final program

American Academy
of Cosmetic Surgery

not a day over twenty-five

25TH ANNIVERSARY SCIENTIFIC MEETING

JANUARY 15–18, 2009

JW MARRIOTT DESERT RIDGE RESORT & SPA

PHOENIX, ARIZONA

25

PROGRAM CHAIRS:
PATRICK G. MCMENAMIN, MD
JOSEPH NIAMTU III, DMD
ROBERT SHUMWAY, MD

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GENERAL INFORMATION

AACS Meeting Registration

Location: Ballroom Foyer

HOURS:

Tuesday, January 13	**4:00 pm - 6:00 pm**
Wednesday, January 14	**7:00 am - 8:00 pm**
Thursday, January 15	**6:30 am - 4:00 pm**
Friday, January 16	**6:30 am - 4:00 pm**
Saturday, January 17	**7:00 am - 3:00 pm**
Sunday, January 18	**7:00 am - 12:00 pm**

Exhibit Hall

Location: Grand Canyon Ballroom

HOURS:

Thursday, January 15	**8:30 am - 6:30 pm**
(Welcome Reception)	**5:30 pm - 6:30 pm**
Friday, January 16	**8:30 am - 4:00 pm**
Saturday, January 17	**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 Grand Sonoran Ballroom E-G unless otherwise indicated.

AACS 25th Anniversary Luncheon

Location: Grand Saguaro Ballroom South

The deadline for purchasing tickets for the Anniversary Luncheon is Friday, January 16 at 12:00 pm (noon).

Speaker Ready Room

Location: Desert Suite 1

HOURS:

Wednesday, January 14	**7:00 am - 6:00 pm**
Thursday, January 15	**7:00 am - 6:00 pm**
Friday, January 16	**7:00 am - 6:00 pm**
Saturday, January 17	**7:00 am - 5:00 pm**
Sunday, January 18	**7:00 am - 12:00 pm**

CME Hours and Session Evaluations must be submitted at either of the Cyber Cafés located in the Ballroom Foyer.

Please complete hours and evaluations after each session attended.

WEDNESDAY, JANUARY 14, 2009

SCHEDULE-AT-A-GLANCE

7:00 am - 8:00 pm	Registration Open
7:30 - 8:00 am	Continental Breakfast
8:00 am - 5:30 pm	The Art of Liposuction Surgery Workshop
8:00 am - 5:30 pm	The Art of Cosmetic Breast Surgery Workshop
8:00 am - 5:30 pm	The Art of Cosmetic Facial Surgery Workshop
8:00 am - 5:00 pm	The International Society of Cosmetogynecology Workshop
9:30 - 10:45 am	Coffee Break
12:00 - 1:00 pm	Lunch
3:00 - 3:30 pm	Coffee Break

WEDNESDAY, JANUARY 14, 2009

The Art of Liposuction Surgery

Presented by the American Society of Lipo-Suction Surgery
Program Chairman: Gerald G. Edds, MD

Location: Grand Saguaro West

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

8:10 am Nuts and Bolts for the New Liposuction Practitioner
ROBERT A. SHUMWAY, MD

Objective: Valuable instructions on "how" to get started in performing quality liposuction procedures for qualified patients.

Material & Methods: An overview of initial physician training, methodology, hardware, technology, and risk factors were reviewed as per author's experience with past patient exposures since 1988. Answers to pertinent questions were reviewed.

Results: Proposed answers to the following questions: Am I the right doctor? Where do I get the best training and credentialing? Matching the right procedure with the right patient. What methods of liposuction will I use? What instruments and hardware do I buy? What are the different types of vacuum lipectomy available today? How much will it cost to get started? What about marketing? How much do I charge the patient? What are the most common risks? What complications must I absolutely avoid? Medico legal issues?

Conclusion: Getting started in the cosmetic liposuction business can be very rewarding to the surgeon who is well prepared and who has an overall, well organized, written execution plan of initiation. Answers to the above questions are the "nuts & bolts" of getting started for the novice practitioner.

Notes

8:40 am **Tumescent Liposuction: Historical Perspective, Safety Standards in Liposuction**
GERALD G. EDDS, MD

The history of Liposuction began in the mid 1970's with Fisher utilizing a morselizing device with a power sprayer and an aspirator tube. In 1977, Yves-Gerard Illouz, MD, described his original tunneling technique of suction lipectomy. Over the past thirty-one years, liposuction has become a mainstay of cosmetic surgery. This discussion will detail the extraordinary accomplishments that have made liposuction a safe and predictable surgical technique. The appropriate application of the tumescent technique as described by Klein as well as practice guidelines will be discussed.

9:10 am **Reducing Litigation Risk in Liposuction**
RONALD A. FRAGEN, MD

Information not available at press time.

9:40 am **Basic Techniques in Liposuction**
GERHARD SATTLER, MD

Liposuction techniques have become more and more standardized in our observation. Still, the biggest part of the performance of the liposuction surgery relies on the individual style of surgery, how the patient is treated.

This presentation focuses on basic techniques which should be respected by everyone in every liposuction surgery. For example, movement of the canula, tumescent technique, and postoperative care are some of the topics being presented.The interpretation of these facts should be the foundation of a liposuction surgeon.

10:20 - 10:30 am **Coffee Break**

10:30 am **Clinical Photography for Liposuction**
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 principals that will enhance the accuracy of liposuction 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, not satisfied with the accuracy of their present photography, switching from conventional to digital photography or upgrading their present digital equipment.

10:50 am **Analysis of Tumescent Technique**
GERHARD SATTLER, MD

Since the introduction of the tumescent technique for liposuction surgery, several changes regarding the motivation for this kind of anesthesia have been observed. As the infiltration of high volumes of tumescent fluid not only anesthetize the target zone but it also prepares the section site for surgery. The dynamic continuous infiltration leads to a defined distribution of the fluid in several stages. This finally results in the state of tumescence. In this condition when the hydrostatic pressure of the fluid prepares the anatomical structures, the surgical intervention is carried out in a safer and more predictable manner. Different formulas of the tumescent fluid have been described, but so far none of them has shown a convincing advantage in order to overrule Jeff Klein's genuine formula.

11:20 am **Efficacy of Gradually Reduced Lidocaine Concentration in 3000 Patients Undergoing Liposuction Using Tumescent Local Anesthesia**
LOEK HABBEMA, MD

Objective: To determine the minimum concentration of lidocaine required to provide adequate anesthesia in patients undergoing liposuction using exclusively TLA.

Methods: From 1996 to 2008, liposuction using exclusively TLA was performed on 3000 patients by one surgeon. Initially, the concentration of lidocaine used was taken from the guidelines published in the medical literature. Gradually, the concentration was reduced to find the minimum concentration required for complete anesthesia.

Results: The concentration of lidocaine was gradually reduced from 1000 mg to 500 mg added to 1000 mL of saline. Further reduction to 400 mg has been successful for most of the areas treated.

Conclusions: For patients undergoing liposuction using exclusively TLA, the concentration of lidocaine required for adequate anesthesia is 400 mg/L for most body areas. For certain areas, 500 mg/L can give more working comfort. By using these concentrations high volumes are available for infiltration before the maximum dosage is reached.

Notes

11:40 am **Technical Aspects of Different Machines**
JANE A. PETRO, MD

Since the introduction of the removal of fat through small puncture wounds, the proliferation of canulae and machines designed to facilitate that removal has created a significant industry. Whether the energy source (laser, ultrasound, negative pressure) or the placement of the energy (internal/external) results in improved results remains controversial. Few well designed clinical trials have compared either equipment or technique. This presentation will evaluate the technical aspects of the currently available equipment focusing on the clinical evidence, and the basic science between them as well as a comparison of the relative costs of the devices.

12:00 - 1:00 pm **Lunch**

1:00 pm **Perioperative Care of the Liposuction Patient**
GERHARD SATTLER, MD

While local anaesthesia for liposuction surgery is highly recommended these days, the question rises how the patient is guided and checked during surgery, since the liposuction surgeon is occupied performing the surgery. So, we believe, it is highly recommended that an anaesthesiologist is present during the whole time of the surgery. He supports the patient as well as the surgeon with all the possible immediate intensive care options which might be needed unexpectedly. Also a very mobile OR table is of great importance. The patient is free to move around on the o.r. table and should stretch the targeted tissue sides as tight as possible. For pain reduction during surgery, drugs like remifentanyl help to perform a complete pain-free procedure.

1:30 pm **Liposuction Safety Studies**
C. WILLIAM HANKE, MD

The safety of liposuction utilizing tumescent local anesthesia is unprecedented. Multiple studies have documented low complication rates and excellent results. The studies in the literature will be reviewed with the emphasis on avoiding liposuction complications.

2:00 pm **Treatment of Liposuction Complications**
MARK BERMAN, MD

We will take an A to Z approach to discuss prevention and treatment of complications from liposuction. Particular attention will be paid to areas of correcting common liposuction defects.

2:30 pm **Advances in Minimally Invasive Lipoabdominoplasty Technology**
MARCO A. PELOSI II, MD

This presentation illustrates the author's system of office minimally invasive lipoabdominoplasty using tumescent local anesthesia. Several modifications of the original surgical technique and new instrumentation have been incorporated, making the procedure more efficient, faster, and safer. A video demonstration of our current lipoabdominoplasty system will also be presented.

Notes

3:00 pm **Breast Reduction by Liposuction Using Tumescent Local Anesthesia and Powered Cannulas: Safe and Effective**
LOEK HABBEMA, MD

Objective: To collect data concerning the safety and efficacy of liposuction using tumescent local anesthesia and powered cannulas.

Methods: One hundred thirty women were treated. Complications were registered. Postoperative mammograms were made after one year.

Results: As an average 50% of the breast volume was removed. No serious complications that needed hospitalization were recorded. Postoperative mammograms showed no new calcifications that needed further evaluation.

Conclusion: Liposuction using tumescent local anesthesia and powered cannulas is a safe and effective treatment modality for breast reduction.

3:30 pm **Take Home Pearls in Liposuction: Liposuction Training: Where and How?**
PATRICK G. MCMENAMIN, MD

A new consumer-driven resurgence of liposuction is occurring. Brought on by laser liposuction and expectations of an easier recovery, more people are actively seeking the new technologies and promises of better results. Most experienced lipo-surgeons have settled into their standardized routines and are using tried and true methods to generate consistent results.

Over the past eight years, six notable changes in my liposuction technique have significantly improved my outcomes. These include:

1) Slightly lower suction pressures (25 inches Hg) first proposed by Dr. Michael Elam
2) Tumescent lidocaine in the 50-55 mg/kg range
3) Spiral cannulas for debulking and refinement
4) Use of the Blugerman rasp for evenness of anesthetic distribution, fat disruption with a lipo-shifting component, and finesse sculpting after suctioning for evenness of skin texture and tightening
5) Manual spreading of the skin at the termination of the liposuction procedure to “recreate” the tumescent condition for final smoothing and sculpting
6) Use of a penrose drain to facilitate fluid drainage after large volume liposuction to minimize seroma formation

In addition to standardized, time-tested methods other evolving technologies can be considered. Dissolving fat with chemical injections (lipo dissolve) and laser lipolysis are two techniques on the horizon stimulating interest.

Preliminary results and considerations of laser lipolysis will be presented.

Discussion of advances in liposuction training and provision for newer surgeons entering the field will be discussed.

Notes

4:00 pm **Emerging Technologies in Liposuction**
Laser Assisted Liposuction
EDWARD B. LACK, MD

Since the evolution of tumescent liposculpture by Jeffrey Klein, numerous attempts at improving liposuction results have been attempted by industry. All of these attempts have involved mechanical tools which would either augment the skill of the practitioner or in fact replace the need for clinical skills altogether. Mechanically assisted liposuction, ultrasonic assisted liposuction, external ultrasonic assisted liposuction, laser assisted liposuction, and now laser lipolysis have all attempted to improve the quality of liposuction results and at the same time replace human judgment and human mechanics with machine driven protocols. This lecture will examine the author's experience with laser lipolysis, discern its potential benefits and potential morbidity, and compare this technology to previous attempts at mechanical improvement of liposuction surgery.

4:15 pm **Low-Level External Laser**
SUSAN M. HUGHES, MD

As the first non-study owner of the Zeronia machine, I treated 13 patients and was disappointed to find no change in 7 patients. 1 patient lost 1½" in the hips, 3 with ½ to 1" mostly in hips, and 2 incomplete treatments. Disappointed, the company replaced the machine and confirmed treatment parameters. Then the company revealed results of their clinical studies, and there were many parameters that disqualified patients for the treatment. Responders were in a small window of BMI between 25-30, so it is not for the obese population. These treatment ineligibility factors go on to include previous liposuction, or tummy tucks, diabetes, cardiovascular disease, surgery, irritable bowel syndrome, etc. With the new machine, 2/6 patients showed no change and 4/6 patients lost between 1-3", again mostly in hips. The study is still ongoing.

4:30 pm **Histopathologic Analysis of 1064 nm and 1320 nm NdYag Laser Lipolysis Body Sculpting**
NEIL S. SADICK, MD

Background: Laser lipoplasty offers the potential advantage of skin tightening following removal of the subcutaneous fat. The search continues for an optimal wavelength that would allow for efficient lipolysis while inducing dermal remodeling.

Objective: The main objective of this study is to determine the histological effects of 1064 nm and 1320 nm Nd:YAG lipolysis on fresh ex vivo human abdominal fat pads at variable fluence.

Materials and Methods: Ipsilateral 1064 nm Nd:YAG and contralateral 1320 nm Nd:YAG lipolysis at variable fluence were performed on ex vivo human abdominal fat pads. Histological analysis of post-lipolysis specimens was conducted.

Results: Our data demonstrates the fluence-dependent tissue alterations. For 1064 nm Nd:YAG, at an optical energy density of 27 to 89 J per cm^3 of dermis only focal coagulation was seen. For 1320 nm Nd:YAG, at an optical energy density of 27 J/cm^3 of dermis focal coagulation was observed, whereas energy density of 62 and 89 J/cm^3 resulted in more extensive coagulation.

Notes

4:45 pm External Ultrasound in Liposuction
JAMES L. ENGLISH, MD AND
CAREY J. NEASE, MD

Introduction: Several preliminary studies have shown the potential benefits of external ultrasound assisted liposuction (XUAL). This study was undertaken to report our experience with XUAL at a single cosmetic surgery center over a one-year period. The primary question being addressed was whether XUAL of the abdomen would result in a higher rate of adverse events when compared to the traditional tumescent technique.

Materials and Methods: This prospective, non-randomized study included 2 groups of 15 patients undergoing abdominal liposuction. The first group underwent traditional tumescent liposuction without the use of XUAL. The second group included XUAL as a pre-treatment to the abdomen followed by aspiration of the abdominal fat in the usual manner. Patients were treated identically pre- and post-operatively with the exception of the addition of XUAL in group 2. Data collected included the patients' BMI, volume of aspirate, and the incidence of post-operative seroma.

Results: At the first post-operative appointment it was notable that 2 of 15 patients in group 1 (13%) had developed a significant (>50cc) lower abdominal seroma. Both patients were successfully treated with a single closed drainage procedure in the office via needle aspiration. In group 2 at the first post-operative visit it was notable that 5 of the 15 patients (33%) presented with a significant (>50cc) lower abdominal seroma. All patients in group 2 were successfully treated with drainage of the fluid via either needle aspiration or by opening the midline lower port and placing a passive drain in several cases. The data provided sufficient evidence that group 2 has a significantly different seroma rate with 95% confidence, which gives borderline results at 5% significance.

Conclusions: Based on this information we have concluded that there may be an increased incidence of seroma formation with XUAL of the abdomen. Further studies with a larger sample size may prove that there is a statistically significant difference between the two groups.

4:45 pm Panel Discussion
LOEK HABBEMA, MD, C. WILLIAM HANKE, MD, JANE A. PETRO, MD AND GERHARD SATTLER, MD

5:30 pm Session Adjourns

Notes

The Art of Cosmetic Breast Surgery

Presented by the American Academy of Cosmetic Surgery
Program Chairman: Robert M. Dryden, MD

Location: Grand Sonoran E

Moderators: ROBERT M. DRYDEN, MD AND MAURICE P. SHERMAN, MD

8:00 am Welcome and Introduction
ROBERT M. DRYDEN, MD

8:05 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 1990's 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.

8:20 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 also 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 by 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 and 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.

Notes

8:40 am **Proper Informed Consent**
ROBERT V. CATTANI, MD

Dr. Cattani will carefully review all that is necessary to properly issue informed consent and all that can be possibly included to maximize your protection in this highly litigious field.

He will also cover the documents and clerical pathway that must accompany each and every breast surgery operation. This will include documentation of photography, chest measurements, clinical pre-op testing, as well as postoperative care both immediate and long-term.

9:00 am **Breast Augmentation Considerations**
MAURICE P. SHERMAN, MD

For the cosmetic surgeon new to cosmetic breast surgery, the basics of the surgical procedures may appear uncomplicated or straightforward. However, there are numerous considerations necessary to clearly understand and explain to patients in order to obtain satisfactory results. This discussion will detail issues of evaluation, implant types and sizes, approaches and anatomic variables which are important points to understand when performing this surgical procedure.

9:20 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" (post-graduate 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 the 12 month follow up visit (or last visit prior to the 12 month visit, whichever occurred last). 4 different approaches were utilized by the author and compared, including InfraMammary 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: 100 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. Four of these were to manage hematomas in the early phase, 4 were to manage position problems, and 2 were to upsize. 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 post-operative bleeding is highly recommended for approaches remote from the breast, such as TrAx and TUBA.

9:35 - 9:55 am Coffee Break

Moderator: THEODORE E. STAAHL, MD

9:55 am **The Roy Morgan Appreciation Lecture – The Evolution of Cosmetic Breast Surgery**
WILLIAM ROY MORGAN, MD

A brief summary of many of the important considerations that have been observed in the practice of cosmetic breast surgery with emphasis on breast augmentation will be presented. Many of the problems that can occur with this surgery, and how to avoid and/or manage them will be discussed.

The most favorable approaches, implants and implant placement will be reviewed. A DVD of recent surgeries along with the before and after results and an eighteen year follow-up of this technique will be made available.

The advantages of including breast augmentation in the practice, of anyone who is interested in any aspect of cosmetic surgery, will be explained.

10:15 am **Periareolar Breast Augmentation**
MARK BERMAN, MD

Nuances of the periareolar approach to breast augmentation will be discussed to help the participant understand improved techniques for performing breast augmentation via this incision.

10:30 am **Augmentation Pearls**
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 pre-operative, intra-operative and post-operative skills breast surgery can be one of the most enjoyable facets of cosmetic surgery. In today's society with the emphasis of our culture 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 intra-operative technique of choosing the right implant, fashioning the appropriate pocket and applying appropriate dressings is extremely important and will be demonstrated. Post-operative care, exercises, and correction or treatment of complications will be addressed.

10:50 am **Transaxillary Subfascial Augmentation**
J. DAN METCALF, MD

Background: Various approaches to breast augmentation are being used. This approach provides many advantages over other approaches.

Objective: To improve tissue coverage and decrease rippling without some of the undesirable side effects of submuscular placement.

Method: The axillary approach dissection and placement of the implant is performed deep to the deep pectoral fascia.

Results: Improvement in tissue coverage and decline in the incidence of rippling compared to submammary approach.

Conclusion: Better tissue coverage and less rippling can be accomplished with the subfascial approach compared to submammary approach.

Notes

11:05 am **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 1990's, subfascial placement of the implants greatly improves the appearance, recovery process, controlled healing, and long-term results of saline breast augmentation. Dr. Howard Tobin has demonstrated almost 50 percent occurrence of rippling with subpectoral placement. We have experienced a slight increase in rippling with subfascial placement which has not detracted from the overall aesthetic results. Over 450 subfascial implant patients over 5½ 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 is better than subpectoral placement.

11:35 am **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, which 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.

11:50 am **Panel Discussion**

12:00 - 1:00 pm **Lunch**

Moderator: RONALD A. FRAGEN, MD

1:00 pm **TUBA & Extended Crescent Mastopexy**
ROBERT A. SHUMWAY, MD

My goal is to present basic TUBA techniques coupled with the Crescent and Bernelli periareolar NAC lifts. The presenter will show an array of clinically different ptotic breasts that would be suitable for the above surgeries.

The results from a large breast study reveal the highly successful use of TUBA and NAC mastopexy for glandular ptosis, for grade I & II ptosis, and for patients who need breast reshaping. Before and after photography will be evaluated with emphasis on long-term appearance.

The pearls and pitfalls of any TUBA procedure will be detailed to help both the novice and expert TUBA surgeon avoid potential problems or healing concerns. In conclusion, the TUBA operation keeps the surgical incision away from the breast while the NAC Mastopexy Lift keeps the breast incision superficial and very well hidden. These procedures are powerful tools and offer excellent results for dedicated cosmetic breast surgeons.

Notes

1:20 pm **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 superior 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.

1:50 pm **Breast Augmentation Complications**
J. DAN METCALF, MD

Background: Most approaches to breast augmentation are rather simple, whereas treatment of common complications can be quite difficult.

Objective: Improve treatment and outcome of common complications of breast augmentation.

Method: Demonstration of treatment of common complications of breast augmentation.

Results: Improvement in outcome of treatment of common complications of breast augmentation.

Conclusion: Breast augmentation is generally a very simple operation. Methods of more difficult treatment of complications are presented.

2:30 pm **Mastopexy for Beginners**
THEODORE E. STAAHL, MD

This paper will go over the ABC's for evaluating, measuring, and marking the ptotic breast. The crescent, Benelli, and vertical design mastopexies will be shown. Appropriate pre-op and post-op cases will be discussed.

2:50 pm **Pros and Cons of the Various Augmentation Approaches and Pocket Positions**
MAURICE P. SHERMAN, MD

The four major approaches and three pocket positions in cosmetic breast augmentation are detailed with emphasis on correct techniques, indications, avoidance of problems and expected post-operative results.

Notes

3:10 - 3:30 pm Coffee Break

Moderator: MARK BERMAN, MD

3:30 pm Anesthesia Emergencies
ANTHONY ROGERS, MD

Information not available at press time.

4:10 pm What is New in Cosmetic Breast Surgery
MARK BERMAN, MD

This discussion will update participants with highlights from new areas being considered with regards to breast augmentation. We will discuss new innovations with breast implants, different filler materials being explored, new systems being considered and updates on current research.

4:30 pm Panel Discussion

5:00 pm Session Adjourns

Notes

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The Art of Cosmetic Facial Surgery

Presented by the American Academy of Cosmetic Surgery
Program Chairman: Ronald L. Moy, MD

Location: Grand Sonoran F

8:00 am **Welcome and Introduction**
RONALD L. MOY, MD

8:05 am **Facial Rejuvenation with Implants**
STEVEN B. HOPPING, MD

Some of facial aging is gravity, but in many patients much of facial aging is atrophy. There has been a pyardyne change in our thinking and approach to facial rejuvenation.Traditional SMAS facelifts provide two dimensional lifting of the soft tissues of the face. Although SMAS lifts can provide some increased volume by repositioning soft tissue, they are unable to replace or augment facial volume that has been diminished by time and aging. Facial rejuvenation with alloplastic implants can give permanent volumetric gains which when combined with SMAS lifting achieves a three dimensional face lift. The concept of a three dimensional facelift focuses on (1) skeletal enhancement with alloplastic implants, (2) SMAS lifting and repositioning by plication or imbrication and (3) skin rotation and redraping. In many patients, each of these three elements need to be corrected to achieve a truly natural aesthetic improvement.

8:25 am **Face Lifting Techniques**
RONALD L. MOY, MD

The lecture will review current techniques for face-lift and minimal incision face-lift, patient selection, and complications as well as their avoidance.

8:50 am **Salient Steps of Face and Neck Lifting**
PATRICK G. MCMENAMIN, MD

Face and neck lifting is an addressable surgical procedure that rejuvenates the foundation of the lower two-thirds of the face. Starting with patient evaluation and anesthetic techniques (tumescent), an incremental approach to submentoplasty and cervicofacial liposculpting will help the surgeon understand the sequential steps and thought processes that can accomplish the necessary surgical goals. These include improving the anterior neck, cervicomental angle, jowls, and jaw line.

With the face and neck lift, the focus will shift to incision selection, flap elevation, and Superficial Musculo Aponeurotic System (SMAS) techniques including plication and imbrication. Safe techniques that avoid the facial and greater auricular nerves and enhance the earlobe appearance will be presented.

