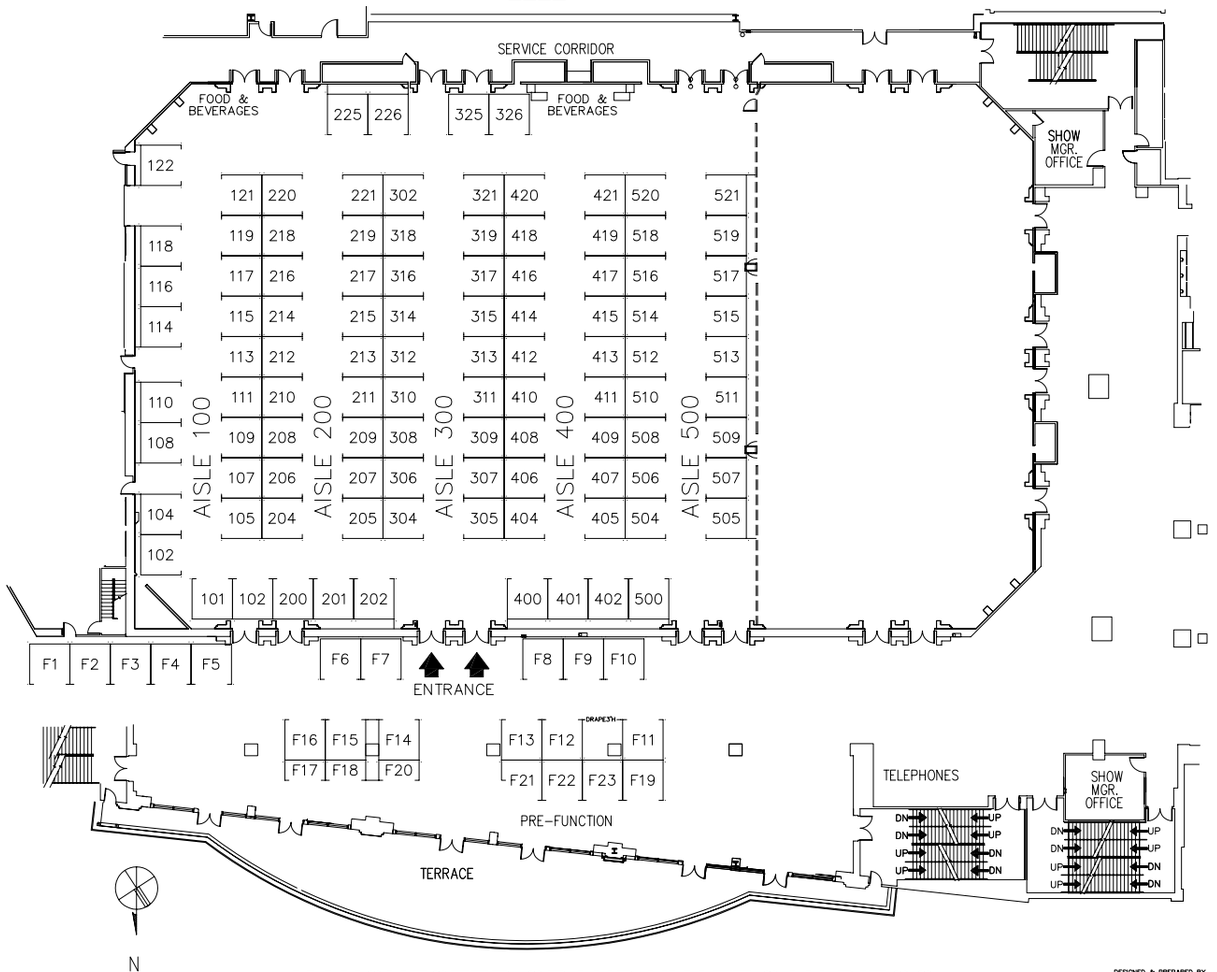
Physician's Choice of Arizona, Inc. - 101
Ienhance.com / Cosmeticsurgery.com - 102/200
Merck Human Health - 103
Silimed, Inc. - 104
Cutera - 105
Cardinal Health - 107
HK Surgical - 108
Care Credit - 109
Liposuction.com - 110
Whittmore Enterprises, Inc. - 111
Body Care Resort, Inc. - 113
Radiancy, Inc. - 114/116
G. R. Industries - 115
Valeant Pharmaceuticals - 117/119
Friendly Light, LLC - 118
BioForm - 121
Miller Medical - 122
Anthony Products, Inc. - 201/202
MedNet Technologies - 204
Candela Corporation - 205
PBHS Web Site Design - 206
Wells Johnson Company - 207/209
DUSA Pharmaceuticals, Inc. - 208
Skinceuticals, Inc. - 210
Church & Dwight, Co, Inc. - 211
Reliance Medical Finance Company - 212
Myotonology, Inc. - 213/215
Cosmetic Surgery Magazine - 214
Annette International Corporation - 216
Medical Technology, Inc. (MTI) - 217
Lyco Science - 218
Locateadoc.com - 219/221
Jan Marini Skin Research, Inc. - 220
Tulip Medical Products - 225
Surgitel / General Scientific Corp. - 226
ASSI - Accurate Surgical - 302
Medicis Aesthetics - 304/306
Canfield Clinical Systems - 305
Erchonia Medical Lasers - 307/309
Aesthetic Marketing Concepts - 308/310
Caleel-Hayden, LLC - 311
Care-Tech Laboratories, Inc. - 312
Microsurgery Instruments, Inc. - 313
Crescent Products - 314
SkinMedica, Inc. - 315
Obagi Medical Products - 316
Quality Medical Publishing, Inc. - 317
Dermik Laboratories, Inc., 318
Allied Biomedical Corporation - 319
Atrium Medical Corporation - 321
CosMedix - 325
Reliant Technologies - 326
Mentor Corporation - 400/401/402/500
Marina Medical - 404/406
Thermage, Inc. - 405/407/409
Biodermis - 408/410
Boiron - 411
