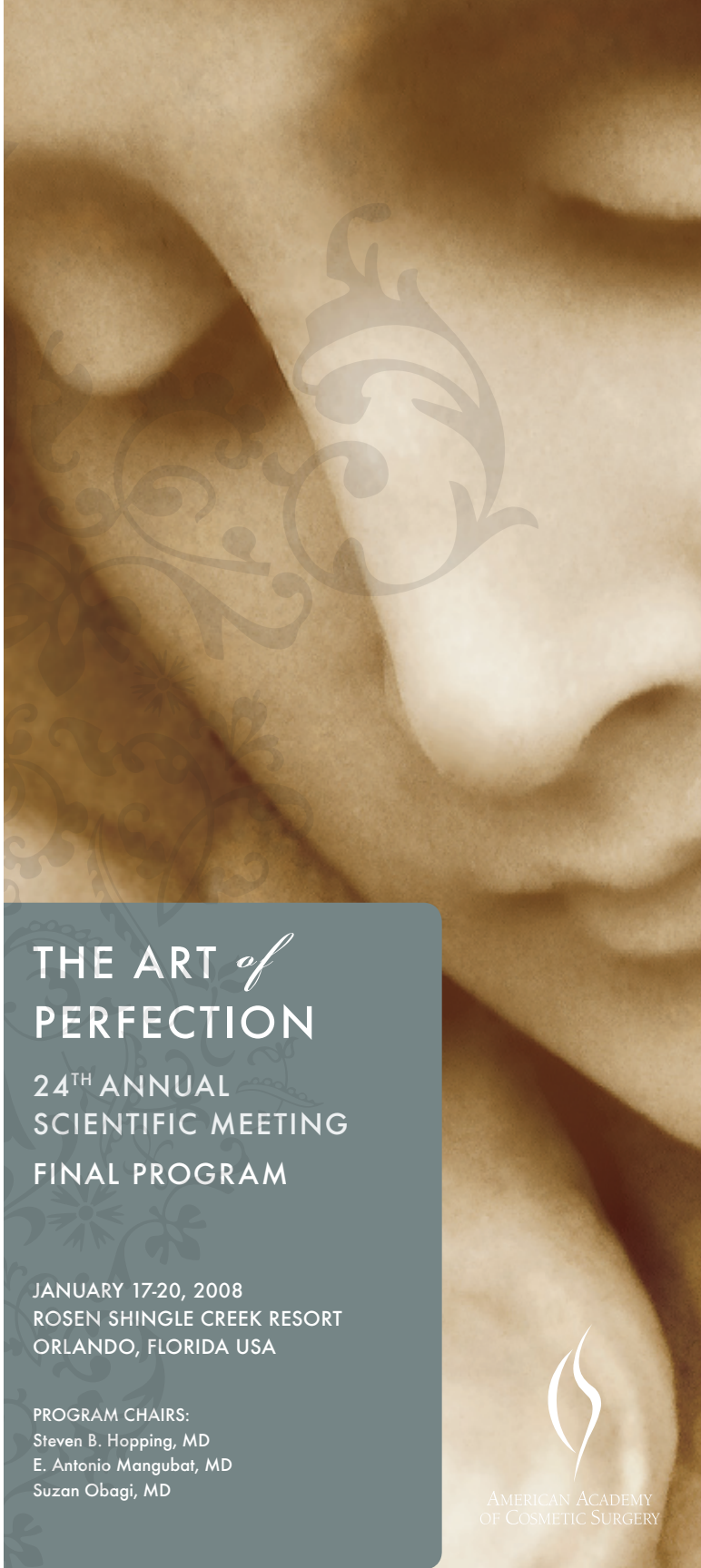

THE ART of PERFECTION

24TH ANNUAL SCIENTIFIC MEETING

FINAL PROGRAM

JANUARY 17-20, 2008
ROSEN SHINGLE CREEK RESORT
ORLANDO, FLORIDA USA

PROGRAM CHAIRS:
Steven B. Hopping, MD
E. Antonio Mangubat, MD
Suzan Obagi, MD

AMERICAN ACADEMY OF COSMETIC SURGERY

Meeting SPONSORS

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General INFORMATION

AACS Meeting Registration

Location: Registration Desk #2
Gatlin Foyer

HOURS:

Wednesday, January 16	6:30 am - 8:00 pm
Thursday, January 17	6:30 am - 4:00 pm
Friday, January 18	6:30 am - 4:00 pm
Saturday, January 19	7:00 am - 12:00 pm
Sunday, January 20	7:00 am - 12:00 pm

Exhibit Hall

Location: Gatlin Ballroom CD

HOURS:

Thursday, January 17	8:30 am - 4:00 pm
(Welcome Reception)	6:00 pm - 7:30 pm
Friday, January 18	8:30 am - 4:00 pm
Saturday, January 19	8:30 am - 12:00 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 Gatlin Ballroom E unless otherwise indicated.

Social Activities

AACS Golf Tournament

The deadline for purchasing tickets for the AACS golf tournament is Saturday, January 19, 2008 at 12:00 pm (noon).

Speaker Ready Room / Video Library

Location: St. John's 32/33

HOURS:

Wednesday, January 16	7:00 am - 6:00 pm
Thursday, January 17	7:00 am - 6:00 pm
Friday, January 18	7:00 am - 6:00 pm
Saturday, January 19	7:00 am - 1:00 pm
Sunday, January 20	7:00 am - 1:00 pm

CME Hours and Session Evaluations must be submitted at either of the Cyber Cafés located in the Gatlin Foyer or in the Exhibit Hall.

Please complete hours and evaluations after each session attended.

WEDNESDAY, JANUARY 16, 2008

SCHEDULE-AT-A-GLANCE

6:30 am - 8:00 pm	Registration Open
7:30 - 8:00 am	Continental Breakfast
8:00 am - 5:00 pm	American Society of Hair Restoration Surgery Workshop
8:00 am - 5:00 pm	American Society of Lipo-Suction Surgery Workshop
8:00 am - 5:00 pm	Cosmetic Breast Surgery Workshop
10:00 - 10:30 am	Coffee Break
12:00 - 1:00 pm	Break for Lunch
3:00 - 3:45 pm	Coffee Break

WEDNESDAY, JANUARY 16, 2008

The Art of Hair Restoration Surgery

Presented by the American Society of Hair Restoration Surgery

Location: St. John's 26/27

8:00 am **Introduction**
BERNARD P. NUSBAUM, MD

8:06 am **Incorporating Hair Restoration Surgery into a Cosmetic Surgery Practice**
SHELDON S. KABAKER, MD

Information not available at press time.

8:22 am **Budget Allocation for Marketing in Hair Restoration Surgery**
MATT L. LEAVITT, DO

Information not available at press time.

8:38 am **The Consultation**
ROBERT LEONARD, MD

Of all the patient encounters hair restoration surgeons have with their patients, the initial consultation is, by far the most important. It is during this examination where you will learn all (or, at least, most) of what you will need to know about all aspects of your patient.

You also need to determine at this visit if he is medically and/or psychologically stable to undergo this cosmetic procedure. Did he recently have an MI with an intra-coronary stent placement and is now taking aspirin and Plavix? You certainly need to know these things long before surgery day. It is during the consultation where these important facts need to be discovered. Does the patient have Body Dysmorphic Disorder? How about allergies to any medications that you might use on him during or after surgery–you *need* to learn about them, not on surgery day, but during this most important patient visit with you.

Will the patient be satisfied just to talk with you about what may be bothering him about his hair? Will he be happy just to stay the way he is right now? Does he want an appropriate amount of new hair or are his expectations beyond what you can provide to him? These are important to know in order to determine whether or not he should undergo the therapies you may recommend. I shall review these important aspects of the hair restoration consultation.

8:54 am **Inflammatory Scalp Disorders**
MARK WALDMAN, MD

The hair transplant surgeon needs to be aware that there are other causes of alopecia besides a genetic etiology. Often, these types of alopecias are "hair emergencies" that require medical therapy as opposed to surgical intervention. The transplant surgeon should be aware of the clinical findings seen with inflammatory alopecias because transplanting into these conditions can often lead to disappointing outcomes with very poor graft survival.

9:09 am **Question & Answer Session**

9:25 am **Medical Therapy**
KENNETH J. WASHENIK, MD, PHD

Information not available at press time.

9:41 am **Donor Harvesting – Donor Strip Harvesting Maximum Yield and Cosmesis – The Use of a Tissue Spreader**
PAUL T. ROSE, MD

In harvesting the donor strip, one must be careful to avoid damage to the follicles along the incision lines. Dr. Arturo Sandoval has described a technique of partial depth incision followed by the use of a hemostat to spread the tissue and provide blunt dissection to avoid damage to the hair follicles.

Dr. Robert Haber has developed an instrument based on an Iconoclast to perform a similar action.

Dr. Rose recently presented a device that also accomplishes the same end but with a different mechanism. In this lecture, the author describes the newest version of the Rose Tissue Spreader and compares it to the other available devices.

9:57 am **Factors Influencing Graft Survival**
WILLIAM PARSLEY, MD

Few subjects in hair restoration attract as much attention as graft survival. While most cases have excellent graft results, all surgeons have occasional cases with less-than-expected survival. Additionally, some surgeons seem to consistently achieve better survival rates than others. So what are the secrets?

Most of the focus on techniques to improve survival center on donor tissue and the recipient bed. Factors affecting donor tissue

include follicular size and vigor, donor excision techniques, graft preparation, graft storage and the insertion of grafts into the recipient sites. Factors affecting the recipient bed include local factors (scarring, infection, sun damage, dermatologic disorders) and general health factors (serious illnesses, smoking, etc.). Factors that hair surgeons generally consider most significant are continuous graft hydration throughout the surgery, avoidance of transection, limiting recipient incision size and depth and minimal manipulation of the grafts.

Current interest is moving in the direction of advanced storage solutions. Osmolality and pH are basic factors, but newer solutions may contain free radical scavengers and antioxidants. Additionally, growth and regulatory factors can be added. Sporadic studies are encouraging.

10:13 am **Question & Answer Session**

10:28 am **Coffee Break**

10:39 am **Panel: FUE/FIT/Body Hair Transplants**

JAMES HARRIS, MD

FUE is a relatively new addition to the field of hair restoration offering a minimally invasive option for graft production. Since its introduction several years ago, there have been enhancements to the methodology and instrumentation for performing this procedure; the historical perspective of FUE will be presented. This lecture will provide some insights into the challenges in performing this procedure as well as some of the advances in instruments that will allow successful incorporation of FUE into the average hair restoration practice. The technological challenges will be described and the methods to deal with these challenges will be presented. The advantages and disadvantages of FUE to both the patient and physician will be elucidated as well.

PAUL T. ROSE, MD

FIT/FUE have become increasingly popular. Various problems can be encountered when performing the FIT/FUE technique. In this lecture we will discuss an approach to FIT and ways to solve some of the problems inherent to FIT/FUE.

A key issue in harvesting follicular unit with the various punches available is the rate of transaction. Standard 0.75-1mm punches have been used as well as nickel titanium punches with or without the use of a blunt punch.

Most of the techniques require a two-step approach, in which the graft to be harvested is "scored" with a sharp punch. The sharp punch enters a short distance into the epidermis and dermis. This is followed by the use of the sharp punch or dull punch such as the Harris SAFE punch to further cut into the skin and free up the graft.

In this presentation the author will discuss the design of the Rose SL punch and demonstrate its usage. The RSL punch is a slotted punch that allows for a single-step approach or two-step approach. The unique design of the punch allows for better alignment with the hair in the follicular unit and diminishes the risk of transaction.

JOHN COLE, MD

Information not available at press time.

11:20 am **Panel: Hairline Design**
PAUL J. MCANDREWS, MD
& RONALD L. SHAPIRO, MD

The artistic design of the hairline is critical in determining the final result a patient will attain. A physician can use the latest advances in technique and technologies, but if design of the hairline is incorrect, the final outcome will be a failure and the hair transplant will be unnatural. The aging face is intricately associated with the hairline and the design of the hairline is not a static piece of art; therefore, the physician has to have the foresight to design a hairline that not only looks good today, but also tomorrow. The young patient with hair loss is eventually going to have very extensive hair loss and a young hairline will not naturally match the overall extent of baldness as he ages; therefore physicians must protect the patient (i.e. his desires) from himself.

Four essential features in the artistic design of a hairline that need to be observed in order to keep a hairline looking natural are:

1) The correct placement of the anterior edged of the frontal hairline
2) The correct placement of the lateral edged (width) of the frontal hairline
3) The direction of the hair exiting the scalp
4) The asymmetry of the frontal hairline

These critical features will be discussed in more detail.

11:51 am **Question & Answer Session**

12:00 pm **Lunch**

1:00 pm **Lateral vs. Parallel Slits**
SHELLY FRIEDMAN, DO

Information not available at press time.

1:16 pm **Multiunit Grafting**
ROBIN UNGER, MD

Dr. Robin Unger will be discussing the topic of multiunit graft hair transplantation. Although single follicular units (FU) are indispensable in modern transplanting, there is still an important role which can be fulfilled by multiunit grafts. If larger grafts are utilized, the same amount of hair can be moved more rapidly and the follicles are much more protected from damage. These include double and triple follicular units which can be used to add density into areas which already have a thin background of permanent hair; for example, in female patients and patients with previous follicular unit transplantation. They are also useful in treating areas with pre-existing hair when the desired end result is high density. Slot grafts, containing 4-6

FU are used in select patients who want very high density and are willing to undergo multiple surgeries. The discussion will focus on planning, techniques of dissection, and surgical pearls regarding recipient site creation.

1:32 pm **Graft Placement in Hair Transplantation**
GLENN CHARLES, MD

The importance of proper graft placement in hair transplantation.

Goals:

1. Overview and comparison of different techniques
   a. "Critical step" – high potential for trauma to graft at this step
   b. Poor placing may lead to poor density
   c. Proper placing maximizes density
2. Potential problems leading to poor graft survival
3. Pearls of placing
   a. Good visualization – use of magnification
   b. Control bleeding
   c. Matching recipient site size to graft size
   d. Hydration
4. Placing techniques
   a. Pre-made single vs. two-person
   b. Stick & place single vs. two-person
5. Instrumentation for placing grafts

1:48 pm **Quality Assurance: Six Sigma**
CARLOS J. PUIG, DO

Information not available at press time.

2:03 pm **Question & Answer Session**

2:19 pm **Complications in Hair Restoration Surgery**
ROBERT NIEDBALSKI, DO

Description: For the most part, Hair Restoration Surgery can be completed without any undue risk. There are, however, a number of problems that can arise from time to time. This discussion will outline the more serious of these complications and the risk factors associated with them, and provide information on how to manage these problems when they occur.

Learning Objectives:

- Review the most serious complications in hair restoration surgery
- Discuss risk management strategies to reduce the incidence of complications
- Describe the management of these complications

2:35 pm **Excisional Techniques in Repairs**
E. ANTONIO MANGUBAT, MD

Because hair deformities can vary so widely in severity, morphology and etiology, they can present a formidable challenge not only to repair the anatomic defect but also to correct the residual cosmetic deficiencies. Most repairs require a combination of cosmetic and reconstructive techniques to achieve the best results. Hair transplantation is a key cosmetic surgery component in correcting these unique deformities and is the mainstay of refining and completing repairs; however, large defects are often best handled by specialized excisional techniques. Furthermore, understanding the ramifications of future hair loss due to androgenetic alopecia greatly assists surgical planning. This presentation identifies the various techniques useful in repairing hair deformities and presents several case reports demonstrating various challenges and the respective solutions.

2:51 pm **Novel Approaches to Post-Op Care**
ALAN J. BAUMAN, MD

Information not available at press time.

3:07 pm **Laser Therapy for Woundhealing (After Hair Restoration Surgery) and Hair Loss**
DAVID PEREZ-MEZA, MD

Low level laser therapy (LLLT) or cold or soft therapy has been used in medicine for more than 30 years, with many medical and rehabilitative applications from A (arthritis) to Z (Herpes Zoster), including pain management and woundhealing.

There is little information about the use of laser therapy after hair transplant surgery and for the treatment of patients with hair loss.

During my presentation I will discuss:

- General aspects of low level laser therapy, including possible mechanisms of action, dose, out power, wavelength
- Differences between LLLT and LED (light emitting diode)
- The use of laser therapy after hair transplant surgery
- LLLT for the treatment of male pattern of hair loss

3:23 pm **Question & Answer Session**

3:38 pm **Coffee Break**

3:48 pm **Scalp Tumors Relevant to Hair Restoration Surgery**
RICARDO MEJIA, MD

Information not available at press time.

4:04 pm **Transplanting Facial Hair**
MARCO N. BARUSCO, MD

Objectives: To discuss indications, techniques and potential pitfalls when transplanting facial hair.

Discussion: As with scalp hair, the absence or loss of facial hair due to genetics or disease processes can be distressing and overwhelming to the patient. Cultural influences are also a very important factor when patients look for solutions for their facial hair problems, and must be taken into consideration when planning the procedure.

Any hair-bearing area on the face can be treated with hair transplantation, including the eyebrows, the eyelashes, the sideburns, the beard and the moustache. Of the areas above, the two most common to receive hair transplants are the eyebrows and the sideburns, followed by the other areas.

As with any surgical procedure, a thorough evaluation of the patient, including skin and hair exam are a must before indicating surgery. The likely cause of the hair loss must be determined, in order to prevent poor growth and to increase the likelihood of optimal surgical outcome for the patient. The preoperative evaluation of these patients must also include family history as it relates to facial hair and prior grooming habits (use of eyelash extensions, prior hair removal treatments with laser, plucking, waxing and others).

The patient's expectations and goals must also be deeply evaluated, and the surgeon must be prepared to answer any questions or concerns that the patient may have, including the number of hair transplant grafts necessary, how many surgical procedures the patient needs to achieve their goals and the expected results from the surgeries. Any deviation of the above may lead to an unhappy patient, even if the surgical technique and outcome are perfect.

I will discuss the specific technique that I utilize for each of the above facial areas, as they vary (sometimes dramatically) in different zones of the face.

4:20 pm Eyelash Transplant Complications: Avoidance and Management

ALAN J. BAUMAN, MD

Introduction: The use of 'one-step' eyelash transplantation as previously described and demonstrated by Dr. Marcelo Gandelman (Sao Paulo, Brazil) is well suited for cosmetic and reconstructive upper eyelash enhancement. The author will present a brief overview of his methods of patient selection, patient education and informed consent, in addition to his OR setup, technique and post-op care. The author will also describe and demonstrate his novel approach to the technique; a 'pairing' method of implantation which allows larger numbers of hair follicles to be implanted into the lid, as well as several 'pearls' for improved efficiency and aesthetic outcome. Information regarding a new, nonsurgical cosmetic eyelash enhancement treatment will be presented.

Methods: The technique described requires the operating surgeon to have two assistants.

Pre-op/Prep: Diazepam 10mg p.o., scalp-wash performed; alcohol swab prep of lid, topical 4% lido applied to lid and donor area.

Donor Area: Local anesthesia is applied to an area of untrimmed scalp (2% lido w/ 1:100,000 epi) using computerized injection, 0.5% bupivicaine applied.

- Small linear harvest (e.g. 5cm x 0.5cm), with trichophytic closure is performed using single layer running 5-0 Monocryl.
- Surgeon: Using loupe magnification, implantation is started medially working toward lateral aspect. Care is taken to ensure proper orientation, position and curl. A staggered 'entry' pattern is recommended.
    1) Needle entry (~10mm from lid margin), working superficially to the
    2) Needle exit (at lid margin)
    3) Disengage the hair from eye-needle and pass the empty needle off field (to be 'rethreaded' by Tech #2)
    4) Pull hair through, upward/vertical motion, orienting the hair curl and base of the follicle appropriately
    5) The follicle base should be positioned under the skin, just beyond the needle entry point
    6) Trim hair to ~2.0cm length
    7) Repeat

After the last lash is implanted, a cold compress is applied. Local anesthesia and implantation then commences on contralateral eye. Transplanted follicles and lashes are examined for appropriate orientation; positioning adjustments or removals can be made at this time. Trimming lashes to 15mm length or less is recommended at this time.

Sequelae/Complications/Common Concerns:
Hordeolum (Sty): Staphylococcus aureus is the most common bacteria found in a hordeolum. A hordeolum will generally drain spontaneously within five to seven days, or with the application of hot compresses or soaks. When drained, the sebum has a thick, cheesy consistency. Patients are instructed to contact the office if a sty develops and/or lasts longer than one week.

Conclusion: Due to the potential for serious and/or permanent complications, it is recommended that physicians and their technicians should not attempt to perform eyelash transplantation before receiving appropriate educational training. The author encourages all physicians to obtain full informed consent from all patients who request eyelash transplantation, disclosing the risks, benefits and alternatives, as well as the experience of the surgeon performing the procedure.

4:36 pm Female Hairlines

BERNARD P. NUSBAUM, MD

Hair transplantation is gaining popularity among women. While much has been written about hairline design in male patients, more information is needed in describing natural female hairlines.

Objective: To determine the frequency, dimensions and location of structures which compose the female hairline.

Methods: Hairline characteristics were measured in 360 female volunteers at an informal hair salon setting.

Results: A widows peak was present in 81%. The mean distance from the mid-eyebrow to the frontal midpoint was 5.5 cm. Lateral mounds were observed in 98%. The mean distance from the frontal midpoint to the apex of the lateral mounds was 3.74 cm on the right and 3.97 cm on the left. The mean distance from the apex of the lateral mounds to the apex of the temporal points was 3.78 cm on the right and 3.51 cm on the left. The shape of the temporal recessions was concave triangular or concave oval in 87% of the subjects.

Conclusion: This study provides proposed guidelines for designing the hairline in women.

4:51 pm **Question & Answer Session**

5:00 pm **Adjourn**

NOTES

The Art of Liposuction Surgery

Presented by the American Society of Lipo-Suction Surgery

Location: St. John's 28/29

8:00 am **Welcome and Introduction**
GERALD G. EDDS, MD

8:10 am **Liposuction Guidelines: Avoidance of Litigation**
RONALD A. FRAGEN, MD

After being involved as an expert witness for over 10 years, I have found that by following certain key suggestions in the Liposuction Guidelines physicians will learn to document properly and think in an organized fashion about liposuction as well as being able to defend their actions. In a short presentation I will outline this process.

8:30 am **Liposuction with Tumescent/Local Anesthesia without IV Sedation/General Anesthesia – Safety Aspects**
SUZAN OBAGI, MD

This talk will focus on the use of tumescent anesthesia both in liposuction and in other cosmetic surgery procedures. The emphasis will be on selecting the appropriate concentration for various anatomic areas and the appropriate calculation of dosing. Tumescent anesthesia can be used for several indications including facelifts, autologous fat augmentation, browlifts and liposuction. Further discussion will cover the use of oral analgesia to supplement tumescent anesthesia when needed. Drug interactions that can affect lidocaine levels will be covered as well.

9:00 am **Liposuction Under Sedation or General Anesthesia – Safety Aspects**
JANE A. PETRO, MD

Liposuction, done under local anesthesia using a variety of tumescent, wet, or superwet diluted lidocaine preparations has been demonstrated to be safe and effective. Several recent high profile deaths, in which conscious sedation or general anesthesia have been combined with liposuction or liposuction plus other surgical procedures, highlight the potential risks that surgery always carries. Recent suggestions that combination procedures especially increase liposuction risk may force a reexamination of our surgical strategies in which we try to accomplish as much as possible in one sitting for the patient. This talk will review current research on anesthetic physiology/pharmacology associated with large volume liposuction, drug/drug interactions, and evidence-based clinical protocols designed to reduce the more common risks of excessive fluid shifts, thrombophlebitus, and pulmonary embolism, as well as drug toxicities. The lack of evidence-based medicine with suggestions for future research will also be discussed.

9:30 am **Effectiveness and Safety Among Current Liposuction Techniques**
MARCO A. PELOSI II, MD

Objective: Manufactures' claims of the superiority of their equipment over others is unreliable and biased because of the lack of comparative clinical studies. The performance of abdominal lipoplasty (modified Avelar technique) under local anesthesia gave us the opportunity to conduct an objective intraoperative comparison of current liposuction techniques.

Methods: Abdominoplasty procedure combining liposuction of upper/lower abdomen, flanks and hips, followed by excision of lower abdominal skin only under local tumescent anesthesia (modified Avelar technique).

We evaluated the following liposuction techniques: Suction assisted liposuction with microcannulas (Dermolipo Klein's technique), standard suction assisted liposuction, LaserLipo (Erchonia low level external laser assisted liposuction),Manual disruption assisted liposuction (Blugerman/Mangubat), Ultrasound assisted liposuction (Vaser liposuction), Pelosi power assisted liposuction and SmartLipo laserlipolysis.