Skin redraping, tension-free closure, and postoperative care will also be explained. The surgeon will benefit from simple

steps that can avoid many of the pitfalls of submentoplasty and rhytidectomy. These techniques will facilitate patient and surgeon comfort and safety. A 15-minute video will demonstrate the dynamic aspects of these face and neck lifting techniques.

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9:15 am **Fat Grafting and Volume Replacement**
MARK BERMAN, MD

Fat grafting has become an accepted way of restoring volume and thus, youthful appearance to one's face. A number of methods have been proposed for harvesting and injecting fat. Today, we will discuss my current method using the LipoKit system for harvesting fat and the Tulip injectors for transplantation. Later, a video presentation will be shown to demonstrate these techniques and the method for three-dimensional restoration of the aging face.

9:40 - 10:00 am **Coffee Break**

10:00 am **Suture Suspension; Mid Face**
WILLIAM H. BEESON, MD

Information not available at press time.

10:25 am **Neck Rejuvenation**
ANGELO CUZALINA, MD, DDS

Achieving a beautiful and youthful jaw line and neck contour is a common desire for many cosmetic surgery patients. Certain patients are candidates for isolated facial or neck liposuction if their skin tone and muscle tone are adequate. In addition, the role of chin augmentation to improve a weak chin projection is critical to obtain good facial proportion as well as maximum neck aesthetics particularly when a patient has an anterior or low hyoid position. Often, isolated facelift surgery performed by an assortment of lateral pulling or lifting techniques is performed as an isolated procedure to improve the jowls and neck. A submentoplasty may be mentioned briefly as part of the procedure, but it is not well described and not given the credit it deserves for its role in long-term aesthetic neck improvement.

Specific techniques for maximum neck rejuvenation using lifting techniques along with advanced submentoplasty maneuvers will be addressed. Treatment of extremely ptotic necks and achieving long-term stability with minimal relapse will also be reviewed. Appropriate patient selection and fundamental techniques are described along with how to avoid common mistakes and management of complications. Video shown during the second half of this lecture will include submentoplasty along with posterior neck lifting techniques.

10:50 am **S-Lift History and Evolution**
ZIYA SAYLAN, MD

History: About 80 years ago Dr. Passot and Dr. Joseph have published their first facelift surgeries. Almost three decades ago Skoog demonstrated that a dissection could be made beneath a layer, later to become known as SMAS, and a new era in facelift surgery began. In 1977 Owsley reported about plicating the SMAS tissue which gives an optimal traction of the lower facial tissues. During the following years different surgeons chose to use the SMAS in different ways, but typically a single large flap was elevated

over the lower cheek. In the early 1980s Jost and Lamouche published articles on resection and even segmentation of the SMAS flaps pulling in different directions. In 1998 the author published his first article on “S-Lift, Less is more” and Dr. Daniel Baker published his work "Short Scar Face lift" with lateral SMASectomy.

Objective: After performing S-Lift for over 12 years the technique is now more improved and performed differently in compare 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. The main differences are: The missing tumescent anaesthesia 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. In these cases the incision is similar to a conventional facelift and the surgery is then called an S-Lift plus.

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.

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 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 scaring, short recovery time and more natural results. Part of the aging process is gravity but much of aging is atrophy.

The differences of the S-Lift in 1999 and 2008 are as follows:

- The skin excision previous to surgery is not performed any more. The amount of skin to be taken out is decided at the end of the surgery during the closure.
- That time (1999) 150 to 250 ml of tumescent solution was infiltrated into all operative areas with a blunt needle. This was thought to blow up the region and achieve a kind of hydro dissection. We have seen that swollen cheeks of the patients will harden the closure under tension. The surgeon can achieve an optimal pulling and closure but at the

following day as the tumescent fluid is absorbed a kind of sagging will be left over. The blunt needles for the infiltration do not insert the tumescent solution into the tissue properly. Now we prefer the sharp needles for infiltration. The amount of required local anaesthetic is nowadays not more than 15-20 ml for each site of the face. This also reduces the amount of adrenalin injected which will also improve the blood supply of the flap postoperatively.

- In 1999 the SMAS plication was performed with two sutures of 2-0 Prolene. This was causing an extra hardening of the cheeks and in some cases even after years the ends of the thread was perforating the skin and coming out of the body. Now we are using 2/0 Vicryl so that the material is absorbed in 8 to 12 weeks after an adequate adhesion of the elevated SMAS has been occurred.
- Today a third purse string suture is inserted below the earlobe pulling the platysma and the neck backwards to achieve a better submental angle. It is also combined with submental liposuction, platysmaplasty and a serial platysma notching.

11:15 am **Complications**
JOSEPH NIAMTU III, DMD

Facelift surgery is the king of cosmetic rejuvenation. This procedure has many intricacies and is an extremely technique-sensitive procedure. There exist hundreds of ways to perform facelifts and more and more surgeons are learning the technique. Like any procedure, facelift surgery can cause complications of the minor and major category. Appreciating the possibility of facelift complications and understanding their pathophysiology can go a long way in their prevention. This multimedia presentation will discuss common and uncommon complications seen in facelift surgery with an emphasis on ways and means to prevent them before, during and after surgery. Included in the discussion will be patient selection, anesthesia considerations, pre-op problems, intra-operative problems and post-operative problems. At the end of this presentation attendees should have an understanding of some of the most common and uncommon complications that accompany facelift surgery.

11:35 am **Panel Discussion**

12:00 - 1:00 pm **Lunch**

1:00 - 3:00 pm **Video Session: Cosmetic Facial Surgery Procedures**

1:00 pm **Video: Salient Steps of Face and Neck Lifting**
PATRICK G. MCMENAMIN, MD

1:15 pm Video: Facial Rejuvenation with Implants
STEVEN B. HOPPING, MD

1:30 pm Video: Face Lifting Techniques
RONALD L. MOY, MD

1:45 pm Video: Fat Grafting and Volume Replacement
MARK BERMAN, MD

2:00 pm Video: Suture Suspension; Mid Face
WILLIAM H. BEESON, MD

2:15 pm Video: Neck Rejuvenation
ANGELO CUZALINA, MD, DDS

2:30 pm Video: S-Lift History and Evolution
ZIYA SAYLAN, MD

2:45 pm Video: Complications
JOSEPH NIAMTU III, DMD

Notes

3:00 - 5:00 pm **The Art and Science of Fillers and Botox**

3:00 pm **Choosing the Right Filler for Your Patient**
DEE ANNA GLASER, MD

With an explosion of new filler options, it's imperative that the clinician be able to select the most appropriate filler for their patient. This talk will focus on filler options and combinations of fillers to maximize patient satisfaction and patient outcomes.

3:45 pm **Botox – Enhancing Clinical Results and Business Practices**
SUZAN OBAGI, MD

Botulinum Toxin A (Botox) has revolutionized the non-invasive cosmetic surgery industry and continues to be an important adjunctive treatment for almost every patient. The author will discuss the approach to the cosmetic patient beyond the simple injection of this agent. The lecture will cover newer indications for this procedure, tips for enhancing patient satisfaction, and ways to enhance profitability.

4:30 - 5:30 pm **Panel Discussion**

5:30 pm **Session Adjourns**

Notes

Notes

The International Society of Cosmetogynecology Workshop

Presented by the American Academy of Cosmetic Surgery
Program Chairmen: Marco A. Pelosi II, MD, Marco A. Pelosi III, MD and David L. Matlock, MD

Location: Grand Sonoran JK

8:00 am Welcome and Introduction
MARCO A. PELOSI II, MD

8:06 am History of Cosmetogynecology/ISCG and Where We Go From Here
MARCO A. PELOSI III, MD

8:21 am The Importance for the Cosmetogynecologist to Be an Active Member of an Elite Cosmetic Surgery Society: The Role of the American Academy of Cosmetic Surgery
MICHAEL J. WILL, MD, DDS

8:36 am Proven Strategies to Protect the Cosmetogynecologist and Other Cosmetic Surgeons from Lawsuits
JEFFERY SEGAL, MD

Medical justice preemptively deters frivolous medical malpractice lawsuits, provides early action if a plan member is sued for medical malpractice, and makes effective response strategies available, affordable, and expedient when appropriate. Services common to all plans are:

- Pursuit of counterclaims against expert witnesses in their professional societies and state licensing boards;
- Published database of members on the Internet to notify plaintiffs and their representatives that the physician is backed by an organization with the expertise, will, and funds to fight back;
- Establishment of pre-emptive critical practice infrastructure to deter plaintiffs without interfering with the patient-doctor relationship;
- Proactive early action strategy that can be executed in the event you are sued for medical malpractice;
- Access to PEER team of volunteer defense experts, license to use Patient-Physician contract template language;
- License to use contract template language to prevent being forced into small-claims court;
- Access to program to address unwarranted requests for refunds or write-offs;

- Allocation of up to $100,000 as assignee to pursue viable counterclaims when requested and appropriate Medical Justice is offered across the country and includes plans ranging from prospective (future-events) to historical (prior-events), as well as service for open medical malpractice lawsuits.

Notes

8:56 am **Affordable Malpractice Coverage Options and Solutions for the Cosmetic Surgeons and their Patients**
DAVE PULLEY, MD

Medical complications can arise after any surgical procedure. Since most health insurance companies will not pay for the treatment of medical complications following an elective procedure nor for the elective procedure itself, these situations can present a unique set of challenges to the patient and the treating physicians: who is going to pay the bills for the treatment of complications? Is part of the original payment for the procedure? When unprepared for, and faced with, thousands of dollars in bills, many patients simply resort to filing a lawsuit to get the bills paid. This approach truly is only good for one of the parties involved – the attorneys! Unique insurance products that will provide coverage for medical complications that arise during and after an elective procedure – exactly when there isn't coverage from the patient's health insurance – will be presented. They offer damage control and prevent potential lawsuits before they happen and offer your patient a great benefit to the surgery. The insurance is affordable and provides you and your patient with peace of mind regarding any complications that may occur. As a matter of fact, it's affordable enough that you can either absorb the cost yourself or pass the cost on to your patient and still be competitive with your fees.

9:11 am **Long Duration Combined Plastic and Gynecologic Surgery Performed on an Outpatient Basis is Safe and Results in Minimal Complications**
DAVID L. MATLOCK, MD

Objectives: The purpose of this retrospective pilot study was to evaluate the safety and complication rates of patients undergoing long duration combined outpatient plastic and gynecological surgeries of at least 5 hours in length. The plastic surgery procedures included blunt suction lipectomy, autologous fat transplant to the buttocks, abdominoplasty, abdominoplasty combined with liposuction, breast surgery and facial surgery. The gynecological surgeries were vaginal procedures which included laser assisted anterior or posterior colporrhaphy, laser reduction labioplasty, autologous fat transplant to the labia majora and perineoplasty.

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 5 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 (> 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 averaging at least 5 hours. 43% (n=20) of patients resided out of state or country. Range of age was 22-53 years (average 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, 9 minor complications (19%) for the gynecological procedures which included perineal or clitoral hood dehiscences, 6 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.

Notes

9:41 - 9:52 am Coffee Break

9:52 am **Introduction of the Airbrush Liposculpturing System**
ROBERT L. CUCIN, MD

Recent advances in power assisted liposuction technology offer a new weapon to combat this problem which afflicts one third of Americans today and can help another third of the population who are overweight but not frankly obese. Twin cannula assisted liposuction (TCAL) is unique in that the moving inner cannula is ensheathed in a stationary outer cannula. The patient and the surgeon's upper extremity are both spared the battering ram effect of the cannula against the patient's tissues. Unlike laser or ultrasound assisted liposuction, the tip of the cannula does not get warm, so burns are not possible. Furthermore, the stationary outer cannula acts as a spacer which allows the surgeon to safely aspirate subdermally to encourage greater skin contraction.

TCAL fat removal is faster and more controlled, operations are shorter, and more fat can be removed in each session. Patients tolerate conscious sedation more easily for these shorter surgeries under local anesthesia which allows them to stand during the procedure so the surgeon can appreciate conditions that are concealed with the patient recumbent on the operating table. Patients have shorter convalescences, revisions and complications are less frequent, results are more dramatic, and blood loss is less – allowing more fat to be safely removed in a session. TCAL removes the fat and leaves the fascial vascular lattice uninjured.

10:17 am **Treatment of Axilar Hyperhidrosis with Neodinium-Yag Laser**
GUILLERMO BLUGERMAN, MD

It is a surgical procedure using local anesthesia, where apocrine as well as ecrine glands are removed by laser with the aim of interrupting nerve supply to the sudoriferous glands and removing or destructing the apocrine glands existing in high density in the axillae (armpits).

It consists of marking the axilar area after the Starch-iodine or Minor test in order to identify the areas with higher gland density. Following skin antisepsis, a 2% Xylocaine Klein solution is applied in the incision site. A small 5 mm incision is performed in each side on a vertical medioaxilar line, where the limit is 2 cm above the delimitation by iodine test. Tumescent local anesthesia is applied in the axilar concavity with Klein needle in a superficial plane surrounding the skin, which is the anatomic place of glands. Generally, a total of 200-250 ml of solution is applied in each armpit.

The latency time required for Lidocaine is respected, then a 4 mm pallet is used to separate the subcutaneous and dermic tissues. A Neodinium Yag (Fotona XP) laser fiberoptic is then introduced, going together the deep dermis within the following parameters: QCN mode, power

10 Watt, Ton 1.0, Fiber 300 u, Frecuency 40Hz, Time off 6sec. In this way, a photo-hyperthermic effect with cellular vaporization localized on the sudoriferous glands is achieved, without damaging the surrounding tissue. Thus, the puntiform laser beam destroys both the ecrine and apocrine glands with no skin damage or puncture.

The third step is removing the laser-treated tissue with a 4 mm 30 cm-long ad oc cannula with Becker model perforations, modified from the B&S design. A curettage technique is applied against the subjacent skin with a lineal sway movement until the cannula contour is identified through the skin. The same cannula is binded to an own-design peristaltic pump by sterile tubing.

If liposuction is performed alone, a more aggressive cannula should be used to efficiently remove the apocrine glands. Since the ecrine glands are located in the deep dermis, it is not easy to treat axilar hyperhidrosis simply with liposuction.

Case Study: A Neodinuim Yag laser was used to treat 252 axilar hyperhidrosis patients between 2000 and 2007. The first 180 patients were treated with NdYag DEKA, and the rest were treated with NdYag FOTONA. 74 patients were male and 180 female, with an average age of 27.4 years, being the youngest 21 and the oldest 45.

Each surgery lasted an average of 40 minutes, and patients left the premises between 30 minutes and 1 hr 30 minutes after the procedure. None mentioned pain. Bandages were removed after 24 hours.

Notes

10:38 am **Minimally Invasive Office Lipoabdominoplasty (Pelosi/Avellanet Technique) 2009**
MARCO A. PELOSI III, MD

A comprehensive review of the authors' minimally invasive office lipoabdominoplasty system will be presented. Several new changes in the surgical technique and new instruments have been incorporated making the procedure more efficient, faster, and safer. A videotape demonstration of the current lipoabdominoplasty system will be shown.

11:45 am **Question & Answer Session**

12:00 - 1:00 pm **Lunch**

1:00 pm **The Latest Trends in Transsexual Surgery**
FERNANDO URRUTIA, MD

A review of the current indications, surgical techniques and strategies to prevent potential complications of male to female and female to male transsexual procedures will be presented.

1:36 pm **The Use of Autologous Fat Transfer for Cosmetic Enhancement of the Labia Major**
MARCO A. PELOSI II, MD

Cosmetic augmentation of the labia majora with autologous fat grafting to achieve youthful fullness is feasible, effective, and safe. The procedure has a short learning curve and is associated with an excellent fat survival rate and a high level of patient satisfaction. The author will discuss patient selection, his surgical technique, and results.

1:46 pm **A Simple Filing Technique to Elevate the Nasal Tip, to Project and Sculpt the Tip of the Nose and to Correct Minor Nasal Defects**
IVANHOE ORTEGA, MD AND ARTURO HENRIQUEZ, MD

The nose is the leading feature of the face, as it is often the face's characterizing, or defining, element. A large, unbalanced, or crooked nose draws attention and detracts from what otherwise may be an attractive face. Rhinoplasty remains one of the most difficult procedures to do well in plastic surgery. There are multiple dependent anatomic components, factors, and nuisances to negotiate and manage during surgery. Seemingly minor adjustments made at the time of surgery can result in dramatic changes years later – hence, the apparent increase in rhinoplasty revisions. The use of fillers and Botox to achieve nasal enhancement offer a "rhinoplasty minus the knife" for the patient requesting a quick, minimally invasive improvement in the nasal appearance. The authors will present their nasal filing technique and present their short and long-term results.

Notes

2:06 pm **A Comprehensive Approach to Minimally Invasive Facial Cosmetic Surgery**
AMIYA PRASAD, MD

A review of current minimally invasive techniques of facial rejuvenation (brow lifting, Blepharoplasty, mid and lower face lifting, liposculpturing) and volume enhancement using fat transfer will be presented.

2:36 - 2:46 pm **Coffee Break**

2:46 pm **The Latest Trends in Sclerotherapy**
JOSE ANTONIO GARCIA, MD

A comprehensive review of the current indications, techniques, and strategies to prevent potential complications of sclerotherapy will be presented.

3:06 pm **MASTER LECTURE: Advances in the Field of Cosmetic Surgery**
E. ANTONIO MANGUBAT, MD

Dr. Mangubat is the recipient of the 2009 International Society of Cosmetogynecology LUISA Award for Outstanding Contributions to Cosmetic Surgery.

The art and science of cosmetic surgery has expanded and blossomed exponentially since I started practice 22 years ago. The noteworthy advancements can be categorized by liposuction, body contouring, facial rejuvenation, and hair restoration surgery. Each of these subjects are expansive and cannot be completely addressed in 30 minutes, however, I'd like to address those areas in which I have made contributions:

- Hair restoration surgery
- Liposuction
- Body contouring

The advancement of hair restoration surgery has been explosive over the past 15 years. The vast majority of hair transplants today are undetectable to the untrained eye. One area of continued challenges is scalp reconstruction. The scalp is typically thick and resistant to movement. Thus covering large areas of hair loss due to illness and injury has proven to be a major challenge, especially when simple scar excision is not enough. Understanding the nuances hair aesthetics, future hair loss due to male pattern baldness, and limitations of scalp movement, and the use of tissue expansion are critical to successful treatment.

Liposuction continues to be a popular cosmetic surgery and has undergone many changes. The introduction of tumescent anesthesia and the micro-cannula techniques of Klein were instrumental in bringing reliable results to the specialty. It also slowed the technique and limited the amount of fat that could be removed in one session. I will review a statistical method of predicting blood loss and review the concept and implementation of fat disruption as

a method of removing large amounts of fat more rapidly (up to 1000ml/min) with improved results.

Lastly, body contouring has evolved beyond the traditional abdominoplasty. Not too long ago, simultaneous abdominoplasty and liposuction were considered taboo. The concept introduced by Avelar in the late 1990s has radically changed this notion. In fact, simultaneous liposuction with abdominoplasty and body-lifting is not only possible, it is an integral part of the new process. The new technique allows the elimination of drains, better size reduction, smoother results, and reduces complications. The new age of cosmetic surgery has arrived and you live in the middle of its development.

Notes

3:37 pm **The Liposhifting Technique for the Correction of Post Liposuction Defects: How I Do It**
GUILLERMO BLUGERMAN, MD

"Liposhifting" is a safe and simple method to treat liposuction irregularities. This method moves fat from around the indentation into the depressed area. Using tumescent anesthesia, a cannula is moved in a crisscross fashion through multiple incisions to loosen the fat globules. The fat is then pushed into the defect by rolling a large cannula toward the indentation. A tape dressing is then applied to keep the fat in position. It takes about 4-7 days for the fat globules to become vascularized. Special instruments devised by the author can obtain predictable fat grafts and comprise a spatula and a tubular "scalpel" with a solid handle. The technique of liposhifting will be demonstrated in detail.

4:13 pm **Cosmetic Breast Augmentation with Autologous Fat Transfer: A Minimally Invasive Alternative to Implants**
CARLOS AVELLANET, MD

Recently there has been a dramatic increase in the number of females requesting breast enhancement using fat transfer. The author's experience with breast augmentation using autologous fat transfer is presented.

4:44 pm **Effectiveness and Safety of Combined Lipoabdominoplasty and Vaginal Hysterectomy**
MARCO A. PELOSI II, MD

For a selected group of healthy, non-smoking women the performance of a minimally invasive cosmetic lipoabdominoplasty procedure at the time of vaginal hysterectomy for benign pathology is feasible, safe and associated with a high level or patient satisfaction. Patients appreciate the minimal downtime and the economic advantages provided by the combination of the two procedures. The author will discuss patient selection, the surgical techniques, and results of the combined approach.

5:01 pm **Question & Answer Session**

5:30 pm **Session Adjourns**

Notes

Notes

THURSDAY, JANUARY 15, 2009

SCHEDULE-AT-A-GLANCE

6:30 am - 4:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 101
8:30 - 9:15 am	Continental Breakfast in Exhibit Hall
8:30 am - 6:30 pm	Exhibits Open
9:45 am - 12:00 pm	General Session: 102 – The Art of Cosmetic Facial Surgery
12:00 - 1:30 pm	Lunch in Exhibit Hall
1:30 - 3:30 pm	General Session: 103 – The Art of Cosmetic Facial Surgery
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Cosmetic Surgery Essentials: 104
5:30 pm	Sessions Adjourn
5:30 - 6:30 pm	Welcome Reception in Exhibit Hall

THURSDAY, JANUARY 15, 2009

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

Breakout #1

Location: Grand Sonoran AB

The New Horizons in Fillers & Neurotoxins
Gary D. Monheit, MD

New products for filling soft tissue and botulinum toxins are currently under investigation or have just received approval for usage in the United States. These new products will be reviewed as to clinical studies, current usage, indications, side effects, efficacy and safety. They will be compared to current products in the United States today.

Breakout #2

Location: Grand Sonoran CD

Face and Neck Lifting Techniques
William H. Beeson, MD

The breakout session will review the full spectrum of surgical procedures and techniques used to address aging changes in the face, head, and neck. Audiovisual techniques will be used to convey techniques and strategy for patient consultation and development of patient specific treatment protocols. Session will also review preoperative evaluation, surgery, postoperative care as well as complication management for all procedures discussed. In today's changing environment, it is critical to have a wide armamentarium of techniques and treatments in order

to be able to exceed patients' expectations for results as well as meet their budget to time constraint. The session will concentrate on both minimally invasive and more extensive surgical procedures including but not limited to endoscopic midface suspension, many lifts, endoscopic neck left, endoscopic forehead lift, and advanced facelift procedures as well as minimally invasive "temporizing" procedures.

Notes

Breakout #3

Location: Grand Sonoran HI

Combined Augmentation and Mastopexy

Angelo Cuzalina, MD, DDS and Michael Kluska, DO

Cosmetic surgery of the breast often involves treatment of both breast hypoplasia as well as ptosis. Many women, particularly following childbirth or significant weight loss, have a combination of breast ptosis as well as atrophic changes and desire a simultaneous breast lift and augmentation. An isolated mastopexy to treat the sagging breast or basic augmentation with implants may be relatively straightforward in select patients; on the other hand, combining mastopexy with implants during the same surgery can be a daunting and risky task for even the most experienced surgeon. This is a review of the many treatment considerations when performing combined breast augmentation and mastopexy. Surgical pearls and pitfalls will be discussed along with specific techniques for various degrees of breast ptosis. New closure methods with barbed suture will be discussed to improve scar results. Despite a large variety of techniques available, a logical process of treatment planning will be introduced along will means to help avoid common complications.

Breakout #4

Location: Grand Sonoran JK

Liposuction Techniques

Guillermo Blugerman, MD and E. Antonio Mangubat, MD

Techniques in liposuction have evolved over the past decade. While the tumescent technique continues to be a mainstay of liposuction surgery today, instrumentation has changed and given the liposuction surgeon greater alternatives and allows better results often with fewer risks. Some of the techniques that will be discussed:

1) Laser lipolysis. There are numerous lasers available today that offer this technique. We will discuss the various options, advantages, disadvantages and approximate cost of each technology.
2) Fat disruption is often misunderstood as an old procedure. While it may use some of the older instruments, this technique allows more rapid fat aspiration with less irregularities and permits a much faster learning curve for the novice surgeon learning liposuction.
3) Ultrasonic liposuction has its original roots in Europe in the 1990s; because of older and crude technology, many of these instruments were found to be dangerous and most surgeons abandoned its use. Only one major US company offers instrumentation and we will review its uses.

Regardless of technique, however, patient safety is of primary importance. While all techniques discussed have advantages and disadvantages, the ultimate safety of any

technique lies in the education, training, and experience of the operating surgeon. We hope this workshop will add to your knowledge and increase the safety of these procedures in your practice.