Cosmetic Surgery Times - 412
Genesis BioSystems - 413
Smiths Medical PM, Inc. - 414
Cosmetic Surgery Suppliers, Inc. - 415/417
LCF Financial - 416
Sciton, Inc. - 418/420
Coapt Systems - 419
IS Clinical by Innovative Skincare - 421
Ellman International, Inc. - 504
Mattioli Engineering Corporation, 505
Dexta Corporation - 506
Robbins Instruments, Inc. - 507
Henry Schein, Inc. - 508
Saunders / Mosby / Churchill - 509
Lumenis (formerly Coherent, Inc.) - 510
Thorne Research, Inc. - 511
Medical Center Pharmaceuticals - 512
Aesthetic Internet Marketing Corp. - 513
GE Insurance Solutions - 514
Plastic Surgery Products - 515
Ferndale Laboratories, Inc. - 516
Iridex - 517
Design Veronique - 518
Mesoestetic Laboratories - 519
Topix Pharmaceuticals, Inc. - 520
Page 1 Solutions, LLC - 521
American Medical BioCare - F1
Palomar Medical Technologies - F2
Aesthetic Buyers Guide - F3
AAAHC - F4
Nextech, Inc. - F5
Inamed Aesthetics - F6/F7
MJD Patient Communication - F8/F9
Shippert Medical Technologies Corp. - F10
Syneron, Inc. - F11
Seattle Software Design - F12
Implantech Associates, Inc. - F13
Surgical Specialties Corporation - F14
Laserscope Surgical Systems - F15/F16
La Roche-Posay / Biomedic - F17
I-Flow Corp. - F18
Allergan, Inc. - F19
KMI (Kolster Methods, Inc.) – F21
KLS-Martin, LP, F22
MicroAire Surgical Instruments, F23

EXHIBIT FLOOR PLAN

AMERICAN ACADEMY OF COSMETIC SURGERY

JANUARY 27-30,2005

ALL BOOTHS 10X10 UNLESS OTHERWISE NOTED – TOTAL 125 BOOTHS
ALL AISLES 10'-0" UNLESS NOTED OTHERWISE



MANCHESTER GRAND HYATT SAN DIEGO
SECOND FLOOR
ELIZABETH BALLROOM

DESIGNED & PREPARED BY SAN DIEGO OFFICES
GES
PLAN USE SUBJECT TO LOCAL FIRE MARSHAL APPROVAL

NOTES

NOTES