Following the end-point liposuction, all patients underwent the removal of the lower abdomen skin only, umbilical transposition or floating umbilicus, rectus diastasis repair when required and abdominal incision closure.

Results: The intraoperative appearance of the liposuctioned sites after the removal of the skin were evaluated by the surgeons (all experts with the techniques under evaluation). In addition, six liposuction experts evaluated the appearance of the liposuctioned sites on videotape.

Conclusions: The results of the ongoing study will be presented at the meeting.

10:00 am **Coffee Break**

10:20 am **Large Cannula Liposuction Revisited: Optimizing Incision Placement, Improving Cosmetic Outcomes**
E. ANTONIO MANGUBAT, MD

The pursuits of smoother results in liposuction surgery lead to the development of small micro-cannulas that are now standards in most cosmetic surgery practices. In achieving smoother results, however, the micro-cannula has added considerably more time to the average liposuction procedure. After introducing the concept of pre-aspiration fat disruption in 2003, I found that I could use much larger liposuction cannulas without sacrificing smoother results. The goal is to destroy the fat by mechanically disrupting the infrastructure of the fat anatomy. Detaching the fat from its stroma without applying suction is similar to plucking grapes off the vine before picking them off the ground. By disrupting the fat before aspirating, you can use much larger instruments to remove the fat without fear of affecting the remaining fat infrastructure and minimize iatrogenic irregularities.

This method has several distinct advantages:

1. Because we can use much larger diameter cannulas, the rate fat removal increases exponentially as a function of radius squared. Initial aspiration speeds up to 1000 ml/min, are common with these larger instruments.
2. Smoother result are achieved because no suction is applied during disruption.
3. Even superficial passes with large 6-8mm disruptors do not leave surface defects because the instrument is used without suction.
4. This method is especially useful for large volume cases as well as beginning liposuction surgeons. It is particularly forgiving to the beginning liposuction surgeon as is affords smoother results regardless of experience level. I have a fellowship training program and my fellows are able to achieve liposuction competence more rapidly using this method.
5. The technology was quite useful in difficult conditions such as gynecomastia and revision liposuction.
6. Finally, longer and bigger bore cannulas allow us to
   1. hide incision in more distant and hidden locations like gluteal folds and pubic hair, and
   2. reduce surgery and anesthesia time, decreasing cost and increasing safety.

10:40 am **Tumescent Anesthesia – Technical Pearls**
CURTIS J. PERRY, MD

The introduction of tumescent anesthesia revolutionized liposuction, allowing the procedure to be performed with improved results and increased safety in the office-based surgical setting. The basic concept of tumescent anesthesia is very simple. Patients are given little or no sedation. A diluted solution of lidocaine with epinephrine is then used to anesthetize and vasoconstrict much larger areas of the body than could possibly be safely managed using traditional concentrated solutions. However, the actual practice of tumescent anesthesia in which comfortable infiltration and effective anesthesia is consistently obtained for different sites in patients with varying body types can be challenging and is technique-dependent. This presentation will review the basics of pharmacokinetics and emphasize the nuances of technique and patient evaluation to safely maximize patient comfort during the infiltration and anesthesia during the procedure.

11:00 am **Vaser Assisted Liposuction**
MAURICE P. SHERMAN, MD

The use of ultrasonic emulsification in liposuction has been known and utilized for the past 15 years. VASER technique is a third generation improvement in this principle, with 5 years of clinical use, presently marketed as "Liposelection". The technique, rational for use, clinical results and benefits, as well as untoward results will be reviewed by the presenter.

11:20 am **Vaser Assisted Liposuction: A Retrospective Analysis of Entrance Sites, Healing Results, Complications, Operating Times and Results**
ROBERT A. SHUMWAY, MD

Objective: The objective of this paper is the evaluation of VASER complications relative to other methods of liposuction.

Methods: This retrospective review involved 100 patients. The author used VASER Liposelection for two years between 2003 through 2005. A comparison and relative ranking was made between VASER vs. SAL, e-UAL, and PAL regarding: 1. Entrance sites and healing results, 2. Any evidence of full-thickness skin cicatrix, 3. Generalized quality of postoperative skin evenness, and 4. Overall operating time and expense.

Results: The VASER Liposelection technique took the longest average time followed by e-UAL, SAL and then PAL. Incisional scars were largest with VASER followed by PAL, e-UAL and SAL. Full thickness skin scarring occurred very rarely with e-UAL, PAL and VASER and never with SAL. The "smooth skin" results were rated best with VASER and e-UAL, while PAL and SAL had the highest skin unevenness postoperatively.

Conclusion: VASER increased operating time and expense, had the worst score for skin incision scars but provided nice, smooth skin contour results with very modest dermal scarring. Overall, VASER complications were low with good results compared to other liposuction modalities.

11:40 am **Fat Transfer – Current Concepts**
MARK J. GLASGOLD, MD

The dramatic role of volume loss in the pathophysiology of the aging face is widely appreciated and the use of autologous fat grafting for replacement of this volume is gaining in popularity. We are currently studying quantitative data on the long term (over 1 year) results of fat transfer procedures using the Vectra 3D Imaging System from Mirror Image.

We have developed an empiric approach to the fat transfer procedure called Complementary Fat Grafting, which simplifies the procedure into an easily learned step by step process. It also emphasizes the integration of fat grafting with more traditional rejuvenation procedures.

We will review our one year fat transfer data and introduce the concepts of Complementary Fat Grafting in this talk.

12:00 pm **Lunch**

1:20 pm **Abdominoplasty Using Liposuction Undermining in the Treatment of the Ptotic Abdominal Wall**
TITUS DUNCAN, MD

Traditional abdominoplasty, with wide flap undermining, has been the mainstay of treatment for patients presenting with significant skin excess, skin laxity and ptosis of the abdominal wall. Good results have been achieved using this approach; however, significant morbidity and prolonged convalescence have been commonly reported.

Combining traditional abdominoplasty with liposuction to improve abdominal wall contour has been discussed extensively in the literature. It is the general consensus that caution be exercised with this surgical combination because of the increased risk of flap necrosis and seroma formation. In an effort to improve the overall results of this body contouring procedure use of liposuction undermining as portrayed in the technique of lipoabdominoplasty, uses liposuction to create a sliding skin flap that possesses a rich lymphatic, neural and blood supply. Sliding skin flaps possess several advantages including reduction of dead space, improved abdominal wall contouring and preservation of abdominal wall sensation. Several reports have espoused improved outcomes including faster recovery, decreased seroma formation and flap necrosis in patients undergoing lipoabdominoplasty techniques.

We herein report our recent experience using liposuction undermining for patients undergoing abdominoplasty in the treatment of the lax and ptotic abdominal wall.

1:50 pm **Laser Assisted Liposuction**
GARRETT M. CRABTREE, MD

The presentation will start with a discussion of the laser, fibers and hand pieces including the changes that have occurred since the FDA approval. A description of how the laser interacts with tissue and the clinical changes that result. Clinical indications as well as variations in treatment methods will be discussed followed by a video of the laser being used to treat a patient.

2:10 pm **Laser Assisted Liposuction – Histobiological Studies**
NEIL S. SADICK, MD

Information not available at press time.

2:30 pm **Low-Level Laser Assisted Liposuction with Emphasis on Superficial Liposuction**
ROBERT F. JACKSON, MD
& DOUGLAS D. DEDO, MD

Low-Level Laser Assisted Liposuction, developed by Dr. Rodrigo Neira. In addition to superficial liposuction, techniques developed by Dr. Marco Gasparotti have been used by the author almost exclusively for the last six or seven years.

The Low-Level Laser Assisted Liposuction first introduced by Dr. Neira at our Academy meeting in Dearborn, Michigan. Results in transitory cell membrane permeability of fat cells. This results in easier removal of fat with liposuction, less pain for the patient, smoother results, and less bruising. Dr. Susan Lim and others have confirmed the microscopic and cellular evidence. The clinical evaluation by a multi-site study of surgeons here in the US has allowed for market approval by the FDA for the above parameters.

The superficial liposuction technique developed by Dr. Marco Gasparotti can be combined very safely to give the optimum results and truly lipo-sculpture. We must be able to work in both the deep and superficial planes if we are to achieve and hold the optimum appearance. Techniques will be discussed in the use of both modalities to accomplish true sculpturing.

3:00 pm **Coffee Break**

3:20 pm **Preventing Complications in Liposuction**
CURTIS J. PERRY, MD

Liposuction complications may be divided into two general classifications. The first are medical/surgical complications which impact patient safety, such as drug reactions, infection, hypothermia and thromboembolism. While rare, these complications can be catastrophic. Whenever possible, prevention is preferred. When unavoidable, early detection and timely management are critical to a successful outcome.

The second are unwanted aesthetic results leading to an unhappy patient. To reduce these problems, patient selection and correctly matching the patient to the proper procedure is of the utmost importance. The surgeon must assess the tensile strength and elasticity of tissues and be aware of the differences between anatomical sites on the same patient. Operative technique avoiding over suctioning and patient positioning errors will also reduce unwanted results. Careful preoperative attention to patient expectations will significantly reduce the unhappy patient.

Preoperative patient evaluation, intraoperative protocols and techniques and postoperative management to prevent these complications will be discussed.

3:40 pm **Risk Management in Liposuction Surgery**
GERALD G. EDDS, MD

Many risks in liposuction surgery are manageable by attention to detail and adhering to recognized standards of care. With liposuction still being one of the most commonly performed cosmetic procedure and in light of a very negative and contentious medico-legal environment, it behooves all of us to address risk management in a proactive fashion. Manageable risks include DVT/PE, cannula injuries, drug toxicity, adverse sequela of inappropriate combinations of procedures, lack of adequate informed consent and others. A discussion of claims experience will be used to elucidate the importance of Risk Management, and methods of Risk Reduction will be discussed.

4:00 pm **Complications Panel & Case Presentations**

5:00 pm **Adjourn**

WEDNESDAY, JANUARY 16, 2008

The Art of Cosmetic Breast Surgery

Location: St. John's 30/31

8:00 am **Welcome and Introduction**
PATRICK G. MCMENAMIN, MD

8:10 am **Introducing Breast Augmentation to Your Practice**
PATRICK G. MCMENAMIN, MD

Cosmetic Breast Surgery is a challenging and stimulating addition to your surgical practice. It offers your patients greater choice and access to an array of cosmetic surgical procedures. Breast augmentation is one of the most satisfying cosmetic surgical procedures for both the patient and the surgeon. For experienced, capable surgeons, there are many considerations before undertaking this expansion of your surgical skills. We will focus on the decision process to add Cosmetic Breast Surgery to your practice and discuss training, credentialing, mentoring, malpractice, documentation of your experience, and certification of your capabilities. Political and regulatory implications will also be discussed. Implants, surgical approaches, implant placement and position, and complications will be covered. The most common technique we use is transaxillary subfascial round smooth saline augmentation, a technique that was developed in the 1990s by J. Dan Metcalf from Oklahoma City. This is an introduction for the surgeon considering the addition of Cosmetic Breast Surgery to his or her practice, and will include audience participation and panel Q and A time.

8:25 am **The Breast Examination & Tumescent Augmentation**
ROBERT M. DRYDEN, MD

The approach to evaluation of the potential breast augmentation patient should be as complete and compulsive as the general medical history and physical examination that we were taught in medical school. The presentation will cover the important information that should be obtained in the history, as well as the findings that should be documented on the physical examination. An example of a breast augmentation form that the presenter has used successfully is presented. Compulsive evaluation will eliminate failure to recognize deformities, asymmetries and other abnormalities that might compromise the surgical result and establishes a record of often overlooked variations that may be noticed only postoperatively by the patient. Such an approach is beneficial to the surgeon with respect to his surgical plan and also to the establishment of patient rapport.

By making the surgical experience less traumatic utilizing tumescent anesthesia, the surgeon is not only helping the patient but also helping his own practice. The avoidance or minimization of discomfort in conjunction with surgery (particularly cosmetic breast surgery) is becoming increasingly important in this very competitive world. The tumescent anesthesia is placed into the

dissection plane, whether under general or local anesthesia. This author's tumescent solution is prepared in a ratio of 1000 mL of normal saline, 150 mL of 1% Xylocaine, 12.4 mL of 8.4% sodium bicarbonate, 1 mL of 1/1000 epinephrine and 1/4 mL of triamcinolone (10 mg). This tumescent solution decreases intraoperative and postoperative discomfort. Postoperative swelling and postoperative long-term pain appear to be significantly reduced.

8:45 am **Proper Documentation**
ROBERT V. CATTANI, MD

Information not available at press time.

9:05 am **Breast Augmentation Considerations**
MAURICE P. SHERMAN, MD

Information not available at press time.

9:25 am **My First 100 Cases**
DAVID A. HENDRICK, MD

Objective: Breast Augmentation is a popular procedure for cosmetic surgeons of all experience levels. Training in cosmetic breast surgery is available through both "traditional" (postgraduate residency or fellowship training) and "non-traditional" pathways (didactic courses, hands-on experience, and proctorship). The author presents his experience and results from his first 100 consecutive breast patients following "non-traditional" training in cosmetic breast surgery.

Methods: A retrospective chart review was performed by the author of his first 100 consecutive breast patients. Data regarding patient demographics, type of breast case, augmentation approach and implant placement, aesthetic results, complication rates, and patient satisfaction was collected and analyzed. All patients were scheduled for free follow-up visits through 36-months in order to compare to published national data on 12-month and 36-month complication rates and reoperation rates. Aesthetic results and patient satisfaction data were determined from 12-month follow-up visit (or last visit prior to the 12-month visit, whichever occurred last). Four different approaches were utilized by the author and compared, including InfraMannary Fold (IMF). TransAreolar (TrAr), TransAxillary (TrAx), and TransUmbilical (TUBA). Implants were placed in submuscular, subfascial, and subglandular tissue planes. "Lessons learned," procedural "pearls," and the author's own personal evolution in performing cosmetic breast surgery were developed and are presented for the new cosmetic breast surgeon to consider.

Results: ICO breast patients were operated on by the author between 12/27/01 and 2/24/04 (26 months). The average breast augmentation patient was a 36-year-old married woman with children who was referred by another patient. 92% of patients made their 3-month follow-up, 59% made their 12-month follow-up, and 21% made their 36-month follow-up visit. 26% were IMF approaches, 2% were TrAr approaches, 40% were TrAx approaches, and 30% were TUBA approaches. Average results for each approach were judged excellent to good; however, for this initial patient population, the best results were achieved with the IMF approach. With the exception of a 4% hematoma rate (all of which were TrAx approaches before utilizing tumescent vasoconstrictive techniques), complication rates and reoperation rates were comparable to or better than published national averages. There was an 11% reoperation rate at 36 months. The patient satisfaction rate at last follow-up (up to 36 months) was found to be 100%, 75% were happy with their size, 23% expressed a desire to upsize, 2% expressed a desire to downsize. Only 2% had upsized at the 36-month point. None had downsized.

Conclusion: Cosmetic breast surgery can be performed safely and satisfactorily by a "non-traditionally" trained cosmetic breast surgeon with results that can compare favorably to national published data "norms". Extremely high patient satisfaction rates can be expected. Extensive didactic coursework, appropriate "hands on" experience, proper proctoring, and observance of good surgical practice and skill are critical to achieving safe and satisfactory results. For the novice breast surgeon, the IMF approach may provide for the best initial results. Complications and their management as well as the need for reoperation (in some cases) must be anticipated and prepared for. Tumescent anesthesia to avoid intra-and postoperative bleeding is highly recommended for approaches remote from the breast, such as TrAx and TUBA.

9:40 am **Coffee Break**

10:00 am **Awards Presentation**
PATRICK G. MCMENAMIN, MD

10:05 am **The Roy Morgan Appreciation Lecture: Complications of Cosmetic Breast Surgery**
DAN METCALF, MD

Introduction: Regardless of procedure, breast augmentation is a relatively simple procedure if not for complications.

Materials and Methods: Diagnostic methods and treatments of most complications presented.

Results: Results of treated complications presented.

Conclusion: Although breast augmentation can be a simple procedure, treatment of complications presented can be very demanding.

10:45 am **Saline Versus Silicone Gel Implants**
E. ANTONIO MANGUBAT, MD

The FDA release of silicone gel implants for general public availability brings a new era to breast augmentation surgery. In the 16 years since silicone gel implants were banned by the FDA, many surgeons have finished training without gaining much experience using them. Furthermore, those of us who trained with silicone gel implants have lost some of the touch of experience. The new implants are different and behaving

differently in use. This presentation will discuss the current data and implications on the current practice of breast augmentation surgery.

11:00 am **What is New in Cosmetic Breast Surgery**
MARK BERMAN, MD

Objective: While there are multiple treatments for various types of breasts with various types of breast implants, there are a few problems very difficult to correct. Two particularly annoying problems are intractable capsule contracture and severe rippling. An e-PTFE bladder has been developed to maintain patency of the breast pocket – even in very difficult cases – and provide natural appearing and feeling breasts. Also, submuscular augmentation has been advocated in thin patients to avoid rippling. However, a number of these patients have type B breasts not well suited for submuscular augmentation or have already existing pre-pectoral implants. Superior pole fat grafting has been useful to ameliorate this problem.

Methods: A substantial number of patients who have undergone multiple breast augmentations and revisions (more than two treatments) were treated by total capsulectomy and revision mammoplasty using an e-PTFE bladder (Pocket Protector®). Most cases have been followed beyond one year, a small number are within the last year. Additionally, rippling will be evaluated and treated with autologous fat grafting in order to ameliorate this condition.

Results: Results will be analyzed, both photographically and according to their Baker classification. Patients with rippling will be viewed.

Conclusions: Patients with intractable capsular contraction were successfully treated with the Pocket Protector®. Patients with rippling were successfully treated with autologous fat transplantation.

11:20 am **Pearls of Cosmetic Breast Surgery**
ROBERT F. JACKSON, MD

During this session, the attendee will benefit from the author's experience of almost 30 years of breast surgery. Techniques will be given to help both beginners and those who are currently doing a significant amount of breast surgery to avoid complications and handle complications when they occur. Using preoperative, intraoperative and postoperative skills breast surgery can be one of the most enjoyable facets of cosmetic surgery. In today's society, it is extremely important to many of our female patients to feel good about the appearance of their breasts.

The use of the preoperative evaluation to establish appropriate goals will be given. The intraoperative technique of choosing the right implant, fashioning the appropriate pocket and applying appropriate dressings is extremely important and will be demonstrated. Postoperative care, exercises, and correction or treatment of complications will be addressed.

11:40 am **Panel Discussion**

12:00 pm **Lunch**

Moderators: Robert M. Dryden, MD, Maurice P. Sherman, MD & Robert A. Shumway, MD

1:00 pm **Transaxillary Subfascial Augmentation**
DAN METCALF, MD

Introduction: Rippling has been the most prevalent problem with saline implants. Author has developed axillary subfascial augmentation to combat this problem.

Materials and Methods: Axillary subfascial augmentation has been performed in over 3,000 women.

Results: Although no operation can completely eliminate rippling, this surgery is beneficial in improving bad outcomes secondary to rippling.

Conclusion: Subfascial augmentation decreases incidence and severity of rippling in saline implants.

1:20 pm **Video: Transaxillary Subfascial 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% occurrence of rippling with subpectoral placement. We have not experienced an increase in rippling with subfascial placement. Approximately 350 subfascial implant patients over 4-1/2 years comprise the basis for these conclusions. Video documentation of transaxillary, subfascial breast augmentation will be used to demonstrate the technique. Our results lead us to conclude that subfascial placement of saline breast implants are better than subpectoral placement.

1:30 pm **Video: Transaxillary Mastopexy**
ROBERT M. DRYDEN, MD

Many patients avoid having a traditional mastopexy due to the potential of having "ugly" scars. The axillary "endoscopic" mastopexy developed by Gerald Johnson of Houston, Texas is an excellent alternative procedure to be used in conjunction with augmentation or even at times without augmentation. A pocket is created through the axilla in the subglandular plane, and the breast tissue is then sutured to the pectoralis fascia and muscle superiorly overlying the third rib. If the patient desires larger breasts or needs an implant to fill out the breast more satisfactorily, the implant is then inserted. For the six-month period after surgery, the patient is required to wear a supportive

brassiere 24 hours a day, even while showering. This supportive action permits the occurrence of scar contraction and healing. The transaxillary mastopexy procedure will be reviewed in greater depth including the showing of preoperative and postoperative photographs.

1:40 pm **Areolar & Inframammary Breast Augmentation**
MAURICE P. SHERMAN, MD

Information not available at press time.

2:00 pm **Total Submuscular Augmentation**
RONALD A. FRAGEN, MD

Total submuscular breast augmentation is a special technique to employ maximum coverage and padding of the breast implant. The implant is placed under both the pectoralis major muscle and the serratus anterior muscle. This pads the implant in all areas, whereas placing the implant only under the pectoralis major muscle leaves the inferior lateral area under less coverage; this can lead to palpability and rippling of the implant, two common and unwanted sequelae. Understanding this technique and the anatomical approach will give you another tool for successful breast augmentation.

2:15 pm **Pros and Cons of Inframammary and Areolar Approaches and Pocket Positions**
MAURICE P. SHERMAN, MD

Information not available at press time.

2:35 pm **Mastopexy**
THEODORE E. STAHL, MD

The history of the vertical mastopexy will be presented. Particular attention will be given to the Lejour modifications. The surgical procedure will be gone over in detail. The author's long-term results and slides will show the stability of shape and projection over time. Also, combined treatment with breast augmentation and vertical mastopexy will be presented. The application of these vertical mastopexy techniques to breast reduction versus other breast reduction procedures will be elaborated upon.

2:55 pm **Extended Crescent Mastopexy**
ROBERT A. SHUMWAY, MD

The crescent mastopexy is a simple and effective way to treat nipple-areolar ptosis. It also allows for improvement of preoperative nipple asymmetry. The "extended crescent mastopexy" is a nice variation on this theme. Over time, the author has developed this type of mastopexy without using the Benelli purse-string suture, which can cause undesirable bunching and circumareolar scarring. The extended crescent allows for more lifting, a tighter breast envelope, and better closure. The various types of closure suture material will be discussed. In conclusion, the extended crescent mastopexy is an aggressive way to lift the NAC with minimal periareolar incisional scars. This procedure can be a powerful tool for any cosmetic surgeon.

3:15 pm **Coffee Break**

3:25 pm **Video: TUBA & Extended Crescent Mastopexy**
ROBERT A. SHUMWAY, MD

Objective: Transumbilical Breast Augmentation (TUBA) was invented in 1991 by Dr. Gerald Johnson, MD. Since then, TUBA surgeons have refined their techniques to include elegant approaches to the pre-pectoral and retro-pectoral surgical planes. The objective of this talk is to introduce modern and refined TUBA techniques to the audience by discussion and by video.

Methods: The author has performed over 3,000 TUBA cases since 1994. A retrospective chart review of 300 cases (one-tenth) provided a broad sampling of six important variables regarding technique changes of the author's personal TUBA methods extending over 14 years. The six variables studied were: 1. Surgical pocket development, 2. Instrumentation, 3. Types of implants, 4. Ancillary procedures, 5. Navel closures, and 6. Postoperative bandages and care. A TUBA video was developed specifically for instructional purposes.

Result: The TUBA results were critiqued by video camera. Excellent TUBA surgery results were dependent on the appropriate generation of adequate and precisely made surgical pockets (prepectoral and retropectoral). The evolution of useful TUBA instruments produced improved results. The types of saline implants used were always smooth and round, but there was a 50% increase in the number of high profile prostheses used over time. Navel closure evolved into a multi-layered, interrupted, chromic suture with umbilicoplasty modifications for improved aesthetic results. The aesthetic crescent mastopexy was introduced as appropriate. Postoperative dressings and bandages were abandoned for simple, less restrictive approaches. Patients and families were always taught the Shumway isometric superior pocket "stenting" technique maneuver pre- and postoperatively.

Conclusion: The author has presented personally honed and highly evolved techniques for TUBA. It is a versatile and sophisticated approach for keeping surgical incisions away from the breast. TUBA is truly an elegant way to augment the breast with saline implants, and this approach can be fully mastered by all dedicated cosmetic surgeons.

3:55 pm **Anesthesia Emergencies**
ANTHONY ROGERS, MD

Information not available at press time.

4:15 pm **Digital Photography**
CURTIS J. PERRY, MD

Accurate, professional-appearing patient images are essential for medical legal documentation, self-assessment and promotional materials. It is now possible to easily and cheaply create digital images that rival the best of film photography, using digital camera and computer technology that was either exorbitantly expensive or nonexistent just a few years ago. This presentation

will explain photographic principles to allow anyone to easily create professional appearing patient images. The latest in digital camera and computer equipment will be reviewed. Emphasis will be placed on practical, cost-effective equipment options. This information will be useful for those adding photography to their practice, switching from conventional to digital photography or upgrading their present digital equipment.