Notes

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

9:15 am Welcome & Opening Ceremony
STEVEN B. HOPPING, MD
AACS PRESIDENT

9:45 am - 12:00 pm General Session: 102 – The Art of Cosmetic Facial Surgery

Moderators: PATRICK G. MCMENAMIN, MD AND GARY D. MONHEIT, MD

9:45 am Safe Blepharoplasty 2008 "Less is Best"
STEVEN B. HOPPING, MD

Introduction: Blepharoplasty for rejuvenation of the eyes is frequently requested by young and aging patients. The results can provide long-term satisfaction or dissatisfaction to patients. Unfavorable results can be very difficult to correct and are best avoided in this elective, aesthetic operation. Current blepharoplasty techniques are different from past blepharoplasty practices. Contemporary blepharoplasty emphasizes fat preservation, conservative skin excision, and lower lid suspension-tightening to prevent rounding or ectropion.

Objective: This study reviews the effectiveness, complications, and satisfaction of current techniques of blepharoplasty surgery designed to minimize unfavorable outcomes.

Methods: A retrospective review of 50 consecutive patients undergoing cosmetic blepharoplasty was undertaken. This represented 35 women and 15 men. Long-term aesthetic results, complications and patient satisfaction at six months was reviewed.

Discussion/Results: Blepharoplasty can provide long-term aesthetic improvement for patients with premature or aging eyes. Conservative skin and fat removal or repositioning with lower lid suspension techniques provide faster recovery and fewer unfavorable outcomes. Ancillary procedures such as browpexy, brow lift, chemical peeling, and free fat grafting can enhance aesthetic results. Long-term complication were less than 6% and most often involved unsatisfactory incisional healing or aesthetic results. Short-term complications are frequent and patients must be informed preoperative of such expectations. Patient surveys revealed satisfied or very satisfied results in 84%.

Conclusion: Blepharoplasty is a commonly requested procedure to improve premature and aging eyes. Current blepharoplasty techniques including conservative skin excision, fat preservation, and lower lid horizontal suspension along with ancillary techniques can provide satisfactory clinical results with minimal unfavorable outcomes.

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10:00 am **My First 400 Facelifts: The Good, the Bad and the Ugly**
JOSEPH NIAMTU III, DMD

Introduction: Facelift surgery is the ultimate rejuvenate procedure. This type of surgery involves art and science and has a significant learning curve. Once mastered, facelift surgery is the pinnacle of procedures in a cosmetic facial surgery practice and is very rewarding for the surgeon, staff, and patient.

Materials and Methods: The author began performing cosmetic facial surgery procedure 11 years ago and performed his first facelift in 1997. This procedure went from several a year to several a month to the present several a week. Much has been learned about patient selection, anesthesia, operative techniques, postoperative care, complications and marketing of facelifts during this 11-year period. The author will present a multimedia presentation detailing pearls and pitfalls of developing a facelift practice that will be beneficial to the novice surgeon beginning the journey as well as to to the experienced facelift surgeon who might appreciate alternative ideas. The topics will include:

- Selecting the correct patient
- Anesthetic implications
- Instrumentation
- Incision do's and don'ts
- Mastering camouflaged incisions
- Avoiding pitfalls with hairlines and scars
- SMAS options
- Postoperative management
- Common complications
- Marketing the facelift practice

Results: Over the past decade the author has gone from performing several facelifts a year to over 80 per year. Facelift surgery is a comprehensive procedure that cannot be taught or learned in a short time but requires experience. Safe and predictable results can be achieved by close observation to sound clinical techniques and the average surgeon can learn facelift surgery.

Conclusion: Although minimal invasive facelifts are in vogue, they cannot serve the average patient who frequently requires more comprehensive procedures. After performing the "first 400" facelifts, the author can relate pearls and pitfalls learned over the past decade of performing this surgery. These tips can benefit the novice and experienced facelift surgeon.

Notes

10:15 am **Laser Facelift**
ROBERT A. SHUMWAY, MD

Objective: To explain and demonstrate precautions and results in performing laser rhytidectomy.

Methods: A retrospective chart review from January 1995 to the present of 100 consecutive CO2 laser facelifts performed at the author's surgery center. The study was evaluated for technique, results, and complications. The laser facelifts were divided into 4 categories – Group A: Complete rhytidectomy with full face CO2 laser resurfacing; Group B: Complete rhytidectomy using CO2 laser incisions with "under-the-skin flap" laser dermal tightening; Group C: Partial rhytidectomy with dermal flap tightening and full face CO2 laser skin resurfacing; and Group D: Partial rhytidectomy with partial face CO2 laser resurfacing. The patients had before and 6-month after photos taken. All patients completed a 10-point satisfaction questionnaire. Any complications were documented into the following 10 categories: (1) incisional hypertrophic scarring, (2) skin necrosis, (3) hematoma, (4) sensory or motor nerve injury, (5) persistent hyperpigmentation, (6) hypopigmentation, (7) persistent erythema, (8) skin infection, (9) laser skin cicatrix, (10) alopecia.

Results: Group A had the most dramatic cosmetic improvement by 6-month photography with the highest patient satisfaction scores. However, Group A also had the highest overall complication rate at 6% (1 hematoma, 2 persistent erythema, 1 hypopigmentation, 1 hyperpigmentation, and 1 yeast infection). Group B had fewer postoperative complications with a high patient satisfaction score. Group B complication rate was 2% (1 hypertrophic incisional scar and 1 hyperpigmentation). Group C had an intermediate complication rate of 4% (1 bacterial skin infection, 1 temporary sensory nerve parathesia, 1 hypopigmentation, and 1 persistent hyperpigmentation) with very good overall patient satisfaction scores. Group D showed a complication rate of 2% (1 hyperpigmentation and 1 acne skin infection). The patient satisfaction score was between good to very good. There were no incidences of skin necrosis, motor nerve injury, laser skin cicatrix, or permanent alopecia.

Conclusions: Laser facelifts are an excellent approach to facial rejuvenation today with a relatively low incidence of minor complications. It is important to match the correct procedure with the appropriate patient. The author does not recommend the laser facelift approach for smokers or ASA Class III patients. Lifted facial skin flaps can be compromised by "over-lasering" the skin or using laser fluences that are too high. In summary, an experienced cosmetic laser surgeon can create an unparalleled result using the appropriate blend of cosmetic surgery with the aesthetic CO2 laser.

Notes

10:30 am **Use of Platelet-Rich Plasma (PRP) in Cosmetic & Reconstructive Surgery**
ROBERT W. ALEXANDER, MD, DMD

Objectives: Purpose of presentation is to explain the isolation, utilization, and applications for use of Platelet-Rich Plasma (PRP) in cosmetic surgery involving soft tissue, cartilage, and bone surgery. Explanation of the basic science of wound healing as it relates to platelet isolation and degranulation. Discussion of use of PRP+ in major body contouring procedures, facial soft tissue cosmetic surgery, nasal surgery, and grafting will be presented.

Methods: Isolation techniques for PRP in clinic, ASC, and Hospital Operating Rooms settings will be presented. Activation of PRP and its delivery system options will be explained. Clinical photographs and sample of cases in which PRP and PPP are recommended will be presented.

Results: Utilization of PRP+ in open soft tissue surgical cases shows great advantages when compared to either non-use or fibrin gel products. The advantages of fibrin gel are amplified with the addition of important wound healing stimuli provided with concentrated platelet-derived inflammatory elements, making PRP a much more desirable additive. Elimination of most drain needs in large cosmetic and reconstructive surgeries reduces the recuperation times and risks associated with maintaining an exteriorized opening.

Conclusion: Widespread advantages are achieved with isolation of concentrated platelets and their important wound healing contributions. The acceleration of wound healing and patient recuperation makes utilization of PRP+ a very important improvement in care for cosmetic surgical patients for soft tissue surgery and all grafting procedures.

10:45 am **The Anterior Face Lift**
BEATRICE LAFARGE, MD

Introduction: Over the past 20 years, cosmetic surgery has witnessed a remarkable evolution of facial rejuvenation surgery. After "the deep plane and SMAS techniques," surgeons began to promote "soft techniques." These soft techniques featured less undermining and fewer scars, permitting a quicker recovery and a better result for our patient. The philosophy of rejuvenation surgery is now to begin earlier, before aging is advanced, with localized face lifts and to mix in medical procedures (acid hyaluronic, botulinic toxin, peeling, soft laser) with surgery. We propose less aggressive procedures with a better understanding of what causes "aging" of the face, like contracture of mimic muscles that produce most of the wrinkle. The anterior face lift which I have proposed to my patients for more than 20 years is today the major rejuvenation procedure used in my practice. The procedure causes little scarring, it is very efficient, and the results are long lasting, even on the submental area and the upper part of the neck.

Method: A video of the technique will show a very simple procedure of plicature of the SMAS; at the same time liposculpture and fat rejuvenation can be done. The result is gained not from traction of the skin, but from elevation of the deep structure, more in the vertical plane.

Results: After more than 1000 patients treated, we can say that it is efficient, natural and long lasting.

Notes

11:00 am **Because There is Nowhere To Hide: Strategic Management of Facelift Complications**

ALBERT E. CARLOTTI, MD, DDS

Objective: It is well known amongst experienced surgeons that "if you are going to operate, you are going to have complications." Less than ideal outcomes with body cosmetic surgery can be covered during management and allow patients to continue their lifestyle for the most part. However, even the smallest glitch in normal healing with facial cosmetic surgery can emotionally challenge the patient and doctor alike. There is truly "nowhere to hide" for the patient or the doctor during recovery. This presentation will review a whole host of complications of common methods of facial rejuvenation as well as a strategic management of both the physical and emotional issues encountered by the patient.

Methods: This presentation will review complications which have managed as result of less than desirable outcomes, patient non-compliance and other surgeons' complications for reoperation in the author's practice. A review of over 1000 cases will be discussed to comment on complication rates. Outcomes will be divided between "minor" and "major" issues of delayed or abnormal healing. Specific case presentations will be discussed with photographic progress from diagnosis to resolution.

Results: A variety of minor complications of delayed or abnormal healing can be strategically managed with early diagnosis, candid disclosure to the patient and true "hands-on" management that may range from pure emotional support to reoperation. Major complications typically are a result of patient non-compliance or lack of proper presurgical teaching. Once encountered, major complications may be improved upon, yet never completely corrected.

Conclusions: With proper patient pre-operative teaching, surgeon training and experience, strong teamwork with the doctor/staff and the patient, major complications can be avoided. The doctor-patient relationship is crucial in bridging the gap between the early acknowledgement of the complication and its resolution. Nevertheless, in the cases of reoperation of other surgeons' complications, the goal should always be "better" and not "perfect." Most minor issues of delayed or abnormal healing can be strategically managed and corrected. Major issues in the select category of tissue necrosis may only be improved upon moderately. A carefully constructed treatment plan, diligent written and photographic documentation of progress and management of realistic expectations by the patient are essential to avoid losing the patient to another surgeon or facing potential litigation.

Notes

11:15 am **Favorable and Unfavorable Effects of Maxillary Advancement on Nasal Esthetics**
CHRIS SKOUTERIS, DMD, PHD

Objective: The purpose of this presentation is to review the effects of the Le Fort I osteotomy for maxillary advancement on the esthetic appearance of the nose. Special emphasis is given on the surgical techniques that can be employed in an effort to minimize unfavorable outcomes on nasal esthetics.

Methods: The discussion is limited to cases of maxillary advancement without concomitant superior repositioning and to the effects of such movement on the alar base, nasal tip, columella, and nasolabial area.

Results: The most noticeable change in the nose following maxillary advancement is flaring of the nostrils. Changes affecting nasal projection and columellar length are less obvious. The nasolabial angle is usually corrected by maxillary advancement within the normal range of 90o - 110o. Flaring of the nostrils can be corrected by surgical widening of the pyriform aperture and by the application of the cinch suture.

Nasal projection and columellar shortening can be controlled by anterior nasal spine ablation and proper nasal septal repositioning. The subspinal osteotomy does not seem to affect nasal projection. It is of interest that the midfacial changes that are associated with maxillary advancement tend to adequately mask co-existing nasal esthetic deformities.

Conclusion: Nasal esthetic changes following maxillary advancement can be favorable or unfavorable in certain patients. Meticulous clinical assessment combined with soft tissue analysis is essential in predicting these changes so that appropriate measures are taken to prevent unpleasant outcomes. Patients must be properly informed of these possible changes that can affect the overall aesthetics of the face, keeping in mind that further corrective surgery may need to be performed.

11:30 am **Predictability in Surgery: Combining Orthognathic Surgery with Facial Aesthetic Surgery**
TIRBOD FATTAHI, MD, DDS

Objective: The purpose of this presentation is to highlight the benefits of skeletal surgery of the maxillofacial region at the same as facial aesthetic surgery to augment the final aesthetic result.

Method: Each patient who desired corrective jaw surgery to improve skeletal/dental relationship underwent a complete facial aesthetic evaluation to determine if concomitant aesthetic surgery can be performed at the time of orthognathic surgery. The complimentary procedures included: alloplastic genioplasty, augmentation malarplasty, and cervicoplasty with liposuction and platysmaplasty.

Results: Records of all patients who underwent a combined orthognathic surgery and facial aesthetic surgery were reviewed. The most common complimentary procedure performed overall was a cervicoplasty with liposuction and platysmaplasty at the time of maxillary or mandibular corrective jaw surgery. Submalar and tear trough augmentation was the common procedure performed at the time of isolated maxillary corrective jaw surgery. The complimentary aesthetic surgery did not prolong the recovery period for the patient. All patients were then followed for a specific period of time (up to 2 years) and evaluated at each appointment to determine overall aesthetic value of combined orthognathic and facial aesthetic surgery.

Conclusion: By altering the skeletal foundation of the face and maxillofacial region at the time of facial cosmetic surgery, a much more profound and predictable aesthetic result can be obtained. Establishment of a harmonious maxilla-mandibular relationship significantly augments the final aesthetic outcome, especially if both skeletal and soft tissue surgeries can be performed simultaneously.

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11:45 am Panel Discussion – Managing Difficult Problems in Facial Cosmetic Surgery

Moderator: JOSEPH NIAMTU III, DMD

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

1:30 - 3:30 pm General Session: 103 – The Art of Cosmetic Facial Surgery

Moderators: MOHAN THOMAS, MD AND STEVEN B. HOPPING, MD

1:30 pm Dual-Porosity Expanded Polytetrafluroethylene (ePTFE) (Surgisoft/Surgiform) Implants for Lip, Nasolabial Groove and Melolabial Groove Augmentation – 7-Year History – 1000 Implant Sites
JIM E. GILMORE, MD

Objective: Presentation of clinical outcomes and techniques involving over 1000 clinical sites of implantation of dual porosity ePTFE(Surgisoft/Surgiform) including patient satisfaction, surgical techniques and caveats, complications, and management. The presentation will include: overview of anatomy and alternatives to treatment; description of technique; incorporation of evidence-based study (IRB) of 170 patients and 612 implants; clinical study overall of a total of over 1000 implant sites and outcomes; and management of complications.

Results: IRB peer reviewed retrospective chart review and photo documentation of cases from 2001-2005 revealing complication rate of 8/612. With an overall favorable observer analysis in the majority of cases (esthetic and anatomic). In over 1000 implant sites a complication rate of not exceeding >1.0%.

Conclusion: Dual-porosity expanded polytetrafluroethylene implant(Surgisoft/Surgiform) is safe and reliable to use in facial implantation – periorofacial and other facial anatomic sites. Projected learning topics for attendee audience include:

- Anatomic, esthetic, physiologic evaluation of the face
- Selection of appropriate candidates
- Presentation of alternatives
- Stepwise and video of procedure – with emphasis on precise planning and accurate surgical detail and wound care
- Pre, intra, and post operative management
- Techniques to prevent complications
- Management of complications

1:45 pm **Revision Rhinoplasty in the Multiply Operated Nose**
LANE F. SMITH, MD

Introduction: The multiply operated nose is defined as a nose that has had three or more complete rhinoplasty operations. The literature on this subject is sparse and questions remain as to how many rhinoplasty operations can be successfully performed on a nose and still have improvement.

Methods: A retrospective chart review was performed from 2002 to 2007. 20 consecutive patients who had three or more previous rhinoplasty operations and underwent another complete rhinoplasty were evaluated for complications and results and technical pearls. All patients were followed for at least one year post-operatively.

Results: 20 patients were reviewed with an average of 3.9 previous rhinoplasties, and a range of 3 to 9 previous operations. All 20 patients (100%) noted an improvement after one operation. 17 patients (85%) were found to anatomical derangement at the time of surgery. 2 patients (10%) required a second major surgery. 5 patients (25%) required minor touch-up surgery. No major complications (skin necrosis, hemorrhage) occurred.

Conclusion: Successful revision rhinoplasty is always possible on the multiply operated nose. The external approach, realistic expectations, increased tip support, correction of the commonly found anatomical derangements, improved osteotomies and expections for minor touch-up procedures contribute to a successful outcome in revision rhinoplasty in the multiply operated nose.

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2:00 pm **Ethnic Rhinoplasty – A Problem Oriented Technique**
MOHSEN TAVOUSSI, MD, DO

Objective: To describe a number of procedures that will address the complex problems associated with ethnic rhinoplasty, specifically the recessed or high dorsum, wide, bulbous or droopy tip, thick skin and flared, alae and wide base.

Methods: 230 patients of various ethnic backgrounds had closed or open rhinoplasty. The preoperative evaluations as well as intraoperative findings directed the techniques chosen to correct the deformities. These techniques included dorsal augmentation with silastic implant, reduction of dorsum, aggressive defatting of thick sebaceous nasal tip skin to allow adequate redrapping, suture refinement of nasal dome with or without cephalic trimming, refinement of the middle vault with suturing techniques to narrow the vault or use of the spreader graft for airway improvement and/or correction of collapsed upper lateral cartilages, tongue-in-groove retro setting of the medial crural cartilages to correct droopy tip, excision and reconstruction of excessively tall dome, and a novel alar repositioning technique (ART), to reduce flared alae specifically those that are more laterally placed, without a visible scar.

Results: Of 230 patients of different ethnicity who had rhinoplasty, 120 (52.2%) were Latin, 60 (26.1%) Middle Eastern, 40 (17.4%) Asian, 10 (4.3%) African-American. 23 (10%) had secondary rhinoplasty, 8 patients with post-traumatic injuries, 6 patients had multiple cleft nose/cleft palate surgeries, 1 patient had Crouzan syndrome. 50 (21.7%) had silastic nasal implants for correction of depressed nasal dorsum. 1 patient (Crouzan syndrome) had a silastic implant carved intraoperatively for depressed nasion. 5 patients had a silastic augmentation of depressed nasolabial angle. 33 (14.3%) patients had alar repositioning technique (ART), a novel procedure for correction of flared, laterally implanted alae and wide base. Follow-up period was up to 5 years. There were no major complications such as nasal skin necrosis or epistaxis. No visible scars were noted. Minor complications were: occasional tip-supratip fullness, which were treated with steroid injections; 2 cases of nasal implant extrusion through intranasal incision sites, which were trimmed and replaced; and 2 implant infections, which were removed and replaced 3 months later. Overall, there was a high degree of patient satisfaction.

Conclusions: Ethnic rhinoplasty is a simplified description of a complex sets of problems associated with various types of ethnic noses. These problems were adequately addressed with our technique, which achieved a more balanced nose consistent with the classical descriptions of ideal nose with very high patient satisfaction.

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2:15 pm History of Rhinoplasty

ROBERT L. SIMONS, MD
FEATURED SPEAKER

This address will detail the personalities and techniques that have so interestingly intertwined in the quest for better Rhinoplasty Surgery in the past 60 years.

About the Speaker: Robert L. Simons, MD is one the nation's most renowned cosmetic surgeons, with more than 30 years of experience. Board-certified in facial plastic and reconstructive surgery and otolaryngology, Dr. Simons served as director of the division of Facial Plastic and Reconstructive Surgery at the University of Miami School of Medicine for more than 25 years. He holds the position of voluntary clinical professor of otolaryngology at the medical school. Dr. Simons is past president of the American Academy of Facial Plastic and Reconstructive Surgery. In 1988 he edited a book for the Academy: "Coming of Age: A History of the AAFPRS". He also served as president of the American Board of Facial Plastic and Reconstructive Surgery, 1991-1995. A noted author of numerous articles and chapters on various aspects of facial plastic surgery with special expertise in rhinoplasty, Dr. Simons frequently presents at medical meetings and symposiums in the U.S. and aboard. Dr. Simons earned his medical degree from the University of Pennsylvania and his undergraduate degree from Dickinson College. He completed an internship in surgery at Albert Einstein Medical Center, Philadelphia and a residency in otolaryngology at Mt. Sinai Hospital, New York, New York.

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3:00 pm	Panel Discussion – Managing Difficult Problems in Cosmetic Facial Surgery
Moderator:	STEVEN B. HOPPING, MD
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Cosmetic Surgery Essentials: 104 (Sessions will run concurrently)

Breakout #1

Location: Grand Sonoran AB

S-Lift, Fat Transfers

Steven B. Hopping, MD and Ziya Saylan, MD

The S-Lift is a short scar facelift that avoids a post auricular hairline scar. Short scar facelifts have become a popular technique for younger patients desiring natural rejuvenation and have been marketed variably as the MAC Lift, Quick Lift, LifeStyle Lift to name a few. It is also helpful in patients who have had previous rhytidectomies and can be a consideration in patients with a significant smoking history. It can improve the sagging neck and jowl and can be extended to improve midface laxity. The S-Lift incorporates SMAS plication or imbrication techniques and is readily combined with platysmaplasty in patients with significant banding.

The many variations of the S-Lift short scar facelift will be discussed including indications, modifications, complications and technical updates. Dr. Ziya Saylan popularized the S-Lift in Europe and first published the technique in the American Journal of Cosmetic Surgery in 1999. The pursestring SMAS plication sutures developed by Dr. Saylan will be presented as well as the presenters' latest improvements and philosophies.

Breakout #2

Location: Grand Sonoran CD

History of Liposuction

Gerhard Sattler, MD, C. William Hanke, MD and Loek Habbema, MD

This breakout session provides a complete as possible history about how and by whom liposuction has been developed, in the U.S. but also in Europe. Coming from a dangerous, life-threatening undertaking to a safe and predictable surgical procedure today, the historical evaluation gives us the understanding for developments of this specialty.

From Fischer and Fischer, Ilouz and Fournier, Dolsky, Klein and Lillis, Hanke and many others, the knowledge of the evolutionary development explains most of the circumstances of liposuction as it is today.

Notes

Breakout #3

Location: Grand Sonoran HI

Lasers and Fillers

Neil S. Sadick, MD

This session will outline a structural approach to non-invasive rejuvenation incorporation, lasers, lights, radiofrequency sources and fillers. New generation laser technologies will be presented emphasizing new approaches to whole body rejuvenation. Third generation fractional technologies, plasma and novel cellulite approaches will be highlighted. New generation fillers for volume repletion and off face usage will be expounded upon. Combination approaches, which are state of the art in non-invasive rejuvenation, as well as the avoidance and management of complications, round out this all-inclusive session.

Breakout #4

Location: Grand Sonoran JK

Revisions and Refinements in Cosmetic Breast Surgery

Jacob Haiavy, MD, DDS and Clayton Frenzel, DO

Breast augmentation is one of the most common cosmetic surgical procedures performed in the United States. Although the satisfaction rate from the procedure is quite high when all goes well, the dissatisfaction can be significant when the surgeon needs to correct problems. This session will identify the reasons for necessary revisions such as capsular contracture, implant malposition, leakage, rippling, asymmetry and synmastia. We will discuss and demonstrate possible techniques of correction for each problem. Case studies will be presented.

4:00 - 5:30 pm

Breakout #5

Location: General Session – Grand Sonoran E-G

Free Paper Session

Moderators: ANTHONY J. GEROULIS, MD AND FAISAL QUERESHY, MD

4:00 pm Aesthetic Management of the Lateral Canthus and Eislers Fat Pad
CATHERINE J. HWANG, MD

Objective: Lateral canthal surgery is traditionally accomplished with an open exposure of the canthal tendon. However, the open canthal incision has potential disadvantages. The traditional incision disarticulates the lower tendon from the upper, which can lead to length disparity between upper and lower tendon, misalignment of the mucosal or cutaneous elements of the canthal junction, and scarring or web formation in the multicontoured skin of the canthus. We demonstrate the use of an upper eyelid crease incision to access the canthal tendon and anterior lateral orbital fat (Eisler's fat pad).

Methods: Surgical video and results on the lateral canthus and Eisler's fat pad sculpture performed at the Jules Stein Eye Institute on over 50 consecutive patients.

Results: Improved anatomical and aesthetic results.

Conclusion: This approach affords improved anatomical results with the ability to sculpt Eisler's fat pad and provide less distortion to the lateral canthal region.

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4:10 pm **Earlobe Management During Facelift Surgery**
JONATHAN HOENIG, MD

Purpose: To report our results and technique to address earlobe ptosis during facelift surgery.

Methods: This is a retrospective evaluation of 100 consecutive patients undergoing facelift surgery who were noted preoperatively to have earlobe ptosis and/or contour irregularities as well. All of these patients underwent concurrent earlobe reduction and sculpting during facelift surgery. Our technique involves analysis of the degree of earlobe ptosis and attention to any contour irregularities. Markings are drawn to achieve desired contour and ptosis correction, and flaps are fashioned and sutured to obtain the desired result.

Results: All patients reported improvement in cosmesis of earlobe position and contour. Improvement in earlobe ptosis and correction was observed with digital photographic analysis. No complications were observed in this patient cohort.

Conclusions: Facial ptosis and desire for facelift surgery is a common presenting complaint of the cosmetic patient. Ptosis of the earlobes and earlobe contour irregularities, however, are an equally common occurrence, which can be overlooked. We have found that careful surgical attention to earlobe contour and position results in an overall improvement in aesthetic facelift results.

4:20 pm **Modification of Deep Plane Facelift to Prevent Postoperative Pre-Auricular Parotid Fullness**
SAMIEH RIZK, MD

Objectives: Determine success of a modification of the deep plane facelift to address rounder, fuller faces with a large, sagging parotid.

Methods: This is an IRB-approved retrospective analysis of 65 patients who underwent deep plane facelift using a new technique to address parotid fullness. The technique is unique in its use of superficial cautery of parotid tissue (in immediate pre-auricular region only) before suture imbrication of the SMAS. The superficial lobe of the parotid gland is also imbricated to give additional reduction of parotid volume. Partial SMASectomy is performed over the parotid prior to tight SMAS closure over the parotid gland. This all occurs before suturing of the platysma to the mastoid periosteum in the neck. Charts were reviewed for complications and cosmetic results.

Results: In a 7-year period, 54 males and 8 females underwent the parotid reduction technique. Cosmetic result in the pre-auricular region was excellent in all cases. There were 2 salivary fistulas which resolved spontaneously with scopolamine patch and avoiding chewing from 2-3 weeks. Collections were aspirated every 2 days until complete

resolution. All fistulas occurred during the first year of the introduction of this technique and are attributed to lack of tight SMAS closure over the parotid region. Initially, interrupted suture placation of the SMAS was performed. This was then converted to running locking suture of the SMAS. After this modification, fistula complication was eliminated.

Conclusions: Cautery and imbrication of the parotid is an effective and safe means to decrease postoperative parotid fullness, especially in male patients.

Notes

4:30 pm **Suture Guided Placement of Chin Implants**
DUSTIN M. HERINGER, MD

Objective: Silicone chin implants are commonly used to treat microgenia. One of the difficulties encountered by novice and even seasoned surgeons when placing these implants is folding or bunching of the distal ends of the implant resulting in malposition and asymmetry. Suture guided assistance facilitates placement of the implant and eliminates bunching or folding of the distal ends resulting in a well-positioned implant.

Methods: A 4.0 silk suture attached to a Keith needle is passed through one of the distal ends of the silicone implant. A second 4.0 silk suture is passed through the contra-lateral end. Using either an external or intra-oral approach, the standard techniques are used to create an adequate tunnel beneath the periosteum for the chin implant. A needle driver is used to pass the Keith needle into the end of the tunnel and out through the overlying tissues and skin laterally along the inferior border of the mandible. Both ends of the suture are then grasped and pulled laterally, pulling the distal end of the implant along the course of the tunnel. When the implant is centered at the midline, the same process is repeated on the contra-lateral side. The implant can then be centered along the midline utilizing these two sutures. After the implant is centered, one end of one of the silk sutures is released and the suture is pulled out. The other suture is then released leaving the implant in proper anatomic position without folds or bunching of the ends.

Results: All the chin implants this author has placed using this technique have been placed in proper anatomic position without folding or bunching of the distal ends.

Conclusions: Suture guided placement of chin implants is a safe and straightforward technique that facilitates placement and ensures proper positioning of the chin implant without folding or bunching of the distal ends.

4:40 pm **Facial Rejuvenation in Harmony with Bodily Reshaping: Weekend Facelift and Ultrasound-assisted High Definition Liposculpture**
KEIKO TAKASU, MD

Objective: It is important that a cosmetic surgeon should seek the latest cosmetic and rejuvenation procedures for the sake of his/her patients' safety, satisfaction and balanced beauty. In order to achieve this goal, a surgeon must consider balanced rejuvenation between the face and the body. The most effective method is for a surgeon himself/herself to actually experience the procedures using his/her body and face.

Methods: Nine years has passed since Dr. Katsuya Takasu, my father-in-law underwent the first rejuvenation surgeries of his face, including full facelift, lower blepharoplasty, single hair transplantation, removal of buccal fat, phenol peel and golden thread implant. For the maintenance of the first surgeries and for further rejuvenation of his face and body, he then went through thermal therapy, the second lower blepharoplasty and interstitial laser lipolysis of the abdomen. Moreover, in June 2005, he underwent the third rejuvenation session composed of fractional resurfacing of the facial skin, mid facelift combined with single hair transplantation and interstitial laser of the cheeks and neck. In August 2007, in order to improve the sagging buccal fat and cheeks, Dr. Takasu received the third facelift. I, Dr. Takasu's daughter-in-law performed the surgery. The maintenance facelift is called Weekend Facelift, because it enables a patient to go back to work from the next Monday. The duration of the procedure is 40 minutes to one hour in total for both sides. Moreover, in order to solve the great age imbalance between the face and the body, I performed ultra-sound high definition liposculpture on Dr. Takasu. This liposculpture requires a surgeon to precisely remove deep and superficial fat around muscle groups in the abdomen and in the chest, to curve a David statue out of a chubby body.

Results: The new maintenance facelift brought about a maximum lifting effect with minimum incision. In addition, the ultra-sound high definition liposculpture greatly contributed to the balanced rejuvenation effects between the face and the body.

Conclusions: Dr. Katsuya Takasu and I believe that one can be a brand-new classic car as long as one receives good, state-of-the-art maintenance procedures.

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4:50 pm **New Technologies for a Better Browplasty**
BRETT S. KOTLUS, MD

Objective: Endoscopic or "small-incision" browplasty has become a mainstay of upper face rejuvenation. Technology-driven improvements to the procedure have recently emerged. We describe a minimal-incision browplasty technique that demonstrates these advances.

Methods: One central and 2 temporal hairline incisions are used for brow access. After brow dissection and periorbital release, a bioadhesive is used for subperiosteal fixation. Relaxation of the medial brow depressors is accomplished via radiofrequency neuroablation.

Results: This technique results in a natural and effective brow elevation. Bioadhesive obviates the need for implants or bone tunnels, and neuroablation replaces previous methods of muscle extirpation, avoiding several associated complications.

Conclusions: Cosmetic procedures have justifiably moved in a less-invasive direction, while patients expect the same or better results. Our "better browlift" meets both of these criteria with the aid of recent technological advances and the use of minimal overall incision length.

5:00 pm **Ethnic Rhinoplasty: A Universal Preoperative Classification System for the Nasal Tip**
JEREMY B. WHITE, MD

Objective: Ethnic rhinoplasty is a complex procedure, particularly with respect to the nasal tip, that has a revision rate that is significantly higher than the rate for Caucasian surgery. Multiple authors have discussed what they propose as the ideal technique combinations in non-Caucasian rhinoplasty. There is an increasing demand for rhinoplasty in these patient populations, but their facial features continue to diversify with the combination of characteristics from other ethnicities. This factor further complicates the preoperative thought process. We present a universal nasal tip classification system that emphasizes skin thickness and cartilage strength, rather than ethnic background, to overcome this challenge. This concept will aid surgeons in preoperative planning and enhance their ability to communicate technical ideas to other surgeons.

Methods: Case and experience review.

Results: This concept has been used successfully to aid surgeons in preoperative counseling and planning regardless of ethnicity.

Conclusions: This new classification system is useful in helping surgeons to determine their surgical plans preoperatively and to understand the nasal tip as a function of its anatomic components, rather than as part of an ethnic stereotype.

Notes

5:10 pm **Combined Rhytidectomy and Resurfacing: A Retrospective Analysis**
JEREMY KAMPP, MD

Objective: There has been reluctance among some cosmetic surgeons to perform concurrent rhytidectomy and resurfacing procedures because of the potential for impaired healing and possible increased risk of complication. The objective of this study is to delineate the safety, efficacy, and side effect profile of simultaneous rhytidectomy and resurfacing in patients with significant facial skin laxity and photoaging.

Methods: We performed a retrospective case review including 18 consecutive patients treated with combined rhytidectomy and carbon dioxide laser resurfacing (14 patients) or plasma resurfacing (4 patients). Resurfacing parameters using the Sharplan 40C carbon dioxide laser were 100 µs dwell time, 12 Watts, 0% overlap, and 2 passes. Parameters for the Portrait PSR3 (Rhytec) were 3.5 J with a single pass. Clinical improvements, complications and healing times were tabulated and compared.

Results: Impaired healing, skin necrosis, and skin slough were not observed in combined procedures with either resurfacing modality. Of patients who underwent plasma resurfacing, 75% and 25% had excellent and moderate improvement, respectively. Of patients who underwent carbon dioxide laser resurfacing, 71% and 29% had excellent and moderate improvement, respectively. The only complication in this series of cases occurred in a single patient who had reactivation of herpes simplex virus on perioral skin after treatment with the carbon dioxide laser. This complication was transient and did not result in scarring.

Conclusions: Concurrent rhytidectomy in combination with plasma or carbon dioxide laser skin resurfacing can produce excellent results and simultaneously addresses skin surface changes and laxity associated with cutaneous aging without increased incidence of complications.

5:20 pm **Revision Rhinoplasty: Addressing the Alar Rims and the Alar-Tip-Columellar Complex**
MICHAEL S. SCHWARTZ, MD

Objective: Primary rhinoplasty is a difficult operation, and revising poor outcomes in rhinoplasty is extremely complicated. Nasal anatomy is straightforward, however the surgeon must combine a refined aesthetic sense with an ability to predict the outcome of surgical maneuvers employed to achieve the desired changes. Each maneuver impacts and is dependent upon the others, and coupled with intraoperative edema frequently a 'routine' procedure turns into the perfect storm. Attempts to refine the nasal tip often involve resecting or suturing together various combinations of lateral, intermediate, and medial crura of the lower lateral cartilages. A common mistake is to suture together or overresect the lateral crura. This disrupts the

structural support of the alar rims, and often accentuates a prominence of the caudal tip and columella, concurrently elevating the alar rims. The ability to re-establish a natural and attractive relationship of the columella, tip, and alar rims once they have been distorted is extremely difficult. Especially difficult is lowering the alar rims once they have retracted cephalad. The author describes a new technique for lowering the alar rims and restoring the natural harmony of the tip, columella, and alar rims.

Methods: An external approach is used to expose the nasal tip, columella and dorsum. If the columella is too prominent caudally it is raised by resecting indicated portions of medial crura, nasal spine, and/or caudal septum. Lateral crura are dissected free to the medial crural junction, and onlay grafts are secured in place when indicated. A pocket or sleeve is meticulously dissected to the border of each alar rim, and the lateral crura are repositioned into the sleeve bilaterally, after thinning them appropriately. A single 6-0 prolene mattress suture over a telfa bolster is secured through full-thickness alar rim on each side.

Results: Three patients are presented, each of whom exhibited variations of hanging columella, tip deformity, and elevation of the alar rims after undergoing a primary and revision rhinoplasty. Each patient presented to the author having been told it was not possible to improve their noses further. In each case the columella was raised, the tip restructured using existing and onlay cartilage grafts, and the alar rims lowered by repositioning the lateral crura into a newly-created alar rim sleeve.

Conclusion: Once the relationship of the nasal tip, columella and alar rims is distorted, it is imperative to first recognize the structural and aesthetic problems and then be able to address them in a logical and stepwise fashion. It is difficult to lower the alar rims once they have retracted superiorly. By dissecting a new sleeve into the border of each rim and securing the lateral crus in a location more caudal than even its original anatomic position facilitates restoration of the rim to its original position and, in conjunction with raising of the columella and restructuring the tip, restores a natural and pleasing harmony of the lower third of the nose. The author will describe the nuances of this technique and its applications in revision rhinoplasty.

5:30 pm Sessions Adjourn

5:30 - 6:30 pm Welcome Reception in Exhibit Hall

Notes

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FRIDAY, JANUARY 16, 2009

SCHEDULE-AT-A-GLANCE

6:30 am - 4:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 105
8:30 - 9:15 am	Continental Breakfast in Exhibit Hall
8:30 am - 4:00 pm	Exhibits Open
9:15 am - 12:00 pm	General Session: 106 – The Art of Cosmetic Body Surgery
9:45 am	2009 Webster Lecturer Douglas D. Dedo, MD
12:00 - 1:30 pm	Lunch in Exhibit Hall
1:30 - 3:30 pm	General Session: 107 – The Art of Cosmetic Body Surgery
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Cosmetic Surgery Essentials: 108
5:30 pm	Sessions Adjourn
7:00 pm	Webster Society and Cosmetic Surgery Foundation Recognition Dinner

FRIDAY, JANUARY 16, 2009

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

Breakout #1

Location: Grand Sonoran AB

TUBA

Robert A. Shumway, MD and David A. Hendrick, MD

This session will cover the history, evolution, and various techniques of Trans-Umbilical Breast Augmentation. This course is intended for both beginner and advanced cosmetic breast surgeons who have an interest in adding the TUBA technique to their repertoire of approaches to breast implant surgery. Topics covered will include patient evaluation, instrumentation, techniques for subglandular and submuscular placement, complications and their management, and revision breast augmentation using the TUBA technique. The speakers will present examples of their early successes and failures with many before and after photos. Live videos will be shown followed by an open forum discussion. Whatever your experience level, if you have ever contemplated using the TUBA approach, this session is for you.

Breakout #2

Location: Grand Sonoran CD

Eyelid Rejuvenation

Marc S. Cohen, MD and Nancy G. Swartz, MD

The object of this breakout session is to teach the participant how to rejuvenate the eyelids with state of the art blepharoplasty and minimally invasive treatments like fillers and Botox Cosmetic. This course, taught by two oculoplastic surgeons, will provide a step-by-step, how to do it review of sophisticated upper and lower blepharoplasty technique. Emphasis will be placed on how to get the best results and avoid complications by choosing the correct procedure for each patient. 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 clinical examples to help the participants understand the important principles of eyelid rejuvenation. We believe that this presentation will be of value to the beginning, moderate and advanced blepharoplasty surgeon.

Notes

Breakout #3

Location: Grand Sonoran HI

Hospital Privileges for the Cosmetic Surgeon: The AACS Credentialing Packet Introduced

Peter Gaido and Edward B. Lack, MD

Improper hospital privileging with respect to cosmetic surgery places cosmetic surgery patients at risk. National hospital privileging standards require an assessment of physicians based on their education, training, experience, and proven competence. Unfortunately, there are physicians who employ anti-competitive methods to block their competitors from obtaining cosmetic surgery privileges. The Academy's Cosmetic Surgery Standards Panel (CSSP) was formed to assist cosmetic surgeons responding to false advertising, consumer deception, and anti-competitive conduct, and to improve the legal and regulatory climate applicable to the practice of cosmetic surgery and those who perform cosmetic surgery. As its initial project, the CSSP developed the Privileging Block Informational Packet. The Packet was designed to arm physicians with comprehensive information to protect their legal rights and oppose their competitors' improper attempts to preclude them from obtaining cosmetic surgery privileges. The Packet is designed to assist physicians facing privileging blocks. In addition, the Packet provides vital information that will assist physicians who plan to apply for cosmetic surgery privileges. Academy past-president Edward B. Lack, MD, and the Academy's general legal counsel, Peter A. Gaido, will discuss the contents of the Packet and its application to physicians seeking, or being blocked from obtaining, cosmetic surgery privileges across the country.

Breakout #4

Location: Grand Sonoran JK

Advanced Rhinoplasty Techniques

Robert L. Simons, MD and Steven B. Hopping, MD

This session will focus on basic fundamentals as well as more advanced techniques of rhinoplasty. The changing and current philosophy of rhinoplasty surgery as well as historical perspective add to the evolving nature of this most fascinating cosmetic procedure. Preoperative selection, intraoperative execution and tips on avoiding and treating unfavorable results will be discussed.

Dr. Simons will share his 40-year experience with an emphasis on analysis, the Endonasal of approach and virtual dome division.

Breakout #5

Location: General Session – Grand Sonoran E-G

Complications in Liposuction

Jeffrey A. Klein, MD

The speaker will present a discussion of liposuction complications. Topics of particular attention will include infections, full thickness skin necrosis, the first law of Thermodynamics associated with ultrasound and laser assisted liposuction, pulmonary embolus and problems in the literature with unbiased reporting of the risks and benefits of new liposuction techniques.

Notes

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: MICHAEL J. WILL, MD, DDS AND CLARK O. TAYLOR, MD, DDS

9:15 am Buttock Lifts on the Rise
ANGELO CUZALINA, MD, DDS

Objective: The reason buttock lifting is increasing in popularity will be discussed. Techniques pearls to avoid complications and get maximum results will be reviewed along with patient selection criteria. Massive weight loss from gastric bypass surgery has changed from an open technique to a laparoscopic one. Because of this, these patients no longer have a large vertical abdominal scar and are less apt to want an inverted T type abdominoplasty which can tighten the upper, outer buttock. A standard abdominoplasty limits the anterior scar size but leaves laxity posteriorly that requires a body or buttock lift.

Methods: Patients selected for this technique were ones who typically had massive weight loss on their own or most commonly following gastric bypass surgery. The technique involves a slightly arched horizontal incision just above the buttock across the lower back and below underwear level. Dissection is taken down to the investing fascia over the low back and extends inferiorly half way down the buttock medially and further laterally for additional posterior thigh elevation. Deep tissue fixation to the fascia above improves stability. The addition of gluteal implants, fat grafting into the gluteal muscles, and /or secondary dermal flap rotations beneath the main flap can be used simultaneously to further enhance the results.

Results: 31 patients undergoing buttock lifting by the same surgeon were reviewed over the past 5 years. 11 of these procedures were performed over the past year. Complications included 1 hematoma, 4 seromas and 2 small areas (less than 2cm width) of wound dehiscence. No major complications were noted. Drains were used in all but 1 patient who did have a postoperative seroma. Significant elevation was achieved in all patients that improved aesthetics of the buttocks as well as the posterior and lateral thighs. 24 (77%) of the patients had other simultaneous perigluteal procedures to enhance the result that did not appear to increase the complication rate. However, enhancement of the greater trochanter depression was not as improved as desired in patients that were extremely thin prior to surgery despite use of augmentation techniques. Compared to a past review of abdominoplasty in the same patient subset, the buttock lifts resulted in equal patient satisfaction levels and slightly lower complication rates.

Conclusions: Lifting of the buttock can be a superb procedure to offer the right patient. With an ever-increasing number of patients having gastric bypass or lap band surgery, the number of buttock lifts is increasing rapidly as well. The technique described has a relatively low complication rate and can be used with simultaneous gluteal augmentation techniques.

Notes

9:30 am **Buttocks Fat Grafting**
JOSE L. SALAS, MD

Latin patients have always aspired for a prominent and well contoured buttocks; with the increased demand of buttocks implants, there were patients (not many) that were satisfied with the results, but most of them presented some degree of unsatisfactory result both aesthetic and functional.

With the arrival of Liposuction and repositioning of the patient's own fat, results have been greater both functional and aesthetically. The purpose of this abstract is to explain how we have managed these types of patients and demonstrate their results, which in most cases are satisfactory; as well as compare advantages and disadvantages for each patient trying to anticipate the possible result.

9:45 am **25 Years of Cosmetic Surgery: Past, Present & Future**
DOUGLAS D. DEDO, MD
2009 WEBSTER LECTURER

As we celebrate the 25th Anniversary of the AACS we must acknowledge the genius of a man who had the foresight to put together an educational organization that would further cosmetic surgery by drawing on all the disciplines that practice the art of cosmetic medicine and surgery of appearance. As the natural evolution of the Academy develops, the number of physicians who had the opportunity to witness, learn and work with Dr. Webster will decrease but it is the responsibility of the older members to make sure his legacy continues. Dr. Webster was the ultimate teacher. Perhaps the greatest loss to those of us who knew him and those of you who will not get the chance, is he was a gentleman and a friend. What topic would accurately reflect 25 years of growth? The answer was liposuction. We brought it to this country. We named it. We taught it. We refined it. We continually stay at the forefront of new liposuction technology to benefit our patients. Furthermore, when you take the contribution of the cosmetic surgeons who researched and taught liposuction, you will see Dr. Webster's legacy emulated.

Present day liposuction, with blunt tipped cannulas and criss crossing tunnels was developed by the French. Dr. Yves-Gerard Illouz learned of Georgio Fischer's 1976 technique of a powered cutting cannula that suctioned and cut fat from under the skin. Illouz wanted to create multiple collapsing tunnels instead of one large raw surface and he had to use an abortion cannula as he was unable to get a Fisher cannula. Illouz was the first to understand liposuction and recognize the importance of maintaining the integrity of the septa and hence the circulation to the skin.

In 1980 the first American Physician to study the French Technique was Norman Martin, MD, an otolaryngologist who went to Paris to observe Illouz. With his encouragement to Dr. Richard Aronson, Dr. Illouz was invited to speak at the January 1981 meeting of the American Society of Cosmetic Surgery (a forerunner of the Academy). In attendance was Dr. Jules Newman, an otolaryngologist and Dr. Rick Dolsky a plastic surgeon who in the Webster legacy of listening and learning went on to form the educational organization the American Society of Liposuction Surgery. In 1983 liposuction was done under general anesthesia, with big cannulas up to 1 cm in diameter using the dry technique.

The next breakthrough in liposuction that literally revolutionized the technique and made it extremely safe was in 1987. Dr. Jeffrey Klein, a dermatologist, in true Webster fashion, did eloquent basic research on the tumescent technique for liposuction proving the safety and efficacy of dilute xylocaine and adrenalin as a means of anesthesia and vasoconstriction. Now the procedure could be done without any significant blood loss, large volumes of fat could be removed and patient morbidity was greatly reduced while the results were enhanced.

Over the years different modifications have been developed to try to improve the technique of liposuction. Ultrasonic liposuction, pulsed ultrasonic liposuction, power assisted liposuction, low level laser activated liposuction, and most recently laser lipolysis with a myriad of wavelengths have been introduced. Dr. Neil Goodman, a gynecologic cosmetic surgeon has convinced me that these lasers, contrary to manufacturers' recommendations, are not necessary to melt the fat. Instead, their usefulness is contracting the skin by heating it to a sufficient level after fat has been removed to achieve a mini tuck and marked skin tightening. Unfortunately, burns and delayed healing make this technology a double edge sword.

Expansion of the low level laser energy to a multiple diode machine has shown promise to achieve body contouring without surgery. A three center IRB blinded study showed an average of 4.6 cumulative inches lost in 59% of the treated patients while the control group had an average .7" loss.

What does the future hold for liposuction? Typical of Dr. Webster's legacy, our members are continually looking for ways to expand the roll of liposuction in particular as it pertains to stem cell research. My prediction: As the secrets are discovered to isolate stem cells from fat, the volumes that we have been discarding will be used to separate these omnipotent cells to allow us to finally do breast augmentation that lasts and the space facelift of Dr. Mark Berman. Today, we can isolate stem cells from peripheral blood to treat over 70 diseases. Next on the horizon will be stem cells from fat that will be injected into the myocardium after an infarction to regrow healthy cardiac muscle. How ironic, fat cells to grow healthy hearts.

In conclusion, as we start toward our next 25 years, I would encourage all of us to strive to emulate the legacy of the father of Cosmetic Surgery, Dr. Richard Webster: listen and learn; question and investigate; publish and educate. For when we have a collaborative effort from all of the cosmetic surgery disciplines, our patients will be the ones to benefit!