4:35 pm **Panel Discussion**

5:00 pm **Adjourn**

NOTES

THURSDAY, JANUARY 17, 2008

SCHEDULE-AT-A-GLANCE

6:30 am - 4:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 101
8:30 am - 4:00 pm	Exhibits Open
8:30 - 9:15 am	Continental Breakfast in Exhibit Hall
9:15 am - 12:00 pm	General Session: 102 – The Art of Facial Cosmetic Surgery
12:00 - 1:30 pm	Lunch in Exhibit Hall
1:30 - 3:30 pm	General Session: 103 – The Art of Facial Cosmetic Surgery
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Nuts / Bolts Sessions: 104
5:30 pm	Adjourn
6:00 - 7:30 pm	Welcome Reception in Exhibit Hall

THURSDAY, JANUARY 17, 2008

7:00 - 8:30 am **Bright Eye Sessions: 101**
(Sessions will run concurrently)

Breakout #1

Location: St. John's 22/23

The Art of Cosmetic Surgery in Ethnic (Fitzpatrick III, IV, VI) Patients
Steven B. Hopping, MD, Pearl E. Grimes, MD & Ronald L. Moy, MD

STEVEN B. HOPPING, MD

Subjective: Cosmetic facial surgery in patients with darker skin (Fitzpatrick types IV-VI) requires special considerations. In general, this patient population can age differently than their Fitzpatrick types I-III counterparts. A careful history regarding keloid tendencies and healing abnormalities is important. Often other modalites including minimal incision surgery with less risk of scarring should be considered first. Fortunately, surgical rejuvenation of the eyes and nose rarely exhibit adverse scarring.

Objective: The indications and options for ethnic patients (Fitzpatrick IV-VI) seeking facial rejuvenation and improvement is discussed. Techniques of rhinoplasty, blepharoplasty and rhytidectomy with special considerations given darker skin patients are discussed. Outcomes information and results are reviewed.

Assessment: Patients with darker skin (Fitzpatrick IV –VI) are candidates for facial cosmetic surgical procedures. Keloid formation especially on the face may be a contraindication to facelift surgery. These patients can still be considered candidates for rhinoplasty and blepharoplasty because of the protective nature of the midface against keloid formation and adverse scarring.

Plan: At the completion of this presentation, participants should understand the indications and contraindications of facial cosmetic surgery in darker skin patients (Fitzpatrick IV – VI). They should also understand the limitations, complications and outcomes of such procedures.

PEARL GRIMES, MD

Fillers are rapidly increasing in popularity in darker racial ethnic groups. Popular filling agents include hyaluronic acid, poly-L-lactic acid, calcium hydroxylapatite, collagen and polyacrylamide. Key indicators for use of injectable fillers in darker racial ethnic groups include nasolabial lines, jowl/sagging cheeks, tear trough deformities, lip augmentation, marionette lines and perioral rhytids. Often the cultural aesthetic ideal dictates protocols and procedures used for restoration of facial volume and symmetry in people of color.

Recent studies have documented the efficacy and safety of hyaluronic and non-hyaluronic acid fillers for soft tissue augmentation in darker racial ethnic groups.

Grimes assessed the efficacy and safety of a variety of filling substances for correction of nasolabial folds and marionette lines in 66 African Americans. 61 were female and five were male. Their mean age was 52 years. Injected fillers included bovine collagen (25) Restylane (20), Human collagen (15) and avian hyaluronic acid (5). 60% of the subjects achieved excellent correction while 40% had moderate correction. Four patients experienced post inflammatory hyperpigmentation at the injection site, which resolved with topical steroids and hydroquinone 4%. None experienced hypertrophic scars or keloids at the injection site.

A multi-center, double-blind randomized trial evaluated the efficacy and safety of the Juvederm-based family of products compared with crosslinked bovine collagen in Caucasians and non-Caucasian subjects. 420 patients completed the 24-week split face study. Of that group, 26% were non-Caucasian including 11% African American, 12% Hispanic, 2% Asian and 1% other. One of three Juvederm fillers was injected in one fold and bovine collagen (Zyplast) in the opposite fold. The Juvederm products resulted in significantly longer-lasting results compared to bovine collagen. At 24 weeks, all of the Juvederm family of fillers (J30, J24HV and J30HV) had nasolabial scores of mild, significantly less than bovine collagen. Efficacy was similar in Caucasians and non-Caucasians.

The most frequent side effects of collagen and hyaluronic acid fillers include temporary erythema and edema at the injection site, which resolves in several days in most patients. Similar effects have been observed with calcium hydroxyapatite. Despite the propensity of darker skin to hyperpigment in response to trauma, studies document minimal long-term risks after use of fillers. We are aware of no reported hypertrophic scars or keloids following the use of the new hyaluronic acid fillers or calcium hydroxyapatite.

Breakout #2

Location: St. John's 24/25

The Art of Advanced Chemical Peeling
Peter Rullan, MD & Suzan Obagi, MD

PETER RULLAN, MD

Advanced Medium and Deep Chemical Peels

1. Understand the difference between medium and deep peels
   a. By depth of injury
   b. Different effects of chemical agents and in different combinations
   c. Skin conditioning before-and-after peels
   d. Avoiding and treating complications from peels
2. Understand how the new "modified phenol peels" (as defined by the work of Drs. Hetter, Stone and Fintsi) differ from the "Baker-Gordon" phenol peel
   a. By the Croton oil and phenol concentration
   b. By the depth of injury
   c. By the application technique
3. Understand the technique of "phenol chemabrasion" in the treatment of deep wrinkles and acne scars
   a. The Fintsi technique using "lay peeler" formulas
   b. The cardiac/scarring/ pigmentation and other safety concerns
      i. Can phenol peels be done safely in Fitzpatrick skin types 3-5?
   c. How to combine "phenol chemabrasion" with fillers or subcision in the treatment of scars and wrinkles
   d. Can Fractionated Laser resurfacing be combined with CROSS?

SUZAN OBAGI, MD

While newer technologies have come and gone, peels remain a strong tool in our approach to facial rejuvenation. This course will cover medium-depth and deep peels (TCA and Phenol Peels). The course will focus more on performing these procedures. It will encompass patient selection and management of complications. Emphasis on how these procedures are used in place of or in conjunction with lasers and dermabrasion.

Breakout #3

Location: St. John's 26/27

The Art of Botox® and Fillers
Leslie S. Baumann, MD & Neil S. Sadick, MD

Noninvasive procedures are playing an increasingly important role in cosmetic surgery. In this regard, the introduction of novel fillers and Botulinum toxins are playing an increasingly important role. The present session will emphasize updated indications and technique modifications employing Botulinum toxins Type A. Also to be covered are results of the F.D.A. Reloxin studies. In addition to the utilization of short, intermediate and long-acting fillers will be expounded upon. Newer roles of volumetric fillers and bioregenerative agents will be covered. Indications, techniques and modifications, as well as the recognition and management of potential adverse events

will round out this all-inclusive session. At the completion of this session, the attendee should have enhanced updated knowledge concerning the scope of fillers and toxins employed by the practicing cosmetic surgeon.

Breakout #4

Location: St. John's 28/29

The Art of Eyelid Rejuvenation
Marc S. Cohen, MD & Nancy G. Swartz, MD

The object of this breakout session is to teach the participant how to do a state-of-the-art blepharoplasty. This course, taught by two oculoplastic surgeons, will provide a step-by-step review of how to perform a sophisticated upper and lower blepharoplasty. Emphasis will be placed on how to get the best results and avoid complications. Topics covered will include upper and lower blepharoplasty, correction of structural eyelid defects in cosmetic eyelid surgery, and rejuvenation with periocular fillers and botox. The course will employ extensive surgical series and videos to help the participants understand the important principles of blepharoplasty. We believe that this presentation will be of value to the beginning, moderate and advanced blepharoplasty surgeon.

Breakout #5

Location: St. John's 30/31

Financial Management and Benchmarking
Trudy Shelley, Senior Practice Consultant, Allergan Practice Consulting Group

Successful practices are diligent in gathering, measuring, and managing information. In addition, these practices routinely compare or benchmark actual operating results to prior periods, budget forecasts, and/or available industry benchmarks. This presentation takes the mystery out of the financial benchmarking process, offering useful tools to facilitate data reporting and interpretation. In addition, an update on the Allergan/BSM Financial Benchmarking Database will be provided.

Trudy Shelley is a management consultant with the Allergan Practice Consulting Group, a specialty pharmaceutical company based in Irvine, California.

Ms. Shelley consults with dermatology and plastic surgery practices in the areas of financial analysis, practice valuations, human resource issues, strategic planning, marketing, practice efficiency, and other general practice management matters.

Ms. Shelley has over 15 years of experience in sales, management, and practice management consulting. Prior to joining the Allergan Practice Consulting Group seven years ago, Ms. Shelley served in a number of sales and management positions with Allergan's ophthalmology division, and Merck and Company, including senior sales executive, district manager, and health science manager.

Ms. Shelley has been a guest speaker at various national, regional, and local dermatological meetings. She holds Bachelor of Science degrees in both Business Administration and French from Wittenberg University in Springfield, Ohio.

8:30 - 9:15 am **Continental Breakfast in Exhibit Hall**

9:15 am - 12:00 pm **General Session: 102 – The Art of Facial Cosmetic Surgery**
Moderators: Edward B. Lack, MD & Suzan Obagi, MD

9:15 am **Welcome by AACS President**
EDWARD B. LACK, MD

9:30 am **Evaluation of a 1320 nm Laser for Skin Tightening, with and without Liposuction**
EDWARD M. ZIMMERMAN, MD

Objectives: To determine if a 1320nm, pulsed laser has value for fat melting/smoothing and/or skin tightening with and without liposuction, using modified, tumescent anesthesia.

Methods: 50 consecutive patients using this new technology with tumescent anesthesia, with and without significant liposuction were evaluated – immediately after surgery, at six to eight weeks post op and over six to 10 months. All procedures were performed by the same physician, using essentially the same techniques and equipment. Male and female patients, age range 24 to 80 years old were treated. Treatment sites included: lower face, neck, chest, "Buffalo Hump", axillae, flanks, upper arms, torso, buttocks and thighs. Most patients had traditional liposuction and then laser skin tightening. A few patients had minimal to no liposuction, or only laser fat melting and then skin tightening. Lower fluences and mid to higher hertz were useful for popping fat cells (photo-acoustic lysis). Higher fluences and hertz were delivered through a 500 micron fiber, drawn slowly and repeatedly across the inferior (inside) aspect of the tissue after traditional liposuction (modified with IM medications) was performed to initiate skin tightening. Alternatively, a surgical plane was established by blunt dissection after tissue tumescence. The surface temperature of dry tissue was monitored by infrared digital thermometer. It was attempted to bring the surface temperature up to 40 degrees C. Subsets of fluence, hertz and pulses that were used to melt fat photo-acoustically, or to induce enough dermal injury with heat, to lead to skin tightening were demonstrated and compared.

Results: All patients appeared to have clinically smoother contours and tighter skin than previous patients who did not have the benefit of this technology. Whether the smoother contours are secondary to tighter skin or smoother fat resection remains to be determined.

In some cases, skin laxity was actually observed to improve during the procedure.

Fat melting settings were useful in treating fibrous areas including: male breast, anterior/lower rib cage, low back and areas of previous liposuction or scarring. Some side effects including lack of effect, minor superficial burns and skin sloughs were noted during the "learning period" with the laser. None of these were significant, although prolonged healing was noted in five to 10 percent of patients who had areas that stayed pliable and doughy for several weeks to months before returning to normal consistency and tightness. Several torso lipo patients complained of a "girdle-like" tightness several weeks after their procedure. In general, patients who utilized the 1320nm laser had less bruising and postoperative fluid discharge compared to controls and smoother, tighter skin as time from surgery increased and tissue edema completely resolved.

Conclusions: It is clear that while this technology adds additional time to traditional tumescent liposuction, it adds value in decreased bruising and fluid discharge postoperatively and eventually an improved contour and tighter skin. While there is a learning curve in adapting this equipment into one's practice, it provides a new treatment for mild to modest skin laxity, with and without liposuction that does not require skin excision.

9:45 pm Advanced Laser Lipolysis with FDA Approved 1064 Nd:YAG Laser

NEIL S. SADICK, MD

Laser lipolysis has been a major advance in the liposuction venue. The present study outlines our research center's experience with our first 50 cases, in terms of patient outcomes and satisfaction. Skin tightening, bruising and contouring were assessed by blinded physician observation and graded on a quartile scale.

In addition, histologic analyses of effect on the epidermis, dermis and subcutaneous tissues were carried out with a subset of patients. Histopathological analyses reveals fluence-dependent changes at all levels of cutaneous structures, which account for both the adipocyte lipolysis and dermal remodeling effects associated with the clinical efficacy noted with this procedure.

In this state-of-the-art procedure, newer high energy systems will also be highlighted. It appears that laser lipolysis with the 1064-Nd:YAG laser is associated with improved patient outcomes.

10:00 am Lower Eyelid Rejuvenation: When to Fill and When to Cut

MARC S. COHEN, MD

Objective: To discuss a method for determining if patients requesting lower eyelid rejuvenation are best treated with volume enhancing fillers or with traditional blepharoplasty surgery.

Method & Results: The recent widespread recognition of the importance of fat deflation in the aging face has brought about a paradigm shift in facial cosmetic surgery. We now understand that lower eyelid changes can be attributed to the development of periorbital hollows in many patients. Enhancing the appearance of the lower eyelid is often best accomplished by augmenting volume rather than removing skin and fat. Our evolving understanding of the anatomy of aging in conjunction with the development of a practical treatment option with hyaluronic acid fillers has resulted in better outcomes and far fewer patients requiring lower eyelid surgery. However, it is important to remember that many patients requesting eyelid rejuvenation have structural and cosmetic defects of the lower eyelid that are not due to inadequate volume. These patients often require surgical repair. For these patients, fillers are not the answer. This presentation will review a step-by-step method to evaluate patients to determine the best approach to lower eyelid rejuvenation. Our approach is to consider the five R's in evaluating lower eyelids:

1. Removing excess tissue
2. Reinforcing lax lower eyelids
3. Resurfacing to improve skin quality
4. Relaxing dynamic rhytides with Botox®
5. Refilling areas of volume loss with hyaluronic acid fillers

By considering each of these options, a complete treatment plan can be devised and patients will obtain optimal cosmetic rejuvenation.

Conclusion: Rejuvenation of the lower eyelids is often best accomplished with hyaluronic acid fillers alone. However, it is important to remember that not all lower eyelid defects are due to loss of volume. For optimal results, we must systematically evaluate patients to determine which of the many therapeutic options available is most effective.

10:15 am Advances in Aesthetics and Cosmetic Surgery in Darker Skin Types

PEARL E. GRIMES, MD

Featured speaker

Darker racial ethnic groups constitute the majority of the global population. They are often classified as Fitzpatrick Skin Types IV-VI. Such populations include Hispanics, Latinos, Africans, African Americans, Caribbeans, Native Americans, Pacific Islanders, East Indians, Eskimos, Asians, Malaysians and Aleuts.

All races show keen interest in procedures to enhance one's aesthetic appeal. Data from the American Society for Aesthetic and Plastic Surgery for 2005 revealed that the overall number of cosmetic surgical procedures increased 544% since 1997. Darker racial ethnic groups accounted for 20% of all cosmetic surgery procedures performed in the United States.

When considering cosmetic procedures in darker racial ethnic groups, clinicians should be cognizant of the special structural and physiologic differences in the skin of such individuals. These differences can significantly impact and influence cosmetic surgery outcomes. Advantages of deeply pigmented skin include enhanced photoprotection while photoaging changes are minimized. However, the increased content of epidermal

melanin is often associated with pigmentary complications including hyperpigmentation and hypopigmentation. Other issues of major cosmetic concern include hypertrophic scars and keloids. There has been an explosion in new cosmetic surgical techniques and technologies since the late 1990s. Despite this rapid growth, historically there is a dearth of published knowledge regarding cosmetic surgery in darker skin types. However, major recent advances have indeed occurred in expanding our knowledge of the efficacy and safety of a variety of cosmetic procedures for this group of patients. Such procedures include chemical peels, injectable fillers, laser hair removal, botulinum toxin injections, non-ablative and ablative resurfacing procedures as well as radiofrequency treatments.

10:45 am **A New Paradigm for Reversal of Skin Aging**
CARL R. THORNFELDT, MD

Objective: The effectiveness of a novel treatment paradigm to reverse/prevent the signs and symptoms of extrinsic aging process has been documented in four prospective controlled, double-blind clinical trials. The four tested regimens (ER, ERL, EIC) all have a dual mechanism of action: optimization of stratum corneum permeability barrier function coupled with safely reversing/preventing chronic inflammation. The test cosmeceutical formulations are based on highly-purified extracts of date, flax, meadowfoam, rosa mosqueta and lavender in emollient bases. These products do not contain retinols, alpha hydroxy acids, soy or tea. EIC also contains two herbal peptides.

Methods: These non-prescription cosmeceutical products were compared in 81 patients. ER to two mass marketed moisturizers, ERL prescription emollient tretinoin (Renova™) and EIC to nonprescription Idebenone (Prevage MD™). The test cosmeceuticals produced statistically significant results in all epidermal, histologic and dermal parameters of extrinsic aging. All three clinical trials were conducted by a nationally prominent contract research organization with board certified dermatologists grading each clinical parameter.

Results: In a six-month trial versus prescription Renova on dermal ultrasound, ERL produced highly statistically superior ($p<0.001$) dermal thickening. Histologically, ERL produced statistically superior ($p<0.05$) increased epidermal glycosaminoglycan content. There was no statistical difference in any of the epidermal parameters of roughness, fine lines, wrinkles, firmness, hyperpigmentation and clarity between the two products. ERL but not Renova eliminated all visible premalignant actinic keratoses. The test cosmeceuticals induced statistically significant less eyelid contact dermatitis than Renova. ER was statistically superior in all epidermal parameters that were clinically graded in a 16-week and a 12-week trial against commercial moisturizers. The numerical results of ER in both clinicals were superior to those published results of products containing glycolic acids, polyhydroxy acids or kinetin. In the 12-week study against Prevage MD the test cosmeceutical (EIC) was statistically superior in all epidermal parameters. EIC did produce significant dermal thickening while Prevage MD had no measurable impact. With regards to safety, EIC induced no contact irritation while Prevage MD induced a reaction in 30% of the panelists.

Conclusions: These profound clinical results substantiate the validity of this new paradigm for reversing/preventing signs and symptoms of extrinsic aging using a novel botanical-based cosmeceutical to safely reverse/prevent chronic inflammation and optimize barrier function.

11:00 am **Improving Cervicomandibular Definition with Augmentation Genioplasty**
ROBERT H. BURKE, MD

Objective: Describe transoral insertion of implants for mandibular-chin augmentation with review of the Michigan Center experience over a 10-year period.

Methods: Chart review of Michigan Center for Cosmetic Surgery Cases from 1-1-97 to 12-31-06. Preoperative assessment included cephalometric analysis. Presized implants were chosen at the preoperative appointment after review of clinical, radiographic, and photographic findings. Surgery was completed under local anesthesia alone or with conscious sedation. All patients received preoperative antibiotics immediately prior to the procedure. Often the procedure was done in conjunction with other surgical procedures at the same operative session. These included face and body procedures. Implants were placed and secured with a double layer surgical closure and 48 hours of external pressure via facial dressing. All patients were prescribed chlorhexidine for twice daily rinses during the first postoperative week.

Results: These implants were easily placed transorally, avoiding external incisions. Although the ideal candidate had minimal facial assymetry and no other facial skeletal deformities, they also provided clinically acceptable results where there was an underlying skeletal deformity including long face syndrome. They provided increased cervicomandibular definition in all cases, in some instances obviating the need for a rhytidectomy. In other cases, with skin and fascial laxity, cervicofacial rhytidectomy was also required for optimal results. Although introduced through a clean contaminated surgical field, there were no instances of postoperative wound infections. No underlying mandibular bony resorption was noted. Satisfaction was high, with only one patient with a preexisting facial deformity (who had elected not to have corrective skeletal surgery) indicating unhappiness with the result. The most difficult problem was created by thin, tapered implant distal edges which required recontouring prior to placement. Two implants required unilateral distal repositioning due to over-folding of these edges. Transient sensory alteration occurred infrequently in the mental nerve distribution. No facial weakness was noted postoperatively.

Conclusions: Transoral chin augmentation is easily performed on an outpatient basis under local anesthesia alone or combined with conscious sedation. Using a transoral approach avoids external incisions and scars. It may be safely performed in

conjunction with face and body procedures at the same operative session. There is a high degree of safety, a low incidence of postoperative wound infection (zero in this analysis), a high degree of patient satisfaction.

11:15 am **Clinical Experience of Adverse Outcomes Associated with Poly-L-lactic Acid**
NEIL S. SADICK, MD

Objective: To provide the authors' expertise to assess adverse effects with PLLA, and to offer insight on prevention and management of these adverse events.

Methods: The authors present data on adverse events associated with PLLA from their clinical practices, as well as an overview of the safety of semi-permanent products from the literature.

Results: Data from 58 patients treated with PLLA showed that there were nine occurrences of bruises, six of edema, one allergic reaction and one occurrence of benign white nodules. Among 61 patients in the other practice, two patients developed intradermal papules and five patients developed minor bruising within three days of the treatment.

Conclusions: The risk of papules and nodules may be greatly reduced with correct reconstitution of the product and injection technique and massage of the treatment area. Thus, the significant benefits of PLLA coupled with the low and manageable risks provide an acceptable benefit/risk profile.

11:30 am **The Malar Tear Trough Implant**
ROBERT M. SCHWARCZ, MD

Objective: To design an alloplastic implant that addresses both a tear trough deformity, and malar hypoplasia.

Methods: Working in conjunction with an implant manufacturing company, a novel implant is designed to cover both tear trough and malar areas simulataneously. The implant is positioned through a standard sublabial subperiosteal approach with the superior extension placed medial to the infraorbital nerve complex.

Results: The Malar-Tear Trough Implant addresses both tear trough and malar defects with a single implant when placed in the appropriate patient.

Conclusions: Many patients requiring malar augmentation also display signs of a tear trough deformity, often overlooked when addressing the cosmetic improvement of the malar area. This newly designed implant covers both areas with the same ease of placement as standard midface subperiosteal implants. It is an innovative addition to the implant arsenals that can be offered to patients and improve cosmetic outcomes.

11:45 am **Panel Discussion**
Moderator: Suzan Obagi, MD

12:00 - 1:30 pm **Lunch in Exhibit Hall**

1:30 - 3:30 pm **General Session: 103 – The Art of Facial Cosmetic Surgery**
Moderators: Steven B. Hopping, MD & Mark Berman, MD

1:30 pm **S-Lift Updated**
ZIYA SAYLAN, MD

Objective: After performing S-Lift for over 12 years, the technique is now more improved and performed differently compared to the early cases. This presentation will emphasize the improvement of a minimally invasive technique developed and utilized successfully by the author over the past 12 years.

Methods: The purse string formed plication of the SMAS and its fixation to the zygomatic bone (so called S-Lift) was developed by Dr. Ziya Saylan in 1996 and is performed all over the world by a number of doctors who have been personally trained by him and Dr. Steven Hopping during more than 12 workshops and many scientific publications. Dr. Steven Hopping was a supporter and co-innovator of this method from very beginning. The attendees of their meetings have modified this technique and named it different than S-Lift. The origin of these surgeries is primarily the S-Lift and the purse string formed plication of the SMAS which was described by Dr. Saylan and Dr. Hopping at their workshops.

Results: The main differences of the updated S-Lift are: the missing tumescent anesthesia and the skin excision in front of the ears previous to surgery. A third pulse string formed plication under the earlobe and different suturing materials. Also, a serial Platysma notching and an extended neck dissection is performed in older patients to achieve better results. The incision is similar to a conventional facelift and the surgery is than called an S-Lift Plus.

Conclusions: S-Lift is a procedure where the soft tissue (SMAS and ESP) is plicated like a purse string and fixed to the periosteum of the zygomatic bone, a deep dissection is not necessary. The suspension achieved is much more stable compared to conventional facelifts. The S-Lift is a safe, quick and a simple procedure with effective results, suitable for younger patients with very satisfactory aesthetic results. Complication rates and recovery times are low. The procedure limits scarring and gives a more natural look than standard facelifts. The proper combination of less invasive procedures in younger patients can provide results equal to more traditional techniques often with less scarring, short recovery time and more natural results. Part of the aging process is gravity but much of aging is atrophy.

1:45 pm **Complications of the Minimally Invasive Face and Neck Lift**
RICHARD W. BRYANT, MD

Objective: In selling a cosmetic procedure to a patient, the honest surgeon must not only sell the advantages of the procedure, but also educate the patient about the potential risks and hazards a procedure may produce. In recent years there has been a move towards more minimally invasive cosmetic

procedures, including the short scar rhytidectomy. Part of the growing popularity of these minimally invasive facelifts are the selling points of lower cost, decreased postoperative recovery time, and decreased risk of morbidity when compared to the more traditional face and neck lifting procedures. However, in our experience these procedures are fraught with complications similar to those of the traditional techniques.

Methods: A retrospective case series of patients referred to our clinic for evaluation of complications status post minimally invasive face or neck lifting procedure.

Results: Complications encountered included flap necrosis, keloids, hypertrophic scarring, salivary fistulas, extrusion of suture material, infection, pixie ears, early recurrence of platysmal bands and late hematoma.

Conclusions: Although short scar minimally invasive facelifting and necklifting techniques offer the advantages of lower cost with shorter recovery time for the patient, they do not necessarily offer less risk of complication. In our referral-based practice, the minimally invasive procedures have shown similar complication profiles as the more invasive traditional procedures.

2:00 pm **Minimal Incision and Endoscopic Approaches to Facial Rejuvenation**
OSCAR RAMIREZ, MD
Featured speaker

The science and art of facial rejuvenation has evolved significantly in the last two decades. The traditional concept of skin lifting and pulling (facelifting) has been challenged for those who proposed a more comprehensive and radical approach: volumetric facial rejuvenation. This required an in-depth analysis of the facial proportions, aesthetic goals, changes that occur with aging and an assessment of what the contours of youth and beauty are. Parallel to those developments, or perhaps triggered by these, new procedures started to appear in the surgical armamentarium. Among these techniques were the minimal incision and endoscopic approaches. A brief history of endoscopic plastic surgery will be presented. My personal involvement with the inception and evolution of those techniques will be discussed. I will describe step by step the techniques of Endoforehead, Endomidface and Endo Cervicoplasty. I will define the applications and limitations of each one of those procedures. Methods to incorporate contour and volumetric changes will be presented. I will discuss the potential and actual complications that may occur. I will emphasize the aesthetic goals attained in many case examples.

2:30 pm **Mini Open Brow Lift: Safety, Simplicity and Longevity**
JOSEPH NIAMTU III, DMD

Objective: To evaluate a mini open subcutaneous brow and forehead lift technique as compared to endoscopic and other brow techniques. Also to show that this technique allows a precise and lasting elevation of the brow and forehead without elevating the hairline. And to describe a specific incision design provides an extremely esthetic scar by allowing hair follicles to regrow through the actual scar.

Methods: This technique involves a mini open approach where a follicle sparing incision is made 4 mm posterior to the natural hairline using an extreme beveled incision. A subcutaneous dissection is performed under direct vision and, unlike endoscopic techniques, no specialized instrumentation is required. Similar to facelift surgery, skin cut backs are made and suspended with key sutures and the excess skin is excised. The skin excision is performed with a corresponding reverse bevel incision. The bi-beveled incision is designed in a manner that allows hair to regrow through the incision. The incision is closed with two layers and no postoperative dressing is required. 45 consecutive cases of open subcutaneous brow and forehead lift were performed and evaluated in terms of ease of technique, scar quality, postoperative stability and patient/doctor acceptance. The patients were carefully followed with standardized digital photography and were surveyed with questions concerning their experience with this technique.

Results: The technique has proven to be simple, safe and provides lasting brow and forehead elevation. The trichophytic follicle sparing technique is, in fact, effecacious in allowing hair regrowth through the surgical scar. All patients to date were satisfied with postoperative scars. The patients were carefully followed with standardized digital photography, which confirmed excellent and lasting clinical results with esthetic scars. Informal written patient survey confirmed the acceptability of the procedure and its place in the cosmetic surgery practice.

Conclusions: Most surgeons that deal with endoscopic brow lifting will admit that the results are variable. In addition, significant armamentarium and learning curve is required with endoscopic techniques. Endoscopic and traditional coronal brow techniques also elevate the forehead, which can be problematic in patients with already high hairlines. The mini open subcutaneous technique will not elevate the hairline and may even shorten it. This is a straightforward procedure that can be performed with minimal instrumentation. It is a direct vision procedure and includes skin excision that insures a lasting elevation of the brow/forehead complex. Although the scar is initially more visible than endoscopic techniques, it heals extremely well and becomes almost imperceptible with time. This procedure is well accepted by the surgeon, staff and patients and has a minimal learning curve. Any surgeon searching for a simple and predictable procedure should closely examine this technique.

2:45 pm **Percutaneous Brow Suspension**
MOHAN THOMAS, MD

Objective: Endoscopic brow lift is fast becoming the gold standard in brow lift. Lateral brow lift is the key component in periorbital rejuvenation. Medial brow lift is unindicated in

most cases and carries the chance of giving the surprised look. A new and easy method using the principles of endoscopic lift, but without the specialized instrumentation and achieving the same results is presented. Bilateral brow suspension can be done effectively in about 10 minutes. Brow aesthetics, assessment, planning and technical details are discussed.

Methods: 25 cases of brow lift were done using this method, with minimum follow-up of one year. 1cm long incisions are placed inside the hairline in line with the lateral limbus. Subperiosteal dissection is done on the lateral half of brow. The lateral brow is lifted and suspended with sutures to dermis of parietal scalp. Compression dressing is applied to forehead.

Results: The brow position was maintained in 23 of 25 cases. Two patients required revision on one side. Average operating time is 10 minutes. No other complications were encountered. Elevating lateral brow alone was sufficient in all these cases to restore brow aesthetics. Glabellar lines can be softened to some degree by altering the vector, but muscle resection was not done in any of these cases.

Conclusions: Suture suspension of lateral brow is quick, easy and sufficient to restore brow aesthetics. Surprised look, alopecia, and abnormal sensation on scalp can be fully avoided with this method.

3:00 pm **Facial Implants: Making Your Patients Younger, Not Just Tighter**
JOSEPH NIAMTU III, DMD

Objective: The objective of this paper is to convey the importance of midface implants in harmonizing cosmetic facial surgery procedures. Astute cosmetic surgeons realize the importance of rejuvenating the midfacial structures. Unfortunately many patients receive upper and lower facial rejuvenation without attention to the midface. For this reason, some surgeons make their patients look tighter, but not younger. A youthful midface has volume and form, and as we age the malar structures migrate toward the jowls, producing a flattening of the midface and loss of the youthful oval face. Many options exist, including lifting and implant procedures. Implants provide multiple advantages including customization, longevity, symmetry, ease of placement and removal.

Methods: The author has placed hundreds of midface and chin implants and chronicles these cases in a multimedia presentation. Midface implants are easily placed in several minutes using local anesthesia. Local anesthetic infiltration is utilized and a 1cm incision is made intraorally in the buccal sulcus in the region of the canine tooth. Subperiosteal dissection is performed in a specific fashion in order to confine the implant in as small as pocket as possible. It is also important to protect the infraorbital nerve and to tail off the dissection in a tapered configuration over the zygomatic arch. With proper technique, no implant fixation is required. The incision is closed with 4-0 gut suture and the patient is seen one week later. Preoperative diagnisis, intraoperative technique, postoperative care and complications are discussed.

Results: Midface implants provide a simple but effective means of facial rejuvenation. No special instrumentation is required, and the implants can be placed in as little as 10 minutes. The learning curve is reasonable with an excellent safety margin.

Conclusions: A youthful midface has volume and form, and as we age the malar structures migrate toward the jowls, producing a flattening of the midface and loss of the youthful oval face. If facelift and blepharoplasty are the "cake" of rejuvenation, midfacial implant augmentation is the "icing" on the cake. Failure to address midfacial rejuvenation is an error made by even some of the most accomplished surgeons. By augmenting this area, it is possible to restore the form and volume of the youthful face. Although many options exist, none are as versatile as specialized implants. They are simple to place, come in multiple configurations, are reversible, have low rates of complications, and unlike soft tissue suspension procedures do not relapse.

3:15 pm **Panel Discussion**
Moderator: Steven B. Hopping, MD

3:30 - 4:00 pm **Coffee Break in Exhibit Hall**

4:00 - 5:30 pm **Nuts and Bolts Sessions: 104**
(Sessions will run concurrently)

Breakout #1

Location: St. John's 22/23
The Art of Facelifting
Steven B. Hopping, MD & Oscar Ramirez, MD

STEVEN B. HOPPING, MD

Facelifting and facelift patients represent some of the greatest challenges to the cosmetic surgeon. Our quest to fulfill our patients "desire to turn back time" has resulted in the development of myriad approaches to achieve these rejunerative goals. A brief history of the evolution of facelifting will be presented. A reflection of where facelifting has been and where it may be heading will be discussed. Patients more and more are demanding minimal incision approaches to facial rejuvenation that challenge surgeons' skills and ingenuity. Often multi-disciplinary techniques are required in our efforts to achieve such results. Dr. Oscar Ramirez has been at the leading edge of endoscopic facial rejuvenation for many years. A world-renowned master surgeon and teacher, Dr. Ramirez will share his state-of-the-art concepts and techniques of what may prove to be the new standard in the evolution of facial rejuvenation.

OSCAR RAMIREZ, MD

Modern techniques of "facelifting" should emphasize concepts of rejuvenation, beautification and life extension. From the artistic point of view, facial rejuvenation should have definitive aesthetic models of youth and beauty. Surgical execution should be based on sound anatomical knowledge and precise maneuvers to not only rejuvenate the facial contour but also rejuvenate the

facial expression. The essential maneuvers to obtain volumetric restoration will be presented. More advanced concepts of management of the deeper layers and of the skeletal foundation will be discussed. Simple techniques such as fat grafting and modifications of the standard "facelifting" will be outlined. More advanced concepts of specific facial implants and management of the deep neck structures will be discussed. For those not familiar with the intricacies of these techniques, the fundamental aesthetic knowledge of facial contour and proportions as applied to facial rejuvenation using fillers and other nonsurgical methods will be discussed.

Breakout #2

Location: St. John's 24/25

The Art of Upper Face and Eyelid Rejuvenation (Browlifting)
Susan Hughes, MD, Angelo Cuzalina, MD, DDS, & Joseph Niamtu III, DMD

Aesthetic concerns in the upper facial third and midface affect a wide range of age groups. The challenge is in accessing each patient to determine who may really benefit from any procedure. The endoscopic brow lift was developed nearly 15 years ago and is considered by many as the gold standard when dealing with brow ptosis and a normal hairline. However, open brow lifting using a trichophytic incision has had resurgence in popularity and can be an invaluable technique when properly performed on the appropriately selected individual. Both techniques offer a dramatic effect when used to specifically elevate and correct lateral brow hooding. The indications and details of each procedure, along with an anatomic review, will be addressed by each author.

The periorbital regions and midface are often neglected or misunderstood regions of the face that may benefit from brow lifting techniques mentioned, but typically require a variety of additional procedures for total rejuvenation that often includes soft tissue augmentation and skin resurfacing procedures. Critical assessment of the eyelids and their supportive tissues is mandatory for results with minimal complications, and will be reviewed by the authors.

Society's idea of beauty at any one moment in time will ultimately help guide the patient and surgeon to choose the ideal treatment plan for an individual versus merely raising a brow 'higher'. Total rejuvenation is more complex and involves multiple modalities and often tissue replacement. History will prove what best restores youth to the upper face. This two-hour review will include a discussion with the panel at the end to help answer questions and promote ideas for treatment of a region that cannot be best served by only one modality of treatment.

Breakout #3

Location: St. John's 26/27

The Art of Autologous Fat Transplantation
Mark Berman, MD & Suzan Obagi, MD

MARK BERMAN, MD

These two doctors will cover the basics for fat grafting techniques, from harvesting to injection. They will explain how we age (the three-dimensionality of the aging process) and why and how fat can be used to restore facial contours depleted by aging. In fact, they will show how fat grafting should be considered as the primary method of performing blephaorplasty and is fundamentally necessary for improving the aging face. They will explain how fat can be used on developmental defects that occur regardless of age, as well as to repair many iatrogenic defects following surgery for the aging face. Also, they will demonstrate fat graft for use in repairing other iatrogenic defects. There will be an emphasis on technique and opportunity for discussion.

SUZAN OBAGI, MD

The role of facial volume restoration is continuing to gain importance. Most patients undergoing cosmetic surgery will benefit from some degree of volume replacement, especially in the midface. This course will cover two different approaches to autologous fat augmentation. Patient selection, intraoperative techniques, and complication management will be covered. Emphasis will be on proper placement of fat in various anatomic sites.

Breakout #4

Location: St. John's 28/29

Pushing the Limits in a Board Certified World
Dana Fox

Everything you thought you knew about medicine has changed! You thought going to the best medical school and training under the most prestigious physicians in your chosen specialty would assure a vibrant practice. Not so today. It's a whole new, more competitive, more aggressive world.

Learn how to take your medical pathway and turn it into a unique cosmetic surgery story that will attract more of the patients you want. This course will deal with how to talk about "you" in a very proactive way; it's not about advertising or marketing, it's about transitioning from traditional medicine into aesthetic medicine.

Determine:

- What percentage of your practice will become cosmetic
- What procedures you will you lead with
- What skills your staff will need that they don't have now

4:00 - 5:30 pm **Free Paper Session**

Location: General Session – Gatlin E

Moderator: E. Antonio Mangubat, MD

4:00 pm **Techniques for Hair Restoration in Women with Androgenetic Alopecia**
MARCO N. BARUSCO, MD

Objectives: To provide the participants and faculty with a review of hair loss in women, including etiology, clinical patterns, diagnosis and treatment modalities.

Importance: For women, the presence of hair loss is extremely stressful due to the overall lack of social acceptance of women with thin hair, and depression and anxiety disorders are very prevalent in this population. Among the many causes of female hair loss, the most common is the Androgenetic Alopecias (AGA). Physiologically, hairs that are genetically predisposed to suffer from the hormonal aggression undergo a process of miniaturization, during which each hair follicle's growth cycle changes, with lengthening of the telogen phase and shortening of the anagen phase. This process translates to clinically visible thinning of the hair shafts, which causes the scalp to be seen. With the progression, hair styling becomes increasingly difficult, creating severe distress and frustration to the patient. As in men, there is a strong familial pattern to the incidence of FPA and enormous variability as it relates to age of onset, degree of hair loss and amount of hair lost. However, FPA has distinct characteristics that differentiate it enough from MPA to warrant different approaches to diagnosis and treatment.

Methods: Medical treatments are available for FPA. They will be discussed as well. Perhaps the most challenging aspect of the treatment of women with AGA is to manage the expectations of the patient. Women may have large areas of loss and miniaturization also in the donor hair zone, limiting the possibility of success. Medical treatment associated with surgery is always preferred over surgical treatment alone. As with any medical procedure, the physician must perform a thorough examination of the patient's scalp, including hair analysis under magnification. Medical history, current medications and hair loss history must be known in detail. In our office, we have developed a hair loss questionnaire that addresses in detail every aspect of this condition, as experienced by the patient. Once determined that surgery is the best course of action for the patient, the planning should involve the determination of the area (or areas) to be addressed, the most adequate area for harvesting of the donor hair and the instrumentation that fits best the type of hair. The surgical technique has to be precise, and the physician must be extremely careful with the surrounding natural hairs in the area in order to avoid unnecessary trauma. Results from hair restoration surgery are typically seen fully within 12 months, and most women will require further surgery as their hair loss process progresses.

Results: Preoperative; one year post-surgery.

Conclusions: With the right planning and execution, the patient will have very natural results and will be forever thankful. When done correctly, restoring the hair for these patients will not only improve their appearance, but most importantly their psyche.

4:10 pm **Eyelash Transplantation: A Novel Approach**
ALAN J. BAUMANN, MD

Introduction: The use of 'one-step' eyelash transplantation as previously described and demonstrated by Dr. Marcelo Gandelman (Sao Paulo, Brazil) is well suited for cosmetic and reconstructive upper eyelash enhancement. The author will present a brief overview of his methods of patient selection, patient education and informed consent, in addition to his OR setup, technique and post-op care. The author will also describe and demonstrate his novel approach to the technique, a 'pairing' method of implantation which allows larger numbers of hair follicles to be implanted into the lid, as well as several 'pearls' for improved efficiency and aesthetic outcome. Information regarding a new, nonsurgical cosmetic eyelash enhancement treatment will be presented.

Methods: The technique described requires the operating surgeon to have two assistants.

Pre-op/Prep: Diazepam 10mg p.o., scalp-wash performed; alcohol swab prep of lid, topical 4% lido applied to lid and donor area.

Donor Area: Local anesthesia is applied to an area of untrimmed scalp (2% lido w/1:100,000 epi) using computerized injection, 0.5% bupivicaine applied.

- Small linear harvest (e.g. 5cm x 0.5cm) with trichophytic closure is performed using single layer running 5-0 Monocryl.
- Surgeon: Using loupe magnification, implantation is started medially working toward lateral aspect. Care is taken to ensure proper orientation, position and curl. A staggered 'entry' pattern is recommended.
  1) Needle entry (~10mm from lid margin), working superficially to the
  2) Needle exit (at lid margin)
  3) Disengage the hair from eye-needle and pass the empty needle off field (to be 'rethreaded' by Tech #2)
  4) Pull hair through, upward/vertical motion, orienting the hair curl and base of the follicle appropriately
  5) The follicle base should be positioned under the skin, just beyond the needle entry point
  6) Trim hair to ~2.0cm length
  7) Repeat

After last lash is implanted, a cold compress is applied. Local anesthesia and implantation then commences on contralateral eye. Transplanted follicles and lashes are examined for appropriate orientation, and positioning adjustments or removals can be made at this time. Trimming lashes to 15mm length or less is recommended at this time.

Sequelae/Complications/Common Concerns:
Hordeolum (Sty): Staphylococcus aureus is the most common bacteria found in a hordeolum. A hordeolum will generally drain spontaneously within five to seven days, or with the application of hot compresses or soaks. When drained, the sebum has a thick, cheesy consistency. Patients are instructed to contact the office if a sty develops and/or lasts longer than one week.

Conclusion: Due to the potential for serious and/or permanent complications, it is recommended that physicians and their technicians should not attempt to perform eyelash transplantation before receiving appropriate educational training. The author encourages all physicians to obtain full informed consent from all patients who request eyelash transplantation, which includes the risks, benefits and alternatives, as well as the experience of the surgeon performing the procedure.

4:20 pm Safe & Effective Eyelash Enhancement with Lumigan

NANCY G. SWARTZ, MD

Objective: Lumigan (bimatoprost) Ophthalmic Solution can increase the number, length, thickness, and color of eyelashes. This presentation reviews the safe and effective use of this medication for enhanced cosmesis.

Method & Results: Universally, woman desire longer, thicker and darker eyelashes. This issue is especially troublesome as women age and lose lash length and volume. In the past, this has been addressed primarily through the cosmetic industry with mascara, artificial lashes, eyelash tinting, and eyelash extensions. More recently, eyelash transplants have become available. However, these procedures are tedious, difficult to perform, and yield mixed results. Most cosmetic surgeons do not offer any treatment options to their patients for this common problem. Prescription topical prostaglandin agonists such as bimatoprost have been FDA-approved for the treatment of glaucoma for many years. These eye drops offer an excellent safety profile and, in fact, have become a first line treatment for primary open angle glaucoma. Side effects are usually mild and reversible. One of the most common "side effects" of topical prostaglandin agonists such as bimatoprost is growth and darkening of the eyelashes. Thus, bimatoprost offers a noninvasive medical treatment to significantly improve appearance by enhancing eyelashes. This presentation will demonstrate the science behind the lash growth caused by bimatoprost. There will be a review of what non-ophthalmologist cosmetic surgeons need to know in order to safely select patients for this treatment. Additionally, there will be a step-by-step discussion on how to implement this treatment, with the goal of optimizing results and minimizing complications.

Conclusion: Most women desire longer, thicker and darker eyelashes. Because there have not been good treatment options in the past, this cosmetic need has been ignored by most cosmetic surgeons. Bimatoprost offers an easy, exciting and effective way to enhance appearance by increasing the number, length, thickness and color of eyelashes. With the appropriate management, this treatment is safe for most patients and is easy to incorporate into an aesthetic practice.

4:30 pm Lower Eyelid Skin Pinch Blepharoplasty: A Small Procedure with Big Results

JOSEPH NIAMTU III, DMD

Objective: To discuss the history, basis and technique of lower eyelid skin pinch blepharoplasty as it relates to cosmetic eyelid surgery.

Methods: The author will discuss the historical significance and evolution of lower eyelid skin pinch blepharoplasty, and detail his personal experience of dealing with lower eyelid dermatochalasia over the past decade. This procedure and its relevance and comparison to other methods of lower eyelid dermatochalasia including skin/muscle excision, laser resurfacing and chemical peel are reviewed.

Results: 30 cases of lower eyelid skin pinch blepharoplasty are reviewed in a multimedia presentation focusing on diagnosis, preoperative considerations, intraoperative technique, postoperative management and complications.

Conclusions: The skin pinch blepharoplasty is a safe and simple procedure to assist in the management of excess skin in the lower eyelid. It is easily learned by the novice and has a place in the armamentarium of the advanced eyelid surgeon. This procedure can provide safe and effective treatment of lower eyelid dermatochalasia without significant risk of middle lamellar disruption or eyelid malposition.

4:40 pm Anterior Platysmaplasty as a Routine Component of Cervicofacial Rhytidectomy

TIRBOD FATTAHI, MD, DDS

Objective: The purpose of this study was to evaluate the aesthetic value and benefit of anterior platysmaplasty as a routine component of every cervicofacial rhytidectomy performed.

Method: Every patient desiring facial rejuvenation who was deemed to benefit from a cervicofacial rhytidectomy was counseled on the benefits of a deep plane face lift (sub-SMAS) as well as anterior platysmaplasty in order to improve the appearance of the entire face and the anterior neck. The anterior platysmaplasty was explained in detail to each patient using diagrams and illustrations. The sub-MAS face lift was also explained, including the benefits of the posterior and lateral pull of the platysma. Each patient underwent a standard platysmaplasty and open submental liposuction through a submental incision and a sub-SMAS face lift. The redundant portion of the platysma or bands (if present) was sharply excised, and the anterior edges were imbricated to create a pleasing cervico-mental angle. The posterior edges of the platysma were elevated via the face lift approach and anchored to the deep fascia of the mastoid region to further delineate the jaw line. Fibrin sealant was applied to the surgical site prior to closure. No drains were used. The anterior platysmaplasty was performed in every patient, regardless of the degree of platysmal redundancy or banding. Photographs of each patient were taken at every postoperative appointment. Patients were asked to subjectively assess their degree of satisfaction at four months postoperatively.

Results: Each patient was very satisfied with the overall result of the surgery, especially the appearance of the anterior neck. All patients reported a "tight" feeling in the anterior neck in the first week following surgery; otherwise, no patient reported any adverse effect associated with the platysmaplasty component of the procedure. There were no complications associated with the anterior platysmaplasty.

Conclusion: Irrespective of the amount of platysmal laxity in the anterior neck, or the presence/absence of platysmal banding, an anterior platysmaplasty through a submental incision (including removal of the anterior portion of the platysma muscle) significantly improves the overall results and benefits of a cervicofacial rhytidectomy. The author has found that when performed simultaneously with a sub-SMAS face lift, the combination of anterior vector of pull via the platysmaplasty and the posterior and lateral vector via the sub-SMAS platysma elevation, the appearance of the neck can be significantly improved. This is done now routinely by the author on every patient requesting a cervicofacial rhytidectomy. It is important to highlight that the anterior platysmaplasty can also be combined with mini-face lifts (S-Lift, J-Lift), or mid-face lifts.

4:50 pm **Volumetric Face Lift**
VIJAY SHARMA, MD

Objective: Transferring the fat from lower half of the face to the upper half by liposuction, Lipo shifting and Lipo grafting.

Methods: Auto fat grafting from lower half of face to the upper half. Fat is being extracted by liposuction and then reimplanted in the upper half of the face.

Results: Volumetric Facelift is based on Lipo shifting to reestablishing the lost glory.

Conclusions: With auto fat grafting from lower half of face to the upper half we can do the reversal of triangle, make the face less heavy in lower half, and revitalize the prominent cheek area.

5:00 pm **Restylane® Versus Juvederm™ in the Nasolabial Fold: A Prospective Blinded Study**
WAYNE P. FOSTER, MD

Objective: Compare two hyaluronic acid products for longevity, patient satisfaction, physician satisfaction.

Methods: Hyaluronic acid products have become a common filler for facial rhytid augmentation. Variations in molecular cross-linking change the viscocity, softness and durability of the product. Claims have been made concerning the quality, durability and patient satisfaction of the products but not independently verified or refuted by our approach at the time of the submission of this abstract. This study is to directly compare two popular hyaluronic acid injectable fillers.