10:15 am **Simultaneous Body Contouring Operations After Weight Loss Surgical Procedures**
EVGENI KOLESNIKOV, MD, PHD

Objective: The number of bariatric surgical operations has reached more than 200,000 a year in the United States. Almost every patient after losing weight needs 2 or more body contouring procedures. The aim of this study was to identify safety and efficiency of simultaneous body contouring operations in post-bariatric surgery patients.

Methods: From January 2000 to June 2008, 1691 patients underwent weight loss surgical procedures: 1553 Roux-en-y gastric bypass, 303 Lap BAND operations, 138 intragastric baloon (BioEnterica BIB) insertions (OSBC center). Female - 1407 (83.2%), average age was 41.7 (16-67) years, average BMI was 47.2 kg/m2 (35-80). Simultaneous body contouring surgical operations were performed after weight loss and weight stabilization: abdominoplasty and incisional and/or umbilical hernia repair - 82 patients, abdominoplasty and breast reduction or lifting surgery - 19 (6 with implants), liposuction was used as part of abdominoplasty operation in 33 cases and as corrective procedure postoperatively in 28 patients. Mesh was used for hernia repair in 12 patients. In 59 patients abdominoplasty operations were done using "Tightening jacket" technique, created in our center. Monitoring of patient's metabolic status was performed during the time of preparation for the body contouring procedure. On-Q pain pump used postoperatively in 46 patients.

Results: Average weight loss after bariatric surgery was 63.4±7.1 kg. Average time from bariatric surgery to body contouring procedure was 24.3 (14-59) months. Mortality - 0, thromboembolic events - 0, hematoma - 4 (3.1%), seroma - 6 (4.6%), wound infection - 3 (2.3%), wound tissue necrosis - 3 (2.3%), other minor complications - 4 (3.1%). Average hospital stay was 2.9 days. Advantages of "Tightening jacket" abdominoplasty: possibility to correct medium size lateral folds, 10-15 cm shorter lower horizontal incision, good access to the epigastrium for incisional hernia repair. Utilizing On-Q pump helped to reduce pain and amount of narcotics used postoperatively in patients with simultaneous body contouring operations. 87% of patients after post-weight loss body contouring procedures were satisfied with the results of operation.

Conclusions: "Tightening jacket" abdominoplasty is an operation of choice for the patients with upper midline vertical scars after bariatric surgery, lateral abdominal skin folds and necessity to repair incisional hernia. Simultaneous body contouring operations can be done safely without significant increase in hospital stay and complications. Patients matabolic status should be carefully monitored and stabilized before considering body contouring procedures.

Notes

10:30 am **Tumescent In-office Power Assisted Laser Lipolysis (TOPAL): A Prospective Clinical Study of 500 Consecutive Procedures**
AYMAN EL-ATTAR, MD

Objective: To evaluate the indications, contra-indications, safety, efficacy, patient satisfaction, and cost-effectiveness of tumescent in-office power assisted laser lipolysis (TOPAL). To open new horizons and new applications of this technique that may trigger more interests and further studies.

Methods: 100 consecutive patients underwent TOPAL. Patients underwent a total of 500 procedures. All patients had preoperative history and physical examination to exclude any medical or surgical contraindications. Of the initial 112 patients screened for the procedure, 12 were excluded for concurrent severe medical conditions or abdominal hernias. The study included 80 females and 20 males. Age range was 18 to 67. Weight range was 52 to 127 Kg. 76 patients were not taking any concurrent medications, and 22 patients were receiving medications that interfered with Cytochrome P450 hepatic enzyme, for whom dose modification was addressed. MicroAire System was used for power suctioning. Laser lipolysis devices included 10 watt 1064 nm Nd:YAG Cynosure Smartlipo™.

Results: Results appeared immediately after the procedure with progressive improvement over 45-120 days after the procedure. All patients showed significant reduction in circumference (6.3±2.3 cm) and significant improvement in skin tightening with significant improvement of striae. There were 2 mild skin burns, 1 mild hematoma that resolved without aspiration, and 1 mild skin infection, and 3% of the patients required another session for touch up. No other complications were noted.

Conclusions: TOPAL results seem superior to laser or traditional liposuction alone. It can be used for heavier patients who do not benefit from laser lipolysis by itself. TOPAL is safe, with fewer complications than those reported for traditional liposuction. The touch up rate for this technique is much less than that reported for traditional liposuction. The recovery time for TOPAL is uniformly low regardless of the preoperative weight of the patient, as compared to traditional liposuction. TOPAL has novel new indications including: Treatment of multiple lipomas (Dercum's disease); treatment of axillary hyperhidrosis; skin tightening after massive weight loss as a non-surgical alternative to massive skin excisions; and treatment of striae distensae.

Notes

10:45 am **A Double-blind, Prospective, Clinical, Surgical, Histopathological and Ultrasound Study Comparing the Effectiveness and Safety of Liposuction Performed Using Laserlipolysis and Internal Ultrasound Lipoplasty Method, and Assessing the Evolution in Patients**
GUSTAVO LEIBASCHOFF, MD

Objective: A clinical and instrumental study was carried out to determine the effects of laserlipolysis as compared to the internal ultrasonic liposuction procedure. The study was aimed at determining the performance of these devices in patients with lipodistrophy in the saddle bags.

Methods: The study had a prospective, longitudinal, and double-blind design. A group of female patients with lipodistrophy in the saddle bags was investigated. Liposuction was performed in all patients: laserlipolysis was applied on one side, and the internal ultrasound procedure was applied on the other side. Pictures were taken from all patients before the procedure, and 1, 6, and 21 days after the procedure. All patients were clinically evaluated before the liposuction procedure, and then 1, 6, and 21 days after the procedure. Histopathological studies were performed in all patients; bilateral fat biopsy specimens were collected before and after the procedure. A bilateral ultrasound study (7.5-10 Mhz variable frequency) was conducted in all patients before the liposuction, and 30 days after the procedure. As this was a double-blind study, neither the team performing the ultrasound nor the team performing the histopathological studies nor the patients, knew what device the surgical team had used on each side. The study was conducted in patients with lipodistrophy. The surgical team applied laserlipolysis on one side and treated the remaining side with internal ultrasound. In every case, the laserlipolysis and the internal ultrasound procedures were applied for the same length of time. The surgical team made a bilateral aspiration with a syringe and a 2mm-microcannula, with a maximum of 200cc of emulsion in both sides. Prior to liposuction and after superwet-tumescent anesthesia, fat tissue samples were collected from both sides (left and right). Then, after performing liposuction, samples were collected again from both sides.

Results: From a clinical point of view results showed, to physician and patients, an improvement in signs (localized obesity) in both sides; however, the side treated with laserlipolysis showed fewer side effects (no pain, small bruising, and little edema) than the other side. The ultrasound studies showed similar fat tissue results bilaterally. The histopathological study showed a better effect on the adipose tissue in the laser treated side.

Conclusion: From a surgical point of view, the laserlipolysis technique is easier to perform, and scars are smaller as compared to those caused by internal ultrasound.

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11:00 am **Laser Lipolysis Without Suction: A Single-Arm Trial**
BRETT S. KOTLUS, MD

Purpose: There has been a heightened interest in laser-assisted fat reduction procedures. We aimed to determine if lipolysis with the 1,320 nm Nd-YAG, short-pulsed laser without subsequent suction is an effective means of upper arm contouring.

Methods: Unilateral laser lipolysis of the upper arm was performed on 5 patients. Subcutaneous, intradermal, and skin surface temperatures were monitored with flexible thermocouples throughout the procedure to aid in the establishment of a treatment endpoint. Photographs and arm circumference measurements were evaluated before and 3 months after laser lipolysis. Patients were given the choice of undergoing the procedure on the contralateral arm at 3 months.

Results: All patients achieved no improvement to modest improvement in upper arm contour. 1 of 5 patients elected to have lipolysis performed on the contralateral arm.

Conclusions: Laser lipolysis may be safely performed with the parameters utilized in this small trial. Minimal improvement was seen with laser lipolysis without suction. The low level of patient satisfaction demonstrated that this method of lipolysis may not be the current treatment of choice for upper arm contouring.

11:15 am **Cosmetic Surgery in Our World Today**
GERHARD SATTLER, MD
FEATURED SPEAKER

Cosmetic surgery is an exciting challenge in a world of today with relocated values and aims. The question "why" should always be in the middle of our understanding, and this is even more relevant for the field of cosmetic surgery and medicine. New methods and techniques cause a slow step alteration of our state of mind and e.g. from a point of view today, it seems, Botulinum toxin A was used to erase wrinkles long before Christ was born.

Cultural and traditional backgrounds need to be respected in the process of teaching on a global scale, since patients' desires and the interpretation of their needs do not necessarily match. Using fillers in the U.S. and Europe, these substances are the same products, but the way they should be used might be different.

In Germany and also in some other parts of Europe, a more pronounced split in the public mind to the subject of cosmetic surgery can be noticed. As the interest in cosmetic procedures is continuously rising, the criticism is increasing at the same time. Lifestyle in the U.S. is markedly different and as luxury items are a sign of social status and security, the results have to be far more pronounced than in Europe, otherwise they would lose

their value. From a European perspective, a natural appearance is the most wanted look, so no one can detect that ever anything "was done". These circumstances immediately affect how, when and why techniques in cosmetic surgery are more or less successful. As important is the development of techniques for the better safety and comfort of our patients. This aspect is independent from traditional backgrounds. In general, no one is looking for pain, longing for invasive surgery while less traumatizing methods are available. So our aim as cosmetic surgeons has to be open for the new techniques and trends, but with the most careful attention we possibly can have.

About the Speaker: Dr. Gerhard Sattler is known for his outstanding work in cosmetic surgery, which has been noted in his native Germany and throughout the world. He introduced tumescent local anesthesia into German medicine and has performed more than 8,000 cases of liposuction. Dr. Sattler earned his medical degree from Johann-Wolfgang-von-Goethe-Universitat in Frankfurt, Germany, and went on to become Senior Resident in the Department of Dermatology at Klinikum Darmstadt. Seeking to create a forum for physicians to learn and share his passions, Dr. Sattler organized the biennial International Darmstadt Live Symposium for Dermatologic Surgery. He is President of the International Society of Dermatologic Surgery, a Board member of Vereinigung operative Dermatologie/Germany, and a member of numerous other professional organizations including the American Academy of Dermatology and the German Society of Antiaging, Section Liposuction. Dr. Sattler is currently the Medical Director of Rosenparkklinik where he specializes in dermatologic surgery, varicose vein surgery, liposuction, and treatments in local anesthesia.

Notes

11:45 am Panel Discussion – Managing Difficult Problems in Cosmetic Body Surgery

Moderator: ROBERT A. SHUMWAY, 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: ROBERT F. JACKSON, MD AND ANGELO CUZALINA, MD, DDS

1:30 pm TUBA & Circumareolar Mastopexy Make a Beautiful Duet
ROBERT A. SHUMWAY, MD

Objective: To teach the basics of TUBA.

Methods: This retrospective review of the last 3000 consecutive TUBA operations performed by the author at his Joint Commission certified surgicenter reveals 3 important techniques and principles that must be mastered by all TUBA surgeons.

Results: The results were: (1) competent use of endoscopy coupled with sound anatomical knowledge, (2) total control of the inframammary crease from the navel, and (3) appropriate patient selection.

Conclusions: The TUBA novice can perform safe and satisfying augmentation breast surgery by effectively learning the above techniques.

1:45 pm Evaluation of a Web-based Patient Education Tool for Breast Augmentation
DANIELLE DELUCA-PYTELL, MD

Objective: To evaluate the utility of a web-based educational tool for women who have had or who are considering breast augmentation.

Methods: A definitive web-based resource, www.breastimplantcare.com, was developed for use by patients and physicians which summarizes in lay-terminology contemporary, evidence-based information for decision-making and long-term follow up regarding breast augmentation. Urchin web analytics v.5.7.03 data for website traffic reporting will be analyzed.

Results: Since data collection has been available (6 months), the website has received over 165,000 hits with over 5,400 unique visitors. The number of daily visitors has ranged from 12-71. The average visitor looks at 5-6 pages of the site. "Monitoring Your Implants" is the most popular page viewed. Patients have contacted this site from a wide geographic area looking for immediate postoperative advice and for help with long-term problems. Those with immediate postoperative questions are referred back to

their treating physician. Though over 300 patients have visited the pages with downloadable forms to be a part of a prospective study funded by the CSF, only one new patient has joined the study from the website from this region.

Conclusions: This web-based educational tool for women who have had or are considering breast augmentation has demonstrated utility in providing information and helping educate women who are considering or who have had breast augmentation. The site is less effective as a recruiting tool for the grant study.

Notes

2:00 pm **Breast Reduction by Liposuction Using Tumescent Local Anesthesia and Powered Cannulas: Safe and Effective**
LOEK HABBEMA, MD

Objective: To collect data concerning the safety and efficacy of liposuction using tumescent local anesthesia and powered cannulas.

Methods: One hundred thirty women were treated. Complications were registered. Postoperative mammograms were made after one year.

Results: As an average 50% of the breast volume was removed. No serious complications that needed hospitalization were recorded. Postoperative mammograms showed no new calcifications that needed further evaluation.

Conclusion: Liposuction using tumescent local anesthesia and powered cannulas is a safe and effective treatment modality for breast reduction.

2:15 pm **Maximum Safe Tumescent Lidocaine Dosage (Dmax) is 30 to 35mg/kg Without Liposuction and 45 to 50mg/kg With Liposuction**
JEFFREY A. KLEIN, MD
FEATURED SPEAKER

Background: Tumescent anesthesia (TA) consists of large volumes of very dilute lidocaine (≤ 1gm/L) and epinephrine (≤ 1mg/L) infiltrated into subcutaneous fat to produce profound long-lasting local anesthesia, vasoconstriction, and surgical hemostasis. Originally used to eliminate general anesthesia and surgical blood loss in liposuction, TA is now recognized as safe and effective for many therapeutic surgical procedures. Current estimates of the Dmax are based on measurements of serum lidocaine following liposuction. The FDA-approved maximum dosage of lidocaine with epinephrine for infiltration is 7 mg/kg. Consensus dosage limits for tumescent lidocaine range from 35 mg/kg to 55 mg/kg. Liposuction may reduce lidocaine bioavailability. An estimate of Dmax should be based on non-liposuction patients because: 1) TA is used for surgeries not involving liposuction, and 2) it is possible that surgery may be cancelled after completion of infiltration but before initiation of liposuction. Lidocaine toxicity is directly related to serum lidocaine concentration, and has a threshold of 6 mg/L.

Methods: This IRB-approved research involved 12 female non-randomized volunteers, one patient participated in two trials, and 11 participated in one trial each. Each trial consisting of 3 separate 24-hour studies at least 12 days apart, totaling 39 separate 24-hour studies. Each 24-hour study began with infiltration of tumescent local anesthesia with concentrations ranging as follows: lidocaine 700 mg/L to 1000 mg/L, epinephrine 0.5 mg/L to 1.0 mg/L, and sodium bicarb 10 mEq/L. In the first two 24-

hour studies, tumescent infiltration was not followed by any surgery. The third 24-hour study included liposuction initiated one hour after T0, the time of completion of the tumescent infiltration. TA was delivered into subcutaneous fat by peristaltic infiltration pump using blunt-tipped Monty infiltration cannulas. Serum samples were obtained, from an indwelling catheter in a peripheral vein, every 2 hours during the first 18 hours (T0, T2, T4, …, T18) and again at 24 hours (T24). Serum lidocaine concentration was determined by HPLC. For each patient, the anatomic site targeted for TA was the same in all 3 studies. The targeted sites were different for different patients and included abdomen (n=4), hips and outer thighs (n=4), inner thighs and outer thighs (n=1), bilateral female breasts (n=1), unilateral female breast (n=1), inner thighs and knees (n=1), back and hips (n=1).

Results: At a lidocaine dosage of 45 mg/kg the mean area under the curve (AUC) of "concentration as a function of time" with liposuction is significantly smaller than the AUC without liposuction, $p < 0.0005$, paired t-test. Thus liposuction significantly reduced the bioavailability of tumescent lidocaine. At a lidocaine dosage of 45 mg/kg without liposuction the measurements of Cmax approximates a random variable with a normal distribution $N(\mu, \sigma^2)$, where $\mu = 3.67$, $\sigma^2 = 0.48$, $\sigma = 0.693$ and the probability $Pr(Cmax \geq 6 \text{ mg/L}) \leq 0.0004$ or 1 chance in 2500. Scatter diagrams the mg/kg dosage of tumescent lidocaine and the associated Cmax reveal linear trends both within individual patients and between patients. By extrapolation using linear regression without liposuction, a mean dosage of 55 mg/kg is associated with a Cmax = 4.4 mg/L; assuming $\sigma = 0.693$, the probability $Pr(Cmax \geq 6 \text{ mg/L}) \leq 0.01$ or 1 chance in 100. Similarly at 50 mg/kg the $Pr(Cmax \geq 6 \text{ mg/L}) \leq 0.0023$ or 1 chance in 437. For 35 mg/kg, the $Pr(Cmax \geq 6 \text{ mg/L}) \leq 0.000004$ or 1 chance in 2,500,000. The chance of liposuction being cancelled before liposuction but after the completion of tumescent infiltration estimated at 0.001 or 1 chance in 1000. Since the (cancellation of liposuction) and (Cmax≥6mg/L when dosage is 50 mg/kg) are independent events, their joint probability is (1/437)x(1/1000) ≤ 1/400,000.

Conclusions: A statistical analysis of 39 patient-trials, involving tumescent infiltration of lidocaine with sequential HPLC measurements of serum lidocaine concentration over 24 hours, indicates that 45-50 mg/kg is an appropriate estimate of the maximum safe dosage of tumescent lidocaine without liposuction, and the probability of lidocaine toxicity $Pr(Cmax > 6 \text{ mg/L}) < 0.0004$ or less than 1 per 2500.

Abstract Summary: An analysis of 39 patient-trials, involving tumescent infiltration of lidocaine with sequential HPLC measurements of serum lidocaine concentration over 24 hours, indicates that 45 mg/kg is an appropriate estimate of the maximum safe dosage of tumescent lidocaine without liposuction. The risk of lidocaine toxicity less than 1 per 2500.

About the Speaker: Dr. Klein received his Bachelors Degree from the University of California at Riverside, his Masters Degree from the University of California at San Diego and his Medical Degree from the University of California at San Francisco. Additionally, Dr. Klein received education in such specialties as dermatology, biostatistics, and epidemiology from the University of London Institute of Dermatology and the All India Institute of Medical Sciences. Dr. Klein completed two fellowships in clinical pharmacology and his residency in dermatology. He is triple board-certified by the American Board of Internal Medicine, the American Board of Dermatology and the American Board of Cosmetic Surgery. He maintains memberships in numerous organizations such as the American Academy of Cosmetic Surgery, the American Academy of Dermatology, the American Medical Association, the International Anesthesiology Research Society and the California Medical Association. Dr. Klein, in addition to his research efforts and his assistant clinical professorship of dermatology with the University of California at Irvine, maintains his private practice specializing in dermatologic surgery and cosmetic surgery in San Juan Capistrano, California.

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2:45 pm **Unique Methods in Cosmetic Surgery: Various Techniques to Improve Patient Safety and Outcome**

GUILLERMO BLUGERMAN, MD
FEATURED SPEAKER

The practice of cosmetic surgery currently demands surgeons to choose techniques providing reliable and sustainable results for their patients, and which, at the same time, are minimally invasive, with reduced scars and quick recovery.

To achieve these aims, we must research constantly and be updated on the emergence of new surgical technologies and techniques that may be beneficial for our patients in achieving the best outcome.

Today's surgeons must have an open mind to changes and they must not think that the techniques learned during their training will be the same used throughout their career. Techniques must change, evolve, adjust to new fashion and beauty criteria that change along time, and where there is no safe and reliable technique, the surgeon must try and generate one that is most suitable.

In our B&S Clinic in the city of Buenos Aires, Argentina, my partner for 23 years, Dr. Diego Schavelzon, and I have always fostered this philosophy, searching for methods and techniques that improve safety for our patients, using treatments based on reliable and proven scientific evidence.

The techniques developed – which will be demonstrated in our presentation – include:

1) Occipital scarless cervicofacial lifting;
2) Percutaneous palpebral bag removal;
3) Mammary gland removal in gynecomasty through mamillary scar;
4) Gluteus three-dimensional remodelling;
5) Safe abdominoplasty modified from Avelar technique;
6) Liposhifting to correct post-liposuction irregularities;
7) Laserlipolisis for subcutaneous-tissue modelling and increased skin tension;
8) Calf augmentation by percutaneous fasciotomy of the gastrocnemios fascia.

We are convinced that safety is one of the aspects in which we must insist the most in terms of elective surgical procedures, such as cosmetic surgeries. Thus, our techniques aim at applying the tumescent anesthesia developed by Dr. Jeffrey Klein.

About the Speaker: Dr. Blugerman has been recognized worldwide for his inventions and has pioneered many trends in cosmetic surgery through the years. He received his medical degree from Medicina de la Universidad Nacional del Nordeste

and was a resident at the Ripetta Plastic Surgery Foundation, Buenos Aires. Dr. Blugerman is an Assistant Professor of Surgery at the University of Nordeste, Corrientes, Argentina. He has authored numerous publications and textbooks and is the author of six books for patient education about Laser Hair Removal, Laserlipolysis, Tumescent Anesthesia in Breast Surgery, Veins Surgery and Rhinoplasty. He is President of SOLAPEL, Hair Latin-American Society and of the Argentinean Association of Cosmetic Medicine and Surgery as well as having served as Vice President of the International Society of Tumescent Anesthesia.

Notes

3:15 pm	Panel Discussion – Managing Difficult Problems in Cosmetic Body Surgery
Moderator:	E. ANTONIO MANGUBAT, MD
3:30 - 4:00 pm	Coffee Break in Exhibit Hall
4:00 - 5:30 pm	Cosmetic Surgery Essentials: 108 (Sessions will run concurrently)

Breakout #1

Location: Grand Sonoran AB

Essentials of Facelift Surgery

Joseph Niamtu III, DMD

Face and neck lift is the ultimate rejuvenative procedure. Successful facelift surgery is a mesh of art, science and experience. This program will be an in-depth multimedia presentation of all aspects of facelift surgery including patient selection, operative techniques, pearls and pitfalls, complications and new techniques. Dr. Niamtu will present actual case pictures and videos of each step of the facelift surgery. This presentation is appropriate for all levels of surgical experience and will serve to educate the novice facelift surgeon or serve as a refresher for those surgeons experienced in facelift surgery.

Breakout #2

Location: Grand Sonoran CD

Advanced Liposculpture

Edward B. Lack, MD and Gerald G. Edds, MD

Much has been learned in the past 2 decades about body contouring. Many advances in technology have been developed including ultrasonic assisted liposuction, mechanical assisted liposuction, laser assisted liposuction, and laser lipolysis. In addition each of these advances has had its own technical improvements. Newer concepts of beauty have created opportunities for improved outcomes. This course will focus on presenting the latest information on planning and executing a liposculpture procedure incorporating aesthetic and technologic advances.

Breakout #3

Location: Grand Sonoran JK

Litigation Stress: The Impact to Subsequent Med Mal Claims Experience

Ted Passineau, Medical Protective, Senior Clinical Risk Management Consultant

Previous research has shown that when physicians are sued for malpractice, a large percentage report the development of mental, emotional and/or physical symptoms commonly associated with exposure to excessive stress. In this session, the presenter, an attorney and experienced risk management professional, will discuss the concept of

statistical risk of loss, including how it is calculated by professional liability insurance companies. He will then discuss his research, which indicates that risk of loss increases when a provider is sued for malpractice for the first time, focusing on the personal dynamics associated with involvement in malpractice litigation. The presentation will conclude with suggestions for coping with the stress associated with malpractice litigation. There will also be a question and answer period.

Notes

4:00 - 5:30 pm

Breakout #4

Location: General Session – Grand Sonoran E-G

Free Paper Session

Moderators: JAMES KOEHLER, MD, DDS AND SUSAN M. HUGHES, MD

4:00 pm **Abdominoplasty – In Search of Excellence**
MOHSEN TAVOUSSI, MD, DO

Objective: Abdominoplasty is a cosmetic surgical procedure with high degree of patient satisfaction when the result produces a natural youthful abdominal wall contour. These include depression of the linea alba as well as outlines of the rectus abdominus muscle and most importantly, natural depression of the umbilicus. A technique is described that consistently will result in a youthful abdomen.

Methods: An extensive skin flap dissection and elevation to xiphoid process centrally and along the costal margins laterally to the flank areas are made. A very tight plication of the rectus sheath produces linea alba depression. Patient's back is elevated and the excessive skin flap is excised. The neoumbilicus site is marked and defatted prior to attachment to the rectus sheath to produce the natural depression. The wound is drained and closed in layers. Antiembolic device and early ambulation are used.