Beginning in February 2007, we injected Restylane® into one nasolabial fold and Juvederm™ into the other in 25 prequalified women, age range 27-60. The injections were randomized to side and the procedure standardized. The five point scale was used to rank the nasolabial folds. The patient was blinded and the observer blinded upon follow-up. The nasolablial folds were then evaluated immediately, at one week and then monthly until all product was undetectable. At each follow-up visit, each patient and the observer independently evaluated the nasolabial fold for product palpability, naturalness of the feel and appearance, improvement of the appearance, complications and lumpiness. The patient was completed when the nasolabial fold returned to baseline in appearance and no product was detectable.

Results: No complications were experienced during this study. Patient evaluation, observer evaluation, and longevity comparisons of the two products will be presented following the statistical analysis.

Conclusions: The data collected will provide insite and either support or refute claims made concerning these two products. We shall also discuss the chemical compound and the chemical difference between the two products.

5:10 pm **A Retrospective Analysis of the Safety Profiles of a New Plasma Skin Regeneration Device Compared to CO_2 Lasers**
KENNETH ROTHAUS, MD

Purpose: Although the CO_2 laser is considered the industry gold standard for laser resurfacing, many cosmetic surgeons have abandoned the technology due to the complications and prolonged recovery. Plasma Skin Regeneration is a new non-ablative technology which at high energy approaches CO_2 results, has a higher safety profile, faster recovery time, and can safely be used as an adjunct procedure for patients undergoing rhytidectomies and blepharoplasties to enhance aesthetic outcomes. In addition, Plasma Skin Regeneration does not require a dedicated operating facility, sedation, or specialized safety equipment. This report analyzes the safety/efficacy profiles of the plasma devices in comparison to the CO_2 laser.

Materials and Methods: A review of current literature regarding patient outcomes (~1,100 patients) from CO_2 laser resurfacing was done. In addition, a retrospective analysis of high energy Plasma Skin Regeneration patients over the past two years (120 patients) at two sites was performed.

Results: The incidence rate of the following complications was assessed: hypopigmentation, hyperpigmentation, persistent erythema, scarring, and bacterial and viral infection. For CO_2 patients, the most common adverse effects noted were hyperpigmentation (transient and other 21-34%), bacterial and viral infection (7-8%) and prolonged erythema. Reports of late hypopigmentation range from 8-20% of CO_2 patients evaluated. Scarring was rare. Average initial recovery time for CO_2 patients is two weeks; however, erythema lasting two to six months was common. Of the 120 plasma patients evaluated, half were over a year post-treatment, and the others were at least six months. Patient and physician-rated improvements with the Plasma Skin Regeneration vary based on energy level used (3.0 to 4.0 Joules) and ranged from 30-70%. The average recovery time

was less than seven days. There were no cases of prolonged erythema and no cases of hypopigmentation in the plasma patients. Herpes Simplex occurred in one patient who did not prophylax with anti-viral medication. Other isolated events were post-inflammatory hyperpigmentation (4%) which occurred in Fitzpatrick Skin Type III and IV only. Isolated spots of delayed healing were occasionally seen when patients prematurely removed re-epithelializing skin and were treated with topical or oral antibiotics as needed. This resulted in one iatrogenic minor scar being observed. Skin tightening and improvement in rhytides were noted in all patients and approached results seen with CO_2.

Conclusions: Due to the risk of complications and prolonged recovery, many cosmetic and laser surgeons have sought alternatives to CO_2 laser resurfacing as an adjunct to surgery. Plasma Skin Regeneration is a new non-ablative technology which, at high energy, approaches CO_2 results in terms of wrinkle reduction and skin tightening. The complication rate with Plasma Skin Regeneration is extremely low, has a high safety profile, short recovery period and represents a technological advancement in resurfacing for the aesthetic surgical patient.

5:30 pm **Adjourn**

6:00 - 7:30 pm **Welcome Reception in Exhibit Hall**

Added Session for Office Staff and Ancillary Personnel

The 2008 Cosmetic Surgery Practice – Office Challenges and Solutions

1:30 - 3:30 pm **Presented by: Julia S. Hopping**

Location: St. John's 22/23

A panel of office managers and staff will discuss the keys to achieving success in today's competitive cosmetic surgery market. Issues from staffing, nursing, office-based surgery, malpractice, marketing, medical spas, office efficiency and productivity will be discussed. Julia Hopping will moderate the panel discussion after a short presentation introducing the issues. Participants will be encouraged to interject.

FRIDAY, JANUARY 18, 2008

SCHEDULE-AT-A-GLANCE

6:30 am - 4:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 105
8:30 am - 4:00 pm	Exhibits Open
8:30 - 9:15 am	Continental Breakfast in Exhibit Hall
9:15 am - 12:00 pm	General Session: 106 – The Art of Cosmetic Body Surgery
12:00 - 1:30 pm	Lunch in Exhibit Hall
1:30 - 3:30 pm	General Session: 107 – The Art of Cosmetic Body Surgery
2:30 pm	Webster Lecture: Robert F. Jackson, MD
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Nuts / Bolts Sessions: 108
5:30 pm	Adjourn
7:00 - 11:00 pm	Webster Society and Cosmetic Surgery Foundation Recognition Dinner

FRIDAY, JANUARY 18, 2008

7:00 - 8:30 am **Bright Eye Sessions: 105 (Sessions will run concurrently)**

Breakout #1

Location: St. John's 22/23

Advances in Liposuction Surgery
Edward B. Lack, MD & Gerald G. Edds, MD

EDWARD B. LACK, MD

Guillermo Bluggerman deserves credit for introducing infrared laser assisted liposuction more than a decade ago. Since then, both Cynosure and CoolTouch have introduced YAG infrared lasers capable of delivering light energy through a fiber optic tip in an attempt to advance or circumvent the liposuction process. They have a made claims of more rapid treatment, better healing, better skin retraction, and the ability to dissolve fatty deposits in small areas without the need for aspiration.

GERALD G. EDDS, MD

Venous Thromboembolism (VTE) Prophylaxis in Liposuction

Current medical literature is quite specific in defining the need for VTE prophylaxis in cosmetic surgery patients. Liposuction patients frequently present with significant risk factors for VTE. Major risk factors include obesity, prior history of VTE, use of

oral contraceptives or hormone replacement therapy, older age, trauma and a prior history of VTE. The incidence of Pulmonary Embolus is as high as 3.5% in obese and bariatric patients. This discussion will include the identification of specific risk factors in liposuction patients, differentiation between active and passive mechanical prophylaxis and explain the risks and benefits of anticoagulant prophylaxis.

Breakout #2

Location: St. John's 24/25

The Art of Abdominoplasty – Traditional vs. Avelar, etc.
E. Antonio Mangubat, MD & Michael H. Rosenberg, MD

Abdominoplasty and liposuction are essential elements to effective body contouring. With traditional abdominoplasty, concomitant liposuction of the abdomen has been either discouraged or very limited in scope, thus limiting the magnitude of the results of the initial surgery. When liposuction of the abdomen is known to be essential, a staged approach is required for patients having the traditional abdominoplasty. This is followed by aggressive liposuction of the abdomen several weeks later.

The main reason for requiring this conservative approach is the significant compromise of the abdominal vascular supply that occurs with traditional abdominoplasty procedures. In fact, the majority of major arteries are lost in the performance of a traditional abdominoplasty, and there is often permanent loss of sensation.

The Avelar Abdominoplasty (named after Dr. Juarez Avelar, who introduced the concept in the late 1990s) changes the entire dynamic of abdominoplasty by allowing the preservation of the neurovascular supply of the abdominal skin while not limiting the amount of skin excision. This increases the safety profile of this procedure in theory and in practice. For instance, those patients with significant transverse abdominal scarring, e.g. a Kocher cholecystectomy incision, have not traditionally been abdominoplasty candidates. Dr. Avelar's concept changes the entire dynamic.

Interestingly, there are abdominoplasty candidates who are not suitable for the Avelar technique. In general, a significant abdominal fat layer is required in order to achieve enough vessel length to allow preservation of the vascular structures. Fortunately, in the USA, this is rarely a problem.

In summary, the Avelar Abdominoplasty has significantly changed the landscape of body contouring by allowing greater shape control and size reduction, eliminating some contraindications, eliminating drains, allowing patients to experience postoperative recovery much like a simple liposuction procedure, and increasing the safety by preserving vascular supply.

Breakout #3

Location: St. John's 26/27

The Art of Tumescent Liposuction
Dee Anna Glaser, MD & Gregory C. Roche, DO

DEE ANNA GLASER, MD

Information not available at press time.

GREGORY C. ROCHE, DO

Dr. Greg Roche will be speaking on tumescent anesthesia for liposuction procedures. A review of the application of tumescent in surgery, I hope to present a "how to do" procedure including safety, effectiveness, control and appropriateness to the audience.

Breakout #4

Location: St. John's 28/29

It's Medicine and Yes, It Is Retail
Susan Browner, Principal, Patient Space

This presentation will help cosmetic surgeons better understand how to:

- Create a continual in-office source of referrals for major surgical procedures
- Offer the ancillary procedures and services that will draw and retain patients in your practice
- Build a profit center that generates a solid cash flow even when you're not in the office

The fact is that a happy patient is a healthier patient. There is no doubt that we all care about how we look. By offering high-quality skin care products and ancillary services, you have a chance to make your patients happier and healthier – the definition of best medicine. But it isn't easy to run a successful ancillary profit center. This course will show cosmetic surgeons how to create a successful profit center and is suited for those just starting, as well as those who have already enjoyed some success.

The challenge for today's doctor is not about breaking new ground in terms of medical ethics; rather, it's about being able to compete successfully when you provide your patients with skin care and cosmetic products and services. Attendees will learn how to succeed in this highly competitive world of "one-on-every-corner" day spas.

Managing the sales experience in a doctor's office is an opportunity to promote the doctor's talents, to increase procedures and to build long-term patient loyalty. The best practices achieve buy-in and cooperation from staff, overcome obstacles to the sale and turn a single-procedure patient into a loyal multiple-procedure patient without creating a strain on the staff.

This approach works for any practice that offers elective aesthetic, fee-for-service based procedures – and is beneficial to plastic and cosmetic surgery specialties, including OB/GYN, Maxillofacial and ENT.

Bottom line: Practices that do not include skin care and other ancillary procedures are not fully meeting their patients' needs, and are not taking advantage of a very important revenue stream.

Breakout #5

Location: St. John's 30/31

Marketing Communications, Are You at Risk?
Theresa Essick, VP Clinical Risk Management
Medical Protective

Setting and maintaining appropriate patient expectations is critical to reducing liability risk in the clinical practice. This program is designed to explore the risk associated with multiple areas of marketing media in the healthcare industry, and offers risk reduction strategies that providers will be able to use in their clinical practice settings.

8:30 - 9:15 am **Continental Breakfast in Exhibit Hall**

9:15 am - 12:00 pm **General Session: 106 – The Art of Cosmetic Body Surgery**
Moderators: Ronald L. Moy, MD & Neil S. Sadick, MD

9:15 am **Avelar Concept Applied to Body Lifting**
E. ANTONIO MANGUBAT, MD

Introduction: Avelar developed the concept of lipo-abdominoplasty, where liposuction is used not only to excise fat but also to mobilize the skin flap. This allowed mobilization and excision of skin equal to that of a traditional abdominoplasty while preserving the neurovascular perforators and increasing the safety of the procedure. Avelar's concept is useful where any large skin excision is planned, including circumferential body lifting, which is the simultaneous combination of posterior body skin excision and abdominoplasty.

Methods and Materials: We applied the Avelar concept to circumferential body lifting in six patients. Standard tumescent liposuction solutions were used for infiltration. Liposuction was carried out using the fat disruption technique previously described. Average supernatant volumes aspirated was 4.6 liters. After liposuction was performed, the skin excision was estimated by using towel clamps to plicate the skin to be excised. The clamps could be adjusted to determine the exact location of the incision. When satisfied with incision location and skin tension, the clamp positions were marked, allowing precise measurement of the skin area to be excised.

Results: Complications and side effects were minor in this limited study. Significant complications, infections, seromas, hematomas, dehiscence, etc. were not observed. Patient satisfaction was universally high and postoperative pain was reported to be less than expected.

Conclusions: Our experience with over 250 Avelar-type abdominoplasties has demonstrated its safety and utility in body sculpting by allowing both the sculpting of the fat layer simultaneously with skin excision. Applying the Avelar concept to body lifting improves the procedure by decreasing bleeding, increasing speed, and improving body contouring because liposuction can be performed simultaneously to refine results. An unexpected discovery is a technique that allows us to pre-measure the amount of skin to be removed before the final excision. Furthermore, we can fine tune the placement of the scar before making the final skin excision. A video of the new procedure will be presented.

9:30 am **Resorbable Internal Staples for Abdominoplasty Closure**
ANGELO CUZALINA, MD, DDS

Objective: Achieving a youthful abdominal contour by abdominoplasty is a common desire for many cosmetic surgery patients. Unfortunately, the incision is usually long and can be time consuming to close. The scar can often have track marks or widen with traditional suture and stapling closure techniques. Over the last 15 months, we have employed a new device called the "Insorb Resorbable" internal stapler device to improve tummy tuck incision closure efficiency and appearance of the scar.

Methods: Patients selected for this technique were ones who were undergoing any type of abdominoplasty where either a low horizontal incision or vertical incision was made. The technique involves standard approaches to abdominoplasty until final closure when the skin edges are advance at the deep fascial layer only followed placement of Resorbable staples in the deep dermal plane by means of the Insorb instrument. No subcutaneous sutures are required and no skin suture needed which increased efficiency during surgery as well as follow-up visits. The device uses small staples that are made of polylactic and polyglycolic acid to firmly secure the skin in an everted fashion from below skin level.

Results: 355 abdominoplasty patients by the same surgeon were reviewed from June 1999 to May 2007. The last 109 have employed the use of Resorbable staples. Patient evaluation forms were used to evaluate our traditional technique vs. the new closure method, which was preferred by both patient and surgeon. The postoperative scar was obviously better than past techniques in the majority of patients, and follow time decreased with no suture removal. The actual surgery times were also notably decreased.

Conclusions: Compared to traditional suturing and/or stapling techniques, this technique saves some time and has produced better quality abdominoplasty scars in our hands. The Insorb Resorbable stapler is a wonderful new tool to improve traditional and Lipo abdominoplasty results. The technique has a short learning curve to get ideal placement of the staples, but has greatly improved our tummy tuck scar results.

9:45 am **Minimally Invasive Lipolysis**
ADAM M. ROTUNDA, MD
Featured speaker

Minimally invasive fat loss is becoming the next frontier in aesthetic medicine. Light and energy devices, as well as injectable therapies, are increasingly acknowledged as viable options in the treatment of our patients seeking alternative methods from liposuction to treat fat. Despite our growing interest and patient demand, we must be cautiously optimistic as we gain a better understanding of the benefits and limitations of these treatments. An overview of existing and emerging technologies will be presented for the audience to gain a better understanding of their underlying science and what future these therapies may have in their practice.

10:15 am **Results of My 3,126 Bilateral Submuscular Breast Augmentations**
TED EISENBERG, DO

Objective: This retrospective study reviews all complications incurred from the author's consecutive 3,000-plus bilateral submuscular breast augmentation procedures performed from 1997 through 2006. These complications were compared with those reported in the *FDA Breast Implant Consumer Handbook: 2004* and the *Mentor's Post-Approval Study*.

Methods: Patients were evaluated postoperatively, from three months to 10 years, for complications including postoperative asymmetry, deflation, capsular contraction, hematoma, infection, and scarring. Breast augmentation operations were performed with round, smooth, Mentor saline implants (Style 1600), ranging in size from 125cc to 775cc and placed submuscularly (100%) through an inframammary incision. All were given prophylactic antibiotics. Patients received general anesthesia in a hospital operating room; all but two were prepped with betadine. Every case was performed with direct visualization, blunt submuscular dissection, and meticulous hemostasis. Maximal submuscular pockets were made to the breast's natural limit and antibiotics were included in the irrigation. Incisions were presutured prior to inflation of the implant. Only I touched the implant after washing my gloves with the antibiotic solution, and the implant was also bathed in the antibiotic solution. The implants were insufflated through a closed sterile fill system, and fill volume limits were strictly adhered to, with no over or under inflation.

Results: Minimal complications were seen. The total reoperation rate for complications was 5.3% over the 10-year period, compared to FDA findings of a 20-26% overall reoperation rate at five years. The most common complication, postoperative asymmetry, occurred in 3.1% of patients; of these, 95 patients had a high-riding implant, and three had a low-riding – or "bottoming out" – implant. The second most common cause for reoperation was deflation, which occurred in 51 patients (1.6%), compared to the FDA reports of 7-10% percent at five years. The incidence of grade III and grade IV capsular contraction was three in 3,126, or less than .09%, while the FDA reported a 10-11% incidence of capsular contraction at five years. Similarly, hematoma occurred at .09%, compared to the Mentor study of 3% at seven years. Infection was seen in two patients, or .06%, contrasted with Mentor's 2% at seven years. Hypertrophic scarring also occurred in only two patients (.06%), while Mentor reported 1% at seven years.

Conclusion: This paper represents a large and long study of submuscular saline breast augmentation by a single surgeon performing the same technique, a fact which helps to standardize the reported results. That these results are more favorable than those reported by the FDA and Mentor may be attributed to surgical technique and the type of implant used. I've also identified that the prevention of postoperative asymmetry, my most common complication, may be limited by certain anatomic factors, such as a short distance between the nipple and inframammary crease especially in nulliparous women, very ptotic breasts, and more pronounced preoperative asymmetries. The outcomes of this 10-year study demonstrate that submuscular saline breast augmentation is a very acceptable, safe and effective method of breast enhancement.

10:30 am **Complications of Breast Augmentation: Techniques for Revision and Repair**
JANE A. PETRO, MD

Objective: Late complications associated with breast augmentation include asymmetry, capsular contracture, infection, extrusion, rupture, scar deformation, double bubble and rippling which may require secondary revisions. An unsatisfactory result may or may not be a complication of the primary procedure. Patient dissatisfaction with size or shape also contributes to reoperation rates.

Methods: Retrospective review of secondary operations on breast augmentations involving removal and replacement over 10 years in patients operated on at the Institute for Aesthetic Surgery and Medicine.

Results: We will review the procedures and outcomes used in over 100 patients who had breast augmentation revisions during the previous decade. Many of these secondary procedures were for patients specifically referred for their revision.

Conclusions: The types of complications seen and their outcomes are dependant on an appropriate primary surgical procedure and, when secondary issues become significant, on an even more complex decision-making process. A successful revision requires multiple surgical skills and a tool kit that includes alloderm, tissue expanders, silicone implants, and a well-informed, emotionally-stable patient. Failure to recognize anatomical limits, medical conditions, emotional instability, and other factors contributing to a poor outcome may also complicate revisions. By reviewing our cases and discussing our results, we will better understand those factors important in reducing

unsatisfactory outcomes. While the emphasis will be on cosmetic augmentations, we will include some examples of breast reconstruction following mastectomy that require revisions as well.

10:45 am **Technique Changes Necessary for Gel Implants Compared to Saline**
ANGELO CUZALINA, MD, DDS

Objective: To outline rationale, surgical technique, sizing and avoidance of common complications associated with placement of silicone gel implants compared to placement of saline implants. Specific attention will be given to addressing the advantages of silicone gel implants while outlining the rationale for their use and how the technique will change for placement of gel vs. saline implants. Surgeons with limited experience using the new gel implants should benefit from a discussion of the changes in technique required for best results.

Methods: A 10-year period of breast augmentations performed by the same surgeon was reviewed. Analysis of complication rates and long-term success are also evaluated, based on number of common complication over this time period and percentages compared between saline vs. gel implants. Common pitfalls are also addressed when placing gel implants, as well as advantages of these implants over saline, particularly for specific patients. Video technique presentation will be included.

Results: The initial year included only 2% of the patients receiving silicone gel compared to saline. Two years ago, before the FDA allowed widespread usage of gel implants, the percentage of gel implants being used in this practice was 12%. Since that time, the percentage of gel implants has risen in this practice to 54%. The dramatic increase in patients wanting gel necessitated a comprehensive approach for sizing and placing gel implants for maximum results. Complication rates for capsular contracture and infection were equal among our patients. Overall patient satisfaction was as high as expected for both groups, based on patient satisfaction surveys. However, the highest scores came from patients who had saline and changed their implants to silicone gel. Over 2,100 patients have undergone breast augmentation by the author, and the most consistent findings were a more 'natural feel' and less rippling for the patients having gel implants.

Conclusions: It is important to understand the rationale, surgical technique, sizing and avoidance of common complications associated with placement of silicone gel implants compared to saline implants. Gel implants can be placed via IMF, periareolar or Axillary incisions. The surgical technique for placement is somewhat different than placement of saline implants, and includes a slightly larger incision and a few tricks for easy insertion with limited implant and patient trauma which will be reviewed. Placement of silicone gel breast implants can be an invaluable service for our patients, with a high satisfaction rate and low complication rate.

11:00 am **Pelosi/Avellanet Minimally Invasive Abdominoplasty System Under Local Anesthesia**
MARCO A. PELOSI II, MD

Objective: In order to overcome the morbidity and prolonged recovery associated with traditional abdominoplasty and the complications related to IV sedation and general anesthesia, the authors have developed a minimally invasive abdominoplasty system under local anesthesia.

Methods: The authors' minimally invasive system combines the use of local tumescent anesthesia (Klein's solution), routine flanks and hips liposuction, a modified Avelar abdominolipoplasty, a modified high lateral tension abdominoplasty (Lockwood), and the use of the floating umbilicus strategy whenever possible instead of routine umbilical transposition. A video is presented to demonstrate the authors' system in 78 consecutive cases.

Results: The surgery was tolerated well by all patients undergoing the minimally invasive abdominoplasty. All patients were satisfied with the final cosmetic results. All patients were able to return to regular activities within four days after the surgery. No intraoperative or postoperative complications occurred.

Conclusions: The authors' technique is quick and simple to perform, eliminates "dog ears" formation, and avoids the need for future liposculpturing of the flanks, hips, and back. It is reproducible and associated with a short learning curve. The technique offers a recovery similar to liposuction while avoiding the morbidity of traditional Abdominoplasty and potential complications related to IV sedation and general anesthesia.

11:15 am **Perfecting Autogenous Fat Grafting: Where We Are Now, Where We Are Going?**
STEPHEN B. BAKER, MD, DDS
Featured speaker

Soft tissue augmentation is a commonly performed procedure in most cosmetic surgery practices. While no material is ideal for soft tissue augmentation, autologous fat has many advantages over other materials. It is biocompatible, abundant, inexpensive, and potentially permanent. Unfortunately, its volume maintenance has proven unpredictable and temporary in most surgeons' experience. The ability to reliably and predictably graft human adipose tissue would have enormous benefit to the cosmetic surgeon.

Our laboratory has been investigating variables that potentially affect the viability of fat cells and, ultimately, the engraftment process. This presentation will attempt to educate the participant as to how this information can be employed in their practice to enhance patient results. Variations in harvesting, processing, injection and storage techniques will be discussed. The use

of FDA-approved growth factors on fat graft maintenance will be discussed, as well as some growth factors that remain investigational. The presentation will also briefly review some of the scientific techniques and their limitations used in evaluating fat graft survival. It is hoped this information will enhance the reader's ability to critically evaluate the literature. Finally, a review of adipose stem cell technology and its potential applications to fat grafting will be briefly reviewed.

Plastic surgeons frequently inject autologous fat into their patients. To date, the majority of experience in autologous fat grafting is anecdotal. The mechanism of fat grafting has not been comprehensively and methodically evaluated by any study to date using modern immunohistochemistry techniques. This presentation evaluates the safety and efficacy of the commonly described variables in autologous fat grafting. It is hoped that by employing scientifically proven techniques, autogenous fat grafting will be made more reliable, and the benefits derived from our research can enhance our patient's results.

11:45 am **Panel Discussion**
Moderator: Ronald L. Moy, MD

12:00 - 1:30 pm **Lunch in Exhibit Hall**

1:30 - 3:30 pm **General Session: 107**
The Art of Cosmetic Body Surgery
Moderators: E. Antonio Mangubat, MD & Robert F. Jackson, MD

1:30 pm **Periumbilical Dermolipectomy: A Novel Technique for Abdominoplasty**
CHRIS NICHOLS, MD

Objective: Various techniques have been devised for abdominal dermolipectomy, excision of stria, and myofascial tightening, collectively grouped under the heading 'abdominoplasty.' Current techniques rely on a transverse skin excision with or without umbilical translocation. This allows skin resection and access to the abdominal musculature for plication and diastasis repair. While traditional abdominoplasty can yield excellent aesthetic and functional results, limitations of current techniques include a large suprapubic scar, disruption of the inferior neurovascular supply to the abdomen, and difficulty excising supraumbilical stria.

We propose a periumbilical dermolipectomy which, in the appropriately selected patient, may surpass these limitations and achieve a limited incision dermolipectomy and fascial tightening. This technique relies on the principles established in short scar breast reduction, whereby tissue is excised and the resultant defect is gathered in a centripetal fashion. This technique allows central abdominal dermolipectomy, excision of the skin most commonly affected by stria gravidarum, wide access to the abdominal musculature for diastasis plication, preservation of the superior, lateral and inferior blood supply to the abdominal skin flaps, and avoidance of a long scar.

Methods: Cadaver torsos were used to pilot the procedure. Redundant tissue was tailor tacked with clips and marked. A peripheral ellipsoid around the umbilicus was centered in the direction of maximal skin redundancy. A de-epithelialized cuff was left to facilitate subsequent placement of a purse-string suture. A periumbilical excision of skin and fat was undertaken. Dissection was continued superiorly and inferiorly to the xiphoid and pubis. The rectus diastasis was plicated. A purse string suture was placed utilizing the previously de-epithelialized dermal cuff and was secured to oppose the abdominal flap to the umbilicus. The umbilicus was then closed without tension to the edges of the adipocutaneous flap.

Results: Significant improvements were achieved in abdominal contour and reduction of periumbilical stria. In extensive dermolipectomy specimens, a significant lift of the ptotic mons and thigh was also a favorable secondary effect of the dermolipectomy. Of note, scalloping of the skin edge occurred in the outer periumbilical flap, the degree of which was directly proportional to the amount of skin excised.

Conclusions: The technique of periumbilical dermolipectomy may offer an alternative to traditional abdominoplasty in appropriately selected cases. The aesthetic benefits of this technique include a shorter scar and targeted excision of stria, with no compromise in access to the abdominal musculature for diastasis repair and plication. Additionally, theoretical benefits include improved cutaneous blood supply which should permit concomitant central and lower abdominal liposuction, currently regarded as perilous in conjunction with traditional abdominoplasty incisions. A limitation of the described procedure is the scalloping created by the purse-string closure of the incision. This cadaver model does not demonstrate whether this is transient and will resolve with time as it does in analogous short scar mammaplasty. Also, the periumbilical scar is in a conspicuous location as compared to a bikini line scar; however, many traditional abdominoplasty techniques also include a periumbilical incision.

1:45 pm **Post-Bariatric Surgery Body Contouring Procedures: Concomitant Abdominoplasty, Hernia Repair and Liposuction**
EVGENI KOLESNIKOV, MD, PHD

Objective: The bariatric surgeon is a person who initiates the morbidly obese patient's weight loss by performing weight loss surgical procedure. He also takes responsibility for the patient's postoperative health and lifestyle change. Very often, the bariatric surgeon is the first doctor to whom patient comes with complains about post-weight loss abdominal skin redundancy, hernia development, functional problems and dissatisfaction with appearance. Successful bariatric operation and significant weight loss postoperatively usually leads to establishing a good, trusting patient-doctor relationship, and very often patients seek help from their bariatric surgeon. Patients with abdominal hernias often ask for hernia repair simultaneously with abdominal body contouring procedure. Many post-bariatric

surgery patients do not have sufficient resources to treat multiple cosmetic defects after massive weight loss in plastic surgery centers.

Methods: 1,287 consecutive weight-loss surgical procedures were performed between January 2001 and April 2007, including 1,131 Roux-en-Y gastric bypass (RYGB) via minilaparotomy incision and 156 laparoscopic operations (75 laparoscopic RYGB and 81 Lap-Band). Female: 1,113 (86.5%), average age: 40.9 years, average BMI: 46.4 kg/m2. The average time between the gastric bypass and body contouring procedure was 22.8 months (14-47); the average weight loss at the time of the abdominoplasty was 64.3 ± 8.9 kg and stabilized. Simultaneous abdominoplasty and hernia repair were performed in 76 patients. Our modified technique (the "Tightening jacket" abdominoplasty) was used in 58 patients with vertical scar after previous bariatric or other abdominal operations. The mesh for large incisional hernia repair was used in nine cases. We did not consider using liposuction preoperatively because of the abdominal hernias, but this technique was used in 16 patients for correction of minor cosmetic defects after body contouring procedures.

Results: All body contouring surgical procedures, including "Tightening jacket" abdominoplasty, that combines vertical elliptical skin excision and horizontal resection to restore body contour of the mid and lower torso, were performed by the bariatric surgeon safely, without major complications. There was no mortality. Postoperative complications were: hematoma: four, wound infection: three, seroma requiring repeated aspiration: six. In eight patients liposuction was used successfully to correct minor postoperative defects. All patients were satisfied with the result of body contouring surgery.

Conclusion: Simultaneous body contouring procedures including abdominoplasty with incisional hernia repair and liposuction can be done safely and economically by the bariatric surgeon. Combination of surgical procedures eliminates the need for additional hospitalizations, operations and general anesthesia. Involvement of bariatric surgeons in post-weight loss improvement of body image can be a positive move towards solving the problem of global epidemic of obesity. Training of bariatric surgeons should include necessary elements of cosmetic surgery trough the professional courses and workshops of the AACS and other cosmetic surgery teaching organizations to qualify them to perform body contouring procedures after massive weight loss.

2:00 pm Liposuction & Lower Abdominoplasty

GERALD H. PITMAN, MD

Featured speaker

Lower abdominoplasty is an under-appreciated and highly effective method for tightening the lower half of the abdomen. Lower abdominoplasty is most frequently performed as an adjunct to liposuction. The procedure takes less than one hour. Recovery and morbidity are similar to that of liposuction.

2:30 pm The Art of the Surgery of Beauty: a Passion, a Profession and a Possession

ROBERT F. JACKSON, MD

2008 Webster Lecturer

Dr. Richard Webster, our founder, mentor and role model had a passion for a profession that has left us, the members of the American Academy of Cosmetic Surgery, a possession that is truly ours and ours alone. To be asked to give the Webster Lecture is one of the most humbling and greatest honors I have been given in my professional career. I hope I can instill through this lecture a rekindling of the passion that he had, and I hope I can reveal the maturity that we now have as a speciality. Lastly, I hope to leave with you the knowledge that we as an Academy (and by extension, the American Board of Cosmetic Surgery) own this profession. It is something we must not take lightly; we must practice in the arena of the utmost safety, constantly improving and honing our skills and sharing them with those surgeons who are willing to sacrifice to learn.

I will discuss those skills, how to achieve them, and how to use them in a very safe manner. This profession has reached a level of maturity that I'm sure would make our most famous founder very proud. Like him, we still have those who would like to take this profession away from us, and we must fight not allow that to happen.

This profession is both science and art, and it is true doctor/patient relationship as no other. The multidisciplinary approach of this profession, in addition to being a platform for the best available educational process, yields the greatest congeniality and camaraderie of any medical specialty. We must preserve those characteristics in honor of Dr. Webster and to rise to the pinnacle of what we can achieve.

3:00 pm Transconjunctival, Sublabial, and Temporal Subperiosteal Approach: Midface Lift for Persistant Lower Eyelid Retraction After Blepharoplasty

RONALD MANCINI, MD

Resident Paper

Purpose: To define a subgroup of post-blepharoplasty patients with persistent lower eyelid retraction despite attempted lower eyelid reconstruction and midface lifting, and to propose a revisional midface lifting procedure to address the complex cicatricial patterns in these patients.

Methods: This is a retrospective observational case series of consecutive patients with bilateral persistent cicatricial lagophthalmos from lower blepharoplasty despite prior lower eyelid reconstruction and midface lifting. An approach for midface lifting and lower eyelid reconstruction was designed consisting of transconjunctival, sublabial, and temporal approaches to the subperiosteal space with manual distraction cicatricial scar matrix lysis. Routine postoperative evaluation of clinical outcome, safety, patient satisfaction, and photographic analysis was performed.

Results: A total of eight patients were identified who underwent revisional midface lift surgery (15 ipsilateral surgeries). In all 15 cases, a three-dimensional cicatricial matrix was identified involving the lower eyelid and midface that limited visual exposure of the subperiosteal space and mobility of the midface despite complete subperiosteal release to the sublabial incision. Manual anterior distraction of the midface via the sublabial incision provided a mechanism for lysis of the cicatricial matrix. The improved midface mobility allowed successful vertical fixation with maximal anterior lamella recruitment and lower eyelid support. No complications were encountered. All patients reported improvement in cosmesis and ocular comfort. Average improvements in lower margin to reflex distance (MRD2) was 0.9mm, scleral show was 0.8mm, palpebral fissure height at the medial limbus was 1.2mm, and palpebral fissure height at the lateral limbus was 1.2mm.

Conclusion: Patients presenting with post-blepharoplasty cicatricial lagophthalmos after unsuccessful lower eyelid reconstruction, including midface lifting, may have a complex three-dimensional cicatricial matrix involving the lower eyelid and midface. A combined transconjunctival, sublabial, and temporal subperiosteal approach with manual scar matrix release for midface elevation and lower eyelid support is a safe and effective management paradigm.

3:15 pm **Panel Discussion**
Moderator: E. Antonio Mangubat, MD

3:30 - 4:00 pm **Coffee in Exhibit Hall**

4:00 - 5:30 pm **Nuts and Bolts Sessions – 108 (Sessions will run concurrently)**

Breakout #1

Location: St. John's 22/23

The Art of Cosmetic Breast Surgery
Robert F. Jackson, MD & Albert E. Carlotti III, MD, DDS

ROBERT F. JACKSON, MD

During this breakout session, the author will attempt to give the attendees his view of the art of cosmetic breast surgery. As cosmetic surgeons, what we are attempting is to sculpture the patient. The female patient should have the perception of softness and roundness and the entire body should have a sense of symmetry and femininity. The ideal breast will be discussed. Various techniques to help the surgeon visualize variations of the ideal will be given. The author's methods will be shown. The preoperative evaluation is extremely important, measurements and documentation can be of great benefit in determining the end result.

The intraoperative technique, sizing, implant selection, pocket preparation and implant placement have to be done meticulously if one is to achieve the preoperative expectation. The author's methods will be discussed.

Postoperatively, adjunctive measures such as exercises, postoperative medication, proper garments and patient compliance will be emphasized. Almost 30 years of experience in cosmetic breast surgery with various techniques, multiple types of implants and assimilation of many of our colleagues expertise has resulted in the current way the author approaches breast surgery today. Breast surgery can become both an art and a science.

This course will be taught with both PowerPoint and video presentations. Ample opportunity will be available for questions and answers.

ALBERT E. CARLOTTI III, MD, DDS

Information not available at press time.

Breakout #2

Location: St. John's 24/25

New Concepts in Fat Metabolism: Mesotherapy and Fat Survival
Stephen B. Baker, MD, DDS & Adam M. Rotunda, MD

STEPHEN B. BAKER, MD, DDS

The ability to nonsurgically remove adipose tissue would have enormous benefit to the cosmetic surgeon. Currently, phosphatidylcholine-deoxycholate combinations are used for nonsurgical lipolysis, but these compounds are not FDA approved. Although anecdotal reports and case series have been reported in the European literature, well-controlled, prospective data is insufficient to support the use of these compounds in humans. For these reasons, the American Society of Plastic Surgeons (ASPS) and the American Society of Aesthetic Plastic Surgeons (ASAPS) have both issued advisory statements recommending that further evaluation of these compounds be performed before endorsing their use. The ability to eliminate fat deposits through a minimally invasive technique would be useful to the cosmetic surgeon. Although it would not serve as a replacement for liposuction, it could be used for revisions, for primary treatment to small areas of adiposity, and in patients who are anxious to undergo surgery. Previous work from our laboratory demonstrates that the blockade of the Neuropeptide Y receptor subtype 2 (Y2R) decreases angiogenesis in peripheral adipose tissue and has direct adipolytic effects on the adipocytes themselves. These observations indicate that Y2R blockade may provide a potential mechanism for pharmacologic lipolysis. The purpose of this presentation is to demonstrate our research in the area of pharmacologic lipolysis and to focus on the translational applications of this research as a method for providing minimally invasive fat reduction. The presentation will also cover the advantages and disadvantages of other potential approaches to nonsurgically eliminate fat.

Breakout #3

Location: St. John's 26/27

The Art of Bariatric Cosmetic Surgery & Body Contouring
Michael H. Rosenberg, MD & Gerald H. Pitman, MD

Cosmetic surgery in patients following large weight loss are increasingly popular procedures in cosmetic surgery, and these patients require special management and care. This course will offer an overview of the relevant procedures, patient selection, how the operative approach is modified in this group of patients, and postoperative care. We will then focus more intently on abdominoplasty, with a video of the procedure and discussion of the presenter's technique.

Breakout #4

Location: St. John's 28/29

Attract More Patients with Fewer Dollars
Dana Fox

Promoting a practice today has never been more challenging. There are smart, cost-effective ways to gain a strong reputation in your marketplace. Whether you are already successful and thriving in a cosmetic surgical practice or just sticking your toe in the water, you'll learn how to think on paper and how to structure a solid marketing plan.

This comprehensive marketing course will help you look at everything in your practice that tells the consumer why you are the right choice. And, you will come away with a better understanding of the real, most deeply-felt reasons that women buy cosmetic surgery.

You'll learn:

- A three step process called "Easy-to-buy"
- What you should expect to spend on marketing
- How to develop and sustain a focus

4:00 - 5:30 pm Free Paper Session

Location: General Session – Gatlin E

Moderator: Suzan Obagi, MD

4:00 pm Breast Augmentation: Minimizing Postoperative Nausea and Vomiting (PONV), Maximizing Patient Satisfaction
TED EISENBERG, DO

Objective: This study evaluates the efficacy of a specific protocol of medications and anesthetics to minimize postoperative nausea and vomiting (PONV) used pre-, intra- and postoperatively for bilateral submuscular saline breast augmentation surgery.

Methods: From 3/6/07 through 4/13/07, 68 patients were given a questionnaire at their first postoperative visit to evaluate their level of nausea and vomiting on the day of surgery, the day after surgery and the second day after surgery, using a scale from 0-10 (with 10 being the most severe). All patients had general anesthesia with a Laryngeal Mask Airway (LMA). Surgical time averaged 42 minutes. The average implant size was 440cc. Preoperatively, all but two patients (who were allergic to sulfa) received 200mg of Celebrex capsule (Pfizer) COX-2 Inhibitor, Alka Seltzer Gold or Bicitra, and had the option of taking 5mg of Valium. Six patients with a prior history of nausea and vomiting were given Emend 40mg PO within three hours of surgery, and Benadryl was withheld on these six patients to evaluate the effects of Emend. All patients received intravenous Propofol, Versed, and Fentanyl for induction, and then Sevoflourane gas was used. Nitrous gas was avoided. Intraopertively, they were given intravenous Zofran 4mg and Decadron 8mg. Postoperatively, patients were advised to take Celebrex and were given supplemental prescriptions for Zofran ODT 4mg and Valium 5mg. Antacids were recommended for postoperative nausea, if needed. Patients also rated their satisfaction with the overall process and the results of their operation on a scale of 0-10.

Results: Most remarkably, of the 68 patients surveyed, 49 (72%) reported no nausea and vomiting on the day of surgery. That number rose to 75% the day after surgery and 78% on the second day after surgery. On average, the remaining 25% had some PONV (3 on the 0-10 scale) on all three days. After surgery, 18 patients took Zofran for two days on average and 23 patient patients used Rolaids/Tums for two to three days on average. 65 patients took Celebrex, while 63 took Valium for three to four days. Finally, 64 patients (94%) reported a 10 in their overall experience, and 61 patients (90%) reported a 10 for the results of their operation.

Conclusion: This approach, which evolved over 10 years and 3,000 patients, has reduced extreme postoperative nausea and vomiting from several days on average to almost zero. I attribute much of this success to the use of intraopertive medication, affecting multiple pathways and nausea receptor sites. Intraopertive medications were more important than postoperative ones. Using the LMA negates the need for a muscle relaxant, thus eliminating the need to reverse the muscle relaxant, an action that is frequently associated with increased nausea. Eliminating nitrous gas may lower post-op nausea and vomiting. The preoperative use of the non-narcotic Celebrex and the anti-anxiety Valium lowers the amount of narcotic needed during and after surgery. I believe that the outstanding level of patient satisfaction is directly related to patients having minimal or no nausea and vomiting after surgery.

4:10 pm Breast Mastopexy – A Personal Evolution
THEODORE E. STAAHL, MD

Objective: The personal experiences of developing a mastopexy practice will be elaborated upon.

Methods: The assorted mastopexy approaches present confusion as to which technique is the best choice. Breast augmentation adds even more complexity to the equation. A simplified flowsheet will be presented to help make decisions. The crescent, Benelli, and vertical mastopexy procedures will be shown.

Results: The author will present patient surgical results to reinforce the decision-making process.

Conclusions: A personal evolution of mastopexy surgery and results should help the beginner and advanced breast surgeon make informed decisions in mastopexy.

4:20 pm Endoscopic Assisted Transaxillary Breast Augmentation Under Local Anesthesia

MARCO A. PELOSI II, MD

Objective: Author's experience with 600 consecutive procedures using an endoscopic assisted transaxillary subpectoral breast augmentation approach totally under local anesthesia.

Methods: A video demonstration of the complete technique is presented.

Results: The surgery was tolerated well by all patients undergoing the augmentation procedure. No intraopertive or postoperative complications occurred. All patients were satisfied with the cosmetic results.

Conclusions: Advantages of the procedure includes: accurate division under direct vision of the pectoralis major muscle and fascia; the electrocautery avoids or minimize bleeding from the divided muscle; and hemostasis is readily achieved with direct coagulation of the vessel. There is a reduced postoperative pain and recovery by eliminating most of the blunt blind dissection, and avoiding complications related to IV sedation and general anesthesia.

4:30 pm Retrospective Analysis of Surgical Complications Resulting from Penile Enlargement Surgery

ALEXANDER A. KRAKOVSKY, MD, PHD

Objective: Male genital rejuvenation surgery (phalloplasty) has become more popular in the United States and Europe during last 15 years. In early stages, surgical technique brought unsatisfactory results and therefore did not receive recognition among the medical community in the U.S. Regardless of that, phalloplasty continue to develop and become accepted in the cosmetic surgery field. Today, phalloplasty is an available genital cosmetic surgery procedure that is able to improve unsatisfactory sexual performance, relationship, intimacy and love.

Methods: During three years, 586 phalloplasty surgeries were performed with Free Dermal Matrix Graft (FDMG). Single augmentation includes girth enhancement only. Combination augmentation procedures include dual augmentation (lengthening and girth enhancement combine), triple augmentation (lengthening, girth enhancement and glanular enhancement combine), and quadruple augmentation (lengthening, girth enhancement, glanular enhancement and scrotal web resection combine).

Results: 97.2% of patients successfully went through surgery and postoperative period without any complications. 3.24% of patients developed surgical complications that were successfully treated medically and surgically. 4.9% of patients experienced localized swelling three to seven days after surgery that resolved spontaneously. 7.3% of patients reported temporary postsurgical retraction that were successfully treated medically and surgically.

Conclusion: The patient's satisfaction with the results of their Cosmetic Genital Surgery was analyzed using the Penis Image Assessment Scale Questionnaire. The assessment was based upon questions related to the size of the penis, satisfaction of sexual experiences and the psychological perspective of the patient to his penis before-and-after cosmetic genital surgery. The results showed patient satisfaction with these types of cosmetic surgical procedures. All surgical complications were successfully treated medically and surgically.

4:40 pm Carbon Dioxide Therapy for the Treatment of Cellulite & Skin Retraction

YAN TROKEL, MD, DDS

Objective: Cellulite has its origins in the microcirculatory alterations. As we know, blood flow regulation is thought to mediated the metabolic functions of adipose tissue. If microcirculation is poor, capillaries tend to gradually close and prevent blood from circulating as before. This leads to tissue alteration, with the accumulation of "deposits" in the form of cushions and "orange peel skin". Carbon dioxide is capable of inverting this process. Injected locally, it has a vasodilator effect that allows the blood to flow again through capillaries that had gradually closed up. It also increases venous and lymphatic drainage and breaks down excess adipose (fatty) tissue. The result is improved circulation, improved tissue oxygenation, breakdown and elimination of adipose deposits and reduced "cushions". In addition to improving cutaneous circulation and tissue oxygenation, carbon dioxide injection also stimulates fibroblasts, thus increasing the dermal thickness with rearrangement of the collagen fibers.

Using the Rioblush System, carbon dioxide gas is injected in the affected zones, improving tissue perfusion.

CO_2 therapy was administered in two weekly subcutaneous applications of CO_2 for 10 consecutive weeks using a programmable CO_2 therapy apparatus (RioBlush and 30GA1/2, 0,3X13 microlance needles. The infusion velocity administered was 80 ml/min, and the total quantity of CO_2 was 400-500 ml per limb.

Results: The results show a statistically significant improvement of the skins compactness, elasticity and reduced dimpling confirming the positive effect of treatment with CO_2. The first results are seen after just a few sessions: quality of the tissue improves clinically (skin texture, firmness and more homogeneous color, important in the treatment of stretch marks). However, to obtain a "temporal cure" – six to 12 months – it is recommended to perform at least six to 10 sessions. Only minimal side effects were observed, and all were quickly resolved. All the patients showed the presence of a crackling sensation beneath the skin, limited to the first hour of CO_2 treatment and 33% of the patients had slight ecchymosis, which resolved without any sequalae. The pain experienced at the area of injection, although frequently observed (55%), was

always short-lasting and never of such major intensity that gas administration had to be interrupted. With the heated gas, we noticed a 60% decrease in the pain experienced by our patients.

Conclusions: Previous research on Carbon Dioxide Therapy has shown a positive result in terms of microcirculation, reduction of adipose accumulation and stimulation of fibroblasts. Our experience has shown subcutaneous and intradermal CO_2 therapy improves skin irregularity and elasticity. Carbon Dioxide Therapy can even correct old surgical scars and stretch marks by reducing their size, by stimulating fibroblasts to produce the elastic fibers and collagen that makes the skin supple and compact and by making them less evident in color. We believe that CO_2 therapy is a safe therapy with no relevant side effects and is an effective treatment for cellulite.

4:50 pm Converging Procedures in Facial Rejuvenation: Portrait® Plasma Skin Regeneration & Aesthetic Facial Surgery

J. DAVID HOLCOMB, MD

Objective: Evaluation of Portrait® Plasma Skin Regeneration and concurrent aesthetic facial surgery.

Methods: Portrait® Plasma Skin Regeneration was gradually introduced and performed over regionally-involved facial skin concurrent with various aesthetic facial surgical procedures since October 2005.

Results: Portrait® Plasma Skin Regeneration has been successfully performed over regionally involved facial skin at low and high energy settings concurrent with browlift, upper and lower eyelid lift, lower eyelid lateral canthoplasty, endoscopic assisted midface lift, malar/submalar augmentation, chin augmentation, lip vermillion advancement, lip augmentation and multi-planar, multi-vector facelift.

Conclusion: Idiosyncratic signs of facial aging – including sagging, volume loss and rhytidosis – are commonly addressed with lifting procedures, augmentation with implants and/or injectable fillers and skin resurfacing.

While these varied procedures have the common goals of redistributing facial volume and smoothing and tightening facial skin, they are often performed in a staged fashion, purportedly to avoid increased risk of woundhealing complications (including infection and flap failure) and increased healing time.

Portrait® (nitrogen) Plasma Skin Regeneration is a novel, non-chromophore-dependent, FDA-approved treatment for benign skin lesions and facial and non-facial rhytids. Established protocols enable treatment of a variety of skin conditions across a wide range of skin types.

Improvement in skin quality following Portrait® Plasma Skin Regeneration treatment may include reversal of photodamage, improvement of dyschromia, surface smoothing and effacement of rhytids, as well as significant skin tightening. The dual zone of effect of nitrogen plasma with a limited zone of thermal damage and a significantly deeper zone of thermal modification enables dermal depth resurfacing of regionally involved facial skin concurrent with aesthetic facial surgery without extending healing time or increasing the risk of woundhealing complications. Excluding peri-oral HSV reactivation, the absence of an open wound immediately following treatment and throughout the regenerative process likely circumvents any increased risk of perioperative infection. With appropriate selection of patients (e.g. nonsmokers) and surgical techniques that avoid thin skin flaps, nitrogen plasma technology safely facilitates convergence of disparate procedures for enhancing facial volume and smoothing and tightening facial skin into a single operative session.

5:00 pm Gluteal Augmentation Using Autologous Fat Transfer & Liposculpturing Under Local Anesthesia

MARCO A. PELOSI II, MD

Objective: Recently there has been a dramatic increase in the number of patients requesting buttocks enhancement. The authors experience with 100 consecutive procedures using autologous fat transfer and liposculpturing under local anesthesia (Klein's solution) is presented.