Results: 320 patients had full abdominoplasty in an outpatient setting, using this technique. 70 patients (21%) had other concurrent procedures including midface lift, neck lift, rhinoplasty, liposuction, breast augmentation, mastopexy and breast reduction. 33 patients (10.3%) had circumferential lipectomy (body lift) or abdominoflankplasty. There was one (0.3%) pulmonary emboli which resolved with antiembolic therapy. There were no other major complications such as flap necrosis. Minor complications included seroma in 6 patients (1.9%), which were treated conservatively, wound dehisence in 14 patients (4.3%). Most of the latter occurred in post bariatric surgery patients.

Conclusions: Most objectives of this technique as described above were achieved in majority of the patients. Type IV abdomen and very obese patients were exceptions. This technique, when applied to selected patients, produced a natural abdominal contour associated with youthful abdomen with high degree of patient satisfaction.

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4:10 pm **Revision of Complex Abdominal Wall Cicatrix and Application of Abdominoplasty Techniques**
WILLIAM R. FULTON, DO

Objective: As in abdominoplasty, epigastric, and other cicatrix often pose a concern due to risk of skin necrosis. In patients with multiple or complex cicatrix, achieving a normal contour with reasonable cosmesis is the goal of scar revision. In the following review, patients suffering abdominal wall disfigurement were treated with abdominoplasty techniques for the purpose of cicatrix revision. Specifically, 3 cases of scar revision required unique management of complex abdominal cicatrix. These patients were treated optimally with cicatrix revision applying techniques of abdominoplasty and reviewed with the literature.

Methods: Three separate patients presented with common dilemmas of abdominal cicatrix. The problems addressed were respectively, (1) large multiple epigastric and vertical cicatrix, (2) a lower abdominal cicatrix in a patient with minimal pannus, and (3) a patient with a deformed umbilical remnant from prior surgery. The first patient was a healthy 28 yr soldier that underwent a transverse laparotomy for necrotizing enterocolitis at 6 days old and an exploratory laparotomy for bowel obstruction at age 27. A reverse abdominoplasty with advancement of an inferior abdominal wall skin flap with wound vac closure at the umbilicus was performed. The second patient was a healthy 33 yr old female soldier with a 10cm left lower abdominal cicatrix with less then 8cm of skin laxity from pubis to umbilicus. She was treated with mini-abdominoplasty with translocation of the umbilicus. The last case was a 49 yr old female with a history of 20 yrs of granulation and excoriation at her umbilical remnant after a caesarean section. She required excision of her umbilical remnant and neoumbilicoplasty.

Results: In these cases, contour was considered a priority rather than cosmesis alone. No major complications occurred.

Discussion: A review of the literature is used to describe the underlying principles of abdominoplasty technique for the purpose of scar revision. The literature generally warns against abdominoplasty for patients with epigastric scars. Mini-abdominoplasty is especially useful in specific situations in patients meeting certain criteria. For umbilical revision, the technique of neoumbilicoplasty has no consensus in the literature but guiding principles exist that can result in a consistently positive outcome. The photos presented represent before and after documentation of successful revision of complex abdominal wall cicatrix. Literature review illustrates techniques of abdominoplasty and variations to accommodate for prior cicatrix. Although a consensus statement of cicatrix management does not exist, various techniques can be applied to achieve a minimally compromised blood supply.

Conclusions: Massive abdominal wall scar revision requires careful consideration of blood supply to the abdominal wall as in abdominoplasty. Outcome expectation and goals are important to discuss preoperatively to achieve patient satisfaction. Reverse abdominoplasty, fleur-de-lis abdominoplasty, mini-abdominoplasty, high lateral tension abdominoplasty, belt lipectomy, and staged procedures can be modified to suit a patient's cicatrix if blood supply is held as a priority in planning.

Notes

4:20 pm **Minimally Invasive Laser Assisted Liposculpture**
ROBERT H. BURKE, MD, DDS

Objective: Minimally invasive laser assisted liposculpture with the Smart Lipo system. The Michigan Center for Cosmetic Surgery has incorporated SmartLipo laser assisted liposculpture into all liposculpture procedures. These have included procedures on the arms, neck, chest, breasts, back, flanks, abdomen, suprapubic region, and upper legs. Adjunctive procedures vary depending on the volume of fat to be reduced, the laxity of the tissues, and the condition of the skin.

Methods: All procedures are performed using local anesthesia and Klein solution. Although most are supplemented with conscious sedation, some are done under local anesthesia alone, and others with oral sedation. None have been done under general anesthesia. Initially the 6-watt system was used. The power was upgraded as available and now the 18-watt system is most commonly used. The power output is altered as necessary with the 6-watt system utilized for the face, the 12-watt for the neck, and the 18-watt for the remainder of the body. There have been no significant complications. Where there is little fat and the goal is tissue contouring or tightening alone, no fat is removed. In some cases small 1.5mm cannulae are used under syringe pressure for minimal fat removal. Power cannulae are used for volume reduction.

Results: In all cases compression garments are placed postoperatively. Many patients require only minimal analgesia postoperatively. Where more aggressive fat removal is combined with liposculpture, acute recovery is slightly longer. Five patients who were treated with the 6-watt system required a repeat of the procedure to increase the final effect.

Conclusions: This system has increased the spectrum of areas that we are able to treat by liposculpture with the additional benefit of skin retraction. Recovery has been rapid and morbidity minimal. There have been no significant complications.

4:30 pm **Transumbilical Breast Augmentation with Adjustable Saline Implants: A Novel Approach**
BRENT R. ROSEN, DO

Objective: To investigate the novel use of adjustable saline breast implants via the transumbilical approach.

Methods: A retrospective review of medical records of 9 patients who underwent breast augmentation via transumbilical approach utilizing the adjustable saline implant. Variables reviewed included age of patients, reason for procedure selection, mean number of post implantation volume changes, range of volume change and follow-up time.

Results: Patients' mean age was 26.3 years. The most common reason for selection of adjustable saline implants was breast and chest wall asymmetry. The mean number of post-implant volume adjustments was 1.33, with a mean addition of 32.5cc (range of -20cc to +150cc.) Mean follow up time was 8 months.

Conclusions: Transumbilical placement of adjustable saline breast implants is a reliable technique for use in cases of asymmetry; avoiding scars on the breast and maintaining a remote insertion site.

Notes

4:40 pm **Treatment of Complications in Breast Reduction**
THEODORE E. STAAHL, MD

Objective: The objective of this talk is to present complications in breast reduction surgery and the evaluation and treatment of them.

Methods: A review of breast reduction surgical complications over the last 10 years will be presented.

Results: The treatment results and modalities will be shown.

Conclusions: A graded treatment regime from skin to deeper tissue injuries will give the physician an approach to plan and care for these problems.

4:50 pm **Acute Internal Hernia Following Abdominoplasty in the Post Surgical Massive Weight Loss Patient**
TITUS DUNCAN, MD

Objective: The rising incidence of obesity and its related co-morbid conditions has lead to an increased number of individuals seeking bariatric surgery. Excess skin and abdominal wall laxity following surgically induced massive weight loss can prove not only to be an issue of aesthetics, but one of hygiene, function and decreased patient self esteem. Abdominal reconstructions via abdominoplasty, body lift or belt lipectomy incorporating abdominal wall plication to improve overall body contour have become an increasingly popular treatment in the post surgical massive weight loss patient. The change in the intraabdominal anatomy in the post bypass patient predisposes them to the long term risk of internal hernia and subsequent bowel obstruction. This risk is magnified following abdominal reconstructive procedures that employ plicating techniques resulting in increased intraabdominal pressure. Consequently the small bowel seeks a pathway of least resistance resulting in internal herniation, bowel obstruction and urgent surgical intervention.

Method: We report a series of 5 post surgical massive weight loss patients that developed acute intestinal obstruction from internal herniation following abdominal reconstructive procedures. We discuss our methods of early detection and minimally invasive surgical intervention to treat this problem.

5:00 pm **Sclerotherapy of Periorbital and Facial Veins**
MEHRYAR TABAN, MD

Objective: Prominent periorbital and facial veins are a common cosmetic concern. Sclerotherapy of varicose veins of the extremities is a common procedure. In this study, we report the use of sclerotherapy for eradication of prominent periorbital and facial veins and/or telangiectatic vessels.

Methods: Retrospective study of 20 consecutive patients with prominent periorbital and facial veins and/or telangiectatic vessels treated with different concentrations of sodium tetradecyl sulfate (sotradecol), depending on the size of the veins. Patients were followed for 6 months.

Results: All 20 patients were successfully treated with resorption of periorbital and facial veins and/or telangiectatic vessels after intraluminal injection of sotradecol (0.1% to 0.75%). Few patients needed a second treatment with a higher concentration of sotradecol. Outcomes persisted throughout follow-up visits. There were no ophthalmic or neurologic complications.

Conclusions: Sclerotherapy could be an effective and safe method in treating annoying periorbital and facial veins and/or telangiectatic vessels.

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5:10 pm **No Vertical Scar Mastopexy: A Prospective Study**
VIPUL R. DEV, MD

Objective: Prospective randomized analysis of a newly, existing no vertical scar mastopexy technique described by Dr. Lalonde.

Methods: 72 patients were enrolled in a random basis from 2005 through 2007 and placed into either of three categories according to surgical technique: (1) the key hole technique, (2) the periareolar, concentric technique, and (3) the no vertical scar Lalonde technique. These patients were described all the risks, benefits and alternatives and left to decide what technique they would prefer. Patients that had breast augmentations did not undergo an immediate mastopexy procedure. These patients underwent the mastopexy procedure about 6 months to 1 year later. All patients were analyzed for complications, scars and cosmetic rating. The key hole and periareolar techniques were completed under the classically described methods in the history of our literature. The no vertical scar mastopexy was performed according to Dr. Lalonde.

Results: 34 patients chose the no vertical mastopexy, 28 chose the periareolar technique, and 10 chose the key hole procedure. 1.6% of the no vertical scar mastopexy patients had complications that included bruising, small dehiscence and mild cellulitis. 4% of patients that underwent the periareolar technique had complications that included widened scar, small dehiscence, umbilication of the NAC, undesirable appearance of the NAC. 2% of the key hole technique patients had complications of dehiscence, widened scar, undesirable appearance, decreased sensation of nipple areola. Cosmetic rating was the highest among the no vertical scar patients with an overall score of 9.2. The lowest cosmetic rating was among the periareolar technique patients at 7.8, and the key hole patients rated theirs at 8.0.

Conclusions: Many techniques exist for the mastopexy procedure. However, more and more patients are seeking not only a better result but a better scar. The Lalonde push up mastopexy technique offers a no vertical scar technique that proves to have a better cosmetic rating among patients. The no vertical scar mastopexy is less time consuming, less cumbersome in preoperative markings, easy to learn with happier patient outcomes.

5:20 pm **Smartlipo/Thermage Combined Skin Tightening and Fat Reduction**
SUSAN B. VAN DYKE, MD

Objective: The purpose of this paper is to explore the practicality and value of combining Smartlipo (alone, without liposuction) and Thermage to obtain superior results on skin tightening and localized fat reduction. Assessment of morbidity and patient acceptance and satisfaction as well as overall objective results are evaluated.

Methods: This is a retrospective study with chart and photographic review of patients treated with both Smartlipo and Thermage at the same sitting. Liposuction was not performed on any patient. 10 patients are currently enrolled and an additional 5 will be enrolled prior to 9/08. Results from combined procedures will be evaluated compared to either procedure alone using evaluation of photographs rated by a blinded evaluator not involved in the patients' care. Treating physician and patient fill out written questionnaires regarding their experience, satisfaction and results.

Results: Combining Smartlipo and Thermage does not add to the morbidity of either procedure. Results photographically appear to be better than either procedure done alone. Patient satisfaction is good. Independent evaluation and physician and patient surveys are not complete at this time. Final results will be available late in 2008 as data continues to be collected and additional patients are enrolled.

Conclusion: Combination of Smartlipo and Thermage (minimally invasive/non invasive) is a logical approach to maximize tightening and fat reduction in the absence of more invasive liposuction. Also both of these procedures are done once to obtain a result. This is a reasonable one time combination treatment. Other minimally invasive/ non invasive treatments for fat reduction/cellulite/skin tightening are often multiple (sometimes as many as 20 treatments). Both Smartlipo and Thermage result in collagen stimulation and skin tightening thru the mediator of heat. Deep heating the dermis from the surface and from the subcutaneous layer should result in a greater degree of collagen reaching the critical temperature that denatures collagen and therefore stimulates collagenesis. This study encourages the combination of procedures that do not increase patient morbidity. Further evaluation of ways to maximally stimulate collagen thru dermal heating need to be undertaken. Secondly, the ability to reduce fat in a significant way without liposuction is intriguing. Laser lipolysis plus radiofrequency fat reduction go hand in hand to maximize fat reduction. To date most of the results from Smartlipo have been difficult to evaluate due to simultaneous invasive liposuction. This study gets completely away from the more aggressive procedure.

5:30 pm Sessions Adjourn

7:00 - 11:00 pm Webster Society and Cosmetic Surgery Foundation Recognition Dinner at the Silverleaf Club (ticketed event)

Buses will depart at 6:45 pm from the ballroom entrance

SATURDAY, JANUARY 17, 2009

SCHEDULE-AT-A-GLANCE

7:00 am - 3:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 109
8:30 am - 9:15 am	Continental Breakfast in Exhibit Hall
9:15 am - 12:00 pm	General Session: 110 – The Art of Cosmetic Lasers and Fillers
8:30 am - 12:00 pm	Exhibits Open
9:30 am	OrthoNeutrogena Aesthetic Lecture Series
11:15 am	Cosmetic Surgery Foundation Socioeconomic Lecture
11:40 am	AACS Membership Meeting: Presidential Address and Elections
12:30 - 2:00 pm	25th Anniversary Luncheon
2:00 - 3:00 pm	Practice Management Session: 111
3:00 - 4:00 pm	Practice Management Session: 112
5:00 pm	Sessions Adjourn
6:00 - 11:00 pm	25th Anniversary Meeting Celebration

SATURDAY, JANUARY 17, 2009

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

Breakout #1

Location: Grand Sonoran AB

Advanced Fat Grafting Techniques: Face and Body

Mark Berman, MD and Suzan Obagi, MD

These two doctors will discuss the rationale and techniques behind fat grafting. They will explain how we age (hint: it has nothing to do with gravity) and consequently, why and how fat should be used to restore facial contours depleted by aging. They will explain how fat can be used to improve 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 grafting to repair other iatrogenic defects associated with other parts of the body. There will be a lot of emphasis on technique and opportunity for discussion.

Breakout #2

Location: Grand Sonoran CD

Avelar Abdominoplasty "A Safe Technique"

Robert F. Jackson, MD and Jonathan Patterson, MD

Over the past five to six years we have adopted the Avelar "combined liposuction/skin resection" abdominoplasty into our practice. It has become our most frequently used type of abdominoplasty and is utilized in approximately 95% of our patients. This breakout session will describe in detail the technique of doing this type of abdominoplasty, it will discuss patient selection and we will also discuss the complications that can occur and how to avoid them. There will be ample opportunity for questions and the lecture will be accompanied with video presentation.

Notes

Breakout #3

Location: Grand Sonoran HI

Cosmetic Surgery Success – Lessons From the Trenches
Panelists: Mark K. Mandell-Brown, MD, Joseph Niamtu III, DMD, and Samir Pancholi, MD

Moderator: DANA FOX, PRESIDENT, STRATEGIC EDGE PARTNERS

This course is about the successful rise of good surgeons who fought the traditional system and have won big time. After all, everyone knows only Board Certified "high-muckity-mucks" should be doing cosmetic procedures, right?

This panel of doctors will tell you how they shifted from their traditional scope of training, built highly successful cosmetic practices and enjoy richer and more interesting careers as a result.

This course is not about surgery, but it is for surgeons. Whether you are a general surgeon, ENT, OMS, OB/GYN, Urologist, or any surgically trained doctor who desires to expand the scope of your surgical practice, you will benefit.

During this course you will learn how different surgeons have built their practices and about the pitfalls to avoid and the chances worth taking. The panel members are diverse in terms of their specialties, their respective years of experience and the ways they each got their start.

You'll learn how to:

- Transition from a traditional clinical practice to an aesthetic-focused practice
- Integrate an aesthetic practice into a clinical practice
- Shorten the learning curve for your staff as you expand and broaden your practice
- Avoid marketing and advertising pitfalls
- Recognize good marketing and advertising opportunities
- Deal with criticism from the medical community
- Change direction if physically you can no longer operate

Breakout #4

Location: Grand Sonoran JK

Facility Accreditation: Playing an Important Role
Susan M. Hughes, MD

In order to perform cosmetic surgery with sedation in your office or ASC, accreditation is now required for most states. AAAHC provides an educational and consultative opportunity for your office based surgical center or ASC. Basic standards will be reviewed, and members of the AAAHC staff will present information on QI &QA studies, the life safety code, and other Medicare deemed status requirements.

Notes

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

9:15 am - 12:00 pm General Session: 110 – The Art of Cosmetic Lasers & Fillers

Moderators: NEIL S. SADICK, MD AND PAUL J. CARNIOL, MD

9:15 am Less Surgery is Better: The Importance of Associated Procedures in the Surgical Treatment of the Aging Face
RONALD W. STRAHAN, MD

Introduction: The classic surgical treatment of the aging face normally encompasses various combinations of forehead, face or neck lifts. To enhance the results of the classic procedures, the literature offers a growing number of associated surgical procedures including rhinoplasty, blepharoplasty, facial implants, skin resurfacing, filler injections, and most recently fat transfer.

Objective: The use of associated or adjunctive procedures in the treatment of the aging face may help reduce or eliminate the more risky extensive surgical maneuvers traditional with face lifting operations. At the 23rd Annual Meeting of the American Academy of Cosmetic Surgery we presented a 10-year follow-up study of 451 cases of surgery for the aging face. Each of these cases had one or more associated or adjunctive procedures. The data was re-analyzed to determine: a) The long-term results of associated procedure(s); b) The impact of the associated procedure(s) and the patient's opinion about their long-term result; and c) The associated procedure(s) most important in planning a treatment plan for the aging face.

Methods: The criteria for inclusion in the study was: a) Surgery performed by the senior author; b) Surgery performed prior to January 1997; c) Patient responded to a questionnaire used to determine 10-year results, 1,100 mailed and 451 responded. The questionnaire for the 10 year follow-up included not only the patient's opinion about the surgical treatment of the aging face, but also their opinion about the long-term results of their associated procedure(s). Direct analysis of the data illustrated the satisfaction rate of each associated procedure and cross analysis of the data determined the impact of the associated procedure(s) on the satisfaction rate of the aging face surgery.

Results: The 451 patients had a total of 585 associated procedures. The long-term satisfaction of the results of the associated procedures was greater than 70% and the long-term satisfaction rate of the face lift procedure was around 50%. The associated procedures with the higher satisfaction rate (in decreasing order) were rhinoplasty, blepharoplasty, facial implants, and skin resurfacing.

Conclusions: This data clearly suggests that the effectiveness of the surgical treatment of the aging face is greatly enhanced by the use of adjunctive procedure(s). This conclusion is dramatically illustrated by three photographs: the patient pre-operatively, the patient post-operatively and with the help of digital imaging the patient post-operatively without their associated procedure(s).

Notes

9:30 am **OrthoNeutrogena Aesthetics Lecture Series – The Evolution of Biodegradable Dermal Fillers**
DEE ANNA GLASER, MD
2009 PRESENTER

Since the approval of bovine collagen in the 1980s, the filler arena has now evolved to include several different classes of fillers, each with unique properties, allowing the clinician and patient to individualize their treatment plans, ranging from short-term to semi-permanent and permanent fillers.

9:45 am **The Art of Facial Fillers**
JOSEPH NIAMTU III, DMD

Introduction: There has been an exponential growth of minimally invasive cosmetic surgery procedures over the last several years and this charge has been led by injectable fillers. Facial fillers in the lips, nasolabial folds and elsewhere on the face have become one of the most popularly requested cosmetic procedures for cosmetic surgeons.

Materials and Methods: Although having a surgical practice, the author is very involved in injectable facial fillers. These procedures are fast, fun, and effective and can make significant differences in the rejuvenation of cosmetic patients. Although easy to perform, there is a significant learning curve in producing predictable outcomes, especially in the lips, tear trough, region and other less commonly injected anatomic areas.

The author will present a multimedia presentation detailing:

- Diagnosis of the filler patient
- What filler to use
- Pain-free filler injection
- Basic and advanced filler techniques for lips, nasolabial folds, brow, tear trough, midface, lower face
- Alternative to needle injection
- Complications

Results: Injectable facial fillers can add an effective and exciting facet to any cosmetic practice and, when proficient, the surgeon can make big changes with little procedures. In addition, filler patients will turn into cosmetic surgery patients and cosmetic surgery patients will generate filler patients. The contemporary practice of cosmetic surgery includes expertise injectable facial fillers.

10:00 am **Complications of Fractional CO2 Lasers, a Review of 373 Treatments**
TRACY M. CAMPBELL, MD

Objective: To determine the frequency and classification of complications associated with fractional CO2 laser treatment.

Methods: A retrospective evaluation of 373 successive 10,600 carbon dioxide (CO2) laser treatments in 287 patients conducted in a single center. Complications of laser therapy, onset, duration, and treatment were identified and analyzed through chart review, phone calls, and email (275 by chart review, 12 via phone, 1 via email). The different laser sites in correlation to the complication rate and laser parameters were also assessed.

Results: The 373 treatments resulted in 47 complications (12.6%) in 40 patients (13.9%). The most frequent complications were allergic/contact dermatitis (4.6%) acneiform breakout (3.48%), other (1.34%), prolonged erythema (1.07%), and herpes simplex virus outbreaks (1.07%). Complications were equally distributed across different ages, skin types (95% Type II, III, 5% Type IV), and laser parameters. They were not equally distributed among body locations and underlying skin conditions. Those who had a history of acneiform eruptions were more likely to have an eruption after treatment, and those who underwent simultaneous treatment of 2 or more body locations were more likely to have a complication. Out of 38 patients, 9 (23.7%) with >2 body areas treated simultaneously experienced complications. Out of 16 patients, 6 (37.5%) with >3 body areas treated simultaneously experienced complications. Because of the multiple areas treated, some patients experienced multiple complications. A total of 14 complications were documented in the 9 patients that experienced >2 concurrent treatments, and a total of 9 complications were documented in 6 patients who experienced >3 concurrent treatments. The 24 patients who had recurrent treatments with a healing period of 1-6 months between treatments had 3 documented complications (12.5%).

Conclusion: CO2 fraction laser skin treatment is associated with a relatively low complication rate when 1 body location is treated, however the complication rate increases with concurrent treatments of multiple body locations. Multiple treatments of the same body location with a healing period resulted in no increased risk of complications. Complications observed in this study were temporary and did not result in long-term scarring or sequelae.

10:15 am **Short Pulse, 1320 nm Laser, Neck and Lower Face Rhytidectomy – No Strings, No Scars**
EDWARD M. ZIMMERMAN, MD

Objective: A 100msec pulsed 1320nm laser (CoolLipo by New Star Lasers) has been used for 15 months to develop a new method to selectively disrupt fat (photo-acoustic lipolysis, causing little heat) and then tighten anterior neck, sub-mental, jowl, and lower cheek skin (selective photo-thermal lysis if water in skin), for which reproducible end points have been determined. No excision or suspension of tissue is utilized, making this a preferred technique compared to the traditional gold standard of upper neck/lower face rhytidectomy.

Methods: Over 30 cases have been performed to refine the use of the 1320nm laser with and without liposuction to define the most effective skin surface and tissue temperatures (measured with a MicroTherma 2T Thermometer and contact probe – www.thermoworks.com) and endpoints: surface temp of 38 to 40 degrees Celsius uniformly reached, warmed tissue become moldable and retains compressed shape, contour is achieved, no visible or palpable skin burns or irregularities. Photo mechanical fat ablation is monitored by decrease in acoustic "popping", ease of moving laser fiber/cannula and achievement of desired body contour and size. Achieving the exact temperature range and holding it for several minutes is the key to tissue tightening by photo thermo lytic effects.

Results: Using the above endpoints and various hand pieces, all patients have benefited from this technique.

Conclusions: The laser lipo neck lift is a safe, reproducible, reasonably effective treatment for ptotic anterior neck and lower face fat and lax skin for all ages and skin types. It compares satisfactorily with traditional rhytidectomy in results, risks and post operative discomfort, but causes no significant surgical scars and has a much shorter recovery. It can be bundled with Botox, and other modalities for optimal outcomes.