Methods: The procedures are performed totally under local tumescent anesthesia. The authors use a combination of autologous instramuscular micro fat grafting and liposculpturing of the hips, lateral thighs, lower back, and abdomen in order to create the gluteal aesthetic unit.

Results: A video demonstration of the complete technique is presented. In the present series of 100 cases, the authors grafted an average of 550 cc per side. The surgery was tolerated well by all patients. All patients were satisfied with the final cosmetic results. No intraoperative or postoperative complications occurred.

Conclusions: The combination of autologous fat transfer and liposculpturing under local anesthesia offers a safe and effective minimally invasive alternative to buttock implants.

5:10 pm Mondor's Disease: An Effective Treatment

RUTH A. RASSEL, DO

Objective: Mondor's disease refers to a visible, cordlike, subcutaneous lesion, which most commonly occurs in the anterolateral wall of the thorax or upper abdomen. The lesion is caused by thrombophlebitis and provokes pain and tenderness upon palpation and movement of the region involved. It has many etiologies, as surgery on the breast is becoming a more frequent cause. The literature reveals extensive information about the clinical presentation, pathophysiology and course of Mondor's disease.

The treatment has included warm compress and anti-inflammatory analgesia as well as antibiotics. These have proved to provide mild-to-moderate relief only and do not significantly shorten the duration or course of the disease.

This work presents two case reports treated with a previously undescribed physical manipulation maneuver of the involved vessel without the need for heat or medications.

We feel this fairly easily applied treatment may be incorporated in the practice of the cosmetic surgeon as the primary and sole treatment for incurred cases of Mondor's disease.

Methods: The procedure is described with visual photography aids. While stabilizing the proximal portion of the vessel with the operators thumb, a very firm pressure is placed along the direction of the vessel with the operator's opposite thumb as if "milking" the vessel as seen in Figures 9 and 10. The operator's upper hand is seen stabilizing the vessel and the inferior hand is applying a downward stroke. The raised lesion of the anterior chest wall is noted to completely resolve in Figures 3 and 4, and the very painful raised axillary lesion is seen to resolve in Figures 7 and 8.

Results: As seen in comparison with the before-and-after photos, the lesions have been treated successfully and note to completely resolve.

The patients expressed instantaneous relief and the cordlike lesion visibly disappeared.

One explanation for these findings is that the force applied to the vessel and surrounding tissues released the perivascular inflammatory attachments along the course of the vessel. This released the cordlike skin retraction classically seen at presentation.

The force may also have dislodged the thrombus into the larger caliber vein, draining the smaller superficial affected vein.

Conclusion: Mondor's disease has been studied clinically, radiographically, and microscopically. The etiology is not completely understood. The medical treatments aimed at the approximate six-week course of discomfort endured by our patients thus far have been ineffective at shortening the duration of clinical symptoms. Our method is quick, safe and effective and may provide relief both physically and mentally to you and your patients.

5:20 pm **Decrease in Intravascular Thrombosis Risk Using Ketamine Dissociative Anesthesia**
ROBERT H. BURKE, MD

Objective: Deep vein thrombosis leading to symptomatic pulmonary emboli may occur following cosmetic surgery. Although there may be multifactoral etiologies, the precipitating event is venous blood pooling due to stagnation within the soleus muscle due to lack of muscle tone and contractions. This tone is more commonly decreased or lost under general anesthesia. Although intermittent decompression stockings have been shown to decrease the incidence of this event, ketamine dissociative anesthesia provides an additional and independent protective effect since soleus muscle tone is maintained. Additionally, ketamine improves platelet function by suppressing aggregation. All cases performed under conscious sedation using ketamine anesthesia during a ten-year period were reviewed. This included a review of intraoperative and postoperative complications.

Methods: Retrospective chart review of all cosmetic surgical cases performed under conscious sedation using ketamine dissociative anesthesia from January 1, 1997 to December 31, 2006. All patients were American Society of Anesthesiologists (ASA) class I or II. All patients were monitored according to accepted standards. All patients received sedation based on their reactions and analysis of vital parameters. Patients were monitored by an RN certified in ACLS, who administered medication based on the surgeon's verbal orders during the procedure. Pretreatment medication included ativan and/or diazepam or midazolam; fentanyl; decadron. Procedures included single and multiple face and body procedures.

Results: There were no major intraoperative or postoperative events. No patients required hospital transfer. The EMS system was never activated. Occasional cases of bradycardia were encountered, responsive to atropine. One case of dyskinesia occurred which responded to benadryl. Two cases were cancelled after initial administration of the sedative and prior to local anesthesia administration. Both demonstrated paradoxical excitement. One tested positive for cocaine. The other was determined to be a chronic benzodiazepam abuser.

Postoperative events of significance and unrelated to the anesthetic included one identified bleeder determined to have developed spontaneous antibody to factor 8. There were no cases of symptomatic venous thrombosis or pulmonary emboli.

Conclusions: There were no instances of symptomatic postoperative deep vein thromboembolism or pulmonary emboli in this series. There were no major intraoperative events. Several minor events occurred, including bradycardia and one episode of dyskinesia.

Ketamine dissociative anesthesia is easily administered, has a high degree of safety, and provides and additional protective effect from deep vein thrombosis by improving platelet function (decreased adhesion) and maintaining soleus muscle tone.

5:30 pm **Adjourn**

7:00 - 11:00 pm **Webster Society & Cosmetic Surgery Foundation Recognition Dinner**
ISLEWORTH COUNTRY CLUB
Black Tie – Invitation Only
** Buses will depart at 7:00pm from the Rosen Shingle Creek Resort Convention Center Entrance*

SATURDAY, JANUARY 19, 2008

SCHEDULE-AT-A-GLANCE

7:00 am - 12:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 109
8:30 am - 12:00 pm	Exhibits Open
8:30 - 9:15 am	Continental Breakfast in Exhibit Hall
9:15 am - 12:00 pm	General Session: 110 – The Art of Cosmetic Surgery
11:00 am	AACS Membership Annual Meeting: Presidential Address & Elections
12:00 pm	Adjourn for Social Activities
7:00 - 11:00 pm	Concluding Event Salsa Fandango *(open to all registered attendees)*

SATURDAY, JANUARY 19, 2008

7:00 - 8:30 am **Bright Eye Sessions: 109**
(Sessions will run concurrently)

Breakout #1

Location: St. John's 22/23

The Art of Rhinoplasty

Douglas D. Dedo, MD, Mohan Thomas, MD & John Rachel, MD

Objective: To present key steps in planning and executing a rhinoplasty, with special emphasis on secondary rhinoplasty and cleft lip nose correction.

Methods: Step-by-step video clips are presented with intervening slides for explanation and theoritical aspects.

Results: A comprehensive educational presentation with good videos and ample scope for interactive discussion.

Conclusions: Rhinoplasty is among the more challenging surgeries in cosmetic surgery. This presentation will be a great aid for beginners in rhinoplasty and also for those planning to do cleft lip nose corrections and secondary rhinoplasties.

Breakout #2

Location: St. John's 24/25

The Art of Blepharoplasty

Bradley N. Lemke, MD & Robert M. Dryden, MD

Blepharoplasty is one of the most commonly performed cosmetic procedures. Eyelid surgery is often combined with other facial rejuvenation techniques and often is associated with high patient satisfaction. This practical course is for cosmetic surgeons at all levels. We will discuss upper and lower eyelid blepharoplasty and its relationship with rejuvenation of the surrounding face. Patient evaluation will be stressed. Step-by-step description of the anatomy and techniques will follow. Adjunctive facial procedures will be correlated. Complications with their avoidance and management will be discussed. The format will be lectures with ample question and discussion periods.

Breakout #3

Location: St. John's 26/27

The Art of Facial Peeling & Skin Health

Zein E. Obagi, MD & Suzan Obagi, MD

Recent advances in skin science and technology have opened the doors for numerous choices where physicians can pick and choose from a variety of skin care products and procedures to achieve a certain outcome for their patients. Proper skin preparation and peel depth selection allows the cosmetic surgeon to treat most patients that come in for facial rejuvenation. This course will cover:

- Skin type & diagnoses
- The importance of skin preparation perioperatively
- Proper selection of the most effective procedure based on mechanism of action and the depth that can be achieved
- How to address ethnic skin

The presentation will compare the traditional approach to skin rejuvenation and current beliefs, and will demonstrate this practical, easy-to-use protocol with photographs of patients' before-and-after treatments.

Breakout #4

Location: St. John's 28/29

The Art of Hair Restoration Surgery

E. Antonio Mangubat, MD

Modern cosmetic hair restoration surgery (HRS) has evolved significantly since its original introduction in the USA in 1959. HRS includes many different techniques including hair transplantation (HT), scalp reduction, scalp flaps and tissue expansion; however, successful HRS requires the understanding of the art of the procedure. HRS is significantly different from most cosmetic procedures. It can be likened to impressionistic painting: the placement of thousands of tiny dots to achieve an aesthetic result. Thus hairline design is perhaps the single most important factor in executing a successful procedure. Understanding the unique dynamics of the team approach is also critical to success. The most common hair loss etiology is androgenetic alopecia (AGA), more commonly known as male pattern baldness; however, identifying other processes that lead to hair loss such as trauma, diseases such as alopecia areata and lichenplanopilaris, and iatrogenic causes, is essential to creating a successful treatment plan and avoiding disaster.

We will examine a brief history of HT, review the basic principles of modern HT, outline the essential steps in performing a successful procedure, provide several examples and finally discuss strategies in how to incorporate HRS into your cosmetic surgery practice.

Breakout #5

Location: St. John's 30/31

Wealth Protection Planning for Today's Cosmetic Surgeon
David B. Mandell, JD

This talk will address how to shield a physician's personal and practice assets from potential liability, how to ideally structure a medical practice, the truth about qualified and non-qualified plans, how to legally reduce taxable income from the practice by $100,000+ per year, how to deal with the medical malpractice insurance crisis, and how to use captive insurance companies.

Specific topics include:

- Non-qualified retirement plans – the retirement tool you haven't heard of
- Using captive insurance companies to reduce risk, protect assets, and lower taxes
- How to reduce your 2007 income taxes from $50,000 to $500,000
- Why your pension, IRA, or 401(k) is a 80%+ tax trap, and what you can do about it
- All about family limited partnerships and limited liability companies
- Alternatives for shielding accounts receivable
- How to be bought out of your practice for millions

David B. Mandell, JD, MBA is an attorney, author, and renown authority in the fields of risk management, asset protection, tax, and financial planning. He serves as at attorney in the Law Office of David B. Mandell, PC and is a principal of the planning firm Jarvis & Mandell, LLC. He holds a bachelor degree with honors from Harvard University, a law degree from the University of California Los Angeles and an MBA from the Anderson Graduate School of Management at UCLA.

As a writer, Mr. Mandell is the author of WEALTH PROTECTION, MD, The Doctor's Wealth Protection Guide and Risk Management for the Practicing Physician. His articles have appeared in over 30 leading national publications including The American Medical News, Physician's Money Digest, and he is often quoted in Medical Economics. He is also a featured expert on the medical website www.Medscape.com and has appeared as an expert on Bloomberg Personal Finance TV and Fox-TV.

8:30 - 9:15 am **Continental Breakfast in Exhibit Hall**

9:15 am - 12:00 pm **General Session: 110 – The Art of Cosmetic Surgery**
Moderators: Patrick G. McMenamin, MD & Dee Anna Glaser, MD

9:15 am **Treating Rippling Associated with Breast Augmentation**
MARK BERMAN, MD

Objective: To understand the principal cause of rippling following augmentation mammoplasty, and to propose a solution to the problem.

Methods: A case study (or studies) will be presented of a difficult case (cases) of severe rippling following augmentation mammoplasty. Several treatments were unsuccessfully employed prior to correcting the problem. In a sense, the patient served as her own control. Eventually, the problem was treated by fat grafting the superior pole of the breast. Details of the technique will be discussed.

Results: The rippling was adequately corrected by the use of fat transplantation to thicken the upper pole of the breast. Photographic analysis will demonstrate the utility.

Conclusions: Fat transplantation to the superior pole of the breast provides a good option for correcting the problem of rippling caused by breast implants in thin individuals.

9:30 am **A Multi-Center, 47-Month Study of Safety & Efficacy of Calcium Hydroxylapatite for Soft Tissue Augmentation of Nasolabial Folds & Other Areas of the Face**
NEIL S. SADICK, MD

Objective: Each soft tissue filler product has its own unique profile in terms of adverse events. Investigators sought to determine the safety profile for the injectable calcium hydroxylapatite (CaHA) implant. In this large-scale study, we examined the safety profile of Radiesse in treatment of nasolabial folds and other facial areas. We examined efficacy in a patient subset.

Methods: With informed consent, researchers over 47 months injected CaHA at two treatment centers into 113 patients (100 women and 13 men, 26 to 78 years old) for a variety of facial aesthetic applications. 75 patients had a single injection session; 38 had multiple sessions. Most patients (102) received 1.0 mL of CaHA per session; 12 received 2.0 mL per session.

Results: Safety. Only seven reported minor, short-term adverse events: transient ecchymosis (3), nongranulatomous submucosal lip nodules (2), and inflammation and edema (2).

Efficacy. Efficacy ratings (1 to 5) were performed for a subset of patients (n=41). Average patient score for look and feel of the implant was 4.6; average physician scores were 4.5 and 4.6, respectively. At six months, patients' average ratings 4.8 and 4.9, respectively; physician's average ratings were 4.5 and 4.9, respectively.

Conclusions: In our study, calcium hydroxylapatite performed well, with a favorable safety profile, low incidence of adverse events, very high patient satisfaction and good durability.

9:45 am Non-Invasive Body Shaping with Focused Ultrasound & Radiofrequency

ZIYA SAYLAN, MD

Objective: Traditionally, body shaping has been performed by liposuction and abdominoplasty. Now a noninvasive technique of body shaping is evolving with more advanced technologies using ultrasound, laser energy, radiofrequency energy, and mechanical massage. The new devices are ULTRASHAPE and TRIPOLLAR. Since 1year we are combining these technologies to improve cellulite, body shape, and skin firming of the abdomen for patients who want a completely nonsurgical treatment.

Methods: Ultrashape device uses focused ultrasound energy to destroy fat cells, making it the first noninvasive alternative to liposuction. With each treatment, one to three centimeters of fat can be removed. Definitely it can never achieve the results of traditional liposuction; but it can improve body contours without surgery like a small volume liposuction. The Ultrashape will decrease the subcutaneous fatty tissue so that an optimal result can be achieved in a noninvasive manner. This device is currently undergoing an FDA review; it is not approved in the USA, but has been used in Europe since 2002 and in Canada since June 2007.

Tripollar Radio Frequency (RF) Technology maximizes the benefits of RF technology while avoiding its drawbacks. Tripollar technology is simple to use yet extremely efficient and powerful. In fact, it is so effective that its results on skin tightening and cellulite reduction are visible right from the first treatment. Tripollar treatment is not painful. Treatment of both superficial and deeper fat layers achieves variable energy focus in different fat layers, resulting in visible clinical results from the first treatment. The Tripolar RF technology directs energy selectively to fat tissue, avoiding heating to other tissues and thus achieving better clinical results. No cooling of skin or applicator is needed. Tripolar RF technology delivers focused energy, achieving better and faster results and is applicable for all skin types and colors.

Conclusions: We are focusing on the proven technology of volumetric tissue tightening developed by Velasmooth and Tripollar, combining this with focused ultrasound energy of the Ultrashape to enhance body shaping results. The synergy of Ultrashape and Tripollar devices makes the technique a superior solution for skin tightening.

10:00 am Current Uses of Autologous Growth Factors During Hair Transplant Surgery

DAVID PEREZ-MEZA, MD

Objective: To present current applications of autologous growth factors in the donor and recipients areas and as storage solution using automated centrifuge during hair transplant surgery.

Methods: Several male patients, 30-50 years old with baldness, Norwood Class 3-5 were included in the study. The patient underwent hair transplant surgery. we followed our protocol to prepare the autologous platelet rich and poor plasma from the patient's own blood using the Smart Prep Machine. The scalp was divided half A or B for placebo (saline solution) or growth factors. The growth factors after being obtained were used as hair graft storage solution and applied to the donor and recipient area. On days 0, 1, 4, 7, 10-14, three and six months: pictures with digital camera were taken and clinical observations of the donor and recipient areas were also done for edema, redness, scabbing, scar width and hair survival and shedding.

Results: Decreased redness, scab formation and anagen and telogen effluvium were found with the autologous growth factors vs. placebo. Minimal difference in hair growth and survival was found between the two groups. Overall better results were obtained using autologous growth factors vs. placebo.

Conclusions: Autologous growth factors showed speeding up the wound-healing process after hair transplant surgery.

10:15 am History and State-of-the-Art – Skin Health Restoration

ZEIN E. OBAGI, MD

Featured speaker

Skin rejuvenation and skin treatments and procedures that enhance the appearance are very popular, and the demands are on the increase.

Recent advances in skin science and technology have opened to physicians the doors for unlimited resources, where the physicians can pick and choose from a variety of skin care products and procedures what they think is best for their patients.

However, these advances led to more confusion than at any time before, as it is evident by the unprecedented rate of treatment failure and dissatisfaction, especially with no downtime procedure or the over-the-counter, anti-aging skin care products where everyone is anticipating a no downtime overnight miracle. In a society where everything is marketed to the hilt, forcing physician and patient to search for the ideal procedure, filler or topical agents that can satisfy the need for quick no downtime process thus putting what really works in pursuit of what is never going to work.

Dr. Obagi, in this presentation will outline a simple practical and comprehensive protocol that will define the objectives of skin rejuvenation in general and skin treatment in particular, that will standardize and unify the approach based on:

- Skin type and the diagnoses
- The importance of skin preparation perioperatively
- Proper selection of the most effective procedure based on mechanism of action and the depth that can be achieved
- Particularly with ethnic skin

The presentation will compare the old traditional approach to skin rejuvenation and current beliefs, and will demonstrate this practical, easy-to-use protocol with photographs of patients' before-and-after treatments.

10:45 am **CSF Socioeconomic Lecture**
ROBERT CORADINI
PRESIDENT, ORTHONEUTROGENA

Information not available at press time.

11:00 am **AACS Membership Meeting: Presidential Address & Elections**

11:50 am **Cosmetic Surgery Foundation Annual Report**

12:00 pm **Adjourn**

7:00 - 11:00 pm **Concluding Event:**
SALSA FANDANGO BUTLER ROOM
ROSEN SHINGLE CREEK RESORT

NOTES

SUNDAY, JANUARY 20, 2008

SCHEDULE-AT-A-GLANCE

7:00 am - 12:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 111
8:30 - 9:15 am	Continental Breakfast
9:15 am - 12:00 pm	General Session: 112 – The Art of Lasers, Fillers and New Technologies
12:00 pm	Adjourn

Sunday, January 20, 2008

7:00 - 8:30 am **Bright Eye Sessions: 111**
(Sessions will run concurrently)

Breakout #1

Location: St. John's 22/23

The Art of Laser, RF Light Source Rejuvenation
Neil S. Sadick, MD, Ziya Saylan, MD & Paul J. Carniol, MD

The present session will present a structural approach to non-ablative rejuvenation employing lasers, intense pulsed light sources and radiofrequency technologies. Type I rejuvenation involving epidermal structures will highlight the second generation advances pulsed light technologies, which by targeting chromosphores can be utilized to improve pigmentation, vascularity and pilosebaceous aberrations (skin smoothing).

Type II rejuvenation involves dermal structures. Lasers and combination laser/radiofrequency sources which stimulate dermal remolding and thus ameliorate rhytides will be covered.

Finally, in Type III rejuvenation involving deep dermis as well as subcutaneous tissue, muscle and bone deeply penetrating broad-band light sources as well as high energy radiofrequency technologies are utilized to improve skin laxity.

This session will also discuss the utilization of the aforementioned technologies for off-face whole body rejuvenation.

At the end of this session, the attendee will understand a rational clinical approach to the vast array of lasers, light sources and radiofrequency technologies available to the practicing cosmetic surgeon.

Breakout #2

Location: St. John's 24/25

Research and Paper Writing

Jane A. Petro, MD & Katheryn Spanknebel, MD

1) **How to design a research project.** This session will discuss how to formulate clinical research questions, and then set up the mechanism for its execution, grant writing, etc.
2) **How to write a paper for medical publication.** This session will also be about how to ask a question, but also style, substance, and literature searching. With all the different sections we are setting up for the journal, we can help people decide if their idea for a paper, whether it is a review article, original research, tips or techniques, is worthy of publication.

Breakout #3

Location: St. John's 26/27

Art 101: Merging Art & Cosmetic Surgery

Laurence Rifkin, DDS

Historically, before the days of photography, anatomists, doctors, and scientists all possessed the basic necessary drawing skills to record their research and discoveries.

The great artist, architect and inventor, Leonardo da Vinci was also an anatomist and created some of the most memorable human anatomy drawings in history. The ability to draw and sculpt is also the ability to see and design.

The contemporary surgeon must possess these visual and didactic skills to create masterpieces out of the human medium.

This introductory art session will stimulate the artistic skills of today's surgeon and motivate further studies in the visual arts and aid in adding an artistic approach to surgery and introduce basic drawing skills to build upon.

Breakout #4

Location: St. John's 28/29

Roadmap to Success

Page Piland, Senior Practice Consultant, Allergan

This session will focus on providing practical insights into the critical success factors of better performing aesthetic practices. Specific recommendations accompany each "success factor" to illustrate the benefit of effectively implementing these programs within a practice. Items such as leadership, development of a marketing plan, personnel management, and customer satisfaction are some of the areas addressed in this session.

Page Piland is a management consultant with the Allergan Practice Consulting Group of Allergan, Inc., a specialty pharmaceutical company based in Irvine, California.

Mr. Piland consults with dermatology and plastic surgery practices in the areas of financial analysis, practice valuations, human resource issues, internal and external marketing, leadership training and team building, sales training, compensation, and cosmetic practice development.

Mr. Piland has more than 15 years of sales, management, and operations experience. Prior to joining the Allergan Practice Consulting Group, he served in a number of sales and management positions in the pharmaceutical industry, including sales representative and sales manager.

Mr. Piland's diverse background includes 14 years of service in the U.S. Army and Army National Guard, youth and family programs, education, transportation, and corporate health and fitness. He received his bachelor's of science degree from the University of Alabama.

Breakout #5

Location: St. John's 30/31

Disclosing Medical Errors & Unanticipated Outcomes

Theresa Essick, VP Clinical Risk Management, Medical Protective

Improving transparency throughout the healthcare arena is vital to promoting and enhancing patient safety and satisfaction. Over the past few years, numerous national initiatives have been advocating, and in some cases mandating, the disclosure of medical errors and unanticipated outcomes to patients regardless of the specialty or the healthcare setting. This program will review many of the details and challenges surrounding this difficult topic and provide risk reduction strategies that providers will be able to use in their clinical practice setting.

8:30 - 9:15 am **Continental Breakfast**

9:15 am - 12:00 pm **General Session: 112 – The Art of Lasers, Fillers & New Technologies**
Moderators: Douglas D. Dedo, MD & Paul J. Carniol, MD

9:15 am **Initial Experience with Novel Saline Facial Implant**
JAMES NEWMAN, MD

Objective: We document out initial experience with a novel facial soft-tissue implant.

Methods: A saline-fillable implant (FulFil; Evera Medical; Foster City, CA) with a thin ePTFE outer membrane bonded, only at the ends of the device, to a silicone inner membrane creating a slip plane between layers, is intended to heal with mild cellular incorporation, without a thick capsule, and to remain soft and elastic. At implantation, saline volume is adjusted as desired through a temporary fill tube and a self-sealing micro-valve.

Prospective data on 120 consecutive patients who received implants in the lips and/or nasolabial folds (NLF) from

September 2005 until December 2006, were gathered at two weeks and three and six months post-procedure. To assess cosmetic results of NLF augmentation, three surgeons independently compared baseline and follow-up photographs using a Global Aesthetic Improvement Scale (GAIS): 0=Worse; 1=No change; 2=Improved; 3=Much improved; 4=Very much improved. To assess persistence of lip enhancement, three surgeons, blinded as to which photographs were acquired when, attempted to determine baseline versus follow-up, and grade augmentation: 0=None; 1=Mild; 2=Moderate; 3=Marked. Patient satisfaction at follow-up was queried: 1=Very displeased; 2=Displeased; 3=Slightly displeased; 4=Neutral; 5=Somewhat satisfied; 6=Satisfied; 7=Very satisfied.

Results: There were 107 females and 13 males with 244 total implants. 83 patients had lip implants, 82 in the upper and 66 in the lower. 45 had 90 NLF implants. As of this report, time since implantation was between 1.5 and 14.7 months; 52 and 32 patients had reached three- and six-month follow-up points. Procedures were performed under local anesthesia and were generally well-tolerated. Patients typically noted mild swelling and pain for 24 to 48 hours. There were no acute complications such as uncontrolled bleeding. There have been no serious adverse events, including infection, erosion, or loss of facial animation. Eight patients required replacement for cosmetic indications; implants were dissected free and removed without difficulty. In blinded comparison of baseline and follow-up lip patient photographs, the panelists correctly identified the augmented lips in 90.4%, 84.6% and 90.4% of patients, with complete concordance in 76%. Mean lip augmentation score was between mild and moderate, with no significant change from three (1.32±0.15) to six months (1.44±0.10). The panelists mean NLF GAIS score, comparing baseline to follow-up photographs, was 2.08±0.09 at three and 1.88±0.09 at six months. Mean satisfaction scores for all patients at three and six months were 5.65±0.32 and 5.54±0.21 (p=NS). At three months, lip only (6.60±0.17) and patients with both lip and NLF implants (6.61±0.10) had higher satisfaction than patients with only NLF implants (5.52±0.17; p<0.05).

Conclusions: Results show promise for facial augmentation using a saline-filled implant that is meant to be permanent but removable. With the limited implant size available during this study, lip augmentation succeeded better than nasolabial (larger sizes now produced). Implantation is straightforward and well-tolerated. At up to six months, augmentation is persistent, facial animation is intact, and there is a wide margin of safety.

9:30 am **The Safety of Long Duration Combination Plastic & Gynecological Surgery Performed on an Outpatient Basis: a Pilot Study**
DAVID L. MATLOCK, MD

Objectives: To evaluate the complication rates and safety of patients having long duration combined outpatient plastic surgeries including blunt suction lipectomy, abdominoplasty, breast surgery, and facial surgery with gynecological surgeries including laser assisted colporrhaphy and laser reduction labioplasty.

Methods: The data was collected by a retrospective chart review of long duration combined plastic and gynecologic surgeries performed at one outpatient surgical center over a one-year period. Between September 2005 and September 2006, a total of 47 patients were identified as having undergone a combined plastic and gynecologic surgery with an average duration of at least four hours. Major complications evaluated were death, myocardial infarction, deep venous thrombosis, pulmonary embolism, and hemorrhage requiring transfusion. Minor complications evaluated included hematomas, seromas, infections, skin necrosis, and tissue dehiscence. Patients were excluded if they were diabetic, had peripheral vascular disease, severe or morbid obese (BMI >35), users of psychotropic drugs, or were heavy smokers (> than 20 cigarettes per day). Patient's age, body mass index, comorbidities, estimated blood loss by each service, operative times by each service, American Society of Anesthesiologists physical status level, type of anesthesia used and patient's residence status were compiled.

Results: From September 2005 to September 2006, 47 patients underwent long duration combined plastic and gynecological surgical cases. 43% (n=20) of patients resided out of state or country. Range of age was 22 to 53 years, (average age 39 years). BMI ranged from 18.7-32.9 (average 24.4). All patients received general anesthesia and had an ASA score of 1. Average combined OR time was 336 minutes (range 205-670 min), average gynecological procedure time was 141 minutes, average plastics portion of procedure 195 minutes.

There were no major complications including DVT, nine minor complications (19%) for the gynecological procedures which included perineal or clitoral hood dehiscences, six minor complications (13%) related to the plastics portion of the procedure. All minor complications were treated on an outpatient basis.

Conclusion: The results of this retrospective review indicate that long duration outpatient combination plastic and gynecologic surgical procedures for a low risk patient population does not result in increased risk of DVT, other major or minor complication rates.

9:45 pm **A Sculptors View of the Aesthetic Face and Body**
LAURENCE RIFKIN, DDS
Guest Lecturer

The sculptor must be able to see the structural support beneath the surface in order to create a surface that is anatomically correct and aesthetically pleasing.

For the contemporary surgeon, a layered approach to diagnosing aesthetic deficiencies will be discussed as well as designing the Aesthetic Face and Body.

In addition, examples of combined dental and oral surgical facial treatments for optimal facial beauty will be presented.

10:15 am **The Effect of Botulinum Toxin Type A on Full-Face Intense Pulsed Light Treatment: a Randomized, Double-Blind, Split-Face Study**
JANE G. KHOURY, MD

Background and Objective: Botulinum toxin type A (BTX) is commonly used in combination therapy, and it has been reported that periocular BTX treatment enhances the aesthetic improvements attained with intense pulsed light (IPL). Our study was conducted to evaluate if BTX treatment of the cheeks also enhances the efficacy of IPL.

Methods & Materials: 15 females enrolled in this prospective, randomized, double-blind, split-face study (14 completed, one lost to follow-up). All received standard IPL treatment and were randomly assigned to receive eight 0.1 mL injections of BTX (BOTOX® Cosmetic) in one cheek (8U total dose) and eight injections of saline in the contralateral cheek. Small wrinkles and fine lines, erythema, hyperpigmentation, apparent pore size, skin texture, skin roughness, and overall appearance were evaluated for eight weeks.

Results: A significantly higher proportion of patients showed improvement in small wrinkles and fine lines with IPL plus BTX than IPL plus saline: 93% versus 29% at week four (P=.003). Adjunctive BTX also achieved a greater degree of improvement in erythema (though statistical significance was not achieved). Other efficacy measures showed comparable improvements with both regimens.

Conclusion: The adjunctive use of BTX enhances the improvement in small wrinkles and fine lines, and possibly erythema, achieved with IPL alone.

10:30 am **Cosmetics in Obstetrics: Comparative Study, Elective Laser Assisted Cosmetic Cesarean Section (Laasog System) vs. Conventional Cesarean Section**
GABRIEL E. DE PEÑA, MD

Background and Objectives: Obstetrics, a field in medicine which has evolved very little in the surgical aspect and has never been considered or looked upon as an aesthetic or cosmetic option.

C-Sections: bloody, painful, coarse, unpolished and definitely not a cosmetic procedure. Taking into consideration that women have always been related to beauty, delicacy, pureness and always preoccupied with their well-being and cosmetic aspect.

We have merged three concepts into one: Obstetrics and Gynecology, Cosmetic Surgery and Laser-Radio Frequency Technology.

Study Design: Laasog System's, Laser Assisted C-Section: out of 97 births delivered by Elective Cesarean Section, we included 97 women with a 37-40 wk pregnancy and 18-35 years of age. 45 traditional C-Sections and 47 Laasog C-Sections. The Lassog System uses a combination of Diode Laser and Radio Frequency, modified skin incisions with or without mini abdominoplasty type paniculectomy, special retractors, modified incisions of the abdominal rectus fascia, plication of the fascia and suture less closure of the skin.

Results and Conclusion: The combination of Laser and Radio Frequency, modified incisions, special retractors that produce less aggression and protect the fetus, suture less closure of the skin are associated with minimal bleeding during the procedure less tissue damage, less inflammation, less traumatic surgical instruments, a reduction in 13 postoperative complication such as infection, hemorrhages, embolisms, DVT, infectious diseases such as HIV, Hepatitis B and C, urinary tract infections, seromas, hamatomas, uterine artery tears, lesion to the fetus produced by the scalpel, less postoperative pain, a quicker recovery and excellent aesthetic results from plicature of the fascia, mini abdominoplasty and suture less skin closure. Which converts a conventional C-Section into a minimally invasive cosmetic procedure. Which means substantial health, cost-effective and aesthetic benefits for the mother.

10:45 am **Selecting the Ideal Candidate for Hair Restoration Surgery**
MARCO N. BARUSCO, MD

Objectives: To review with the participants and faculty the most important aspects of candidate selection when considering a hair transplantation procedure, which will provide physicians that do not practice hair restoration the necessary knowledge to counsel and refer patients for treatment.

Methods: Hair restoration surgery is a field of cosmetic surgery that is very specialized, mainly due to the fact that the process is extremely time consuming and requires specially trained staff and assistants.

In many cases, hair restoration physicians perform this procedure exclusively. Since plastic and cosmetic surgeons may receive inquiries from prospective patients about hair loss and hair restoration options, it is imperative that they have a working knowledge of the ideal candidates for this procedure before referring patients for consultation.

Just like any other cosmetic and surgical procedures, not every patient will be an adequate candidate for surgical hair restoration. Factors such as age of onset of hair loss, pattern, rate of progression and family history – to name only a few – are crucial for the surgery planning and for surgical indication.

In general, poor candidates for hair restoration surgery include:
- Patients with no noticeable hair loss who think that they are losing their hair
- Very young patients, in which the pattern of future hair loss may not be determined accurately
- Patients with systemic or skin diseases that may hinder adequate growth of the transplanted hairs

- Patients with very limited donor hair supply
- Patients with expectations that go beyond the reasonable results that may be obtained

During the lecture, case studies will be presented highlighting the important factors to be considered, with explanations as to why such a patient would or would not be an ideal candidate for hair transplantation.

Results: In surgery, a successful outcome may be measured by many different variables. In cosmetic surgery, however, patient satisfaction is the paramount measure of success. Ideally, every patient we treat would have outstanding results and be extremely happy.

The road to a successful result in hair restoration surgery starts to be paved when the physician first meets the patient. With careful and knowledgeable candidate selection, the chances of success are extremely high.

Conclusions: Before-and-after photographs will be used to illustrate the main points covered during the presentation.

11:00 am **A Novel 1440 nm Wavelength Nd: Yag Laser with Combined Apex Pulse Technology for the Improvement of Facial Photaging**
JANE G. KHOURY, MD

Objective: To evaluate the safety and efficacy of the Affirm 1440nm CAP laser for the treatment of photodamaged skin on the face. In addition, to also determine the ideal treatment parameters and number of sessions required to achieve optimal benefit for these indications.

Methods: Twenty subjects Fitzpatrick skin types I-V with photodamaged on face (rhytids, lentigines and telangectasias) were recruited for four to six treatments sessions at three week intervals. Baseline photographs were taken along with photographs preceding each laser treatment. Two passes were delivered to the entire face with fluences between 3-5 j/cm2 based on subject tolerance. Improvement in pigmentation, telengectasia and rhytids were assessed by investigators prior to each treatment.

Results: Preliminary findings suggest that treatments with the Affirm 1440nm CAP laser for photodamage shows improvement both in rhytid reduction and to a lesser degree in pigmentation reduction. No visible reduction in telengectasia was noted. The majority of patients noted improvement within four treatments. The treatment was tolerated by all the subjects with no significant side effects from the treatment. As this is an ongoing study with six-month follow-up, the final data will be presented at the AACS meeting.

Conclusions: The Affirm 1440nm CAP laser treatment results in visible and measurable improvement of the rhytids and, to a lesser extent, the pigmentation of photodamaged skin. No improvement is seen in telangectasias.

11:15 am **Low Level Laser Therapy for the Treatment of Androgenetic Alopecia in Men**
DAVID PEREZ-MEZA, MD

Objective: To evaluate the efficacy of low level laser therapy in men with androgenetic alopecia.

Material and Methods: 40 healthy subjects were included in this six months and double blind study. Male patients, age 18-48 years. Norwood class 3-5 with no previous surgeries were enrolled. Patients were randomized in Device A or B for placebo or real laser (Laser hood device 670 nm). The devices were used for 20 minutes three times a week for one month, followed by twice a week for five months.

Evaluation: At baseline, two, four and six months: 1) Global photography were taken. 2) An area of 1 cm² with a tiny tattoo in the center was selected for macrophotography for hair counts. Three independent evaluators reviewed and compared the pictures for hair loss and hair regrowth. Patients' own assessments were done at each visit.

Results and Conclusions: The study just finished. Results and final conclusions will be presented at the meeting.

11:30 am **A Randomized Investigator Blinded Study to Compare the Efficacy of Two Topical Cosmetic Skin Products on Photo-Aged Skin**
NEIL S. SADICK, MD

Objective: The present study evaluated the efficacy of the serum alone and the efficacy of the combination serum plus cream of a new topical antioxidant serum and cream containing grapevine extract.

Methods: 60 female subjects ages 40 to 60 (mean age 52.3 years) were enrolled in this four-week study; 56 subjects completed the required visits. All subjects were consented with an IRB (Essex IRB, Lebanon, NJ) approved consent form prior to enrollment. Women who were Fitzpatrick Skin Types I-III, Glogau score II-III, meeting all inclusion and none of the exclusion criteria were enrolled. Subjects used a supplied facial cleanser and serum or serum plus cream twice daily for 28 days. At the four-week visit, subjects completed a form rating the changes in their skin. The principal investigator (PI) and an independent evaluator completed the same form. Both the PI and independent evaluator were blinded to the subject's treatment (i.e. serum alone or serum plus cream). Subjects rated the change in their skin's firmness, radiant glow, texture, smoothness, wrinkles, fine lines, evenness, hydration, and softness on a -5 to +5 scale, where -5 indicates the condition worsened, 0 indicates no change and +5 indicates it greatly improved. There was also an overall improvement rating based on a quartile scale of improvement (0-25%, 26-50%, 51-75%, and 76-100%). At the end of the study, subjects were asked if they would purchase the serum or serum and cream it if it were available. Subjects were revealed the brand and name of the serum and/or cream at the end of the study.

Results: 56 subjects completed the four-week study. According to subject evaluation, 54% of subjects using the serum only noticed greater than 25% overall global improvement in their skin by the end of the study, compared to 60% of women who noted greater than 25% improvement with the serum and cream after four weeks of treatment. Subjects using the serum and cream noted an overall greater improvement in specific changes that were asked, most notably in texture, smoothness, evenness, hydration, and softness. The PI noted 90% of subjects had greater than 25% overall improvement in the serum plus cream group versus 65% of subjects in the serum-only group. The independent evaluator noted a mild improvement in all categories for all subjects in the serum-only group and the serum-plus-cream group. According to the independent evaluator, subjects using both the serum and cream had a greater overall improvement, as well as a greater improvement in firmness, radiant glow, hydration and softness than those subjects using the serum alone. The difference between the groups, however, was not significant.

Conclusions: High dose antioxidant preparations are protective against environmental and UV-induced stressors on the skin. In addition, they produce a global rejuvenation effect, most significantly in texture, smoothness and skin hydration.

11:45 am **Panel Discussion**
Moderator: Douglas D. Dedo, MD

12:00 pm **Adjourn**

NOTES

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San Ramon, CA 94583
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Website: www.ultrashape.com
Phone: 925.242.2069
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WELLS JOHNSON COMPANY
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Contact: Grace Alas
8000 S. Kolb Road
Tucson, AZ 85706
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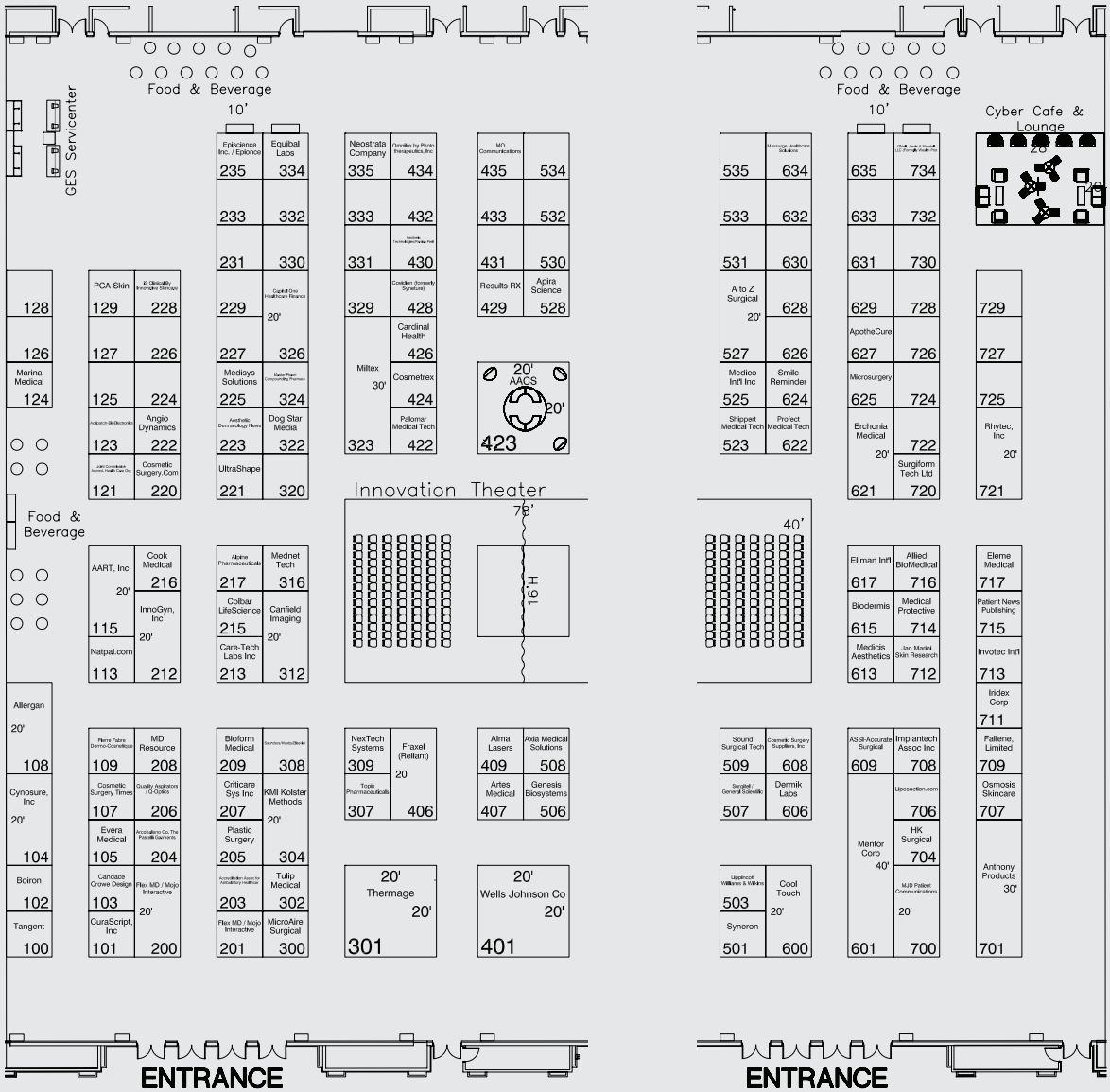

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Advisory Board; Stifel, Proctor & Gamble, Philosophy, Vicky, Revance; Investigator: Galderma, Medicis, Allergan, Johnson & Johnson, Abon, Unilever; Speaker: La Roche Posay.

Paul J. Carniol, MD
I have received research support, lectured for and/or consulted for the following companies and their predecessors at some point in the past 17 years: Allergan, Arthrocare, Candela, Cutera, Cynosure, Iridex, Innotec, Lumenis.

Marc S. Cohen, MD
Medicis. Off label use of Restylane, Juvederm and Botox Cosmetic.

Wayne P. Foster, MD
Commercial relationship with Allergan and Medicis.

Pearl E. Grimes, MD
I have an ongoing relationship (advisory board membership, research grant, speaker's program, etc.) with a healthcare related company(ies) whose product or category of products is mentioned in my article. Skin Medica funded the Clinical Trial.

J. David Holcomb, MD
Manufacture of medical device.

Jane G. Khoury, MD
Off-label use of Botox.

Alexander A. Krakovsky, MD, PhD
Off-label use Alloderm®.

Matt L. Leavitt, DO
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E. Antonio Mangubat, MD
Fat disrupter-KMT-Royalty.

Paul J. McAndrews, MD
Merck consultant.

Ronald L. Moy, MD
Scientific Advisory Board of Rhytec. Lipodissolve is off label.

James Newman, MD
Member of scientific advisory board. Produce has CE Mark approval and FDA clearance – off-label use of cleared product will be presented.

Zein E. Obagi, MD
I own stock in Obagi Medical Products and I may mention certain products this company sells and promotes to physicians such as UV derm creams, CRX creams and blue peel.

David Perez-Meza, MD
I am a consultant for Laser Hair Therapy of North America.

Michael H. Rosenberg, MD
I am the Chief Medical Officer and part owner of Cosmetrex, a group purchasing organization of cosmetic surgeons.

Kenneth Rothaus, MD
Honorarium for speaking at commercial meeting.

Adam M. Rotunda, MD
Former consultant to kythera Biopharmoceuticals, Inc; McGuff Pharmacy provided study medication at no cost; Employee of Allergan, Inc; / Phosphatidylcholine and deoxychalate are not FDA-approved for fat dissolution. Than Light and/or energy devices present.

Neil S. Sadick, MD
Commercial relationship with Radiesse, Dior and Dermik.

Nancy G. Swartz, MD
Allergan: Consultant relationship and commercially derived Honoraria. This presentation includes "off label" uses of substance.

Carl R. Thornfeldt, MD
Founder of Episciences, Inc, which sponsored prospective double blind clinical trials.

Yan Trokel, MD,DDS
Non FDA Approval Pending.

Edward M. Zimmerman, MD
Speaker for Alma; CoolTouch; Rhytec & Allergan. Research support (free fibers) from CoolTouch; paid travel from CoolTouch after abstract accepted. Cool Lipo Not FDA approved for lipolysis and skin tightening at this date – it is pending and may be approved by the meeting date.

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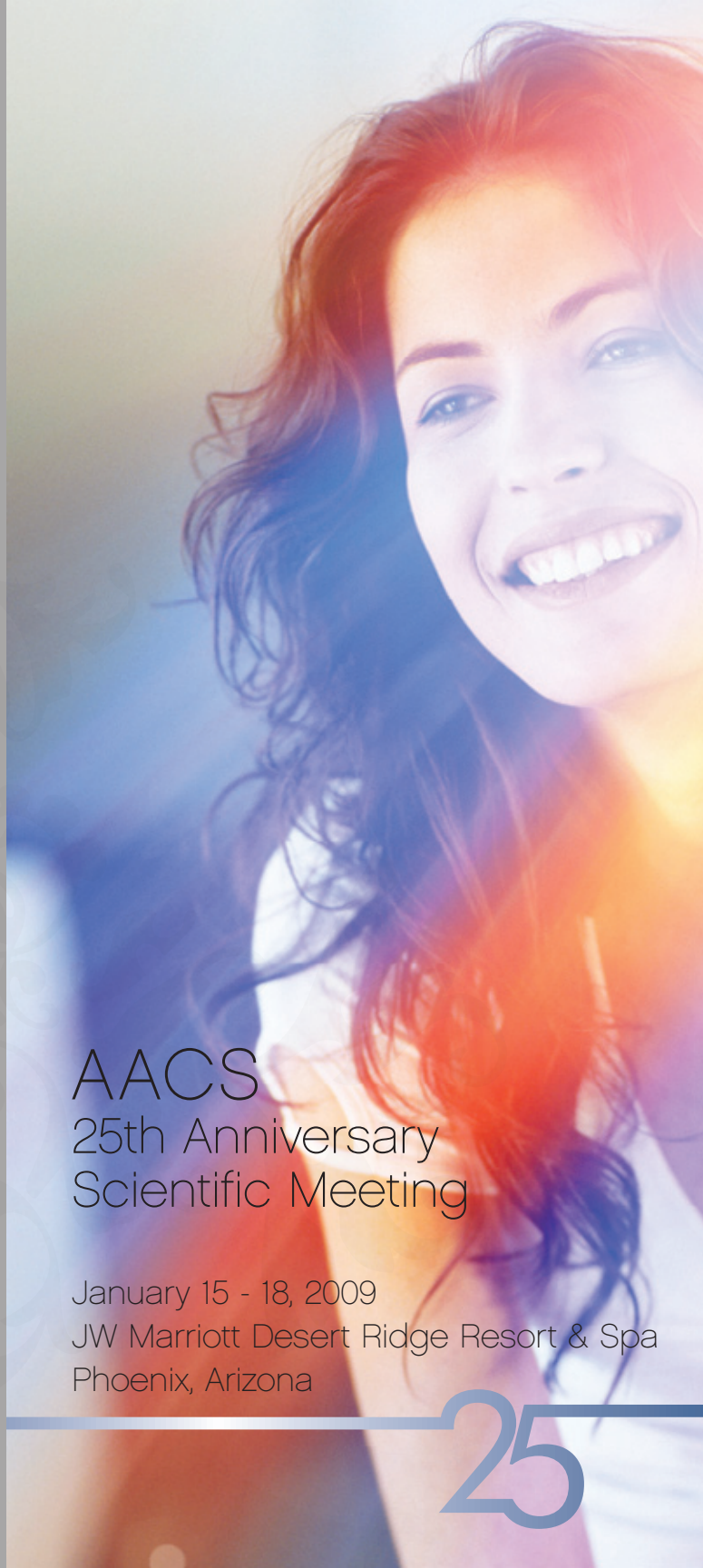

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