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10:30 am **Treatment of Dermatosis Papulosis Nigra Using KTP 532 nm Laser in Skin Types IV, V and VI**
AYMAN EL-ATTAR, MD

Objective: The objective of this study was to evaluate the safety and efficacy of KTP Diolite 532 laser in the treatment of dermatosis papulosis nigra on Fitzpatrick's skin types IV, V and VI.

Methods: 40 participants (12 males and 28 females) were given 3 treatments approximately 3 to 4 weeks apart and were assessed by photography, lesion counts, and patient satisfaction at 4 weeks after each treatment. Laser treatments with the 532 laser were applied onto a total of 1312 lesions on the face, neck, and torso. Assessments of complications caused by laser treatment, including blistering, dyspigmentation and/or scarring, were recorded.

Results: A reduction in the lesions when compared with baseline data was statistically significant for treatment of DPN in all body regions at the 4-week follow-up. Participant evaluations ranged from "satisfied" to "very satisfied." Side effects included transient hyperpigmentation, mild erythema, and itching in 2% of the study participants.

Conclusions: The use of the KTP 532 nm laser for the treatment of DPN on skin types IV, V, and VI is both safe and effective.

10:45 am **Fractionated Carbon Dioxide Laser for Treatment of Acne Scars**
PAUL J. CARNIOL, MD

Objective: Multiple lasers and combination therapies have been used for treatment of facial acne scars. Most recently, fractionated lasers have been used for treatment of facial acne scars. When considering laser treatment of acne scars both treatment efficacy, associated recovery issues, and risks should be considered.

11:00 am **A Study Examining the Treatment of Hand PhotoDamage with the Fraxel SR Laser System**
NEIL S. SADICK, MD

Objective: This off-face study determined the safety and effectiveness of the Fractional Photothermolysis device for the treatment of dyschomia, rhytides and overall skin texture on the aging hand.

Methods: 10 subjects (Male=1, Average age=56.4 years) were enrolled in this study consisting of up to 6 dorsal hand treatments at 3 week intervals with a 1,550nm laser with follow-up visits at 1-, 3- and 6-months after the last treatment visit. The energy ranged from 6 mJ to 12 mJ with total density ranging from 1,000 to 2,000 MTZs/cm^2. A blinded independent evaluator graded improvement during the study. 3 subjects provided biopsies.

Results: Nine of 10 subjects completed all treatment and follow-up visits. Treatments were well tolerated. Improvement in pigmentation, rhytides and texture were progressive and sustained throughout the study. Photodamage as assessed by the study investigator continued to improve with 77.8% demonstrating marked or better (≥3) improvement at one month post-treatment, while 88.9% and 100% exhibited that level of improvement at three months and six months post-treatment, respectively. The histologic markers examined revealed positive changes in the indices of photoaging through six months post-treatment and were well-correlated with the clinical responses documented here within. Given this demonstration of the performance, this device is capable of offering significant long-term efficacy without adverse effects or downtime with respect to other ablative and non-ablative treatment options.

Conclusions: This study demonstrates that the Fractional Photothermolysis device has a beneficial effect for the treatment of dyschomia, rhytides, and overall skin texture on the hands. There was a marked improvement in all patients that completed the study without any adverse side effects revealing the general safety and effectiveness of the treatment therapy.

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11:15 am **CSF Socioeconomic Lecture – Light-based Technology: Shaping New Opportunities in the Aesthetics Marketplace**
LARRY LABER, DIRECTOR, CYNOSURE, INC.

Advances in light-based technology have forever transformed the landscape of the aesthetics market. Today's newest light-based solutions provide patients with superior clinical outcomes, particularly when compared with conventional approaches, such as gels and creams. These solutions are currently available for a broad range of applications, from hair removal and anti-aging to skin rejuvenation and body contouring. Larry Laber, Director of North American Business for Cynosure, will discuss trends and opportunities for light-based technology as a slowing economy drives practitioners to maximize their return on investment now more than ever.

11:30 am **Upper Eyelid Approach to Lower Eyelid Blepharoplasty**
MEHRYAR TABAN, MD
2009 RESIDENT PAPER CONTEST RECIPIENT

Debulking of lower eyelid lateral fat pocket through an upper eyelid approach can safely and effectively address this often hidden fat pocket. It may be ideal for those patients (usually older males) with only prominent lower eyelid lateral fat pocket, upper eyelid dermatochalasis, with or without lateral canthal laxity.

11:40 am **AACS Presidential Address**
PATRICK G. MCMENAMIN, MD

11:50 am **Annual Business Meeting of Members**

12:20 pm **Cosmetic Surgery Foundation Annual Report**
DEE ANNA GLASER, MD
CSF PRESIDENT

12:30 - 2:00 pm **25th Anniversary Luncheon in Grand Saguaro Ballroom South (ticketed event)**

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2:00 - 3:00 pm Practice Management Session: 111 (Sessions will run concurrently)

Breakout #1

Location: Grand Sonoran AB

Marketing in a Fickle Economy

Dana Fox, President, Strategic Edge Partners

Just when you think you understand the market the sand shifts right under your feet, and there you are, wondering what happened to all those cosmetic patients. Where did they go? Who did their surgery? How did they miss your office? Was it something you did? Something you didn't do?

Whether you're already successful and thriving in a cosmetic surgical practice or just sticking your toe in the water, marketing and advertising are going to be a part of your practice.

This comprehensive marketing course will help you to 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 what drives your patients to the decision to seek an elective procedure.

You'll learn how to:

- Develop a unique message that fully leverages your assets
- Assess all of your marketing messages and how well they are working
- Analyze your web presence and how you rate against your competition
- Determine the proficiency of your staff and how well they promote you

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Breakout #2

Location: Grand Sonoran CD

Being #1 in Google Is All You Need, Right?
Eva Sheie, Director of Internet Marketing,
Strategic Edge Partners

This course is about looking at your online marketing strategy in objective terms and then building on what you already have in place. There are dozens of reputable Internet companies doing a fabulous job, but it's not easy to figure out where to spend your money to create the greatest interest in you and your practice.

Understanding today's web marketing and the new "social media" takes more than a few minutes. It really is complicated! Online marketing is the most misunderstood of all existing marketing opportunities. You've got to have a website, it's got to make sense to the reader and it's got to produce measurable results. But who's telling the truth?

Anything you learned last year about search engines is already outdated, and what you will learn in this course will be outdated a year from now. The good news is that you will be further ahead than you are right now, and you'll know enough to have the edge in your community and beyond.

You'll learn:

- What is meant by SEO (search engine optimization) and how much should it cost
- How UEO (user experience optimization) works and how is it different from SEO
- How to develop compelling content and create a visual presence that lets you stand out from your competitors
- How to use online video without clobbering your viewer
- How to use social media websites & blogging to your advantage (LinkedIn, RealSelf, and local news blogs)
- How to quantify the success of your current online messaging and placement and how to compare it to your competitors
- How to determine an appropriate budget to meet your goals, and how to access and track your progress over time
- How to decide which online marketing opportunities make sense for your practice and for your personality
- Why you need a "reputation management" plan to manage negative press and/or disgruntled patients
- Why you need a blog or two (a day) to help you tell your story

Notes

3:00 - 4:00 pm Practice Management Session: 112
(Sessions will run concurrently)

Breakout #1

Location: Grand Sonoran HI

Medical Spa or No, That is the Question

Susan Browner, Executive Consultant, Strategic Edge Partners

Many practices today offer their patients a combination of skin care and other ancillary services in a pleasing, "spa-like" environment. Yet, discerning doctors continue to ask pertinent questions:

- Do we really need to offer these services?
- Do patients expect to receive them?
- Is it profitable?
- Do profits made offset time and efforts required?
- How do the most successful practices integrate these services?

Myth: If you add products and ancillary services, you're likely to fortify your bottom line. Traveling throughout the country in my work with doctors and their practices, I've seen it all:

Fact: Potentially profitable treatment rooms filled with dated products are sitting idle in countless practice settings everywhere.

Fact: Products are purchased but not promoted.

Fact: Aestheticians are paid well but utilized poorly (doing double duty as receptionists or patient escorts into treatment rooms) thus compromising a potentially lucrative revenue stream for the practice.

Fact: Many practices are under-charging for products, failing to utilize inventory controls, and standing by as products walk off the shelves into designer handbags because no one is "minding the store."

Fact: Giving patients the ancillary services and products they crave can be extremely lucrative to the practice if these programs are run well. They must be executed strategically, professionally and consistently.

The presenter will take your questions, offer feedback on your prior experiences with products/skin care & ancillary services, and offer you straightforward input on ways your practice can realistically:

- Create a continual in-office source of referrals for major surgical procedures (up sell)
- Provide the ancillary procedures and services that will draw and retain patients in your practice without draining staff or financial resources
- Build a profit center that generates a solid cash flow – even when you're not in the office

Notes

Breakout #2

Location: Grand Sonoran JK

Surviving a Depressed Economy

Angela O'Mara, President, The Professional Image, Inc.

When the going gets tough, the tough get going. Even during these tough economic times, the savvy cosmetic surgeon can ensure a successful practice. You just have to be willing to change with the times, try some new ideas, and revisit some tried and true methods of practice PR and marketing that you may have let slip by the wayside.

Don't lose sight of the fact that a cosmetic surgery patient is a consumer that shops. In this current economy most shoppers are looking for better bargains, better service and better products. What are you doing to distinguish your practice from the competition? What are you doing to create consumer awareness of your surgical techniques, professional skills, experience and services? What are you doing to convince the public to make you their number one choice when it comes to cosmetic surgery?

This session will help you:

- Sort the good from the bad
- Understand why "image" is everything
- Secure publicity for your practice
- Use e-newsletters to keep in touch
- Spend advertising dollars wisely
- And much more

This session will leave you on an "I can do it" high and infuse you to go back to your practice feeling invigorated and ready to do business!

4:00 - 5:00 pm Bringing your Career to the Next Level

Location: Grand Sonoran AB

4:00 - 4:30 pm Board Certification in Cosmetic Surgery – "It is Worth the Effort"
PETER CANALIA, JD,
ROBERT F. JACKSON, MD AND
MICHAEL WILL, MD, DDS

Objective: The speakers will give evidence as to the advantage of board certification in cosmetic surgery.

Methods: A discussion of eligibility will include the newer and expanded ability and eligibility requirements to become board certified in cosmetic surgery. There will be a discussion concerning the fellowship route as well as the experience route to obtain an eligibility to be allowed to take the examination and sit for the boards in cosmetic surgery. A new concept of certificate of additional training will also be discussed during this lecture.

Conclusions: It is the author's conclusion that not only is board certification advantageous it may become necessary in years to come.

Location: Grand Sonoran AB

4:30 - 5:00 pm **How to Become an AACS Fellowship Director**
ANGELO CUZALINA, MD, DDS AND JAMES KOEHLER, MD, DDS

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Location: General Session Room – Grand Sonoran E-G

2:00 - 3:00 pm **Your Practice in "Lights": The Importance of Staff to a Successful PR and Marketing Program**
ANGELA O'MARA, PRESIDENT, THE PROFESSIONAL IMAGE, INC.

In Hollywood everyone wants to be a star, and in recent years we have seen the launch of the celebrity surgeon! Securing publicity for your practice can be the most credible, cost saving and effective way to promote a medical practice. However, in the hands of the wrong person it could mean the difference between being famous and not being famous. There are agents and there are good agents. If you want to build a successful, ethical and high profile image for yourself through TV, print and electronic media, then you most likely want more than '15 minutes of fame'. You want a long-lasting publicity career that will span the life of your practice and continue to grow into consumer saturation as the years go by.

This session will teach your staff how they can assist you in achieving this dream. It includes:

- What is PR and why does your doctor need it?
- What needs to be in place to ensure a successful PR campaign
- Finding news within your practice
- Creating press releases that sizzle
- Working with an agency

Angela O'Mara is President of The Professional Image, Inc. a medical specialty PR and marketing agency. Since 1988, TPI has worked with cosmetic surgeons around the world who want to build a high profile and high image cosmetic surgery practice. TPI is located in Newport Beach, California, and has become a world authority in the field of cosmetic surgery practice marketing and development.

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3:00 -
4:00 pm **How to Get the Most Out of Your Job… Emotionally, Intellectually and Financially**
DANA FOX, PRESIDENT, STRATEGIC EDGE PARTNERS

Building a highly successful practice takes a team of dedicated people working to make a difference in the lives of their patients. A doctor simply cannot get there alone. You make the difference.

This course is designed to help you become invaluable to your practice and simultaneously reach your own career goals. Plan to laugh and plan to participate, this is not the course for "shy violets" or "stick to the agenda" types and your doctor can only attend with a note from you!

Topics covered in this lecture:

Practice Dynamics

- Customer service is an art form
- The Four Steps to being exceptional
- Your phone quality standard
- It's Show Time: the story you tell and retell enthusiastically to every patient

Internal Marketing and Your Role

- Branding through customer service
- Assessing the health of the practice with your doctor
- Building your practice visibility

Learning the Subtle Art of Sales and Persuasion

- Let doctors be doctors and let someone else ask for the check
- Creating the perfect consultation process
- Follow up makes the difference, it separates the women from the girls

Outside Marketing – Become a Marketing Maven

- Collaborative and relevant internet marketing you can participate in
- How to identify opportunities
- How to work as a team with outside professionals

4:00 -
5:00 pm **Panel Discussion**

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SUNDAY, JANUARY 18, 2009

SCHEDULE-AT-A-GLANCE

7:00 am - 12:00 pm	Registration Open
7:00 - 8:30 am	Bright Eye Sessions: 113
8:30 - 9:15 am	Continental Breakfast
9:15 am - 12:00 pm	General Session: 114 – The Art of New Technologies
12:00 pm	Sessions Adjourn

SUNDAY, JANUARY 18, 2009

7:00 - 8:30 am Bright Eye Sessions: 113
(Sessions will run concurrently)

Breakout #1

Location: Grand Sonoran AB

Publish or Perish: How to Write a Superb Scientific Abstract
Jane A. Petro, MD

The American Journal of Cosmetic Surgery needs to grow and mature. Having an active and well trained peer review panel is one of the key elements in bringing the journal up to the standards required to achieve PubMed legitimacy. This workshop will focus on the elements of good research and writing, and the critical skills that are essential in the review process. Participants will be asked to assist in the design of a new format for evaluation of submitted material. It is hoped that this could be scheduled for a time when members of the review board, and of the editorial board as well as interested attendees (future editorial board, etc) could be likely to attend.

Breakout #2

Location: Grand Sonoran CD

25 Years of Cosmetic Surgery Marketing
Robin Bogner-Ntoh, BS

In a beauty society where the public is bombarded with evolutionary medical and cosmetic advances, it has become essential for cosmetic practices to make their presence known. Over the past 25 years the tools for marketing have changed dramatically. When the AACS was just getting started, computers were large, slow and the Internet let alone email weren't even invented! The AMA and professional societies discouraged marketing and advertising, calling it unprofessional and cheap. Yellow page advertising, newspaper announcements and the ultimate TV interview limited the scope and breadth of building a cosmetic practice. Over the years many members of this Academy pushed the envelope on marketing by expanding into TV spots and radio. Much to the chagrin of organized medicine, the courts sided with the freedom of

speech and the race was on. Just as the AACS has matured with recognition by the AMA, so has the sophistication of marketing. While the goal of any marketing is to bring patients to the office, new tools are available today to achieve success. This paper will review the latest in Internet marketing, web development, streaming video, internal marketing and other modes of building a successful practice for the next 25 years.

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Breakout #3

Location: Grand Sonoran HI

Cosmetic Vaginal Surgery

Marco A. Pelosi II, MD and Marco A. Pelosi III, MD

An overview for gynecologists and cosmetic surgeons from all specialties, this presentation introduces the core elements of this fast growing area of aesthetic surgery. Nomenclature and focused anatomy as they pertain to patient selection, surgical planning and the assessment of existing and novel techniques will be explained. The evolution of cosmetic vaginal procedures from standard therapeutic gynecologic operations will be reviewed. Issues unique to functional vaginal aesthetics will be addressed.

Breakout #4

Location: Grand Sonoran JK

Managing the Challenging Cosmetic Surgery Patient

Ted Passineau, Medical Protective, Senior Clinical Risk Management Consultant

In the course of practice, cosmetic surgeons are likely to encounter "challenging" patients, who fall into one or more of three categories: the difficult patient (one whose behavior causes a dysfunctional physician-patient relationship), the non-compliant patient, or the patient with unrealistic expectations from treatment. In this program, the presenter will discuss the characteristics of these three types of patients and strategies which have proven effective in dealing with them in other contexts. The program will include interactive analysis and discussion of actual case studies involving the challenging patient.

8:30 - 9:15 am Continental Breakfast

9:15 am - 12:00 pm General Session: 114 – The Art of New Technologies

Moderators: DOUGLAS D. DEDO, MD AND SORIN EREMIA, MD

9:15 am **Laser Vaginal Rejuvenation and Laser Reduction Labioplasty: Underutilized Options for Women with Sexual Function Problems Related to Anatomy**
TROY R. HAILPARN, MD

Objective: Emerging gynecologists offering laser vaginal rejuvenation (LVR) and laser reduction labioplasty (LRL) recognize two groups of women whose needs are not being met by today's practicing ob/gyns: those with sexual function problems (SFPs) related to childbirth and those with labial issues. These surgeries offer safe, effective choices to treat documentable anatomic defects affecting sexual function. SFPs can significantly affect the quality of women's lives. This review highlights two neglected problem areas and offers recommendations, including

surgical options, on improving the healthcare presently provided to women. Five years of outcome data (n=695) are presented utilizing LVR (n=519) and LRL (n=420) to address these women's concerns.

Methods: A screening history with questions regarding bladder, bowel and sexual function, as well as labial concerns was used to identify which patients were potentially LVR vs. LRL surgeries. 40% combined the two surgeries. All had a consultation that reviewed pelvic anatomy, before and after pictures, risks and complications, factors that affect long-term results and included a physical exam with a mirror. The LVR and LRL surgeries were done utilizing the techniques of Dr. David Matlock. The cutting instrument was the YAG laser. Vicryl sutures were used for closure. All surgeries were outpatient under general anesthesia, with follow-up for a first post-op day exam and in eight weeks. Patients completed a follow-up questionnaire three months after surgery. SFPs related to childbirth included decreased or no sensation with intercourse (DS), the penis falling out during thrusting (PFO), urination or defecation with penetration, and gas-like noises during intercourse. Related problems included inability to wear tampons (PWT), manually assisting with bowel movements (MABM) by pressing the posterior vaginal wall, constipation (C), and hemorrhoids (H). Stress Urinary Incontinence (SUI), also related to childbirth, was screened for during the exam and treated if appropriate.

Results: Four anatomic defects related to childbirth were identified in the LVR group: A rectocele (R), a cystocele (C), a diminished perineal body (DPB), and gaping introitus (GI). Of the 97.8% women who presented for LVR with DS, 96% had a documentable rectocele. Of the 32.7% women with PFO, 91% had a GI. 48.3% of women presented with SUI and DS, and 100% of them had a cystocele and a rectocele. Six areas of concern regarding the Labia Minora were identified that greatly impact on daily quality of life: Length (70.4%), Asymmetry (30.4%), Pigmentation (30.4%), Inability to wear certain clothing (39%), problems with activities and exercise (34.5%), and 28% had painful intercourse. Only 14% came in for appearance alone. There is much emotional distress associated with labial issues. Even those without dyspareunia shy away from sexual relations due to feelings of embarrassment about the size/asymmetry of their labia. Risks and complications of LVR and LRL are similar to other gyn surgeries (1-2%) in the hands of a skilled surgeon. No major complications occurred.

Conclusion: A greater understanding of the SFPs related to childbirth and labial issues will enlighten doctors to at least recognize these problems and know where to refer their patients if not properly trained.

9:30 am **Cosmetic Vaginal Surgery**
MARCO A. PELOSI III, MD

Objective: An overview for gynecologists and cosmetic surgeons from all specialties, this presentation introduces the core elements of this fast growing area of aesthetic surgery.

Methods: A review lecture. Nomenclature and focused anatomy as they pertain to patient selection, surgical planning, and the assessment of existing and novel techniques will be explained. The evolution of cosmetic vaginal procedures from standard therapeutic gynecologic operations will be reviewed. Issues unique to functional vaginal aesthetics will be addressed.

Conclusion: A general knowledge base is essential to achieving a better understanding of cosmetic vaginal surgery.

9:45 am **Bicipital Augmentation: A Review of 94 Patient Cases**
NIKOLAS V. CHUGAY, DO

Objective: Increased exposure to a wide array of cosmetic surgical procedures by the media has boosted public awareness and acceptance of cosmetic surgery as a whole. Reality, documentary, and "makeover" programs have all helped to eliminate certain taboos previously associated with cosmetic surgical procedures. As a direct result of this phenomenon, men have expressed greater interest in cosmetic surgery. Over the past 5 years, Dr. Chugay and colleagues have been working to promote the use of a bicipital prosthesis for aesthetic augmentation of the biceps muscle. This article is designed to further elucidate the complications that have been encountered with the procedure to date and changes in technique that have made this a viable option for male muscular enhancement.

Methods: A retrospective review of prospectively collected data on 94 patients was examined to determine the cosmetic improvements and complications seen in the patient population. Silicone prostheses were placed below the biceps muscle, in each case, in order to provide greater definition and fullness in the region of the biceps.

Results: Over a 5-year period, 94 patients underwent bicipital augmentation. Of those cases, there were 3 noted complications. One patient suffered a dislodgement of the implant with protrusion of the implant from beneath the muscle. A second patient developed a large seroma due to poor compliance with postoperative instructions for compressive garment use. The third complication encountered was that of compartment syndrome in a patient that underwent both bicipital and triceps augmentation.

Conclusion: Despite the risks inherent in performing surgery in the upper extremity, the bicipital augmentation procedure is a means by which the male physique can be enhanced with minimal risk of complication when performed using our technique.

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10:00 am **A Stitch in Time Saves Nine**
MICHAEL KLUSKA, DO

Objective: With the rising costs in healthcare and the growing competitive cosmetic surgery industry, combined with the increased demand of the public to have cosmetic surgery with less down time, today's cosmetic surgeon must invent ways to be more efficient in order to meet the demands of the cosmetic surgery market place. One of the easiest ways to accomplish this is by being able to perform complex surgeries more quickly and efficiently, therefore allowing the surgeon to service more volume. Hence ¼ the barbed suture! This study was designed to show how bi-directional absorbable barbed sutures allow for rapid wound closure, decreased operatory time and decreased surgical suture costs. Anecdotally, it was noted that the use of barbed suture ultimately lessened physician fatigue associated with current wound closure techniques. Available in both absorbable and non-absorbable materials, Angiotech/Quill sutures allow for rapid bidirectional wound closure without the use of multiple, individual stitches. The barbed suture allows for excellent deep tissue and subcuticular wound edge approximation and does away with knot tying.

Methods: In a recent patient comparison, 20 patients were treated with the barbed suture for routine wound closure in breast reduction and abdominoplasty. These patients were then compared with 20 patients who had similar procedures and were closed with more traditional techniques. The sampling specifically looked at time taken for wound closure, costs associated with different suture techniques and evaluation of the wound at one and three months postoperatively.

Results: Results revealed that abdominoplasty and breast reduction wounds closed with barbed suture took, on average, 20 minutes less to close and healed similarly to those wounds closed with traditional techniques when evaluated at one and three months. In addition, average surgical costs associated with the various types of wound closures diminished on average by $75-100 per patient in suture material.

Conclusion: In summary, with the demand for cosmetic surgery on the rise, the cosmetic surgical industry must respond with better technology. Bidirectional barbed suture is an extremely useful tool in the armamentarium of the cosmetic surgeon to meet these ever-changing demands.

10:15 am **Cosmetics in Obstetrics: Comparative Study, Rejuvenating Laser Assisted Vaginal Delivery (laasog system), vs Vaginal Delivery with Episiotomy**
GABRIEL E. DE PENA, MD

Objective: 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. Vaginal delivery with episiotomy is bloody, painful, coarse, unpolished, produces malformations and scaring of the vulva and perineum, and is definitely not a cosmetic procedure. Taking into consideration the wellbeing and cosmetic aspect of women, we have merged obstetrics and gynecology with cosmetic surgery and laser-radio frequency technology.

Methods: Laasog System`s Rejuvenating Laser Assisted Vaginal Delivery: we included 48 out of 50 patients that delivered by vaginal delivery with episiotomy in our study. They were all in the 38th-41st week of pregnancy and between 18 and 35 years of age. 25 traditional vaginal deliveries with episiotomies were performed and 23 rejuvenating laser assisted vaginal deliveries were performed. The Laasog System uses a combination of diode laser and radio frequency technologies, special retractors, modified skin incisions, modified muscular plicature, and reduction labiaplasty and resection of scars from previous episiotomies.

Conclusions: The combination of laser and radio frequency, modified incisions, special retractors that produce less aggression and protect the fetus, and sutureless closure of the skin are associated with minimal bleeding during the procedure, less tissue damage, less inflammation, the use of less traumatic surgical instruments, a reduction in 13 postoperative complications such as infection, haemorrhages, embolisms, DVT, infectious diseases such as HIV, Hepatitis B and C, urinary track infections, seromas, haematomas, less postoperative pain, a quicker recovery and excellent aesthetic results. The traditional vaginal delivery with episiotomy is turned into a minimally invasive cosmetic procedure, which means substantial health, cost, and aesthetic benefits for the mother.

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10:30 am **A Cost Savings Analysis of Skin Closure Devices: Incorporating Opportunity Cost into Operating Time Efficiency**
ABHISHEK CHATTERJEE, MD

Objective: The surgeon's armamentarium of skin closure techniques is abundant. Our research aims to show the potential costs savings using 3M's Steri Strip S (3S) device when compared to sutures for skin closure. Our previous work has documented the time savings inherent in using this device for linear incisions (19.74 minutes for breast reductions and 11.6 min for abdominal cases). Our goal was to translate time savings into cost savings using two models: 1) the historical model is a strict analysis of variable (OR time costs) and fixed (material) cost, 2) the true cost model estimates the opportunity cost available and adds this to the costs of the historical model.

Materials and Methods: OR time costs per minute ($OR/min) were computed based on our hospital estimates. Direct material costs were based on purchase prices of 4-0 PDS and 3S. Historical cost was computed from the equation: (OR procedure closure time x $OR/min + device costs. In order to assess opportunity cost, the potential time saved in an average surgeon's full OR day by using 3S instead of sutures was estimated. This available time was then re-valued using the profit from an additional surgical procedure that could be performed in the time saved.

Results: Our hospital $OR/min is estimated to be $30. 4-0 PDS costs are $3.75 per suture and 3S costs are $14.82 per device. The average breast reduction used 6 sutures or 16 3S devices for the final layer of skin closure. Similarly, the average abdominal case used 2 sutures and 14 3S devices. When using 3S instead of 4-0 PDS, we noted time saved in the O.R. to be 19.74 and 11.6 minutes per breast reduction and abdominal case respectively. This resulted in historical costs savings of $377.58 and $148.02 per breast reduction and abdominal case respectively. By using profit margin data from carpal tunnel release (a procedure that could be performed during the time saved), we estimated an opportunity cost of $97.30 per minute. By incorporating the opportunity cost, the true cost savings by using 3S instead of 4-0 PDS was $2298.28 and $1276.70, per bilateral breast reduction and abdominal case respectively.

Conclusion: Given that there is a significant time savings in using 3S over suture closure in approximating the skin, we conclude that 3S allows for greater efficiency in operating time use that leads to potential cost savings. However, estimating the costs saved is dependent on additional procedures that the surgeon could perform in the time saved using 3S. Furthermore, while there appears to be cost savings in the historical model, there is a demonstration of greater cost savings if the opportunity cost is applied.

10:45 am **Silicone vs. Saline: Where are we Headed?**

ERIC J. NUVEEN, MD, DDS

In November of 2009, the FDA moratorium on the primary cosmetic use of silicone gel implants was lifted with high expectations of implant manufacturers and physicians. Often touted as a victory for freedom of choice, the expectations were for a dramatic increase in patient requests for silicone gel implants and physicians utilization. Often stated benefits of silicone gel implants were improved feel, less patient complaints of rippling, increased longevity, and many other anticipated advantages.

Now more than a year since market approval, a patient centered reevaluation of silicone and saline options is pertinent to clinical decision making and patient recommendations. Advantages and disadvantages of the current options for cosmetic breast enhancement will be discussed in detail using the latest available data to stimulate debate, fuel continued evaluation, and directly impact practice recommendations.

Notes

11:00 am **Cosmetic and Reconstructive Eyelash Transplantation**

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, 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.

Methods: The technique described requires the operating surgeon to have 2 assistants. 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.

DISSECTION: Surgical Tech #1: Extremely trim, single-follicle grafts are carefully dissected under high-powered magnification, leaving the hair length ~15+cm. Either 'reverse follicular extraction' (M. Gandelman) or careful trimming can be used to eliminate epithelium on the grafts. Follicles producing 'split' hairs are discarded. Surgical Tech #2: threads the hair shafts into French eye-needles (single or 'paired,' as desired), keeps grafts moist with normal saline on a cold surface.

RECIPIENT AREA (LID): Computerized injection (2% lido w/ 1:100,000 epi), starting with a wheal lateral to the lid, and then working superficially and medially across the lid. The local anesthetic is gently massaged toward lid margin slowly.

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 (~10 mm 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. Trimming lashes to 15mm length or less is recommended at this time

POST-OP SEQUELAE/RARE COMPLICATIONS/COMMON CONCERNS: Management of hordeolum (Sty), chalazion cyst, excessive tearing or dryness, trichiasis will be discussed.

Conclusion: Due to time constraints, it would be impossible to present all aspects of cosmetic and reconstructive eyelash transplantation in a lecture setting. 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. Surgeons who wish to offer eyelash transplantation to their patients should first perform the procedure under the tutelage of a mentor. The author encourages all physicians to obtain full informed consent from all patients who request eyelash transplantation, which includes the risks, benefits, alternatives, as well as the experience of the surgeon performing the procedure.

Notes

11:15 am **A Validated Lip Fullness Rating Scale**
COREY S. MAAS, MD

Objective: To develop the Lip Fullness Rating Scale for a reliable assessment compared to a pseudo 3-dimensional morphed scale of lip volume, and to establish the reliability of this photonumeric scale for clinical research and practice.

Methods: A 5-point photonumeric rating scale was developed to objectively quantify fullness of upper and lower lip separately. Nine experts rated photographs of 35 subjects, twice, separately for upper and lower lip. Inter and intra rater variability was assessed by computing intraclass correlation coefficients.

Results: The agreement between the experts is considerably high. Bubble plots demonstrate linearity in judgment by the experts.

Conclusions: The 5-point photoneumeric scale generated spans the fullness of upper and lower lip that seeks correction. The scale is well stratified with low intra and inter rater variability.

Merz aEsthetic Rejuvenation Zone scale development team: Derek Jones, MD, Berthold Rzany, MD, PhD, Joel Cohen, MD, Martina Kerscher, MD, PhD, Timothy Flynn, MD, Gerhard Sattler, MD.

The Merz team: Dr. Roman Goertelmeyer, Dr. Bhushan Hardas, Dr. Alexander Gebauer, Dr. Mandeep Kaur, Dr. Rainer Pooth, Ms. Kathy McClure and Ms. Ulli Simone-Korbel & Mr. Larry Buckner Canfield Scientific.

11:30 am **Orbital Superior Sulcus Volumetric Rejuvenation Utilizing Dermis Fat Graft**
CRAIG N. CZYZ, DO

Objective: Aging changes of the superior sulcus require unique considerations for rejuvenation with volume augmentation. The proximity of the superior sulcus to the globe and orbital structures presents challenges that are not replicated elsewhere in the face. Muscles of eye and lid movement, nerves, superior ophthalmic vein, and lacrimal gland pass in close proximity or directly within the superior sulcus. Disruption of these structures may result in a spectrum of complications from minor cosmetic alterations to vision threatening sequelae. This paper describes a method of dermis fat grafting for senescent changes of the orbital tissues, specifically those comprising the superior sulcus.

Methods: Patients with volumetric loss characterized as a sunken superior sulcus or hollow superior sulcus participated in this study and underwent aesthetic alteration of the superior sulcus with volume addition via a dermis fat graft. 5 patients underwent placement of a superior sulcus dermis fat graft, 4 unilateral and 1 bilateral. Photographs and margin reflex distance (MRD1) eyelid measurements

were obtained preoperatively and at follow up. Sulcus depth was graded pre and postoperatively on a 9-point Likert type scale (-4 to 4) by the surgeon and 3 masked, independent observers. Data was analyzed in SPSS software utilizing reliability analysis, nonparametric testing, and means comparison modules.

Results: The mean Likert type scale difference between preoperative and postoperative superior sulcus depth in the surgical eye group was 2.25 ($p < .000$), and 0.25 ($p < .102$) in the control eye group. Intraclass correlation (Inter-rater reliability) for sulcus depth rating was exceedingly reliable and statistically significant (.873, $p < .000$). Comparing the means of preoperative sulcus depth in surgical and control eye groups there was a difference of 2.58 ($p < .000$). Postoperatively the difference was 0.08 ($p < .942$). The mean difference between pre and postoperative MRD1 was 0.67 mm ($p < 0.387$) in the surgical eye group. The mean difference between the control eye group's pre and postoperative MRD1 was 0.50 mm ($p < 0.252$). There were no surgical or clinical complications resulting from the procedure.

Conclusions: The described method of dermis fat grafting may be utilized individually or added to other facial rejuvenation procedures to improve periorbital volume and cosmesis. Sulcus depth was improved in all patients with excellent symmetry in both unilateral and bilateral cases. Lid margin reflex distance (MRD1) was not altered by the placement of graft. The procedure described is effective in volume augmentation of the superior sulcus, has a high safety profile in a surgical area with numerous potential complications, and is reliable for producing symmetrical results in unilateral and bilateral cases.

Notes

11:45 am **Fractional CO-2 Laser Resurfacing vs. 1550 nm Fractional Resurfacing (Fraxel)**

SORIN EREMIA, MD

Objective: Ablative CO-2 laser is resurfacing's gold standard. But prolonged down time, risks, and permanent pigmentary changes, limit patient acceptance. Fractional resurfacing started a new era with the 1550-nm Fraxel laser. While downtime and risks were greatly reduced, and resurfacing of the neck chest and extremities became reality, results for facial rhytides remained unimpressive even after multiple treatments. Recently introduced fractional CO-2 lasers seek to balance downtime, risks, and results. We present and compare treatment results with a fractional CO-2 laser.

Methods: Results from 20 patients treated with a fractional CO-2 laser are compared to results obtained in comparable patients with the Fraxel-1550-nm laser. Four patients were treated prospectively side-by-side, a single fractional CO-2 laser treatment to 1 forearm and 4 Fraxel-1500 treatments to the other. Results for patients previously treated with Fraxel laser and retreated with fractional CO-2 are also discussed. We used a 30-watt, scanned 0.3mm spot, fractional CO-2 laser with widely variable fluence/dwell time and density. The operator can perform conservative or aggressive resurfacing. High fluences while increasing somewhat the 0.3mm tissue vaporization column depth, also generates significant thermal damage laterally, negating the benefits of small spot size. Likewise dense patterns will leave little untreated tissue, moving the operator from fractional resurfacing to fully ablative. While the ideal power settings/dwell time/density selection remains debatable, we selected fluence ranges 50-60 mj/cm-2 and 37-50% coverage on face, and 25-35 mj, 20%-37% coverage on neck/chest/arms. At these settings:

1) Patients can easily tolerate the facial procedure combining basic nerve blocks with topical anesthesia, and topical anesthesia alone for non-facial areas (treated at lower settings).
2) Patients have relatively easy recovery, without need for dressings or special care, and return to normal activities in 5-7 days. Recovery is comparable to severe sunburn, with edema for 2-3 days, followed by peeling revealing a deeper, more fragile pink layer of intact epidermis.

Results: 3-6 months results for a single fractional CO-2 treatment session of facial rhytides were clearly superior to results typically obtained with 4 Fraxel treatments. A single fractional CO-2 laser treatment of nonfacial areas was equal or superior to 4 Fraxel treatments, confirmed in the few patients treated in split forearm fashion. There were no complications with either laser. Pain during treatment of non facial areas was reported as equal or slightly higher with the fractional CO-2. Pain during CO-2 treatment of facial areas not covered by nerve blocks was perceived as

more severe than for treatment with the newer Fraxel 1500, probably comparable to the level of pain encountered with original Fraxel 750 model.

Conclusions: Fractional CO-2 laser resurfacing is an excellent new modality for patients willing to accept a relatively easy 5-7 day recovery. It can provide superior results to minimally ablative 1400-1550nm type lasers typified by the Fraxel-1500, which though have minimal downtime, require 4 separate sessions. It remains to be seen if the fractional CO-2 laser is as effective for acne scars and melasma type facial dyschromias, conditions for which we found Fraxel to excel.

12:00 pm **Sessions Adjourn**

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Website: www.profectmedical.com
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Booth #: 717

Contact: Dixie Sanford
Address: PO Box 382120
Duncanville, TX 75138
E-mail: gbond@qualityaspirators.com
Website: www.q-optics.com
Phone: 972.298.2669
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SANSTONE MEDICAL TECHNOLOGIES

Booth #'s: 805/807

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Fax: 205.290.4269

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Booth #: 101

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Website: www.sciton.com
Phone: 650.493.9155
Fax: 650.493.9146

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Booth#: 312

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E-mail: am@shippertmedical.com
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Booth #: 607

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Booth #: 708

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Phone: 888.471.4777
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Booth #: 803

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Coral Gables, FL 33134
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Website: www.stiefel.com
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Booth #: 308

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Website: www.surgiform.com
Phone: 866.225.5785
Fax: 803.462.1743

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Booth#: 301

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Phone: 734.996.9200
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Booth#: 707

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Phone: 949.716.6670
Fax: 949.716.6555

COSMETIC SURGERY FOUNDATION DONOR

THE AESTHETIC GUIDE

Booth#: 819

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Phone: 949.830.5409
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THE JOINT COMMISSION

Booth #: 404

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Booth #: 806

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Booth #: 413

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Booth #: 701

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Booth #: 401

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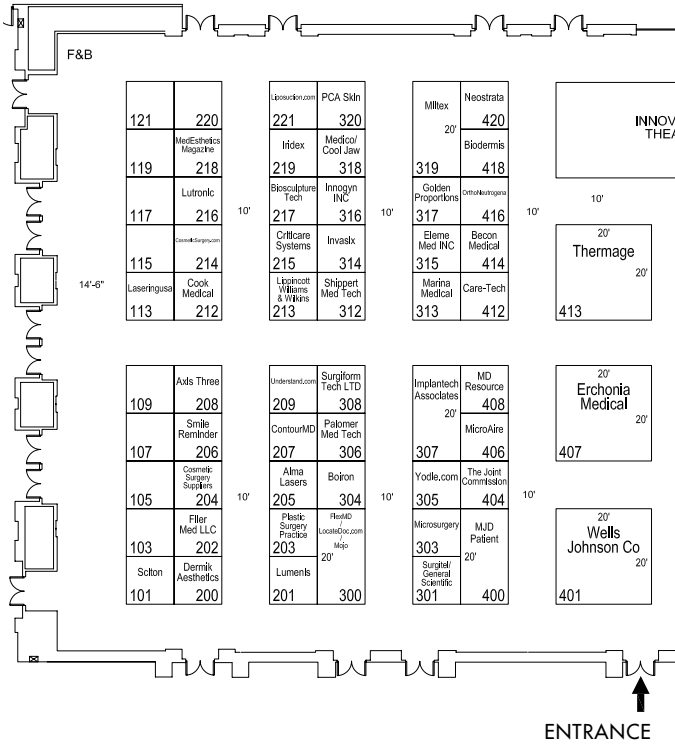

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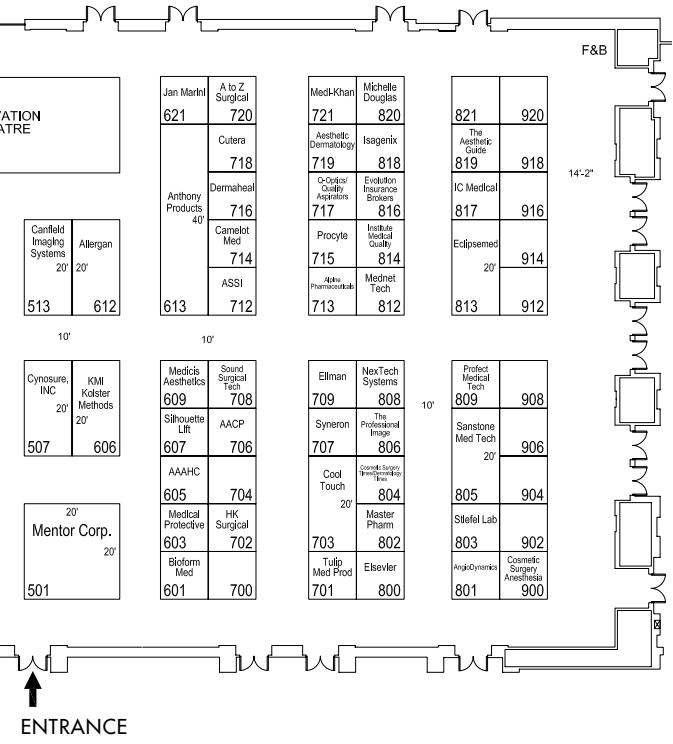

JANUARY 15-18, 2009

JW MARRIOTT DESERT RIDGE RESORT & SPA

PHOENIX, ARIZONA

FLOORPLAN

FACULTY DISCLOSURES

Type of Relationship		Nature of Compensation	
A	Advisory Board	EQ	Equipment
B	Board of Directors	G	Grants
C	Consultant	H	Honoraria
E	Employee	IP	Intellectual Property Rights
F	Founder	NC	No Compensation Received
I	Investigator	OB	Other Financial Benefit
O	Owner	R	Royalty
P	President	RE	Residency or Fellowship Program
SP	Speaker	S	Salary
SH	Stockholder	ST	Stock
T	Trainer	SO	Stock Options
U	Underwriter		

A

ROBERT W. ALEXANDER, MD, DMD
No financial relationship exist with commercial interest.

CARLOS AVELLANET, MD
No financial relationship exist with commercial interest.

B

ALAN J. BAUMAN, MD
No financial relationship exist with commercial interest.

WILLIAM H. BEESON, MD
No financial relationship exist with commercial interest.

MARK BERMAN, MD
SH – Surgiform (pocket protector); C – Medikaan (lipokit). Off label use and FDA 510(k) pending.

GUILLERMO BLUGERMAN, MD
R – A to Z Surgical Instruments; R – Miller Medical Instruments.

ROBIN BOGNER-NTOH, BS
No financial relationship exist with commercial interest.

SUSAN BROWNER
C – Patient Space LLC Strategic Edge Partners.

ROBERT H. BURKE, MD, DDS
T – Cynosure.

C

TRACY M. CAMPBELL, MD
No financial relationship exist with commercial interest.

ALBERT E. CARLOTTI, MD, DDS
No financial relationship exist with commercial interest.

PAUL J. CARNIOL, MD
No financial relationship exist with commercial interest.

ROBERT V. CATTANI, MD
No financial relationship exist with commercial interest.

ABHISHEK CHATTERJEE, MD
G – 3M.

NIKOLAS V. CHUGAY, DO
No financial relationship exist with commercial interest.

MARC S. COHEN, MD
SP & H – Allergan; Medicis.

ROBERT L. CUCIN, MD
ST – Biosculpture Technology, Inc. O – Biosculpture Technology, Inc.

ANGELO CUZALINA, MD, DDS
No financial relationship exist with commercial interest.
Off label use of Quill Sutures for Closures.

CRAIG N. CZYZ, DO
No financial relationship exist with commercial interest.

D

GABRIEL E. DE PENA, MD
No financial relationship exist with commercial interest.

DOUGLAS D. DEDO, MD
EQ - Zerona.

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VIPUL R. DEV, MD
No financial relationship exist with commercial interest.

ROBERT M. DRYDEN, MD
No financial relationship exist with commercial interest.

TITUS DUNCAN, MD
No financial relationship exist with commercial interest.

E

GERALD G. EDDS, MD
No financial relationship exist with commercial interest.

AYMAN EL-ATTAR, MD
No financial relationship exist with commercial interest.

JAMES L. ENGLISH, MD
No financial relationship exist with commercial interest.

SORIN EREMIA, MD
No financial relationship exist with commercial interest.

F

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CLAYTON FRENZEL, DO
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WILLIAM R. FULTON, DO
No financial relationship exist with commercial interest.

G

JOSE ANTONIO GARCIA, MD
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JIM E. GILMORE, MD
No financial relationship exist with commercial interest.

DEE ANNA GLASER, MD
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H

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TROY R. HAILPARN, MD
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C. WILLIAM HANKE, MD
No financial relationship exist with commercial interest.

DAVID A. HENDRICK, MD
No financial relationship exist with commercial interest.

ARTURO HENRIQUEZ, MD
No financial relationship exist with commercial interest.

DUSTIN M. HERINGER, MD
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JONATHAN HOENIG, MD
No financial relationship exist with commercial interest.

STEVEN B. HOPPING, MD
No financial relationship exist with commercial interest.

SUSAN M. HUGHES, MD
No financial relationship exist with commercial interest.

CATHERINE J. HWANG, MD
No financial relationship exist with commercial interest.

J

ROBERT F. JACKSON, MD
No financial relationship exist with commercial interest.

K

JEREMY KAMPP, MD
No financial relationship exist with commercial interest.

JEFFREY A. KLEIN, MD
O – HK Surgical; O – Liposuction.com; O – Liposuction101.com

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No financial relationship exist with commercial interest.

L

LARRY LABER
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EDWARD B. LACK, MD
SP – Cynosure; H – Cynosure. Off label use of phosphatidyl choline for lipodissolve.

BEATRICE LAFARGE, MD
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GUSTAVO LEIBASCHOFF, MD
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M

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C – Merz Pharmaceuticals.

E. ANTONIO MANGUBAT, MD
R – KMI.

DAVID L. MATLOCK, MD
P – Laser Vaginal Rejuvenation Institute, Medical Associates, Inc.

PATRICK G. MCMENAMIN, MD
No financial relationship exist with commercial interest.

J. DAN METCALF, MD
No financial relationship exist with commercial interest.

GARY D. MONHEIT, MD
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N

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O

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ANGELA O'MARA
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IVANHOE ORTEGA, MD
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P

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JONATHAN PATTERSON, MD
No financial relationship exist with commercial interest.

MARCO A. PELOSI II, MD
No financial relationship exist with commercial interest.

MARCO A. PELOSI III, MD
No financial relationship exist with commercial interest.

CURTIS J PERRY, MD
No financial relationship exist with commercial interest.

JANE A. PETRO, MD
No financial relationship exist with commercial interest.

AMIYA PRASAD, MD
No financial relationship exist with commercial interest.

DAVE PULLEY, MD
U – Evolution Insurance Brokers.

R

SAMIEH RIZK, MD
No financial relationship exist with commercial interest.

ANTHONY ROGERS, MD
No financial relationship exist with commercial interest.

BRENT R. ROSEN, DO
No financial relationship exist with commercial interest.

S

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No financial relationship exist with commercial interest.

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I – Merz; I – Allergan; I – Storz; SP – Qmed; H – Merz, Allergan, Qmed & Merz.

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No financial relationship exist with commercial interest.

JEFFERY SEGAL, MD
O – Medical Justice Services, Inc.

EVA SHEIE
E – Strategic Edge Partners.

MAURICE P. SHERMAN, MD
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ROBERT A. SHUMWAY, MD
No financial relationship exist with commercial interest.

ROBERT L. SIMONS, MD
No financial relationship exist with commercial interest.

CHRIS SKOUTERIS, DMD, PHD
No financial relationship exist with commercial interest.

LANE F. SMITH, MD
No financial relationship exist with commercial interest.

THEODORE E. STAAHL, MD
No financial relationship exist with commercial interest.

RONALD W. STRAHAN, MD
No financial relationship exist with commercial interest.

NANCY G. SWARTZ, MD
SP & H – Allergan; Medicis.

T

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No financial relationship exist with commercial interest.

KEIKO TAKASU, MD
No financial relationship exist with commercial interest.

MOHSEN TAVOUSSI, MD, DO
No financial relationship exist with commercial interest.

U

FERNANDO URRUTIA, MD
No financial relationship exist with commercial interest.

V

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H – Thermage.

W

JEREMY B. WHITE, MD
No financial relationship exist with commercial interest.

Z

EDWARD M. ZIMMERMAN, MD
SP – Cool-Touch; SP – Global Medical Technologies/ Innogyn; SP – Alma Lasers.

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